October 10, 2021

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

Re: Comments on Revised Draft of Proposed Regulation 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 appreciate this opportunity to provide our comments to the Office for Consumer Health Assistance for the State of Nevada regarding the Revised Draft of Proposed Regulation LCB File No. R101-19 (dated September 9, 2021), as posted at http://dhhs.nv.gov/Programs/CHA/.

We again thank the State of Nevada for taking important action to protect patients from surprise medical bills in emergency contexts, and we appreciate your ongoing 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 appreciates your efforts taken to date, and we hope our feedback is helpful in furthering seamless implementation of AB 469.

We appreciate your consideration of our previous comments to earlier drafts of No. R101-19, and our additional comments below are provided in response to the most recent proposed regulation referenced above.

Conflicts of Interest Impacting Potential Arbitrators. The addition of new language in Section 5 of No. R101-19 provides additional guardrails to define conflicts of interest impacting a potential arbitrator. We support the goal of ensuring potential arbitrators are non-conflicted and thus able to render a decision impartially. The new extensive list of disqualifying conflicts of interest includes not only the arbitrator but also "any person affiliated with the arbitrator." Further, an individual who receives or has "the right to receive, directly or indirectly, remuneration pursuant to any arrangement for compensation with a health care facility, insurer or provider of health care" might simply have experience as a consultant providing contracted services to numerous entities of varying types. It is possible, given the scope of disqualifying conflicts of interest in the current draft, that few individuals with relevant experience in health care would even have the possibility of serving as arbitrators. If you also take into account potential conflicts of individuals who are "affiliated with the arbitrator", many more individuals would be automatically disqualified from serving as arbitrators. We therefore make the following recommendations regarding conflicts of interest:

(1) We recommend adding a definition of "affiliated with the arbitrator" so that an objective standard is available to identify what constitutes being "affiliated with", such as being "an immediate family member" or similar.
(2) In addition, we suggest that there should be an express requirement for potential arbitrators to disclose their specific potential conflicts of interest to the Department and the parties to the arbitration.
(3) Finally, we suggest that the parties to the arbitration have an option to waive a potential conflict of interest. Specifically, if both parties agree in writing that an otherwise conflicted arbitrator is nonetheless qualified to render an impartial decision for the specific matter at hand, such waiver may be documented, and the parties may proceed with such arbitrator.

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." Section 4 of the proposed regulation states that that the arbitrators must be selected from the American Arbitration Association, JAMS, or their successor organizations. We renew our suggestion that the language of the statute be preserved so that arbitrators from other nationally recognized providers *may* be selected if appropriate. Although claims of $5,000 are likely to be very rare for our practice, we support preserving the scope and meaning of AB 469 as drafted and enacted.

Reporting by Insurers and Health Care Providers. The current draft regulation includes helpful new clarifying updates in Section 6, and we appreciate the efforts to increase transparency by establishing meaningful reporting obligations regarding changes in the number of contracts between health care providers and insurers. Additional clarifications to the reporting obligations of insurers would support the goal of providing visibility into the overall trends in the number of clinicians covered by agreements with such insurers.

We respectfully suggest adding a requirement that insurers also must specify the approximate number of clinicians covered by each contract entered into or terminated/expired. Given the update in language to require reporting of the percentage of increase or decrease in contracts with providers, it is especially important to gain visibility into the relative number of clinicians covered by such contracts. For example, a decrease in number of contracts might appear small in percentage, but termination or expiration of three contracts could be very significant if those contracts were with medical practices that employed many clinicians. Similarly, an increase in the number of contracts could appear significant, but if that increase represented five contracts with individual practitioners, it would not be as relevant to expanded patient coverage as five contracts with medical practices that employ numerous clinicians.

Under the current draft language, an insurer could report that its number of contracts was increasing, when in fact the number of clinicians covered by its contracts had declined. Revising Section 6.2(c)-(d) as follows would address this issue (proposed new language underlined):

> *(c) Whether there was an increase in the number of new provider contracts (and number of clinicians covered by all contracts) entered into by the third party with providers of medically necessary emergency services and the percentage of the increase of number of contracts and number of clinicians covered by such contracts from the immediately preceding year and the types of providers with whom provider contracts were entered into; and*
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> *(d) Whether there was a decrease in the number of provider contracts (and number of clinicians covered by all such contracts) between the third party and providers of medically*

necessary emergency services and the percentage of the decrease in number of provider contracts and number of clinicians covered by all such contracts from the immediately preceding year.

Regulation on Bundling Claims for Arbitration. We renew our recommendation for 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 renew our recommendation of 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.*

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

Sincerely,

US Anesthesia Partners

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St. Rose Dominican

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December 14, 2021

Dena Schmidt
Nevada Aging and Disability Services Division
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Re: AB 469 Regulations; LCB File No. R101-19I

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 letters to you, dated September 27, 2019 and February 4, 2020, St. Rose listed multiple concerns that our internal operationalization working group had in the midst of guaranteeing that we could comply with the state 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. With the passage of the No Surprises Act, this has become even more complicated to operationalize and there are additional concerns that have arisen. St. Rose has a meeting scheduled for December 15 with both OCHA and the Nevada Division of Insurance (DOI) to also walk through some questions we have regarding a potential federal/state crosswalk, and we hope that will be a fruitful discussion.

Because this regulatory body hasn't met in almost two years due to the COVID-19 pandemic, St. Rose would like revisit its previous comments and questions which still apply to the newest set of proposed regulations dated September 9, 2021:

- **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 are 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 120-day withdrawal provision and ask that the timeline be changed to that of an annual basis. St. Rose appreciates that the regulatory body changed this timeline from 30 to 120 days, but we believe an annual timeline allows for less administrative burden.

- **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, and for eliminating section 2.2.e.3, which requested a representative sample of at least three (3) fees received by the OON provider for the same service and was outside the scope of what AB 469 required. As it pertains to the overall arbitration process, St. Rose again 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 2023 Nevada Legislative Session.
- **Further Questions:** In addition to our questions previously asked in our previous letters, 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 letters that St. Rose would still like answered or legislated during the 2023 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. Our questions include:
    - 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?

- **<u>Arbitration Process for Claims Under $5,000:</u>** 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.
- **<u>State-Purchased Health Insurance Policies:</u>** Section 13.2 of AB 469 indicates that this bill does not cover policies sold outside of the State of Nevada. Hospitals currently do not have the ability to know when a patient comes in if the policy was sold within the state or not, and due to the No Surprises Act, which law each patient's case will need to follow. St. Rose requests that along with ERISA plans that have opted-in to participate, state-purchased plans are also listed on the website, and that state-purchased plans have a symbol or code printed on them that makes them easily identifiable for these purposes. 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. St. Rose also suggests that the DOI create a crosswalk that easily shows which law (federal or state) should be followed for each patient.

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,

Jon Van Boening
Dignity Health-St. Rose Dominican
Nevada Market Leader
President/CEO, Siena Campus

Linda Tautz
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Neighborhood Hospitals