



August 21, 2019

VIA EMAIL

Richard Whitley, Director
Nevada Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, Nevada 89706-2009
rwhitley@dhhs.nv.gov

RE: Rule-Making for Assembly Bill 469

Dear Director Whitley:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn. The current law has several issues we feel could hamper

We are writing you to request the department strengthen the Prudent Layperson (PLP) Standard referenced in Assembly Bill (AB) 469 to comply with federal law¹. Our concern is that the PLP standard in AB 469 and state law² do not comply with the federal standard because it fails to reference "including severe pain." Severe pain is an important factor that would compel a prudent layperson to seek emergency care. The definition of "medically necessary emergency services" referenced in the bill weakens the federal standard and the department should stipulate in rule-making that the new law must comply with federal law. By referencing federal law, the department protects patients from problematic policies implemented by insurers that reference diagnosis lists and algorithms to dilute, deny, and delay emergency care. Recently, other states addressed this issue. Maine recently passed a comprehensive law that strengthens the PLP standard and codifies it into state law. We recommend Nevada adopt this language to solidify patient protections for emergency care (**Maine PLP Law**).

Patients should not be put in a position where they are expected to self-diagnose themselves and determine whether or not an emergency condition exists before being seen by a medical professional. Patients may put their health in jeopardy by avoiding or

¹ 42 CFR § 438.114 - Emergency and post stabilization services.

² NRS 695G.170.

delaying emergency care if they are concerned that an emergency visit may not be covered by their health insurance. Even health professionals are frequently unable to determine if an emergency condition exists until after a thorough history, exam and diagnostic evaluation has been completed. As such, CMS has previously stated that the “final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis.”

In 1997, the federal government implemented the prudent layperson (PLP) standard. In 2010, the federal PLP standard was extended to commercial plans. Recently, in 2016, the federal PLP standard was described in the **Medicaid Managed Care Rule** which states that “[t]he final determination of coverage **and payment** [of emergency claims] must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens” (emphasis added).

Last year, in a March 15, 2018, **letter** to EDPMA, CMS Administrator Seema Verma reiterated that “[w]henver a payer (whether an MCO or a State [plan]) denies coverage **or modifies a claim for payment**, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)” (emphasis added).

Additionally, we have serious concerns with provisions in AB 469 related to out-of-network (OON) provider reimbursement being tied to the number of months spent under contract and who terminated the contract. Insurers are not incentivized to contract with emergency physicians because emergency physicians must treat every patient regardless of the patient’s ability to pay as a result of EMTALA³ obligations. Insurers take advantage of this federal mandate by manipulating in-network rates to offer emergency providers “take it or leave” rates or implement harmful policies that limit emergency care. This lopsided market dynamic created by insurers put patients at risk and drive emergency provider reimbursement to dangerously low levels.

To prevent this from occurring, we request the department adopt specific rules on what constitutes contract termination with cause. If the either the provider or insurer fails to perform any contractual term and there is a breach of the contract, then that would be considered to be “cause”. In addition, any material change in the terms of the contract that is not acceptable to either party should also be considered “cause”. This would include new policies implemented by a health plan that could reduce reimbursement, increase administrative burden, or pass the cost of care to the emergency department.

³ 42 U.S. Code § 1395dd. Examination and treatment for emergency medical conditions and women in labor.

By allowing Nevada emergency providers unfettered access to arbitration, insurers will be incentivized to negotiate reasonable reimbursement rates to avoid costly arbitration. Fortunately, AB 469 allows an avenue for an emergency provider to utilize arbitration. However, a significant drawback to arbitration is that the cost of arbitration often exceeds the amount in dispute. Therefore, rules must be implemented by the department to ensure plans are not able to skim a small amount from a large number of small emergency claims. Fortunately, New York has a framework for these small claims which has been working well and has the added benefit of creating an incentive for physicians to keep charges below two thresholds.

This NY standard for small and reasonable emergency claims has proven successful. It not only encourages plans to pay the usual and customary rate for smaller emergency claims, it encourages physicians to charge below both the monetary and reasonableness thresholds and significantly reduces the need for arbitration. The consensus is that NY-style arbitration has worked for all stakeholders: patients, insurers, and providers (see studies from the NY Department of Finance and Georgetown: <https://nyshealthfoundation.org/wp-content/uploads/2019/02/new-yorks-efforts-to-reform-surprise-medical-billing.pdf> and <https://georgetown.app.box.com/s/6onkjljaiy3f1618iy7j0gpzdoew2zu9>). Very few emergency claims have needed arbitration. Further, after the NY law was adopted, the increase in premiums in New York stayed below the national average and the increase in physician charges has not exceeded inflation.

Additionally, we request a clarification on the notification provisions found in AB 469 related to transferring patients. Rules must be adopted to ensure that the insurer is responsible for the costs associated with transferring a patient and such responsibilities do not fall on the emergency providers or emergency department. As written, the law obligated facilities to transfer patients after notification that the patient “has stabilized to such a degree that the person may be transferred to an in-network emergency facility not later than 24 hours after the person’s emergency medical condition is stabilized. Not later than 24 hours after the third party receives such notice, the third party shall arrange for the transfer of the person to such a facility.”

Federal EMTALA law obligates hospitals participating in Medicare, and emergency physicians as their agents, to assess patients for an “emergency medical conditions” (EMC) and to provide stabilizing care once an EMC is determined. EMTALA also mandates that patients must be “stable for discharge or transfer” before they are in fact transferred to another hospital. The department, through state regulations, should make clear that the notification and transfer obligations under state law shall be consistent with EMTALA and that hospitals and physicians who do not comply with state law transfer requirements be held harmless, if the hospital or physicians believe that the patient is not stable for transfer under EMTALA.

Emergency departments are the nation’s health safety net. Even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients. They contribute far more than their share of uncompensated and undercompensated care. It is important to remember, if emergency providers are not adequately reimbursed by commercial insurers, fewer emergency

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physicians will be available in the emergency department; time-sensitive access to emergency care will be delayed as lines for emergency care grow; and some emergency departments in rural and vulnerable neighborhoods in Nevada could be in danger of closing down.

We urge the department to implement rules that strengthen the PLP standard, specify what constitutes contractual termination with cause, clarify patient transfers as they pertain to EMTALA, and adopt an arbitration framework that resembles the successful process used in New York. By addressing our concerns in the rule making process, the department will be implementing a new law that truly protects the patient. Thank you for considering our comments. If you have any questions, please do not hesitate to contact Elizabeth Munding, Executive Director of EDPMA, at emunding@edpma.org.

Sincerely,



Bing Pao, MD, FACEP, Chair of the Board
Emergency Department Practice Management Association (EDPMA)



John D. Anderson, MD, FACEP
President, Nevada ACEP

CC: Dena Schmidt, Administer, Nevada Department of Health and Human Services
Barbara Richardson, Nevada Insurance Commissioner

Niki Thomson

From: Catherine O'Mara <catherine@nvdoctors.org>
Sent: Friday, December 20, 2019 12:58 PM
To: Carrie L. Embree
Cc: Jessica Ferrato; Jaron Hildebrand; Michael Willden
Subject: AB469 Regulations
Attachments: AB 469 DRAFT Regulations revised 12-09-19 ce (2) jlw edits.docx

Dear Carrie:

Thank you for all the work you are doing to develop the regulations on AB469. We know this is a major undertaking and we appreciate your willingness to work with us to ensure that the regulations are workable.

With the holidays coming up there may be some staff out of the office so I wanted to follow up with you today about where we are with the regulations/guidance on AB469. As we get closer to January 1, our doctors and their billing staff are getting very concerned about how to implement and operationalize AB469.

Can you tell us what is the status of emergency regulations or guidance? When should we expect to see those?

We are committed to working through the process as permanent regs are developed and adopted. In the meantime, however, we need to be able to tell our doctors how to prepare for January 1. To that end, we agree with the revisions proposed in the attached document drafted by Jim Wadhams and shared with us yesterday. I believe you have received these. NSMA and our physician colleagues strongly encourage you to adopt these into the emergency regulations and get them out as soon as possible.

Please let us know if you need any more information from us and if you have any information or recommendations that we can share with our physicians.

Again, thank you for your work on this very important regulation.

Sincerely,
Cat

Catherine M. O'Mara, JD
Executive Director
Nevada State Medical Association
(775) 825-6788 (o)
(775) 742-6770 (c)

STEVE SISOLAK
Governor



RICHARD WHITLEY, MS
Director

CARRIE EMBREE, LSW
Governor's Consumer Health Advocate

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CONSUMER HEALTH ASSISTANCE

Governor's Consumer Health Advocate

Bureau for Hospital Patients

555 E. Washington, Suite 4800 | Las Vegas, NV 89101

Telephone (702) 486-3587 Toll Free (888) 333-1597

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December 9, 2019

Revised Draft of Permanent Regulations Regarding AB 469, NRS 439

LCB File No. R101-19

AB 469

Notice

1. Notification by electronic or telephonic means to the point of contact registered on the Department's website or last accepted by the third party for billing questions shall be deemed proper notice under Section 14(2)(a) of AB 469.
2. Maintenance of regular business records showing notification was given shall be deemed proof of receipt.

Sec. 17:

Submission, contents and review of requests for arbitration for claims of less than \$5,000 for medically necessary emergency services.

1. An out-of-network provider requesting arbitration for claims of medically necessary emergency services must submit an application in the format specified in this section.
2. The request must be submitted to the Department within 30 business days from the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17.3.
3. The Department will not accept applications requesting arbitration past 30 business days from the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17. 3. and payment received will be considered payment in full.
4. An application requesting arbitration must be on the prescribed form by the Department and include the following information:
 - (a) Out-of-network provider contact information and location.
 - (b) Date of medically necessary emergency service(s).

- (c) Type of medically necessary emergency service(s) provided.
- (d) Type of provider of health care.
- (e) Specialty of provider of health care.
- (f) Third party contact information.
- (g) Type of third party.
- (h) Documentation of:
 - a. Date out-of-network provider received payment by the third party.
 - b. Amount of payment received.
 - c. Date out-of-network provider requested additional amount to be paid by the third party.
 - d. Additional amount requested by out-of-network provider.
 - e. ~~A representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same region, from health plans in which the provider does not participate.~~
- 5. Within 5 business days after receipt of the application, the Department shall notify the out-of-network provider in writing of receipt of the application.
- 6. Within 15 business days after receipt of the application, the Department shall:
 - (a) Review the application and verify the information contained within; and
 - (b) Notify the out-of-network provider in writing if any section of the application is incomplete and/or request any additional information.
- 7. Within 5 business days of application approval, the Department shall provide in writing a list of 5 qualified State employees to complete the arbitration to the out-of-network provider and third party.

