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 law[1]. Our concern is that the PLP standard in AB 469 and state law[2] 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]henever 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 EMTALA[3] 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/6onkj1jaiy3f1618iy7j0gpzdoew2zu9). 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

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 Mundinger, Executive Director of EDPMA, at emundinger@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