Network Adequacy Advisory Council

June 15, 2023

Agenda Item #6

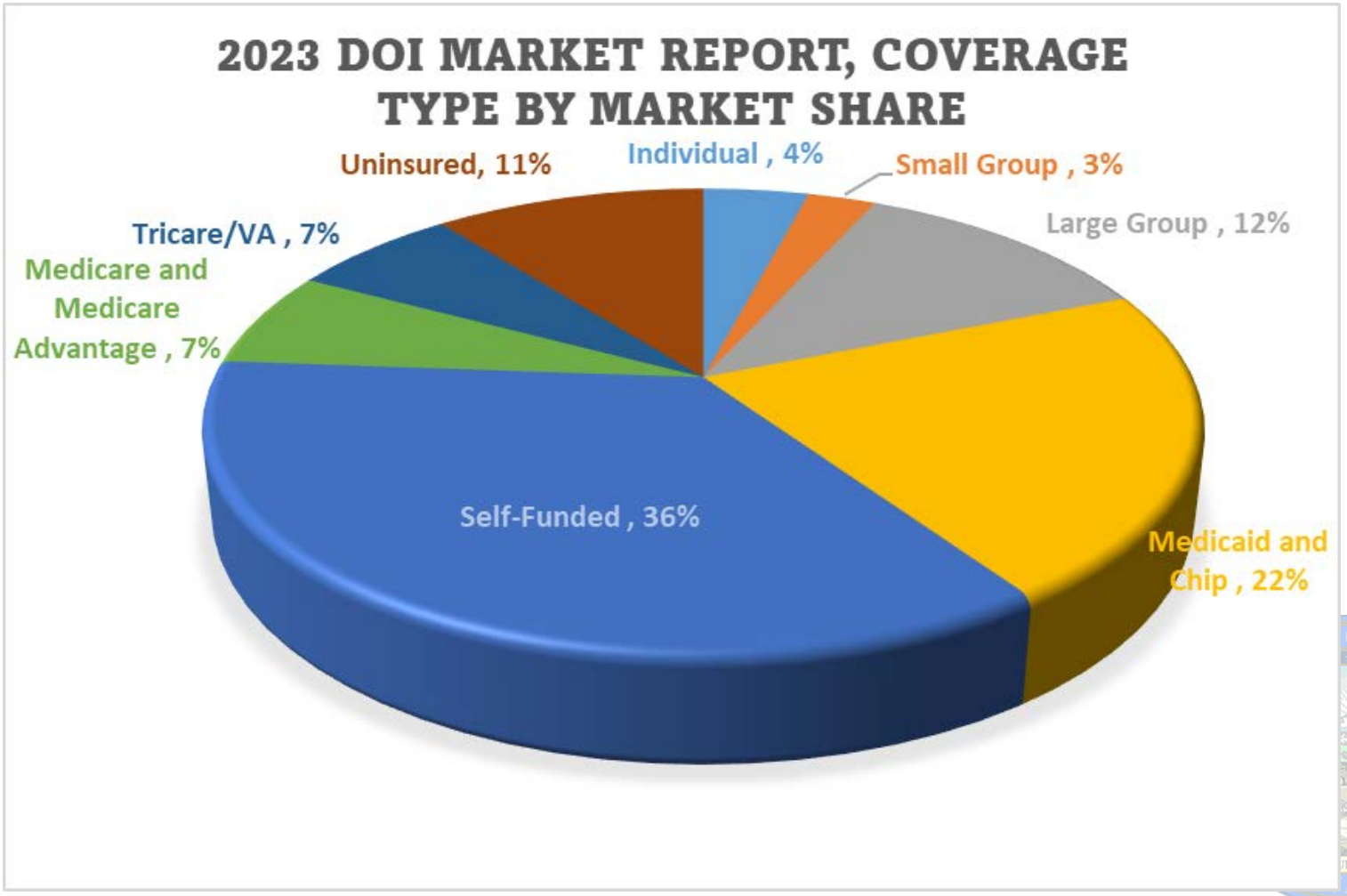
Current Year Health Insurance Coverage Market Overview

Nevada, Sources of Coverage

Coverage Type	Regulation or Administration of	2023 DOI Market Report, Members (000s)	2023 DOI Market Report, Market Share
Individual (DOI)	Title 57, NV DOI (Forms and Rates)	129	4%
Small Group (DOI)	Title 57, NV DOI (Forms and Rates)	83	3%
Large Group (Fully Insured) (DOI)	Title 57, NV DOI (Forms)	380	12%
Medicaid and Chip (NV DHHS)	NRS 422, Nevada DHHS (Administration of)	680	22%
Self-Funded (Federal)	Federal Law (ERISA, HIPAA, COBRA, ADA, TEFRA, DEFRA, ERTA and others	1123	36%
Medicare and Medicare Advantage (Federal)	Federal/CMMS (Medicare and medicare advantage) NV DOI regulates medicare supplement (forms and rates)	210	7%
Tricare/VA (Federal)	Defense Health Agency and Secretary of Veteran Affairs	207	7%
Uninsured	None	333	11%