List of arbitrators, information requested by the arbitrator.

- 1. Within 10 business days from receipt of the list of arbitrators, the out-of-network provider and third party must select an arbitrator based on AB 469, Sec. 17. 4. and submit their selections in writing to the Department.
- 2. Within 5 business days after receiving the list of arbitrators from both the out-of-network provider and third party, the Department shall:
 - (a) If more than one arbitrator remains, randomly select an arbitrator from the remaining arbitrators on the list pursuant to AB 469, Sec 17. 4.
 - (b) Notify, in writing, the out-of-network provider and third party the name of the selected arbitrator.
- 3. The out-of-network provider and third party have 10 business days to submit in writing any relevant information ~~requested by the arbitrator~~ it deems relevant to support its position and to assist the arbitrator in making a determination.
- 4. Within 30 business days of receipt of requested information, the arbitrator will notify the out-of-network provider and third party of the decision as outlined in AB 469, Sec 17. 6.
- 5. If an out-of-network provider fails to provide information ~~requested by the arbitrator~~, the arbitrator may review the evidence and proceed to consider the matter and dispose of it on the basis of the evidence before the arbitrator.
- 6. If the third party fails to provide information requested by the arbitrator, the arbitrator may review the evidence and proceed to consider the matter on the basis of the evidence before the arbitrator and may require the third party to pay the requested additional amount by the out-of-network provider.

Request for arbitration for claims of \$5,000 or more for medically necessary emergency services.

For claims of \$5,000 or more, the out-of-network provider and third party are required to use the American Arbitration Association, JAMS or their successor organizations.

Sec. 18. 1.

Third party Election.

1. A third party that is not otherwise subject to the provisions of sections 2 to 19 inclusive of AB 469 may choose at any time to make an election to participate in the provisions of AB 469 must submit an application in the format specified in this section to the Department.
2. An application of election must be on the form prescribed by the Department and include the following information:
 - (a) The name of the third party.
 - (b) Third party contact information.
 - (c) The type of third party.
 - (d) The date the election goes into effect.
3. A third party not otherwise subject to the provisions of sections 2 to 19 inclusive of AB 469 that made an election to participate in AB 469 may choose anytime to withdraw the election, must submit an application in the format specified in this section to the Department a minimum of ~~30~~ 180 days prior to the effective date of such withdrawal.
4. An application for withdrawal of election must be on the form prescribed by the Department and include the following:
 - (a) The name of the third party.
 - (b) Third party contact information.
 - (c) The type of third party.
 - (d) The date the withdrawal goes into effect.
 - (e) The reason for withdrawal of election.

Reporting.

AB 469, Sec. 19. 2. (a) (b)

1. On or before December 31st of each year, a third party shall report requested information for the immediately preceding 12 months on the form prescribed by the Department and include the following:
 - (a) The name of the third party.
 - (b) Third party contact information.
 - (c) The type of third party.
 - (d) The number of disputed payments by out-of-network providers for medically necessary emergency services that were settled without arbitration.
 - (e) Types of provider of health care that settled disputed payments.
 - ~~(f) Amounts of settled payments.~~
 - ~~(g)~~(f) Number of new contracts with providers of health care that provide medically necessary emergency services.
 - ~~(h)~~(g) Types of provider of health care that entered into new contracts.
 - ~~(i)~~(h) Number of terminated contracts with providers of health care that provide medically necessary emergency services.
 - ~~(j)~~(i) Reasons for terminated contracts with providers of health care that provide medically necessary emergency services.

Niki Thomson

From: James L. Wadhams <jlwadhams@blacklobello.law>
Sent: Wednesday, January 15, 2020 4:35 PM
To: Carrie L. Embree; Charles E. Quintana
Cc: Bill Welch
Subject: FW: Letter to Carrie Embree (NV Hosp. Assn.)
Attachments: 2020.01.15 CR JLW to Embree.pdf; R101-19P in Word with JLW edits.docx

Carrie and Charles,

Our comments on behalf of the Nevada Hospital Association have been transposed to reflect the new LCB draft.

Jim

TISHA R. BLACK
MICHELE T. LOBELLO
JOHN D. JONES



Nevada Strong™

Celebrating 20 years in 2020

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January 15, 2020

Sent via email: clembrree@adsd.nv.gov

Ms. Carrie L. Embree, LSW
Governor's Consumer Health Advocate
Nevada Department of Health & Human Services
Aging and Disability Services Division
3416 Goni Road, Suite D-132
Carson City, NV 89707

Dear Carrie:

On behalf of the Nevada Hospital Association, we offer the following comments on the LCB version of the proposed regulation. We are also attaching a redlined version for your reference.

Revision: Modify Section 2 of the proposed regulation by modifying subsection 2 thereof as follows:

2. A request submitted pursuant to subsection 1 must be in the confidential form prescribed by the Department and include, without limitation:

And delete subsection 2(e)(3) of Section 2 entirely.

Rationale:

We add "confidential" to the request to secure the required privacy protections for the parties found in NRS 439B.754(10), NRS 439B.760(4) and NRS 239.010(1).

Subsection 2(e)(3) of Section 2 of the regulation is unrelated to the "authorization of arbitrators" and should be deleted.

NRS 439B.754 specifically limits the agency's authority in adopting regulations to the identification of arbitrators (*See* subsections 3(a) and (b) for small and large claims). There is no authority in AB469 for the arbitrator to require any information from either party. NRS 439B.754

(6)(a) and (b) Act make it clear that the payer's offer and the provider's counteroffer are the jurisdictional basis for the arbitration.

Revision: Modify subsection 3 of Section 3 of the proposed regulation as follows:

An arbitrator selected pursuant to subsection 2 shall notify the third party and the out-of-network provider that each of them may provide any information the party deems necessary to assist the arbitrator in making a determination. The out-of-network provider and third party shall provide such information to the arbitrator not later than 10 days after receiving the notice. If either party fails to provide information requested by the arbitrator within that time, the arbitrator may proceed and make a determination based on the evidence available to the arbitrator.

Rationale:

As noted above, NRS 439B.754 does not authorize the arbitrator to request any information from the parties. It is the parties themselves that are authorized to tender any information they determine helpful to the arbitrator. These alterations conform to NRS 439B.754.

NRS 439B.754(5) gives the power to the disputants that they "may provide the arbitrator any relevant information to assist the arbitrator to assist in making a determination." The Act makes submission of "relevant information" a right of each party to the arbitration but not an obligation. The Act does not give the arbitrator any power to impose such a requirement.

The arbitrator is required to pick either the offer of the payer or the counteroffer of the provider. (See NRS 439B.754(6)(a) and (b)). The failure of a party to submit supporting information increases the likelihood that the arbitrator would pick the supported position.

Revision: Modify subsection 1(a) of Section 5 of the Proposed Regulation to add the following language:

The name of and contact information of the entity or organization at which it may contemporaneously confirm contact at all times.

Revision: Modify subsection 2 of Section 5 of the Proposed Regulation to require 180 days for a notice of withdrawal to be effective.

Rationale:

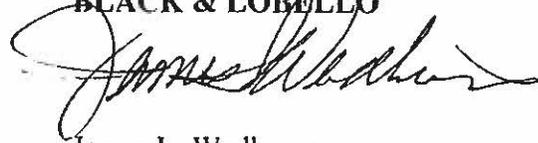
Accessibility to health care is critical to protect the patient. The Proposed Regulations propose both opt in and opt out provisions under Section 5, therefore we suggest that the regulation mandate a point of contact, either telephonic or electronic, that will accept notices 24 hours a day seven days a week or at least contemporaneous confirmation of receipt of the notices provided for in NRS 439B.745. This will provide timely ability for both providers and third parties to address care for the patient.

We also renew our suggestion that for the benefit of the consumer, that the minimum notice for opting out be at least 180 days (preferably 365) The health care consumer is the intended beneficiary of the AB469 protections – adequate notice of their payer’s participation ensures such consumer protection.

Finally, we suggest that since the legislature, NRS 439B.754(10), has declared all of the documents submitted to the arbitrator to be confidential that the regulations indicate that the forms requesting arbitration are “Confidential” and the form on the website be marked as confidential.

Thanks for taking the time to work with us on these regulations and we look forward to continuing this collaborative discussion as the regulatory process continues.

Respectfully,
BLACK & LOBELLO

A handwritten signature in black ink, appearing to read "James L. Wadhams", written over the firm name.

James L. Wadhams

JLW/jh

**PROPOSED REGULATION OF THE
DIRECTOR OF THE DEPARTMENT
OF HEALTH AND HUMAN SERVICES**

LCB File No. R101-19

January 6, 2020

EXPLANATION – Matter in *italics* is new; matter in brackets ~~omitted material~~ is material to be omitted.

AUTHORITY: §§1-4, NRS 439B.754; §5, NRS 439B.757; §6, NRS 439B.760.

A REGULATION relating to health care; prescribing requirements concerning the arbitration of certain disputes over payment for medically necessary emergency services; prescribing the manner by which certain entities may become subject to provisions of law regarding the resolution of such disputes; requiring the reporting of certain information concerning payment for medically necessary emergency services; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

Existing law requires a third-party insurer and an out-of-network provider of health care that have a dispute regarding the payment for medically necessary emergency services rendered to a covered person to participate in arbitration to resolve the dispute. If such a dispute arises, existing law requires the out-of-network provider to request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department of Health and Human Services to provide such arbitrators. (NRS 439B.754) For a dispute over a claim of less than \$5,000, **section 2** of this regulation requires the request to be submitted to the Department. **Section 2** also: (1) prescribes the required contents of the request; (2) provides for the review and approval of the request by the Department; and (3) requires the Department to provide the out-of-network provider and third party with a written list of five randomly selected employees of the State who are qualified to arbitrate the dispute. **Section 3** of this regulation provides for the selection of an arbitrator and prescribes the procedure for the arbitration. For a dispute about a claim in the amount of \$5,000 or more, **section 4** of this regulation requires the out-of-network provider to request a list of five randomly selected arbitrators from the American Arbitration Association or JAMS.

Existing law authorizes an entity or organization not otherwise subject to provisions of law governing the resolution of disputes between a third-party insurer and an out-of-network provider of health care over payment for medically necessary emergency services to elect to have those provisions to apply to the entity or organization. Existing law requires the Director to adopt

regulations governing such an election. (NRS 439B.757) **Section 5** of this regulation prescribes the procedure for making and withdrawing such an election.

