Dear Ms. Bianco,

The purpose of this communication is first to thank EOHHS for allowing comments on this important issue regarding Out of Network Commercial Payments for emergency and non-emergency healthcare services. We also appreciate the Listening Sessions that were provided so that the stakeholder's voices are heard regarding this topic . It is of great importance that the Provider's voice is heard and how the proposal of implementing a default rate of 135% of Medicare would have devasting downstream impacts both financially and administratively. With this said, we are strongly opposed to the default rate of 135% of Medicare for these services.

Protecting the patient from surprise billing is essential and it is critical to have the right mechanisms in place in order to address this issue. As this topic is discussed and vetted, it is of critical importance to have alignment among stakeholders, that the delivery of high quality health care services surpasses administrative issues. As such, administrative issues are resolved via solid working relationships and collaboration among Payers-Providers. This has been the established framework that although at times can be resource intensive, the administrative issues are ultimately worked through and resolved among the parties, leaving the patient/consumer protected and held harmless. It is our belief, that the following salient points be considered when addressing the out of network topic.

The preservation of the role of confidential negotiations between the Payer-Provider to negotiate appropriate payment rates is essential to the overarching and aggregate cost structures of services delivered within a market or geographic region. This allows for an even playing field and requires incentives for Both Payer and Provider to come to agreement on rates. As opposed to a default rate; which provides zero incentive for a Payer to negotiate and establishes an unfair course of doing business that completely erodes an equitable and reasonable negotiation process. Rate setting has been proven not to work and has significant unintended consequences by allowing the Payer to reimburse at non sustainable, low out of network rates, which ultimately drive providers to bankruptcy. This has already been demonstrated with many community hospital closures in the State as well as forced closures of various Emergency Departments in various communities.

Protection for the patient to have access and coverage for emergency care within their communities. Establish and enforce network adequacy standards and restrict plans from selling products that do not provide sufficient access to ALL types of care. This is unfortunately seen in "closed networks" and "narrow networks" that ultimately impact the patient by limiting their choice.

Provide education to patients to understand their health plan benefits, prior to their selection of a product. Many times the patient/consumer does not understand or know their benefits under their health insurance product that they have purchased. Health Plans provide multiple product offerings with hard to understand benefit design language that the patient/consumer needs to interpret. It is important for the Health Plan to provide clear and meaningful language to the patient/consumer. Given the multiple product offerings with multiple benefit designs, it is therefore not possible for the Provider to know what is included within a patient's insurance product and therefore places the Provider in an disadvantaged position with the patient. The Provider should not be held liable to try to explain a patient's benefit coverage especially given how difficult the health plan benefit language is to interpret; thus the author of the language, in this case, the Health plan needs to provide this information directly to the patient/consumer.

Illustrate and ensure adequate provider networks and health plan transparency regarding which providers are in and which providers are out of networks. This is a dynamic issue for all stakeholder, the Patient, the Provider and the Payer. The health care industry has shown over the last decades that Payers change product designs and coverages, consumers change insurance products, many times annually, Providers move to other areas in the country. This state of change which is already complex and difficult to manage would be compounded by rate setting of this service category. It is already very difficult to attract certain specialties to economically challenged communities, rural areas, geographically isolated hospitals such as ours. As such, in order to provide patient access to services and have health care services available within the community, the hospital often must subsidize hospital based physicians salaries. Establishing artificially low rates for these physicians will shift costs to the hospital, endangering the services the hospital is able to provide and clearly would make it more difficult to attract providers to practice in the market.

Sustainability and alignment for a stable health care system. The health care consumer in Massachusetts relies on their health care providers of hospitals and physicians of all specialties to be available when needed. By implementing an artificially low rate for reimbursement would frankly destabilize the provision of health care services to patients. During the EOHHS Listening Session, the Health Plan Representative advocating for the 135% of Medicare default reimbursement, also stated that there needs to be *"reasonable reimbursement"*! The Rand study illustrated that even at 250% Medicare would not be sufficient nor stable reimbursement, thus the fact of the matter is that the way to achieve reasonable reimbursement is through a private negotiation process when all factors and variables for each party can be considered among the parties and the process is within a level playing field. Stability will be achieved when negotiations are fair and equitable.

Allow for the Federal law – No Surprises Act to be implemented. The patient is of utmost concern and must be protected. Patients expect and demand that their hospital and providers to be available to them whenever needed 24/7 365 days year. A such, hospitals need to remain viable and financially stable in order to support the on-going health care needs within the community. Implementing an artificially low default rate of 135% of Medicare is not the solution and for the aforementioned points, it is our opinion that Massachusetts should allow the Federal No Surprise Act to be implemented and evaluated before any actions or steps to be taken in our State. The federal No Surprise Act was vetted for two (2) years and ultimately achieved bi-partisan support. It includes a binding Independent Dispute Resolution (IDR) process. In the event payment disputes between Payer and Provider occur, the legislation created a framework for Providers and Insurers to resolve payment disputes first through negotiation and, if that fails, by using the IDR process. This is the best course of action that allows for the greatest protection to the patient.

Thank you again for allowing comments on this topic.

Sincerely,
Bretta M. Karp
Managed Care Contracting Officer
Berkshire Health Systems, Inc.
725 North Street, Pittsfield MA. 01201
Tel: (413) 822-4153
E-mail: bkarp@bhs1.org