Division of Insurance

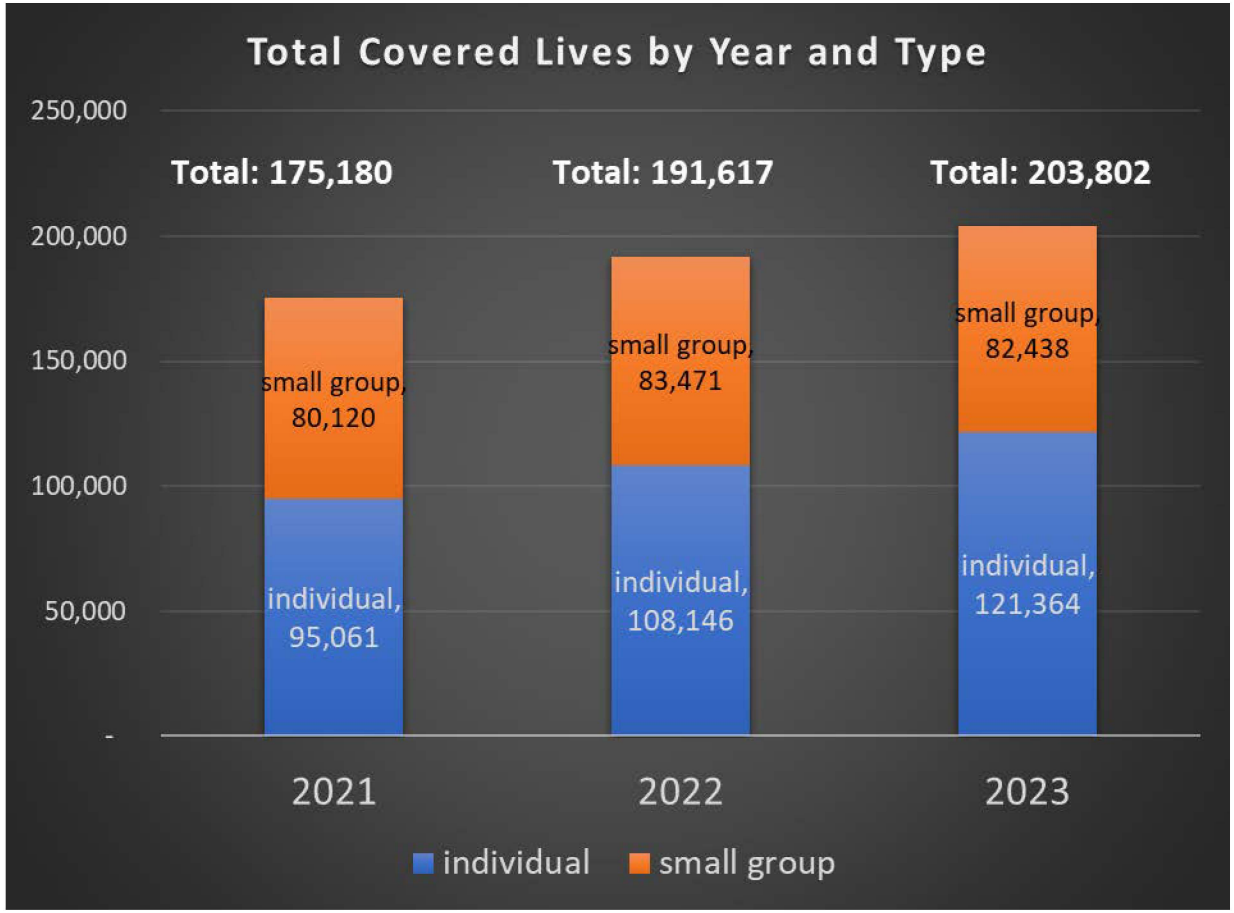
Nevada



State of Nevada
Department of Business & Industry

Division of Insurance

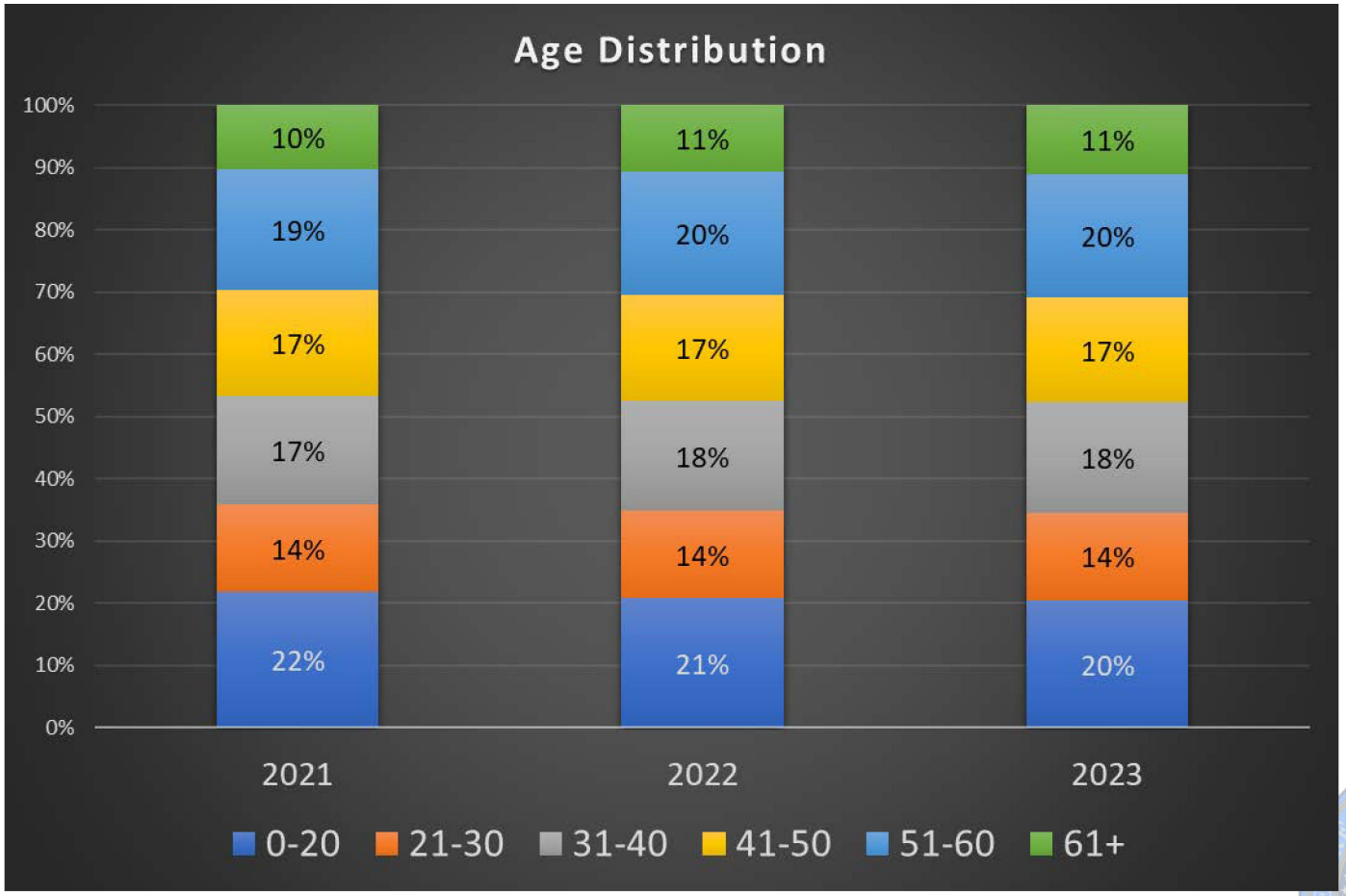
Protect Consumers
Ensure Solvency



State of Nevada
Department of Business & Industry

Division of Insurance

Protect Consumers
Ensure Solvency



State of Nevada
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Division of Insurance