Existing law requires the Department to compile a report which consists of certain information concerning the resolution of disputes regarding the payment of medically necessary emergency services. Existing law requires a provider of health care or third party to provide to the Department any information requested by the Department to complete that report. (NRS 439B.760) **Section 6** of this regulation requires a third party that provides coverage to residents of this State to annually submit to the Department certain information for the purpose of compiling that report.

Section 1. Chapter 439 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

Sec. 2. *1. To request a list of randomly selected arbitrators pursuant to subsection 3 of NRS 439B.754 to arbitrate a dispute over a claim of less than \$5,000, an out-of-network provider must submit a request to the Department. If the out-of-network provider submits the request because the third party has refused or failed to pay the additional amount requested by the out-of-network-provider pursuant to subsection 2 of NRS 439B.754, the out-of-network provider must submit the request by:*

(a) If the third party refused to pay the additional amount, not later than 30 business days after the date on which the third party notifies the out-of-network provider of the refusal.

(b) If the third party failed to pay the additional amount for 30 calendar days after receiving a request for the additional amount, not later than 30 business days after that date.

2. A request submitted pursuant to subsection 1 must be in the confidential form prescribed by the Department and include, without limitation:

(a) The date on which the medically necessary emergency services to which the complaint pertains were provided and the type of medically necessary emergency services provided;

(b) The contact information for and location of the out-of-network provider that provided the medically necessary emergency services;

(c) The type and specialty of each health care practitioner who provided the medically necessary emergency services;

(d) The type of third party that provides coverage for the covered person to whom the medically necessary emergency medical services were rendered and contact information for that third party; and

(e) Documentation of:

(1) The date on which the out-of-network provider received payment from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, and the amount of payment received;

(2) The date on which the out-of-network provider requested additional payment from the third party pursuant to subsection 2 of NRS 439B.754, and the additional amount requested; and

~~*(3) A representative sample of at least three payments received by the out-of-network provider as compensation for the same medically necessary emergency services provided in the same region of this State from third parties with which the out-of-network provider has not entered into a provider contract.*~~

3. If the Department does not receive a request pursuant to subsection 1 within the prescribed time, the out-of-network provider shall be deemed to have accepted the payment received from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the medically necessary emergency services.

4. *Not later than 5 days after receiving a request pursuant to subsection 1, the Department shall notify the out-of-network provider in writing of the receipt of the request.*

Not later than 15 days after receiving the request, the Department shall:

(a) Review the request and verify ~~the information contained therein~~ it is complete; and

(b) Notify the out-of-network provider in writing of any additional information necessary to complete or clarify the request.

5. *The Department will approve a request not later than 5 days after determining that the request is complete and clear. Not later than 5 days after approving a request, the Department shall:*

(a) Notify the out-of-network provider and the third party in writing of the approval; and

(b) Provide the out-of-network provider and third party with a written list of five randomly selected employees of the Office for Consumer Health Assistance of the Department who are qualified to arbitrate the dispute.

Sec. 3. 1. *Not later than 10 days after receiving a list of arbitrators pursuant to subsection 5 of section 2 of this regulation, the out-of-network provider and third party shall strike arbitrators from the list in the manner required by subsection 4 of NRS 439B.754 and provide the name or names of any remaining arbitrator on the list in writing to the Department.*

2. *Not later than 5 business days after receiving the name of any remaining arbitrator on the list pursuant to subsection 1, the Department shall:*

(a) If one arbitrator remains, notify the out-of-network provider and the third party in writing of the name of that arbitrator.

(b) If more than one arbitrator remains, randomly select an arbitrator from the remaining arbitrators as required by subsection 4 of NRS 439B.754 and notify the out-of-network provider and the third party in writing of the name of that arbitrator.

3. An arbitrator selected pursuant to subsection 2 shall ~~request from~~ notify the third party and the out-of-network provider that each of them may provide any information the ~~arbitrator~~ party or the provider deems necessary to assist the arbitrator in making a determination. The out-of-network provider and third party shall provide such information to the arbitrator not later than 10 days after receiving the ~~request~~ notice. If either party fails to provide information requested by the arbitrator within that time, the arbitrator may proceed and make a determination based on the evidence available to the arbitrator.

4. Not later than 30 days after receiving information pursuant to subsection 3 or, if the information is not provided, not later than 30 days after the expiration of the period for submission of the information, as applicable, the arbitrator shall make a determination as provided in subsection 6 of NRS 439B.754 and notify the parties of that determination.

Sec. 4. *An out-of-network provider that wishes to request a list of randomly selected arbitrators pursuant to subsection 3 of NRS 439B.754 to arbitrate a dispute over a claim of \$5,000 or more must request a list of five randomly selected arbitrators from:*

- 1. The American Arbitration Association or its successor organization; or*
- 2. JAMS or its successor organization.*

Sec. 5. *1. To elect to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to an entity or organization that is not otherwise subject to those provisions as authorized pursuant to NRS 439B.757, the entity or organization must apply to the Department in the form prescribed by the Department. The application must include, without limitation:*

- (a) The name of and contact information of the entity or organization at which it may*

| *contemporaneously confirm contact at all times;*

- (b) A description of the type of entity or organization, as applicable, that it is; and*
- (c) The date on which the entity or organization requests the election to become effective.*

2. Any entity or organization may withdraw its election to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to the entity or organization by submitting an application to the Department in the form prescribed by the Department not less than ~~30~~ 180 days before the date on which the withdrawal is requested to become effective. The application must include, without limitation:

- (a) The name of and contact information for the entity or organization;*
- (b) A description of the type of entity or organization, as applicable, that it is;*
- (c) The date on which the entity or organization requests the withdrawal to become effective; and*
- (d) The reason for requesting to withdraw the election.*

Sec. 6. On or before December 31 of each year, each third party that provides coverage to residents of this State shall submit to the Department in the confidential form prescribed by the Department:

- 1. The name of and contact information for the third party;*
- 2. A description of the type of third party that it is;*
- 3. The number of disputed payments for medically necessary emergency services provided by out-of-network providers that were settled without arbitration during the immediately preceding year and, for each such payment, the type of out-of-network provider and the amount of the payment;*

4. The number of new provider contracts entered into by the third party with providers of medically necessary emergency services during the immediately preceding year and the types of providers with whom provider contracts were entered into; and

5. The number of provider contracts between the third party and providers of medically necessary emergency services that were terminated during the immediately preceding year and the reasons for each termination.



January 16, 2020

Ms. Carrie Embree
Governor's Consumer Health Advocate
State of Nevada Office of Consumer Health Assistance
clembrree@adsd.nv.gov
cha@govcha.nv.gov

Re: Comments on Proposed Regulations of the Office of Consumer Health Assistance of the Department of Health and Human Services, LCB File No. R101-19

Dear Ms. Embree:

US Anesthesia Partners (USAP) is a single-specialty physician group focused on delivering superior anesthesia services through a commitment to quality, excellence, safety, innovation, satisfaction, and leadership. We sincerely appreciate the opportunity to provide comments to the Office for Consumer Health Assistance for the State of Nevada regarding the Revised Draft of Permanent Regulations Regarding AB 469, NRS 439, LCB File No. R101-19 (dated December 9, 2019) and the Proposed Regulation of the Director of the Department of Health and Human Services, LCB File No. R101-19 (dated January 6, 2020), as posted at <http://dhhs.nv.gov/Programs/CHA/>.

We thank the State of Nevada for taking important action to protect patients from surprise medical bills in emergency contexts, and we appreciate your leadership and efforts to ensure that the rulemaking process supports continued progress to protect patients while treating medical providers and insurance carriers fairly. As an organization that has always had an in-network strategy, USAP applauds the efforts taken to date, and we hope our feedback is helpful in furthering seamless implementation of AB 469 in 2020.

Our comments below are organized in response to the proposed regulations referenced above and where possible we have offered potential revised language for your consideration. Where applicable, we have provided section references to the December 9, 2019 draft, with cross-references noted to the January 6, 2020 document.

Sec. 17 – Submission, contents and review of requests for arbitration (...). (December 9, 2019 draft)

Section 2 (January 6, 2020 draft)

Subsections 17.2 and 17.3 – Timeframe for Arbitration Requests. We appreciate the drafters' revisions to Subsection 17.2 and Subsection 17.3 to extend the timeframe for submitting requests for arbitration from 10 business days to 30 business days (an update from the previous November 2019 draft). We suggest an additional clarification to the current draft as outlined below.

For added clarity, we propose that Subsections 17.2 and 17.3 be revised as follows, with the underlined language added to the current draft:

2. *The request must be submitted to the Department within 30 business days from the later of the time the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17.3.*
3. *The Department will not accept applications requesting arbitration past 30 business days from the later of the date the third party refuses to pay the additional amount requested by the out-of-network provider or fails to pay that amount pursuant to AB 469, Sec. 17.3 and payment received will be considered payment in full.*

For Section 2 of the January 6, 2020 draft, we suggest that Section 2.1(a) be revised to read "*the out-of-network provider must submit the request by the later of: (a) (...) or (b) (...).*"

Subsection 17.4 – Online Filing of Arbitration Requests and Contents. We recommend considering revising Subsection 17.4 to clarify that arbitration request forms shall be submitted through an online process. It is important for the submission process to be efficient and simple. To that end, any potential for arbitration request forms to be submitted by hard copy through the postal service or otherwise could hinder the efficiency of the process.

In addition, we recommend the drafters consider deleting Subsection 17.4(h)e in its entirety which, as proposed, would require out-of-network providers to disclose in all arbitration requests a "representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same region, from health plans in which the provider does not participate." For providers with a strong history of in-network contracting, this information regarding out-of-network payments might not even exist. Further, over time, this information could simply reflect a pattern and practice of underpayments by carriers who know that their out-of-network payments might be considered in this context. If adopted, this requirement could incentivize commercial payors to offer lower reimbursement rates for out-of-network emergency claims on a global level given their knowledge that such information might be used by an arbitrator as a benchmark in future arbitrations.

