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9127 W. Russell Road #110
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November 10, 2019 Sent via email: clembree@adsd.nv.gov

Carrie Embree
Governor's Consumer Health Advocate
State of Nevada Office of Consumer Health Assistance
clembree@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

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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

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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