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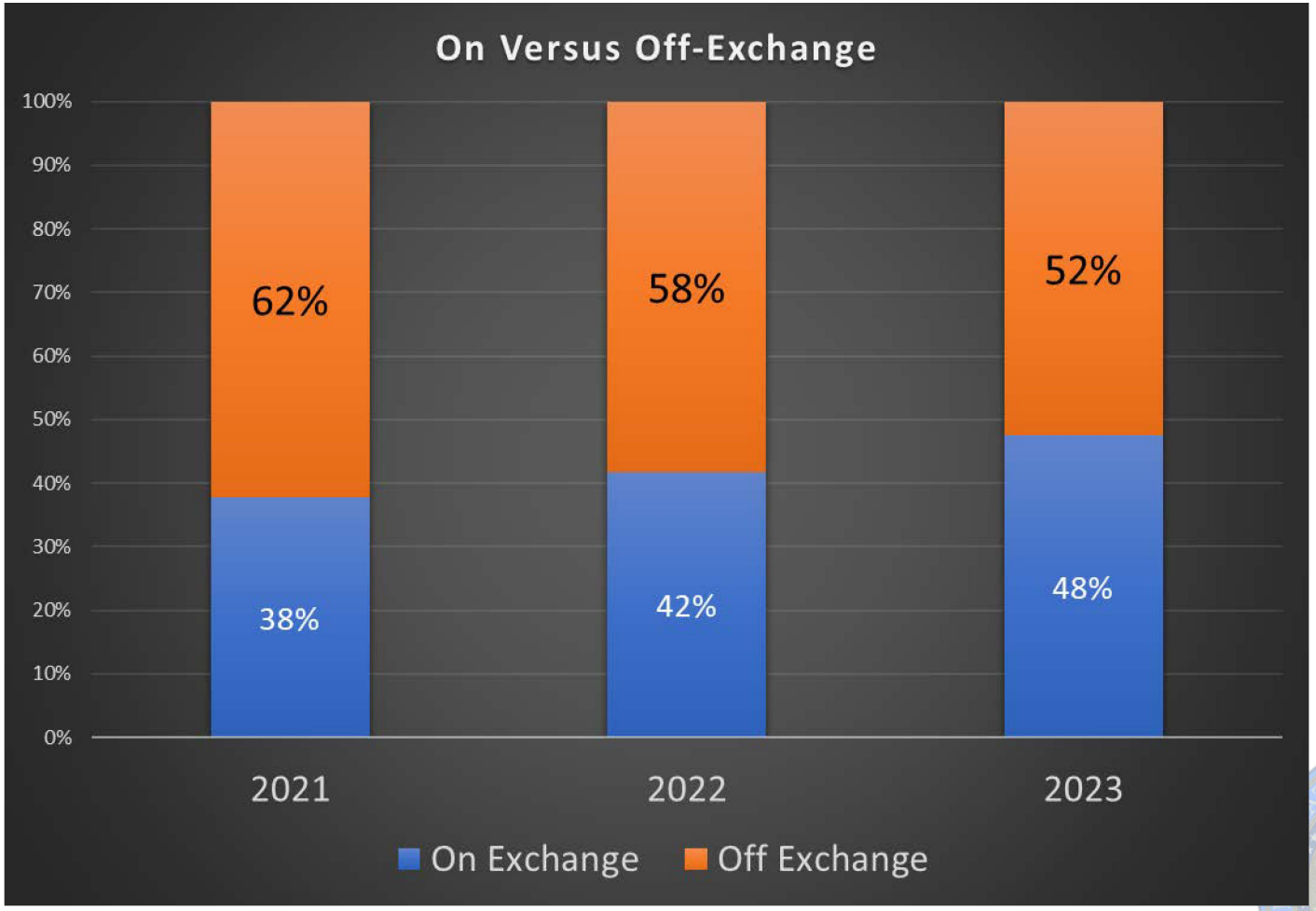