For Section 2 of the January 6, 2020 draft, we suggest that Section 2(e)(3) be deleted to remove the requirement that this information be submitted for the reasons noted as to 17.4 above: "*A representative sample of at least three payments received by the out-of-network provider as compensation for the same medically necessary emergency services provided in the same region of this state from third parties with which the out-of-network provider has not entered into a provider contract.*"

Additional Proposed Revision – Regulation on Bundling Claims for Arbitration. We recommend adding a regulation which specifies that a single arbitration can address multiple disputed out-of-network emergency claims. The text of AB 469 is silent on this issue, but the general spirit of the new law is to facilitate fair and efficient dispute resolution. There could be a multitude of scenarios where conducting a single arbitration covering disputes associated with multiple claims would further this purpose, especially to the extent these claims involve substantially similar issues and parties.

However, we also recognize that there must be some limitations on bundling of claims in a single arbitration. Accordingly, we recommend considering a regulation which provides:

Multiple claims may be heard and determined in a single arbitration proceeding if the following three conditions are met: (1) the claims involve the identical carrier and the same provider or medical group; (2) the claims involve the same or related services; and (3) the claims occur within a period of three months of each other.

Additional Proposed Revision – Clarification as to Arbitrator’s Award. AB 469 provides a specific and detailed procedure for the arbitration process for out-of-network billing disputes as to emergency claims. In short, the arbitrator’s decision is to be final and not subject to any appeals or future litigation. Accordingly, in order to avoid inviting potential litigation and further disputes over an arbitrator’s decision, we recommend the addition of a regulation which provides:

The arbitrator shall render a decision in accordance with the procedures outlined in Sec. 17 of AB 469 without any reference to any other statutes addressing arbitration, such as the Nevada Uniform Arbitration Act and the Federal Arbitration Act, or any other rules of procedure governing arbitration in other private contexts, such as the American Arbitration Association Rules of Arbitration and the Rules of Procedure for Commercial Arbitration of the American Health Lawyer’s Association.

Additional Proposed Revision – Identifying Conflicts of Interest. We recommend a regulation regarding Sec. 17.4 which allows both the commercial payor and the out-of-network provider an opportunity to identify and disclose any personal, professional, or financial conflicts of interest with any of the five arbitrators randomly selected for the parties’ consideration. Qualified arbitrators should be non-conflicted in accordance with the goals of AB 469, and it would be helpful to allow the parties an opportunity to identify and disclose potential conflicts between the arbitrator and any other party to the arbitration before undertaking the task of selecting an arbitrator to preside over an arbitration. This would ensure that the parties have the opportunity to consider five truly “qualified arbitrators” without the inclusion of arbitrators with conflicts of interest, which AB 469 clearly intends.

Other Qualifications of Arbitrators. AB 469/N.R.S. 439B.754(3) permits “For claims of \$5,000 or more, the use of arbitrators from nationally recognized providers of arbitration services, which may include, without limitation, the American Arbitration Association, JAMS or their successor organizations.” The proposed regulations dated December 9, 2019 and January 6, 2020 both state that the arbitrators must be selected from the American Arbitration Association, JAMS, or their successor organizations. We suggest that the language of the statute be preserved so that arbitrators from other nationally recognized providers *may* be selected if appropriate.

Thank you again for the opportunity to share our comments for the foregoing proposed regulations related to the implementation of AB 469, and we appreciate your leadership on this important issue.

Sincerely,

US Anesthesia Partners

Subject: FW: AB 469 - Regulations

From: Chris Bosse <CBosse@renown.org>
Sent: Monday, January 27, 2020 11:04 AM
To: Carrie L. Embree <clembrree@adsd.nv.gov>
Cc: Bill Welch <bill@nvha.net>; James L. Wadhams - Fennemore Craig Jones Vargas (jlwadhams@blacklobello.law) <jlwadhams@blacklobello.law>
Subject: AB 469 - Regulations

Carrie

I very much appreciate the time you took to meet with me prior to the holiday to review my questions/concerns regarding LCB File R101-19. After reviewing the latest version dated January 6th, 2020, the following continue to be my concerns and/or recommendations for your consideration:

1. Section 2 subsection 2 e) 3): As we discussed during our meeting, requiring one party to provide payment data as part of the request for arbitration presents the following concerns
 - a. Patient care services are frequently quite individual (while they may have some similarities like the level of emergency room care provided – levels 1- 5). It may be difficult to find non-contracted emergency services (hopefully not a large volume) that are similar.
 - b. If payers and hospitals can continue our work to contract broadly – there shouldn't be many Nevada Payers that are non-contracted. There may not be examples other than with the payer the dispute is with.
 - c. Not sure why the arbitrator would benefit from payments made by non-contracted payers (since they often don't even pay what our contracted payer would pay – and a least the contracted discounted payments are in exchange for a volume of patient care they agree to purchase). Non-contracted patient care should be paid at a rate that is more than contracted rates.
 - d. There is concern about ensuring payment amounts remain confidential so any payment information provided should be provided directly to the arbitrator under an agreed upon confidential process.
2. Sections 2 and 3 outline a very detailed process with numerous deadlines. These deadlines will apply to each claim that is being disputed. I wonder if OCHA would consider a more simplified process. I am not suggesting that the claims themselves be considered together or batched. Please consider the following:
 - a. For the claims submitted to the State with a request for arbitration in the prior month, the State will
 - i. Provide notice of receipt by the 5th business day of the following month for all requests for arbitration received during the prior month
 - ii. On or before the 10th business day following the month of submission – the state will provide a request for additional information for any missing information related to all claims submitted in the prior month
 - iii. The provider will have 5 business days to provide any missing information.
 - iv. On or before the 17th business day, the state will confirm all valid claims and will provide a list of arbitrators to select from.
 - v. Etc.
 - b. Once the arbitrator has been assigned, each claim will be considered individually.
3. Section 5 outlines the process for opting in.
 - a. This election should be an annual election which should be received by the Department By December 1st each year. This will provide certainty for all parties (patients, providers and payers) and will provide time for the State to accurately reflect the intention of the electing third parties on the website.

- b. This election must include information that will allow providers to comply with the statute – email and phone information that will provide 24/7 access to the third party for notification purposes and will correspond to the time frames that the emergent non-contract care will be provided.

I appreciate the opportunity to provide feedback. Please let me know if you have questions or need additional information.

Thank you,
Chris

Chris Bosse
VP Government Relations
50 W. Liberty St., Suite 1100 Reno, NV 89502
P: 775-982-5761 Office
C: 775-690-6503 Cell
cbosse@renown.org
For what matters most. A Report to Thank our Community

Renown
HEALTH



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February 4, 2020

Ms. Carrie Embree, LSW
Governor's Consumer Health Advocate
Nevada Department of Health and Human Services
Aging and Disability Services Division
3416 Goni Road, Building D, #132
Carson City, NV 89706

RE: *LCB File No. R101-19*

Dear Ms. Embree:

On behalf of the hundreds of Physicians for Fair Coverage (PFC) members in Nevada, we want to thank you for the opportunity to once again provide input on LCB File No. R101-19.

PFC is a non-profit, non-partisan, multi-specialty alliance of physicians dedicated to improving patient protections, promoting transparency, and ensuring access to care for patients in Nevada and nationwide. Our national membership of tens of thousands of physicians care for millions of patients each year in thousands of facilities throughout the country. In Nevada, we have worked closely with our partners -- the Nevada State Medical Association, the Nevada Hospital Association, and many specialty groups -- to pass legislation to end surprise medical billing and provide strong protections for our patients. Now we are pleased to offer comments on the proposed regulations.

Identification of Participants Opting into AB469 – One of the most significant issues for us as providers is how to determine which insurance plans are participating in the provisions of AB469. Our simple solution – which has not been accepted to date – is to include an identifier on an insured's insurance card. We are open and amenable to options, but in an emergency situation, knowing if a patient's plan has opted in or not is critical to the success of the program. We strongly urge reconsideration of this proposal.

General Arbitration Question - As a general concern, unless an online portal has been established, the filing process can be complicated and burdensome. Will there be an electronic online portal of any type for submission of claims? We have found that in states that have done so, the administrative burden for the arbitration process has been significantly reduced, as has the cost. PFC would be happy to connect you with other regulators in states such as New York and Texas who have created simple low-cost portal systems. Texas, for example, which has just implemented its' law passed in 2019 has been able to do so quickly at minimal cost. You may preview it at:

<https://appscenter.tdi.texas.gov/medarb/p/login>

At Section 2, the use of business and calendar days are used interchangeably. In Section 2, we respectfully request that all days be listed as business days.

At Section 2, Subsection 2(e)(3), you require the out-of-network provider to provide a representative sample of at least three payments. This is not a provision that is used anywhere else in the country, and we believe could be used by payers to manipulate payments.

An additional resource, as we outlined in our December letter, for the purpose of reviewing customizable, geographic, multi-payer claims data is FAIR Health. FAIR Health is an independent, non-profit that collects data for and manages the nation's largest database of more than 28 billion privately billed health insurance claims and is entrusted with similar data from the Medicare and Medicaid programs. FAIR Health also has a consumer portal aimed at helping Americans better understand healthcare costs. You may access it at fairhealthconsumer.org.

At Section 2, Subsection 5, the draft language provides that the Department will "determine that the request is complete and clear." We strongly urge the Department to clarify or provide additional guidance on what satisfies their interpretation of "complete and clear" to ensure decisions are not arbitrary. For example, would the Department determine a request containing all items outlined in Section 2, Subsection 2(a-e) to be a "complete and clear" request?

Pertaining to Guidelines for Arbitrators, it is exceptionally important to have these in place to ensure clarity and fairness for all parties involved in a claims dispute. In order to avoid inconsistencies and the likelihood of lawsuits, we request that you consider adding parameters for the arbitrators. Below are examples of fair guidelines used in Texas for those involved in out-of-network claims disputes:

- A party may request arbitration after 20 days from the date an out-of-network provider receives the initial payment for a health benefit claim, during which time the out-of-network provider may attempt to resolve a claim payment dispute through the health benefit plan issuer's or administrator's internal appeal process.
- Written submission of information to an arbitrator is required with the arbitrator providing the date for submission of all considered information. The arbitrator must provide each party an opportunity to review the written information submitted by the other party, submit additional written information, and respond in writing to the arbitrator on the arbitrator's specified timeline.
- Parties are required to check the list of qualified arbitrators and notify the department of any conflicts. The parties are in the best position to know if there is a conflict of interest, and each has 10 days within the request for arbitration to notify the department of a conflict of interest with the arbitrator.
- There are consequences in the arbitration decision for parties that do not participate in good faith. Without enough information, the arbitrator will be limited to basing their decision on the information received. An arbitrator can make a decision even if a party fails to participate.

