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

ELISABETH S. FLEMMING
J. RUSTY GRAF
BRIGID M. HIGGINS
STEVEN J. MACK

BLACK & LOBELLO
ATTORNEYS AT LAW

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JAMES L. WADHAMS
JESSE A. WADHAMS
DELWYN E. WEBBER
SHANNON M. WILSON*

SEAN T. HIGGINS*

*OF COUNSEL
*ALSO LICENSED TO PRACTICE IN FL

January 15, 2020

Sent via email: clembree@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

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.