State of Nevada
Department of Business & Industry

Division of Insurance

Protect Consumers
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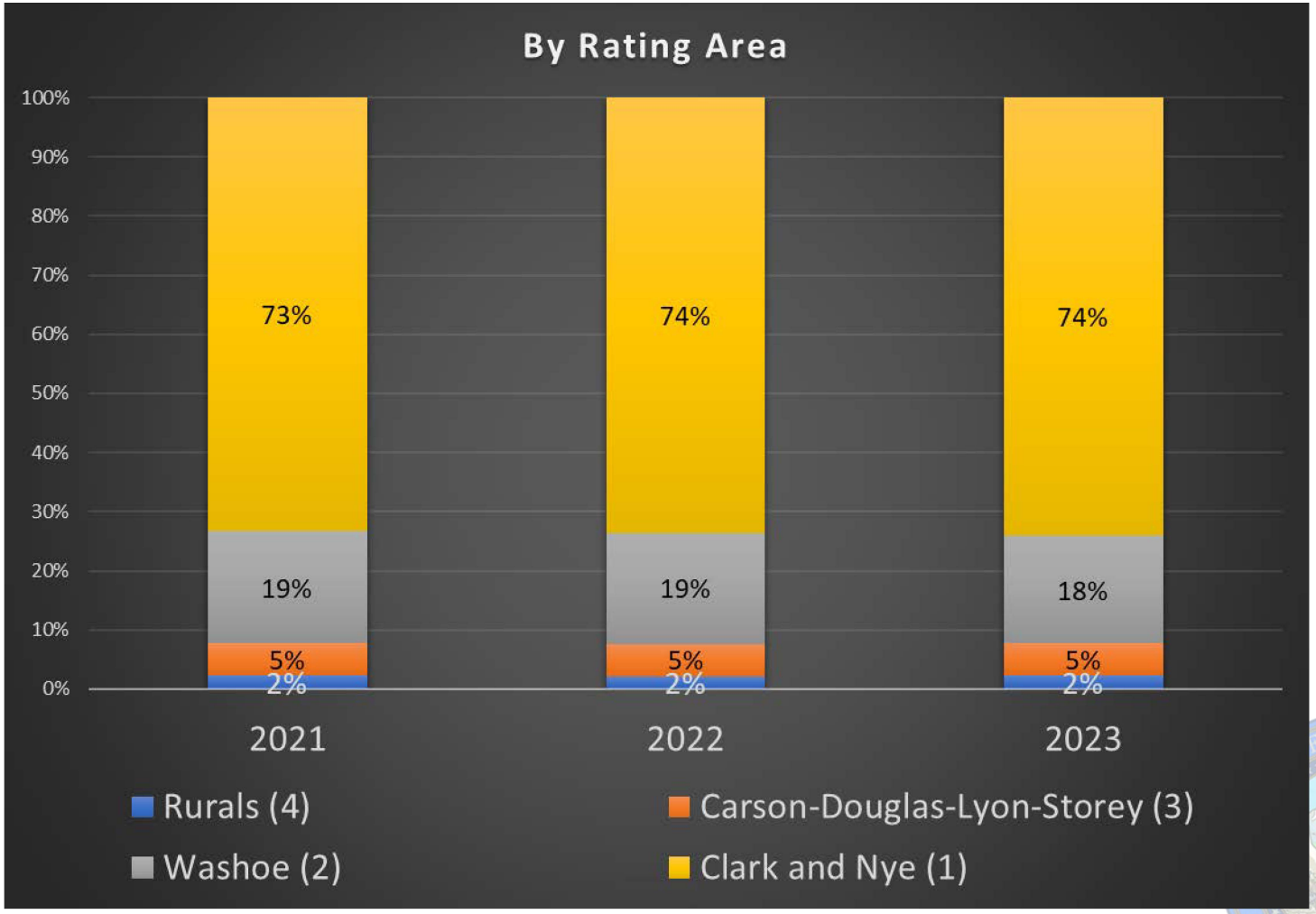
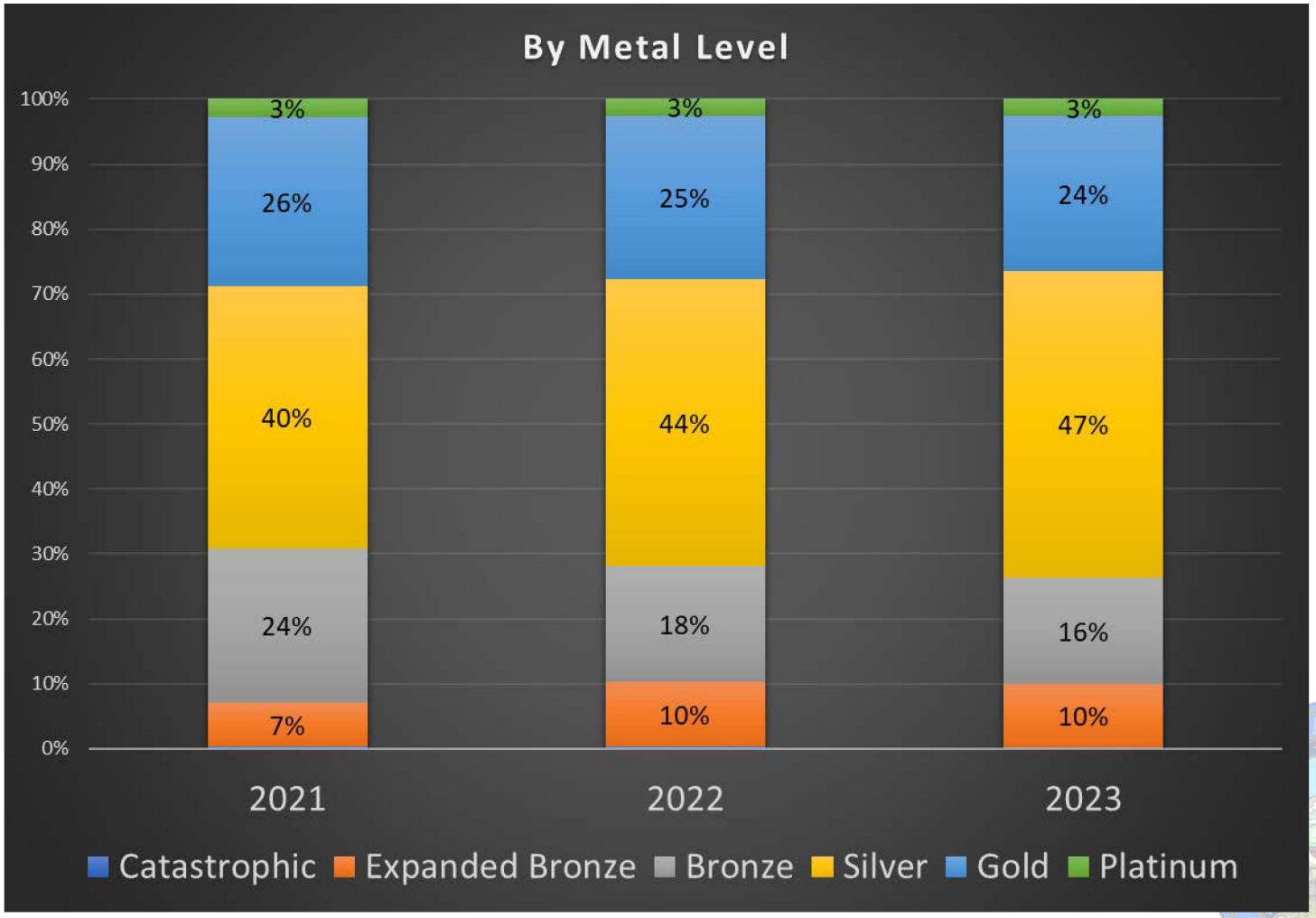


State of Nevada
Department of Business & Industry

Protect Consumers
Ensure Solvency

Division of Insurance



Agenda Item #7

Review of CMS Notice of Benefit and Payment Parameters for 2024

2024 NBPP

Network Adequacy

Removal of Exception for No Network

- Applies to all individual QHP's, SHOP, and SADP's
- Network and ECP standards apply even if plans don't use a provider network
- Exceptions for SADP's when DOI attests that 80% of counties are CEAC

Appointment Wait Time Standards

- Finalized in 2023 NBPP to be implemented in PY2024 with guidance to follow later
- No guidance issue
- Delayed implementation to PY2025