- Provision is made for the submission of multiple claims between the same provider and same health benefit plan issuer or administrator. The regulations allow for the submission of multiple claims to arbitration in one proceeding, with certain limitations.
- More information can be found at:

<https://www.tdi.texas.gov/rules/2019/documents/20196172.pdf>

Thank you again for the opportunity to comment. We are pleased to work with you on this important matter and look forward to continuing our dialogue. Our President and CEO, Michele Kimball (651-955-8878; mkimball@pfc-assn.org), and in-state counsel, Chris Ferrari of Ferrari Public Affairs (702-574-8781; chris@ferraripa.com), stand ready to be of assistance.

Sincerely,



Anthony Gabriel, MD
Chair, Board of Directors

cc: Speaker Jason Frierson, Nevada State Assembly
Allison Combs, Policy Director, Office of the Governor

February 4, 2020

Dena Schmidt
Nevada Aging and Disability Services Division
3427 Goni Road, Suite 104
Carson City, NV 89706

Re: AB 469 Regulations; LCB File No. R101-191

Dear Ms. Schmidt:

On behalf of our three larger community hospitals, four neighborhood hospitals, primary care physician group and wellness centers in Nevada, Dignity Health-St. Rose Dominican appreciates the opportunity to submit comments on the proposed regulations on arbitration for out-of-network (OON) claims under \$5,000, the opt-in process for ERISA plans and other pieces of AB 469. Dignity Health is a part of CommonSpirit Health, a nonprofit, Catholic health system dedicated to advancing health for all people. With operations in 21 states and more than 140 hospitals, we are committed to creating healthier communities, delivering exceptional patient care and ensuring every person has access to quality health care. We appreciate the opportunity to submit comments on this important measure.

In our previous letter to you, dated September 27, 2019, St. Rose listed multiple issues and concerns that our internal operationalization working group had in the midst of guaranteeing that we could comply with the law on its effective date of January 1, 2020. We understand that the state has limited regulatory authority over the implementation of this law, but feel there are still many questions left unanswered as to how this law can be properly implemented. St. Rose would like to specifically thank Ms. Carrie Embree from the Office for Consumer Health Assistance (OCHA) for listening to our concerns and walking through some of these scenarios with us.

In addition to the questions and comments brought forth to you in our last comment letter, St. Rose would like to make the following comments and questions regarding the newly proposed regulations:

- **OON Providers and the Election Process:** One of the main concerns St. Rose has with this law is the difficulty of keeping track of a payer's participation, either due to the election process or the difficulty in determining whether or not an insurance plan was sold in Nevada. We understand that the elected plans will be listed on a website pursuant to section 18 of the bill, but we do not support section 5 of the proposed regulations that allows for a plan to opt-out with only a 30-day withdrawal provision and ask that the timeline be changed to that of an annual basis. This allows both for less administrative burden and less of a chance of abuse of the system.

- **Arbitration Process and Timeline:** St. Rose would like to thank the regulators for changing the request for arbitration timeline from 10 to 30 days in section 2. Per section 2.2.e.3, the state is requesting a representative sample of at least three (3) fees received by the OON provider for the same service. St. Rose requests that this be eliminated from the proposed regulations and it's outside the scope of what AB 469 requires. And as it pertains to the overall arbitration process, St. Rose requests a one-page 'rules of the road' fact sheet from OCHA that includes all materials to be provided so that providers and payers are doing things in the most efficient manner possible.
- **Overall Abuse of the System:** There are still concerns about those who decide to abuse the system. St. Rose understands that the state does not have the current means or regulatory authority to track who is abusing the system, nor to put fines in place for those that do (i.e.: under section 2 of 'Claims of less than \$5,000'). We do understand that there is a reporting mechanism in place and data will be provided both to the public and legislators, but do not believe this goes far enough. St. Rose would like to put on the record that we believe this lack of oversight and accountability is short-sighted and the Assembly and Senate Committees on Health and Human Services should take a look at this provision during the 2021 Nevada Legislative Session.
- **Further Questions:** In addition to our questions previously asked in our letter dated September 27, 2019, these proposed regulations have generated further questions:
 - Section 5 – What about plans that have access to contracted networks? Would AB 469 apply if the patient's plan is mapped to a contracted network, or would a provider bill the plan based on the contracted network?

Questions and concerns from our previous letter dated September 27, 2019 that St. Rose would still like answered or legislated during the 2021 Nevada Legislative Session include:

- **Transfers Post-Stabilization and Medical Necessity:** In section 14.2.a of AB 469, an OON facility shall, when possible, notify the payer within eight hours that their member presented at their facility for medically-necessary emergency services. Further, in section 14.2.b of AB 469, the OON emergency facility shall notify the payer that the patient has stabilized and can be transferred within 24 hours. Questions:
 - What happens with payment if the physician isn't willing to transfer the patient to another in-network facility because of continuity of care?
 - What happens with payment if we give the payer 24 hours' notice and the payer isn't able to move the patient within that timeframe?
 - What happens if the patient refuses to transfer?
 - What happens if the payer at a later date determines the visit was not medically-necessary?
 - What happens if the contracted provider refuses the transfer?
 - What happens if there is not an available bed at the contracted provider?
- **Arbitration Process for Claims Under \$5,000:** St. Rose believes a large portion of the claims it will see coming from this law will be under the \$5,000 cap, and due to their low price point, understands that the cost and efficiency related to this type of arbitration will be very important. And given that contracts between payers and providers can fluctuate, we also understand that volume could dramatically increase if one provider and payer falls out of contract. St. Rose suggests that providers have the ability to submit for arbitration these smaller claims in bulk.

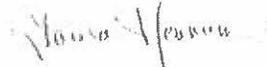
- **State-Purchased Health Insurance Policies:** Section 13.2 of AB 469 indicates that this bill does not cover policies sold outside of the State of Nevada. Hospitals do not have the ability to know when a patient comes in if the policy was sold within the state or not. For example, you could have a Nevada employer whose policy was sold in another state where their corporate headquarters are, and our emergency department staff would not know that from simply looking at the card. CommonSpirit Health suggests that along with ERISA plans that have opted-in to participate, state-purchased plans are also listed. This information will need to be easily accessed by our admitting staff in our emergency departments, not just for billing purposes, but in order to provide accurate patient estimates and contact the pertinent payer once the patient has reached stabilization.

Again, Dignity Health-St. Rose Dominican appreciates the opportunity to respond to these proposed regulations and hope our input is helpful as this matter proceeds. If you have any questions, please feel free to contact Katie Ryan, System Director of Nevada Government Relations at (702) 616-4847 or at katie.ryan@dignityhealth.org.

Very Truly Yours,



Lawrence Barnard
Nevada Market Leader
President/CEO, Siena and
Rose de Lima Campuses



Laura Hennum
Regional CEO, Emerus
Dignity Health-St. Rose Dominican
Neighborhood Hospitals

August 21, 2019

Carrie Embree, LSW
Governor's Consumer Health Advocate
3416 Goni Road, Bldg. D-132
Carson City, NV 89706

Dear Carrie: *Carrie*

On behalf of the Nevada Hospital Association, we submit the following comments for consideration in the development of regulations to further enhance the clarity of AB 469.

While we believe that the statute is very explicit in many respects, there are a few areas where the legislature has either directed the development of regulations or where additional clarity could be brought to the act by regulation.

For ease of tracking, we offer language in the same order as the corresponding sections appear in the act.

Section 14(2)(b). Patient Transfer.

"If the third party (health benefit plan) is notified by the provider of care that the covered person has stabilized sufficiently for transfer, all responsibility for that patient becomes the obligation of the third party at the time it physical removes that patient or otherwise accepts the responsibility for that covered person. If the third party does not accept responsibility for the transfer of the patient within 24 hours of being notified, the third party will be responsible for all charges incurred in caring for that covered person."

Section 17(3). Arbitrators

1. "The Director of DHHS shall maintain a list of persons qualified to arbitrate disputes under this act."
2. "For claims of under \$5000 that list may include employees of the State who have been trained and are qualified to arbitrate disputes and persons identified pursuant to NRS 38.255. For claims in excess of \$5000, the list of eligible persons may include those individuals identified by JAMS, the American Arbitration Association or any other nationally recognized provider of arbitration services."
3. "Upon the written request of an out of network provider, the Director must identify 5 individuals from such lists who have been randomly selected to arbitrate the matters in dispute"

Section 17(6) Arbitrators Decision

1. "The arbitrator must choose either the offer made by the third party pursuant to Section 15(2) of this act or the offer made by the provider under Section 17(2).
2. The arbitrator, in making that decision may only consider the two offers and the information offered by either party to the arbitration pursuant to Section 17(5)
3. The arbitrator's decision is confidential and shall be only communicated to the two parties and no one else other than as required to satisfy the reporting requirements under Section 19(1). Any information filed by either party in support of any arbitration is confidential and may not be shared with the other party involved in the arbitration.

Section 18(2). Covered plans

“Any health benefit plan not identified by NRS 695G.019 or NRS 287.043 is not covered by this act and no person obtaining benefits from a health benefit plan not covered by this act shall obtain the benefit of this act unless and until that plan notifies DHHS in writing that it intends to be bound by the terms of this act for a period of at least one year. If such a plan notifies DHHS in writing, DHHS shall place the identity of that plan in a list of covered plans maintained on the DHHS website with the inception and expiration date of that eligibility clearly delineated.”

“Any authorized insurer shall indicate on the card issued to its member whether the plan is fully insured under 695G.019 or 287.043 or whether that plan must elect to participate under Section 18 of this act.”

Section 19. Reporting of information

Sec. 19 (1) “The arbitrator shall, submit a monthly report to the Director as required by Section 19 of this act by the 7th day of the following month.”

Sec. 19 (2) “A provider of health care or a third party

1. “A provider of health care or a third party (health benefit plan) must provide an information requested by DHHS to complete the report of the arbitrator within 30 days of when the request was received.”
2. “A provider of health care or a third party (health benefit plan) may provide any other information relevant to the report of the Department no later than December 31 of the year for which the report is made.”

We appreciate the opportunity to participate in this important process.

Sincerely,



Bill M. Welch
President/CEO
Nevada Hospital Association

To: Carrie Embree, LSW, Governor's Consumer Health Advocate
From: Dr. Bret Frey, Legislative Liaison – Nevada ACEP
Date: August 30, 2019
Re: Public Workshop August 28, 2019 – Assembly Bill 469 Regulations

AB469 outlaws the practice of balanced billing for emergency care and provides a system for physicians and hospitals to receive a fair payment by third-party payers in the scenario an out-of-network instance occurs.