Two New Stand-Alone ECP Categories

- Mental Health Facilities
- Substance Use Disorder Treatment Centers

ECP Provider Categories

Major ECP Category	ECP Provider Type
Fed Qual Health Center	FQHC and FQHC “Look-Alike” Clinics
Ryan White Program Providers	Ryan White HIV/AIDS Providers
Family Planning Providers	State Owned, Governmental, and Not-for-profit family planning sites
Indian Health Care Providers	Tribes, Tribal Organizations, and Urban Indian Organization Providers; Indian Health Service Facilities
Inpatient Hospitals	Disproportionate Share Hospital, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Sub. Use Disorder Treatment Ctr.	Substance Use Disorder Treatment Providers
Mental Health Facilities	Community Mental Health Centers, Other Mental Health Providers
Other ECP Providers	Black Lung Clinics, Hemophilia Treatment Centers, Rural Health Clinics, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Rural Emergency Hospitals

QHP's Min. Contracting Req. for Certain ECP's

- Required to contract with 35% of
  - FQHC's
  - Family Planning Providers
- In addition to existing 35% requirement
- Affects issuers subject to alternate ECP Standard under CFR 156.235(b)

Agenda Item #8

Legislative Update

Changes to Expand Scope or Authority of Individuals to Provide Health Care

AB311: Authorizes hospitals to enter into agreements with the Armed Forces to allow unlicensed individuals, federal employees, and surgical technologists to provide care under certain conditions, exempting them from licensure and regulation requirements.

AB432: Introduces various changes to the practice of optometry. It includes provisions for notifications to the Nevada State Board of Optometry, allows certain individuals in educational or residency programs to practice optometry, sets requirements for optometric telemedicine, and adjusts fees and ownership regulations.

SB336: Exempts certain practitioners of healing arts from provisions governing other healing arts if they practice within their authorized scope. It also establishes regulations for certified registered nurse anesthetists, allowing them to order, prescribe, possess, and administer controlled substances under specific circumstances.

AB120: Revises restrictions on the provision of voluntary health care services. It modifies the requirement for providers of health care, allowing those who were not initially issued their license within the past 3 years but have practiced within that timeframe to provide voluntary services in the state.

SB117: Grants Medicaid coverage for services provided by community health workers. It expands coverage beyond supervision by physicians, physician assistants, or advanced practice registered nurses to include other types of healthcare providers.

SB310: Introduces the licensure and regulation of expanded function dental assistants and grants a special endorsement for dental hygienists to practice restorative dental hygiene. It authorizes dental hygienists with certain qualifications to prescribe and dispense specific drugs and devices.

Educational or Residency Program Funding

SB350: Establishes the Graduate Medical Education Grant Program, administered by the Office of Science, Innovation and Technology, to award competitive grants for residency and fellowship programs for physicians in Nevada, aiming to create, expand, and retain such programs.

SB375: Appropriates funds to expand nursing programs within the Nevada System of Higher Education to address the projected shortage of registered nurses and improve program capacity, faculty resources, and equipment.

Financial or Rule Changes to Incentivize Providers Programs or Facilities

AB45: Creates a program to repay student education loans for certain healthcare providers working in underserved communities. It establishes eligibility requirements, funding, and administration for the program, aiming to alleviate student loan debt and attract providers to underserved areas.

AB283: Authorizes the Department of Health and Human Services to establish incentive payments for doula services provided in rural areas under the Medicaid program. It also requires seeking an increase in reimbursement rates for doula services and includes an appropriation for related expenses.

Division of Insurance

Licensure Requirement Changes to Increase Supply of Providers

AB270: Introduces the licensure and regulation of anesthesiologist assistants by the Board of Medical Examiners and the State Board of Osteopathic Medicine. It outlines their scope of practice, supervision requirements, licensing fees, and reporting obligations, among other provisions.

AB343: Introduces changes to the licensing and regulation of occupational therapists and occupational therapy assistants. It allows for licenses by reciprocity, sets qualifications for obtaining licenses, revises educational requirements, and establishes a salary for Board members.

AB158: Ratifies the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact, allowing certified emergency medical service personnel to practice in other participating states. It clarifies the legal equivalence of certified personnel under the compact and makes related changes.

Litigation Rule Changes Benefiting Those Bringing Suit

AB404: Modifies limitations on noneconomic damages in civil actions against healthcare providers for professional negligence, increasing the amount over time. It also revises the statute of limitations for bringing actions against healthcare providers and adjusts the limits on contingent fees for attorneys representing plaintiffs in such cases.

Reimbursement Rate Setting or Calculation

SB42: Expands the uses of county funds for medical assistance to indigent persons. In counties with a population of 100,000 or more, the funds can be allocated for enhanced reimbursement rates to public hospitals or supplemental payments through federal programs.

AB277: Establishes provisions for rural emergency hospitals, defining them as a type of licensed medical facility. It authorizes crisis stabilization center endorsements and requires measures to increase Medicaid reimbursement for services provided by rural emergency hospitals.

SB241: Requires the State Plan for Medicaid to cover outpatient and swing-bed services provided by critical access hospitals. It sets the reimbursement rate for these services at the actual cost or the hospital's charge, whichever is lower.

SB221: Mandates the establishment of a specific billing category and reimbursement methodology for clinics that offer services to children with cancer and rare diseases under Medicaid. It appropriates funds for associated costs and programming changes.

Require Approval to Close or Convert Certain Types of Health Care Facilities

SB348: Requires written approval to close hospitals or convert them into different types of health facilities, imposes civil penalties for non-compliance, and enhances patient notification and billing requirements for off-campus emergency medical facilities.

Telehealth

AB276: Expands the definition of telehealth to include communication between providers at different locations. It allows for the use of telehealth during forensic medical examinations of sexual assault or strangulation victims to connect with trained healthcare professionals for guidance.

SB119: Extends the requirement for third-party payers to provide reimbursement for telehealth services until July 1, 2023. It emphasizes coverage for services delivered through means other than audio-only interaction in rural areas and for mental health conditions or substance use disorder treatment.

SB391: Revises provisions related to dentistry in Nevada. It modifies requirements for the State Dental Health Officer and State Public Health Dental Hygienist, expands access to teledentistry for Medicaid recipients, establishes a dental responder permit, creates a Committee on Dental Emergency Management, and imposes regulations for teledentistry and electronic record-keeping.

Willing Provider Rules

SB146: Revises hospital regulations, allowing certified nurse-midwives to perform physical examinations for patients giving birth. It also prohibits health carriers from denying certain healthcare providers from joining their networks, under specific conditions.