We would like to highlight some areas that need clarification through the regulatory process.

1. Arbitration should be conducted in an “economically efficient manner” (Section 17(3)(a))

This portion of the bill outlines the small claims arbitration process for claims under \$5,000. It goes on to specify a process that must include one of the following options: 1. the use of arbitrators that are qualified state employees; 2. arbitration through the judicial district; or 3. a program the judicial district chose. It is critical for emergency physicians that the state prioritize the cost and quality of this arbitration process. The average bill for emergency physicians in Nevada is \$800; the amount of dispute between provider and payer is likely only a fraction of the total bill. To preserve due process rights of both parties, the cost of arbitration must be less than the average bill. Physician practices and administrators don't have staff attorneys; they are often small groups. This process needs to be one that doesn't require the hiring of expensive legal counsel. It is imperative that the small claims arbitration process isn't cost prohibitive for doctors. We would recommend a program that uses unbiased arbitrators qualified in the area of medical billing. In addition, we would recommend a flat fee structure or a percentage fee structure to ensure that the cost for arbitration wouldn't exceed the bill needed to arbitrate, thus guaranteeing access for physicians to a fair process.

In addition, a process needs to be established for submittal of documents to the chosen arbitrator in a clear, simple, and affordable fashion. We recommend a universal form for submittal, an online submission option, and in cases less than \$5,000 there be an option for telephone attendance. Teleconference or telephonic processes may be an important

addition for many of our rural Nevada practices. We also recommend that there be an option for either party submit information not present on the form. This will assist the majority of our emergency practices that have full schedules attending to the state's emergency patients and contend with on-call schedules.

2. Transparency for patients and doctors (Section 18(1,2))

Section 18(1-2) require the Department of Health and Human Services to publish a list of third-parties who have opted into the law. In addition, this section allows for regulations on a third-party electing into the law.

While the law is clear for compliance of commercial plans, this section addresses the ability for additional ERISA plans to participate and protect their patients. It will be important that plans clearly notify their patients when they opt into this law. Patients need to know if they are covered under the law and that this only applies to emergency care. Through this section of the bill, we think it is essential that the Department provide a list of these plans in an easy to find location on their website, keep it updated in a timely basis on plan changes, and provide contact information for DHHS-OCHA if there is an issue. This provision is important for physicians as well. If patients and providers know the plans that are opting into the law, it will create a more efficient process and fewer delays for all involved.

Lastly, we advise the Department to set up a basic procedure for identifying when a network has been rented to a third-party payer and is covered by this law. It will be important in the scenario that a payer has opted in, that they notify their third-party networks to streamline the process and maintain compliance. This will also provide for additional transparency for patients.

Nevada American College of Emergency Physicians (ACEP) was founded in 1973. We represent hundreds of emergency physicians, residents and medical students in the state. We are actively involved in a wide range of issues that matter to emergency physicians and our patients, including emergency medical services, public health and safety, and disaster preparedness and response. Most importantly, we are working to expand access to emergency care across Nevada.

On behalf of our members, I would like to thank you and the state for allowing Nevada ACEP the opportunity to provide input during the rulemaking process on Assembly Bill 469. We played an active role during the 2019 session negotiations and will continue our involvement through this rulemaking process.

There are more than 500 emergency doctors in Nevada. Emergency departments service 1.5 million patients per year statewide. This issue is one that impacts every single emergency physician in the state. We join our partners in the physician community to emphasize some needed clarification through regulation on this bill.

We would like to thank you for your consideration. We will continue to engage and provide input through this regulatory process. We stand ready to be a resource to the state transitions to implementation of AB469.

Sincerely,

Dr. Bret Frey
Legislative Liaison for Nevada ACEP



September 12, 2019

Carrie Embree, LSW
Consumer Health Advocate
3416 Goni Road, Bldg. D-132
Carson City, NV 89706

Dear Ms. Embree,

The Nevada Association of Health Plans (NVAHP) attended the August 28, 2019 Public Workshop regarding draft regulations as they pertain to Sections 17 and 18 of the bill. The following provides written comments consistent with our verbal testimony that day and in response to the testimony of others.

It is our understanding that AB 469 grants the Department to develop regulations to implement various provision of AB 469. Specifically,

- Section 17(3) – Authorizes the Department to develop regulations related to the selection of an arbitrator
- Section 18 – Authorizes the Department to develop regulations on how a third party that is not subject to the requirements of AB 469 may elect to be covered by the provision of AB 469

During the workshop various groups have advocated that the Department develop regulation that go beyond section 17(3) and 18, which we believe is beyond the statutory authority provided for in AB 469. Additionally, these various groups have requested the Department to make substantive changes to AB 469 through regulation that we believe changes the plain meaning, language and intent in AB 469. We are very concerned that the discussion and proposed regulations being discussed are not specific to Sections 17 and 18 of the legislation.

For example, the Nevada Hospital Association's written testimony is specific to section 14(2)(b) that addresses patient transfer issues and the Nevada Hospital Association has advocated that the Department develop regulations that would invalidated the provision of AB 469 that protect Nevadans if a member is not transferred within 24 hours of the payer being notified that the patient is stable and transferable.. The Hospital Associations advocacy is clearly not supported by Section 13(3). Section 13(3) provides that the protection of AB 469 would not apply only after the third party payer has been notified that their member is stable and transferable and 24 hours have passed. The Nevada Hospital Association appears to be advocating that the Department develop

regulations that are both inconsistent with AB 469 and outside the authority granted to the Department by AB 469.

Additionally, written testimony submitted by the Emergency Department Practice Management Association and the Nevada American College of Emergency Physicians demands changes made to such definitions as prudent person (Section 8) and medically necessary emergency services (Section 6). It appears that these organization are requesting that Department substitute the clear language in sections 6 and 8 with definition more to their liking. We believe that any change to any definition would be inconsistent with AB 469 and outside the authority granted to the Department by AB 469.

During the Workshop there was much discussion regarding notification to patients that the claim was in arbitration. Notifying the patient is not required by AB469. Should notification be contemplated as a regulation it must come from the provider and a clear explanation of the process must be provided. We are concerned that notification will further confuse the patient and cause them to question what they should or should not pay. The intent behind the passage of AB469 is to protect the consumer and not make these claims more difficult to understand.

It was stated during the Workshop that it could take upwards of a year to promulgate the regulations and get a final decision by the Legislative Commission. Section 29(2) of AB469 requires the act to become effective on January 1, 2020. We would suggest that a temporary or an emergency regulation be enacted that outlines how a third party can elect to be covered by AB 469 and how the selection of an arbitrator will be done pursuant to section 17 while the Department continues to develop a permanent regulation.

We look forward to continuing to work with the Consumer Advocates Office as regulations are drafted and made available. Please provide all meeting notices, draft regulations and pertinent information to me at tom@tomclarksolutions.com. It is important to note that none of our member companies were aware of the August 28, 2019 Public Workshop as it was not posted in the traditional places. For example, meetings scheduled that occur in the Nevada Legislative Building are posted on the legislative website. This one was not.

The written testimony provided by the Nevada Hospital Association and the Emergency Department Practice Management Associates and Nevada American College of Emergency Physicians were sent to the Department eight days prior to the hearing. We would have provided much more testimony had we been notified of the hearing.

Thank you very much for the opportunity to provide input. I look forward to participating in the future.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tom Clark', with a long horizontal flourish extending to the right.

Tom Clark
Nevada Association of Health Plans

September 27, 2019

Dena Schmidt
Nevada Aging and Disability Services Division
3427 Goni Road, Suite 104
Carson City, NV 89706

Re: Regulations for AB 469 from the 2019 Nevada State Legislative Session

Dear Ms. Schmidt:

On behalf of our three larger community hospitals, four neighborhood hospitals, primary care physician group and wellness centers in Nevada, Dignity Health-St. Rose Dominican appreciates the opportunity to submit comments on the proposed regulations on arbitration for out-of-network (OON) claims under \$5,000, the opt-in process for ERISA plans and other pieces of AB 469. Dignity Health is a part of CommonSpirit Health, a nonprofit, Catholic health system dedicated to advancing health for all people. With operations in 21 states and more than 140 hospitals, we are committed to creating healthier communities, delivering exceptional patient care and ensuring every person has access to quality health care. We appreciate the opportunity to submit comments on this important measure.

St. Rose has been a part of the decades-long debate on this very important issue and are very happy to place the patient out of the middle of these difficult balance billing situations. In the midst of figuring out the operationalization of this new law come January 1, CommonSpirit Health would like to make the following comments and questions:

- **Overall Arbitration Process:** St. Rose is well aware of the overall arbitration process in sections 15-18 of the bill, but believe there still needs some regulatory specificity. CommonSpirit Health suggests that chosen arbitrators have current working knowledge and understanding of medical billing and payer contracting, and that a regulated set of procedures is in place to maintain confidentiality.
- **Opt-In Process for ERISA Plans:** St. Rose believes there needs to be a regulated timeline on when ERISA plans can opt-in or -out of participating in the provisions of AB 469. CommonSpirit Health suggests that an annual timeline is best for both patients enrolled in these plans and our staff who will manage which plans are participating at any given time.
- **Arbitration Process for Claims Under \$5,000:** St. Rose believes the majority of claims we'll see coming from this law will be under the \$5,000 cap, and due to their low price point, understand that the cost and efficiency related to this type of arbitration will be very important. And given that contracts between payers and providers can fluctuate, we also understand that volume could dramatically increase if one provider

and payer fall out of contract. CommonSpirit Health suggests that providers have the ability to submit for arbitration these smaller claims in bulk.

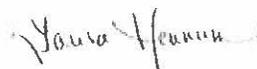
- **State-Purchased Health Insurance Policies:** Section 13.2 indicates that this bill does not cover policies sold outside of the State of Nevada. Hospitals do not have the ability to know when a patient comes in if the policy was sold within the state or not. For example, you could have a Nevada employer whose policy was sold in another state where their corporate headquarters are, and our emergency department staff would not know that from simply looking at the card. CommonSpirit Health suggests that along with ERISA plans that have opted-in to participate, state-purchased plans are also listed. This information will need to be easily accessed by our admitting staff in our emergency departments, not just for billing purposes, but in order to provide accurate patient estimates and contact the pertinent payer once the patient has reached stabilization.
- **Questions - Transfers Post-Stabilization and Medical Necessity:** In section 14.2.a, an OON facility shall, when possible, notify the payer within eight hours that their member presented at their facility for medically-necessary emergency services. Further, in section 14.2.b, the OON emergency facility shall notify the payer that the patient has stabilized and can be transferred within 24 hours. Questions:
 - What happens with payment if the physician isn't willing to transfer the patient to another in-network facility because of continuity of care?
 - What happens with payment if we give the payer 24 hours notice and the payer isn't able to move the patient within that timeframe?
 - What happens if the patient refuses to transfer?
 - What happens if the payer at a later date determines the visit was not medically-necessary?
 - What happens if the contracted provider refuses the transfer?
- **Question - Prompt Pay Discount:**
 - If a provider has a 'prompt pay' discount with an OON payer, how is this handled under this law?