SB146

Stipulates that these carriers may not refuse a request from a healthcare provider to join their provider network, given the healthcare provider satisfies several conditions:

1.The provider must meet and accept all terms and conditions of the network, including credentialing requirements, provisions for contract termination, and agreeing to annual or otherwise specified performance reviews.

2.The provider must be employed by, or have accepted an offer from, a state school of medicine or osteopathic medicine where they teach students or resident physicians for at least 50% of their duty time.

3.The provider cannot have an already established clinical practice in the state when the request to join the network is made.

4.The provider must request to be a participating provider in the carrier's network.

The bill also provides grounds under which a health carrier can deny a request from a healthcare provider to join the network. These include:

1.If the health carrier contracts with a third party for service delivery.

2.If the healthcare providers in the network are paid through capitation agreements.

3.If accepting the new provider would disrupt existing provider network contracts.

The bill also gives health carriers the right to terminate a provider network contract based on terms agreed upon in the contract. Grounds for termination may include failure to maintain specified employment, issues with access, cost, or quality of care, or other issues related to the utilization of the healthcare provider's services.

Agenda Item #9

Update on Impacts of the No Surprises Act

Council Member Questions

1. How does state law work in conjunction with federal law

2. What impact might the law have on the ability (or willingness) of providers and carriers to contract with one another.

Overview of the No Surprises Act

Division of Insurance

The No Surprises Act protects consumers with most types of private health insurance coverage against certain surprise medical bill. It was signed into law in 2020, and most protections went into effect as of January 2022. The new law addresses surprise medical bills in three circumstances:

1. When an enrollee receives emergency care either at an out-of-network facility or from an out-of-network provider

2. When an enrollee uses air ambulance emergency transport services (but not ground ambulance services)

3. When an enrollee receives nonemergency care at an in-network facility but is treated by an out-of-network health care provider without knowingly electing that provider or giving consent to be billed.

In these scenarios, the law guarantees that consumers' costs are limited to in-network cost sharing and bans providers from sending patients balance bills for any amounts beyond that cost sharing.

Reimbursement Process

1. **Claim Submission**: The provider submits the bill to the health plan for adjudication. This starts the reimbursement process.

2. **Determination of the Recognized Amount (RA):** The RA is the amount that determines the member's share of the payment. It is defined as the lesser of billed charges or the Qualifying Payment Amount (QPA). The member's share is determined before the claim is paid, and it remains the same even if the plan ends up paying a higher amount.

3. **Determination of the Qualifying Payment Amount (QPA):** The QPA is the median contract rate for the plan as of January 31, 2019, adjusted for urban market CPI (CPI-U). It serves as a benchmark that is considered during the Independent Dispute Resolution (IDR) process.

4. **Initial Payment:** The plan makes an initial payment to the provider. This is an amount that the payor believes to be an appropriate full reimbursement amount. If the provider accepts this payment, it becomes the Out-of-Network Rate for the claim, and the reimbursement process is complete.

5. **Open Negotiation**: If the provider doesn't accept the payor's initial payment, the plan and provider have 30 business days to negotiate a settlement. If successful, the negotiated amount becomes the Out-of-Network Rate.

6. **Independent Dispute Resolution (IDR):** If the parties can't come to an agreement during the open negotiation, the process moves to the IDR. Both the payor and the provider submit a final offer amount to a Certified IDR Entity. This entity will choose one of the two amounts, typically the one that is closest to the QPA. However, either party can submit information to support their position that the QPA is or isn't the appropriate reimbursement in this case.

Qualifying Payment Amount

QPA is defined as the median contract rate for the health plan as of January 31, 2019, adjusted for the urban market Consumer Price Index (CPI-U). The median contract rate refers to the median amount the health plan typically pays in-network providers for the same or similar services in a similar geographic area. The QPA plays two roles:

1.It is used to determine the Recognized Amount, which is the amount that determines the patient's share of the payment for out-of-network care. The Recognized Amount is defined as the lesser of the billed charges or the QPA.

2.It is a required value that is considered during the Independent Dispute Resolution (IDR) process. If the insurer and the provider cannot agree on a payment amount, they can go to IDR, where an independent third party will make a final decision. The QPA typically serves as a reference point in this process, although either party may submit information to support their position that the QPA is or isn't the appropriate reimbursement in this case.

Independent Dispute Resolution Federal Rules

Interim Final Rule (Part I): Issued on July 1, 2021, this IFR implemented several provisions of the NSA. It provided guidelines on how the Qualifying Payment Amount (QPA) is calculated, reduced the role of bonuses, risk sharing, penalties, and other incentive-based and retrospective payments in the calculation of the QPA.

Interim Final Rule (Part II): Issued on September 30, 2021, this IFR implemented the open negotiations and independent dispute resolution (IDR) processes between providers and health plans. It established the QPA as a presumptively reasonable out-of-network payment and directed the IDR entities to select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.

Final Rules: Issued on August 19, the Final Rules addressed several provisions of the physician and provider payment process for out-of-network care under the NSA. They removed the requirement that Independent Dispute Resolution Entities (IDREs) must presume that the QPA is the appropriate out-of-network rate, among other changes.

Question 1: How does the federal law work in conjunction with state law?

Enforcement

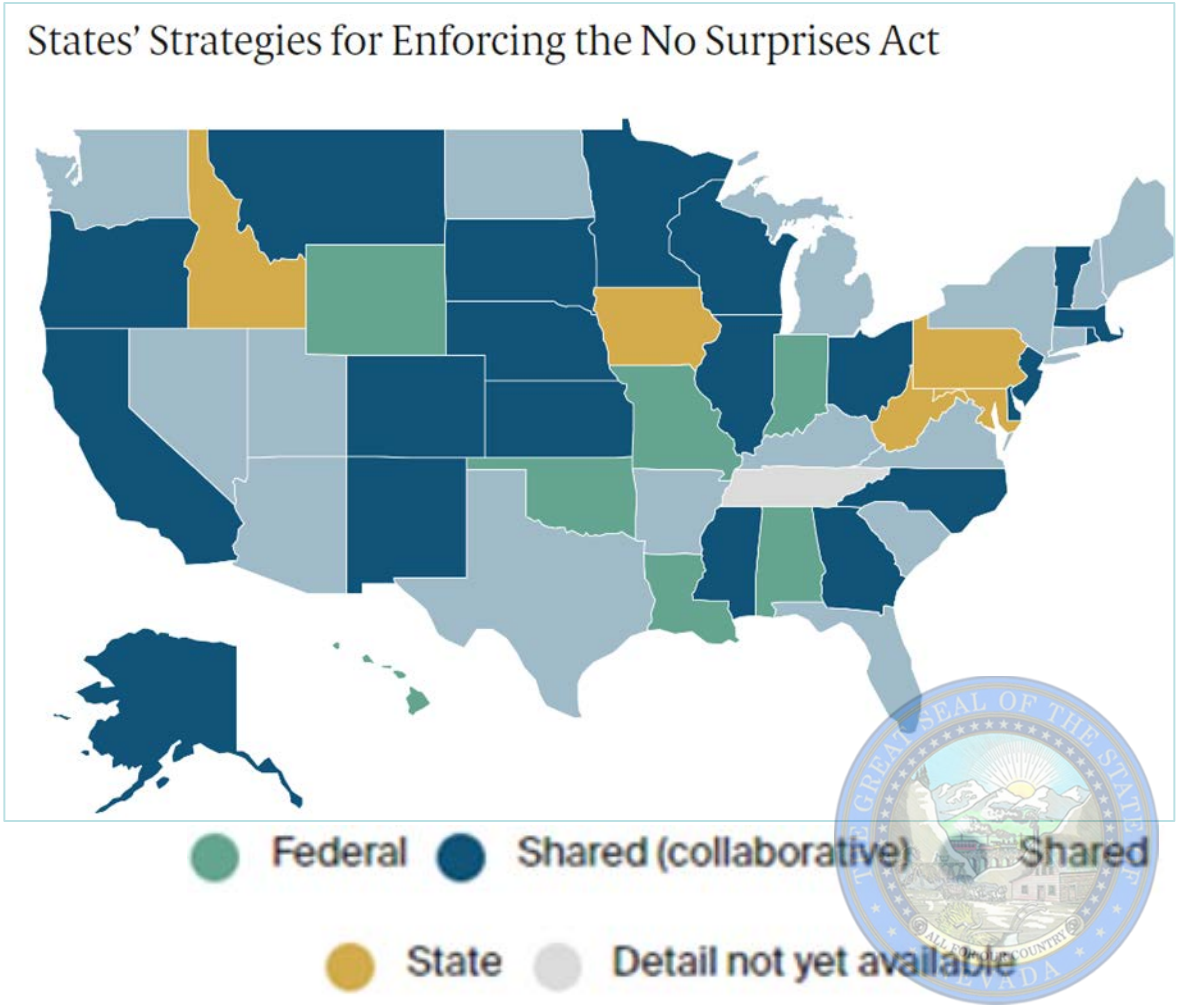
- To enforce the surprise-billing protections of the No Surprises Act, most states are partnering with the federal government.
- In states with existing surprise-billing laws, federal protections take precedence except where state laws are more protective of consumers.
- The primary exception is that the federal law defers to state mechanisms that determine payments to out-of-network providers in lieu of the federal IDR system, where state law has authority.

- In most states, enforcement will be shared through a state–federal partnership. Some states [...] have elected to enforce a specific subset of standards in the law, while the federal government will directly enforce the others.
- [Some] states […] are formalizing their shared roles through collaborative enforcement agreements with the federal government.
- After an initial learning period, it may turn out that the need for active enforcement is rare.

Enforcement

Enforcement varies by state, to include one of the following options:

1. State Enforcement
2. Federal Enforcement
3. Collaborative (formalized state-federal enforcement agreement)
4. Shared (enforcement is divided between state and federal depending on the type of provider, facility or service)



IDR Bifurcation for the State of Nevada

Federal Process Applies to:

- Emergency items and services at critical access Hospitals (hospital that provides access to patients who may otherwise have a difficult time reach a hospital, for example in a rural area).
- Post emergency medical treatment after 24 hours
- Nonemergency items and services out-of-network providers at in-network health care facilities
- Air ambulance services furnished by out-of-network providers

Nevada state-specified law (SSL) determines the reimbursement for:

- Emergency services provided by an out-of-network facility or an out-of-network provider at an in-network facility, except for critical access hospitals.

Nevada law

- NRS 439B.742: Certain hospitals, persons, and health care services are exempted from specific provisions related to insurance coverage and payment for emergency medical services.

- NRS 439B.745: Out-of-network providers cannot charge a covered person more than the copayment, coinsurance, or deductible required for in-network providers for medically necessary emergency services, and out-of-network emergency facilities must notify the coverage provider and arrange for transfer to an in-network facility when the patient's condition stabilizes.

- NRS 439B.748: If an out-of-network emergency facility had a previous provider contract as an in-network facility, the coverage provider must pay a specified percentage of the amount that would have been paid under the previous contract for the emergency services, except for copayment, coinsurance, or deductible.

- NRS 439B.751: Similar to NRS 439B.748, this statute applies to out-of-network providers other than emergency facilities and outlines payment obligations based on the termination of a provider contract or lack thereof.

- NRS 439B.754: Describes the process for determining the amount owed when there is no recent contract between an out-of-network provider and a coverage provider, including arbitration to resolve disputes and the acceptance of payment as full or the request for an additional amount.

What impact might the law have on the ability (or willingness) of providers and carriers to contract with one another?

Considerations:

1. Pressures for contracting between providers and carriers with respect to the No Surprises Act would likely stem from changes to reimbursement brought about by the Act.
2. These pressures may not affect Nevada as heavily as Nevada specifies a formulaic reimbursement amount within its IDR process.
3. Nationwide, claims have been made that either providers or carriers may be exploiting the Act:
   - Some claim that providers are using the system to try and achieve higher reimbursement rates and are flooding the IDR process with requests.
   - Some claim carriers are using No Surprise Act rules and the IDR process to drive down reimbursement levels via faulty QPA calculations and other mechanisms.

Considerations, continued:

4. Most parties agree it is too soon to make definitive statements about impacts of the Act.
5. Some statistics to this point in time are: 9 million surprise bills prevented since January 2022; and 330,000 IDR requests since inception of that process (14 times the amount expected by CMS).
6. California has had a no surprise bill law in place since July 2017. An independent analysis observed a modest shift toward in-network service providers, with a 17% decrease in out-of-network services and an increase of 4% to in-network services after the law's implementation.

Considerations, continued:

7. Possible provider motivations for or against joining a network:
   - Desire to join the network to avoid administrative hassles and the IDR process.
   - Desire to stay out of the network to achieve higher reimbursement through the IDR process.
8. Possible carrier motivations for expanding or constraining their network:
   - Motivations may possibly be more related to reimbursement amounts rather than network adjustments?