Again, Dignity Health-St. Rose Dominican appreciates the opportunity to respond to these proposed regulations and hope our input is helpful as this matter proceeds. If you have any questions, please feel free to contact Katie Ryan, System Director of Nevada Government Relations at (702) 616-4847 or at katie.ryan@dignityhealth.org.

Very Truly Yours,



Lawrence Barnard
SVP, Dignity Health Nevada
President/CEO, Siena Campus



Laura Henum
Regional CEO, Emerus
Dignity Health-St. Rose Dominican
Neighborhood Hospitals

Niki Thomson

From: Bill Welch <bill@nvha.net>
Sent: Thursday, October 31, 2019 2:00 PM
To: Carrie L. Embree
Cc: 'Jim Wadhams'; jessewadhams@blacklobello.law; 'Chris Bosse (Renown)'; Sarah Hunt
Subject: Template draft language for AB 469
Attachments: Proposed reg for AB 469 10.31.19 (003).docx

Importance: High

Carrie, hope all is well with you. Sorry this has taken so long but wanted to follow up with you as I committed to do at the 8/29/19 public workshop on AB469. At that time I had submitted comments on behalf of the Nevada Hospital Association members but promised to provide additional comments.

With that in mind attached you will find a mock up (template) of potential language that may be of help as you work to put together your draft regulation for AB469.

I look forward to seeing the state's final draft regulations on AB 469. I am available if you have any questions or can be of any assistance.

Thanks,
Bill

Bill Welch

Nevada Hospital Association | President / CEO
5190 Neil Rd. Ste. 400 Reno, NV 89502
T: 775.827.0184 | F: 775.827.0190
E-mail: Bill@nvha.net | nvha.net



**PROPOSED REGULATION OF THE
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

LCB FILE NO. R XXX-XX

**The following document is the initial draft regulation proposed
by the agency submitted on 10-XX-2019**

PROPOSED REGULATION OF THE DIVISION OF AGING AND DISABILITY SERVICES

AUTHORITY: NRS 439B.450 & AB 469 OF THE 2019 LEGISLATIVE SESSION

Italics: New proposed language

A REGULATION relating to health benefits covered by health plans issued in Nevada to Nevada residents; establishing a new benefit for persons insured under health plans covered by this act or which have chosen to be covered ("Plan/s"). Despite receiving care from a provider or a facility for medically necessary emergency services which is outside the Plan's network, the covered person will not be responsible for more than the in network deductible, copayment or coinsurance. This regulation establishes the specific persons who will be eligible for this benefit not provided by their contract and how their health plans will be identified. In the case of those plans not automatically covered, this regulation identifies when and how those plans must register its intent to have its covered persons included in the benefits of this act.

The regulation is intended to clarify that the covered person will incur the cost of the estimated deductible, copayment and coinsurance at the conclusion of treatment but that cost may be adjusted to reflect the patient's share of cost based on the final amount paid for services provided.

The regulation also provides that certain sensitive information is protected and not disclosed to the public or competitors.

Finally, the regulation gives clear direction on the information to be posted on the website of the Department to allow Plans to be identified and notified of matters covered by this act and regulation.

Section 1. Chapter 439B of NAC is hereby amended by adding thereto the provisions set forth in section 2 inclusive of this regulation.

Sec. 2

1. Pursuant to Section 11 of AB 469 a "third party" includes:

- (a) A health benefit plan as defined in NRS 695G.019 which is authorized to do business and has issued a health benefit plan subject to regulation by the state of Nevada.*
- (b) Any other entity, not subject to regulation under Title 57, that elects to have this act apply to residents of the state of Nevada.*
- (c) The Public Employees Benefits Program*
- (d) Any entity excluded under Section 11 of AB 469 or not covered by subsections (a) and (b) above is not a third party for purposes of AB 469*

Sec. 3

1. A person whose policy of health insurance is subject to the jurisdiction of another state as to terms, benefits or the manner of sale shall be deemed to be sold outside this State for purposes of AB 469.

Sec. 4. *An out-of-network provider or facility is entitled to be promptly paid a reasonable estimate of the in-network copayment, coinsurance and/or deductible based upon the services*

rendered. The patient's in-network share of cost may be adjusted if necessary, after final adjudication of the claim or invoice based on the patient's in-network health insurance plan design.

Sec. 5. Notification

1. Notification by email or telephonic means to the contact provided on the website maintained by the Director under Section 8 (2)(c) below of the patient's name and member identification number shall be deemed proper notice under Section 14 subsection (2) (a) of AB 469.
2. If the third party is notified by the provider of care that the covered person has stabilized sufficiently for transfer, all responsibility for that patient becomes the obligation of the third party at the time it physically removes that patient or otherwise accepts the custody of that covered person.
3. If the third party does not accept responsibility for the transfer of the patient within 24 hours after being notified, the third party will be responsible for all charges incurred in caring for that covered person after the notice was sent.
4. If the provider of care or facility is unable to identify and notify the payer, the charges for the inpatient services rendered shall be resolved by the provisions of this act as a continuation of the medically necessary emergency services.

Sec. 6. Arbitration Panel

1. The Director of the Department of Health and Human Services (DHHS) or a designee of the Director shall maintain a website listing the organizations that have been approved for use as arbitrators or panels of arbitrators available to be utilized for disputes over the amount of money owed for medical necessary services covered by AB 469 including whether the services were medically necessary as defined by Sections 6 and 8.5 of AB 469.
2. No person is eligible to be listed on the roster of available persons to arbitrate that has not been approved by the State as being generally knowledgeable about AB 469, trained in the process of arbitration and proven to be competent, reliable and independent.
3. Approval of nationally recognized arbitration services shall include the same determination of competency and independence as would apply to individuals.
4. To the extent practicable those persons identified by the state as available for claims under \$5000 should be made available for disputes over \$5000.

Sec. 7. Arbitration Process

1. The arbitrator shall accept and consider from either party any information that party considers helpful to the arbitrator in choosing one of the two amounts in dispute. The arbitrator shall adopt either the offer made by the third party pursuant to Section 15(2) or 16(2) of AB 469 or the additional amount requested by the provider of health care or facility pursuant to 17(2) of AB 469. No other amount may be chosen
2. Unless requested by one of the parties, the arbitrator is not required to hold a formal hearing.
3. If a formal hearing is requested, the arbitrator shall hold that hearing in private allowing each side to make a brief presentation. The arbitrator shall render a decision to the parties within 30 days.
4. Under no circumstances shall the information supplied by one party be shared with the other party unless offered in a requested hearing before the arbitrator nor shall it be made public in any fashion.
5. Other than communication of the decision to the two parties, the decision as to the amount

owed is confidential and shall not be public.

6. The arbitrator shall report at least monthly to the Department as required in Section 19 of AB 469 without violating the confidentiality of the amount or the supporting information.

Sec. 8.

1. In addition to the information required by Section 19(1), pursuant to Section 19(2) all third parties and all providers or facilities that provide out of network emergency services shall report to the Department the number of incidents of out of network emergency services claimed or rendered for the preceding 12 months governed by this act.
2. The Director shall create and maintain the website required under Section 18(1), identifying each third party subject to this act.
 - a. Such listing must include all insurers authorized to sell insurance in Nevada and their health plans approved by the Commissioner of Insurance or otherwise authorized for sale in this state.
 - b. Such listing must also include all third-party benefit plans under Section 2 (1)(b) above which have filed by December 15th their annual election to accept the provisions of AB 469 for a period of one year commencing with January 1 of the ensuing year.
 - c. Each third party identified in (a) or (b) above must provide for listing on the website an email address that will automatically confirm receipt and telephone number with continuous staffing so providers and facilities can obtain plan information and provide notices under this act.

Sec. 9. Nothing in this regulation shall prohibit any payer and any out of network provider or facility from mutually agreeing to any arrangement between themselves that does not expose the patient to any expense for covered medically necessary emergency services greater than the copayment, coinsurance or deductible required for such services provided by an in-network provider or facility.



9127 W. Russell Road #110
Las Vegas, Nevada 89148

November 10, 2019

Sent via email: [clembree@adsd.nv.gov](mailto:clebree@adsd.nv.gov)

Carrie Embree
Governor's Consumer Health Advocate
State of Nevada Office of Consumer Health Assistance
[clembree@adsd.nv.gov](mailto:clebree@adsd.nv.gov)

Re: Comments on Proposed Regulation of the Office of Consumer Health Assistance of the Department of Health and Human Services, LCB File No. R101-19I

Dear Ms. Embree:

US Anesthesia Partners (USAP) is a single-specialty physician group focused on delivering superior anesthesia services through a commitment to quality, excellence, safety, innovation, satisfaction, and leadership. We sincerely appreciate the opportunity to provide comments to the Office for Consumer Health Assistance for the State of Nevada regarding the Initial Draft of proposed regulations related to AB 469, LCB File No. R101-19I.

We also thank the State of Nevada for taking important action to protect patients from surprise medical bills in emergency contexts, and we appreciate your Office's leadership and efforts to ensure that the rulemaking process supports continued progress to protect patients and results in fair treatment to medical providers and insurance carriers. As an organization which has always had an "in-network strategy," USAP applauds the efforts taken to date and we hope our continued feedback is helpful in furthering seamless implementation of AB 469 in 2020.

Our comments below are organized in response to the Initial Draft of proposed new regulations, LCB File No. R101-19I, and where possible we have offered potential revised language for your consideration.

Sec. 17 – Submission, contents and review of requests for arbitration for claims of medically necessary emergency services.