Sources

Source: Commonwealth Fund. (2022, October 20). No Surprises Act: A Federal–State Partnership to Protect Consumers. Retrieved June 14, 2023, from https://www.commonwealthfund.org/publications/fund-reports/2022/oct/no-surprises-act-federal-state-partnership-protect-consumers

https://www.cms.gov/files/document/caa-enforcement-letters-nevada.pdf
Source: Centers for Medicare & Medicaid Services. (2022, March 8). No Surprises Act Enforcement Letters Nevada. Retrieved June 14, 2023, from https://www.cms.gov/files/document/caa-enforcement-letters-nevada.pdf

https://www.cms.gov/files/document/applicability-federal-idr-bifurcated-states.pdf
Source: Centers for Medicare & Medicaid Services. (2022, February 17). Applicability of Federal IDR to Bifurcated States. Retrieved June 14, 2023, from https://www.cms.gov/files/document/applicability-federal-idr-bifurcated-states.pdf

https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
Source: United States Congress. (2020, December 27). Public Law 116-260—No Surprises Act. Retrieved June 14, 2023, from https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

American Medical Association. (2022, January 31). Implementation of the No Surprises Act. Retrieved June 14, 2023, from https://www.ama-assn.org/delivering-care/patient-support-advocacy/implementation-no-surprises-act

MultiPlan. (2022, January 19). How the No Surprises Act Changes Reimbursement. Retrieved June 14, 2023, from https://www.multiplan.us/how-the-no-surprises-act-changes-reimbursement/

American Medical Association. (2022, January 31). Implementation of the No Surprises Act. Retrieved June 14, 2023, from https://www.ama-assn.org/delivering-care/patient-support-advocacy/implementation-no-surprises-act

Lagasse, J. (2023, June 15). No Surprises Act prevented 9 million surprise bills. Healthcare Finance News. https://www.healthcarefinancenews.com/news/no-surprises-act-prevented-9-million-surprise-bills

Agenda Item #10

Provider Directories

Division of Insurance

- This presentation outlines sources of information available to the Division regarding inaccurate provider directories, including:
  - Anecdotal
  - Consumer Services Section
  - State Exchange
  - Carriers

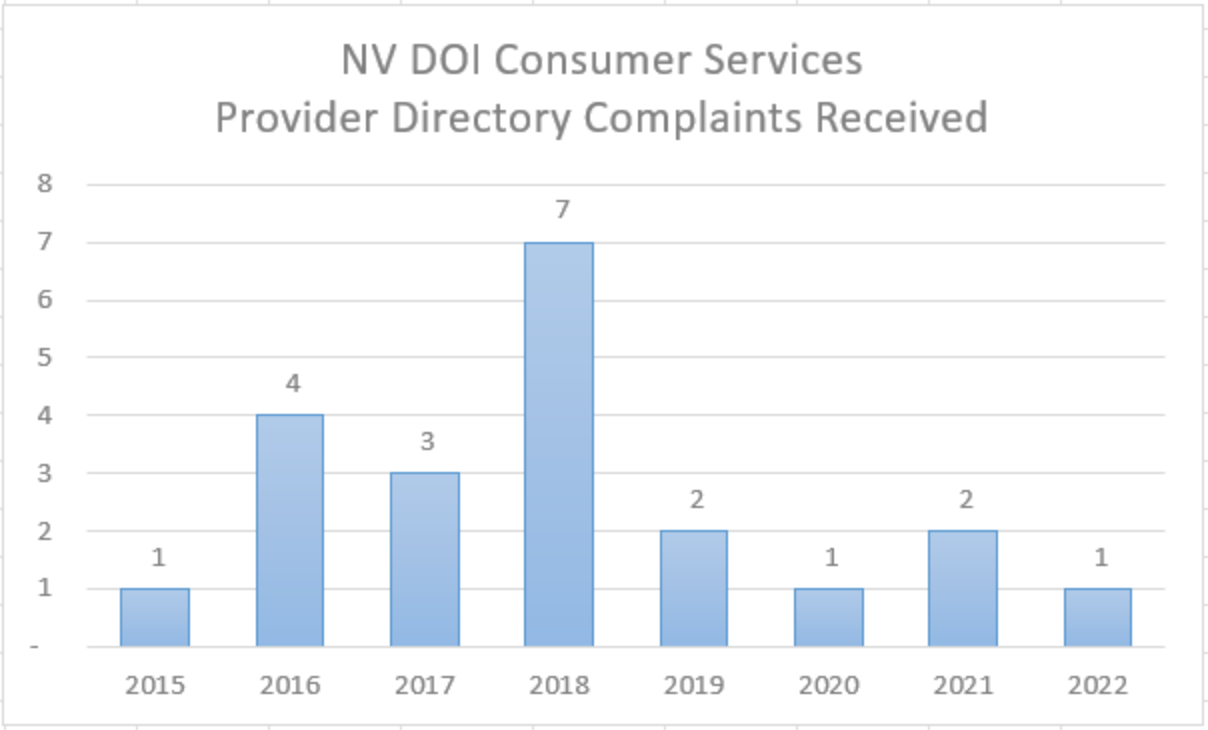
Anecdotal

- Direct contact with Division staff.
  - Recent email from a consumer looking for an oral surgeon for her son; contacted 7 offices in the directory and none were contracted with the carrier.
- Network Adequacy Public Comment
  - Provider attempting to assist clients finding in-network providers. Out of 223 providers/facilities that they were led to believe were local, they found the following issues:
    - Facilities not in the geographical area: 78
    - Facilities that have closed: 9
    - Providers/facilities listed multiple times: 32
    - Inaccurate provider listings: 47
    - Providers listed as independent but work at a previously listed facility: 26
    - Providers no longer living in the area: 1
    - Facilities that only offer in-home services: 7
    - Providers that only offer telehealth services: 2

Consumer Services

Data Represents 8 Companies

2015	2016	2017	2018	2019	2020	2021	2022	Total
1	4	3	7	2	1	2	1	21



Exchange and Carriers

- Exchange
  - Receives complaints regarding inaccurate provider directories.
- Carriers
  - Processes for updating and maintaining provider directories.
  - Processes to ensure accuracy of information
  - Consumer Complaints
  - Survey / Secret shopper calls by the carrier or a 3rd party