Subsections 17.2 and 17.3 – Timeframe for Arbitration Requests. We respectfully recommend the drafters consider revising Subsection 17.2 to allow out-of-network providers 30 calendar days (instead of 10 business days as currently proposed) from the date the third party refuses to pay the additional amount requested or fails to pay that amount pursuant to AB 469, Sec. 17.3. While out-of-network providers should certainly endeavor to submit arbitration requests expeditiously, we respectfully request the drafters consider this proposed revision given the significant consequence for an untimely arbitration request, which amounts to a waiver of the right to arbitrate the third party's unilateral reimbursement rate altogether. Such a 30 calendar day window would also be consistent with laws and

regulations in other states which routinely require arbitration requests to be submitted within 90 days of the original offer of reimbursement by the third party.

For clarity and convenience, we propose Subsections 17.2 and 17.3 be revised as follows:

2. The request for arbitration must be submitted by the out-of-network provider to the Department no later than 30 calendar days from the later of:
 - (a) The date the third party refuses to pay the additional amount requested; or,
 - (b) The date the third party fails to pay the additional amount requested in the time period provided by AB 469, Sec. 17.3.
3. The Department will not accept applications requesting arbitration past 30 calendar days from the later of the date the third party refuses to pay the additional amount requested or fails to pay that amount pursuant to AB 469, Sec. 17.3 and payment received will be considered payment in full.

Subsection 17.4 – Online Filing of Arbitration Requests and Contents. We recommend considering revising Subsection 17.4 to clarify that arbitration request forms shall be submitted through an online process and that both parties shall be notified of the request and the applicable timelines. It is important for the submission process to be efficient and simple. To that end, any potential for arbitration request forms be submitted by hard copy through the postal service or otherwise could hinder the ability of both providers and carriers alike to file a request for arbitration quickly when appropriate.

In addition, we recommend the drafters consider deleting Subsection 17.4(h) in its entirety which, as proposed, would require out-of-network providers to disclose in all arbitration requests a “representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same, region, from health plans in which the provider does not participate.” The intent of AB 469 is to ensure that out-of-network providers are reimbursed “fair and reasonable rates.” Such information would not give the arbitrator useful information. Reimbursement rates commercial payors have offered out-of-network providers on other claims for emergency services in different situations would not necessarily have any bearing on the unique aspects of a specific claim at issue in the subject dispute. In addition, this information could simply reflect a pattern and practice of underpayments by carriers over the last few years that the arbitration procedure is designed to correct. If adopted, this requirement would also incentivize commercial payors to offer lower reimbursement rates for out-of-network emergency claims on a global level given their knowledge that such information might be used by an arbitrator as a benchmark in future arbitrations. Ultimately, all of these risks could yield an increase of the number of disputed out-of-network claims put to arbitration and would unduly burden the Department with a multitude of arbitrations on disputed claims that should have been reimbursed fairly and reasonably at the outset.

Additional Proposed Revision – Regulation on Bundling Claims for Arbitration. We recommend a regulation which specifies that a single arbitration can address multiple claims on disputed out-of-network emergency claims. The text of AB 469 is silent on this issue, but the general spirit of the new

law is to facilitate fair and efficient dispute resolution. Certainly, after AB 469 takes effect, there could be a multitude of scenarios where conducting a single arbitration covering disputes associated to multiple claims would further this purpose, especially to the extent these claims involve substantially similar issues and billing codes.

However, we also recognize that there must be some limitations on the “bundling” of claims in a single arbitration. Accordingly, we recommend considering a regulation which provides:

Multiple claims may be heard and determined in a single arbitration proceeding if each of the following three conditions are met: (1) the claims involve the identical carrier and the identical facility/provider; (2) the claims involve the same or related current procedural terminology codes relevant to a particular procedure or service; and (3) the claims occur within a period of three months of each other.

Additional Proposed Revision – Clarification as to Arbitrator’s Award. AB 469 provides a specific and detailed procedure for the arbitration process for out-of-network billing disputes as to emergency claims. In short, the arbitrator’s decision is to be final and not subject to any appeals or future litigation. Accordingly, in order to avoid inviting potential litigation and further disputes over an arbitrator’s decision, we recommend the addition of a regulation which provides:

The arbitrator shall render a decision in accordance with the procedures outlined in Sec. 17 of AB 469 without any reference to any other statutes addressing arbitration, such as the Nevada Uniform Arbitration Act and the Federal Arbitration Act, or any other rules of procedure governing arbitration in other private contexts, such as the American Arbitration Association Rules of Arbitration and the Rules of Procedure for Commercial Arbitration of the American Health Lawyer’s Association.

Additional Proposed Revision – Identifying Conflicts of Interest. We recommend a regulation regarding Sect. 17.4 of AB 469 which allows both the commercial payor and the out-of-network provider an opportunity to identify and disclose any personal, professional, or financial conflicts of interest with any of the five arbitrators randomly selected for the parties’ consideration on arbitrations for disputes on claims over \$5,000.00. Providers and payors can be in a position to maintain this information, and it would be efficient to allow each of them an opportunity to identify and disclose potential conflicts between the arbitrator and any other party to the arbitration before undertaking the task of selecting an arbitrator to preside over an arbitration. This would ensure that the parties have the opportunity to consider five truly “qualified arbitrators” without the inclusion of arbitrators with conflicts of interest, which AB 469 clearly intends.

Thank you again for the opportunity to share our comments for the foregoing proposed regulations related to the implementation of AB 469, and we appreciate your leadership on this important issue.

Sincerely,

US Anesthesia Partners



December 17, 2019

Carrie Embree, LSW

Governor's Consumer Health Advocate
Nevada Department of Health and Human Services
Aging and Disability Services Division
3416 Goni Road, Bldg. D #132 | Carson City, NV 89706

RE: LCB File No. R101-191

Dear Ms. Embree:

On behalf of the hundreds of physicians in Nevada who are members of Physicians for Fair Coverage (PFC), I want to thank you for the opportunity to provide input on LCB File No. R101-191.

PFC is a non-profit, non-partisan, multi-specialty alliance of physicians dedicated to improving patient protections, promoting transparency, and ensuring access to care for patients in Nevada and nationwide. Our national membership of tens of thousands of physicians care for millions of patients each year in thousands of facilities throughout the country. In Nevada, we have worked closely with our partners in state medical associations, including the Nevada State Medical Association and the Nevada Hospital Association, to pass legislation to end surprise medical billing and provide strong protections for our patients. Now we are pleased to offer comments on the proposed regulations.

At Section 17, Subsection 2(a), the regulation proposes the provider submit the request for arbitration "no later than 10 business days." As payments are complicated and require extensive time to process, we would respectfully request an extension to 90 days.

At Section 17, Subsection (h)(4)(e), you request the provider document a "representative sample of at least 3 fees...." In lieu of this Section of the regulation, in order to ensure transparency and to reduce the administrative burden, we strongly suggest the State subscribe – as other states have -- for a small fee to access FAIR Health data. This data, which can be sorted by geographic area, is encompassed in a simple tool that holds all parties accountable. FAIR Health is an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims and is entrusted with similar data from Medicare, as well as state Medicaid programs. FAIR Health also has a consumer portal aimed at helping Americans better understand healthcare costs. <https://www.fairhealthconsumer.org/>

At Section 17, Subsection 6(a), we would recommend you review New York's guidelines pertaining to out of network billing arbitration. They have fine tuned their system over time and have one of the more consumer friendly and effective solutions in the country. More information can be found at:

https://www.dfs.ny.gov/insurance/health/OON_guidance.htm

At Section 18.1, regarding third party election, we continue to be concerned about how the medical community will be aware of which plans have or have not elected to participate in the provisions of AB469. During the Legislative Session, PFC recommended a notation on the insured's insurance card or in their electronic health record. We continue to believe this will help all involved in the care process to know who is in and who is out. Additionally, we would suggest that any plan opting-in be required to do so for the period of a full plan year to avoid greater confusion for beneficiaries and the physicians who care for them.

Finally, with regard to the actual process of arbitration, we believe this can be done most efficiently, effectively and at lower cost when it is done on-line as other states have done with similar arbitration processes.

Thank you, again, for the opportunity to comment. We stand ready to work with you throughout the regulatory process.

Sincerely,

A handwritten signature in black ink that reads "Michele Kimball". The signature is written in a cursive, flowing style.

Michele Kimball
President and CEO
Physicians for Fair Coverage



December 18, 2019

Carrie Embree, LSW
Consumer Health Advocate
3416 Goni Road, Bldg. D-132
Carson City, NV 89706

RE: Regulations pertaining to AB469

Dear Ms. Embree,

On behalf of the Nevada Association of Health Plans (NVAHP), I am writing to express concerns among our member companies that the Assembly Bill (AB) 469 regulations have yet to be adopted with regards to the Opt-In Process for self-funded employers and the Arbitration process in advance of the January 1, 2020 effective date of implementing the legislation.

We are concerned that since a permanent, temporary or emergency regulations pertaining to the Opt-In process or the Arbitration process has not been adopted, that it makes it more likely that the roll out of the Surprise billing requirements could result in members being balanced billed, confusion with Medical Providers and Medical Facilities as to which self-funded Payers have Opted-In, and which patients are covered by the Surprise billing requirements. Additionally, Payers, medical providers and medical facilities will not know the rules on the arbitration process.

NVAHP previously participated in the August 28, 2019 Public Workshop regarding regulations pertaining to AB469 and sent a letter to Office of Consumer Health Advocate (OCHA) (attached) detailing our concerns. On November 18, 2019, almost three months after the Workshop, we received Draft Permanent Regulations (LCB File No. R101-19).

Since the regulation is still in draft form and it appears that the regulation process will carry into 2020, all Payers, Medical Facilities and Providers are in limbo as to the final rules on the Opt-In and Arbitration process.

The Health Insurance Industry worked very hard on passage of this important legislation with the understanding that it would be difficult to comply with key provisions. We were hopeful that there was enough time between engrossment and the effective date that regulations would be promulgated and a clear path for compliance would be afforded to the industry. That has not occurred.

We recommend that an emergency regulation be adopted until either a temporary or permanent regulation can be adopted. Additionally the Health Department should consider whether a safe harbor for all parties should be put in place for Payers, Facilities and Provider when the parties attempt to comply with AB 469 until regulations are adopted.

NvAHP is willing to participate in the rule making process and assist OCHA in providing updates to its member plans and the health insurance industry. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jack Kim', with a long horizontal flourish extending to the right.

Jack Kim
President

cc: Allison Combs, Policy Director, Governor Sisolak's Office
Assemblyman Jason Frierson, Speaker, Nevada State Assembly
Senator Nicole Cannizzaro, Majority Leader, Nevada State Senate
Richard Whitley, Director, Nevada Department of Health and Human Services