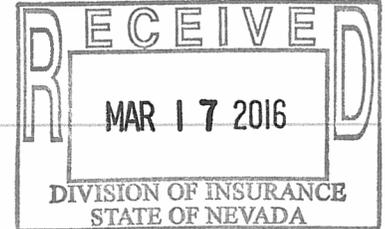


Sue Dummar

From: Alexia M. Emmermann
Sent: Saturday, March 19, 2016 10:55 AM
To: Sue Dummar
Subject: FW: R049-14 Network Adequacy - Second Amended Notice of Intent

I don't think this was forwarded to you as a comment...



From: Kim, Jack [<mailto:Jack.Kim@uhc.com>]
Sent: Thursday, March 17, 2016 2:00 PM
To: Glenn Shippey
Subject: FW: R049-14 Network Adequacy - Second Amended Notice of Intent

Can we change section 13 to say "At least once a month the provider directory much be updated to include each provider of health care who has left the network plan...."

I think the problem with just adding 30 days is that some months have more than 30 days and Feb has less. Using the term month would make it consistent with the line above it. It would also help with directories that are being more often than once a month.

From: Sue Dummar [<mailto:sdummar@doi.nv.gov>]
Sent: Thursday, March 17, 2016 1:21 PM
To: 'Megan Comlossy'; Kim, Jack
Subject: R049-14 Network Adequacy - Second Amended Notice of Intent

Please see the attached Notice issued today by the Commissioner of Insurance. Thank you.

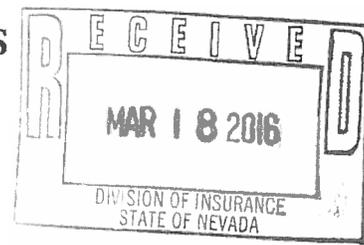
Sue Dummar, Legal Secretary
State of Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706-7986
Phone (direct): 775.687.0704
Phone (main): 775.687.0700
E-Mail: sdummar@doi.nv.gov

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NEVADA ASSOCIATION OF HEALTH PLANS

March 18, 2016



This letter is in response to the Revised Proposed Regulation of the Commissioner of Insurance, LCB File No. R049-14, October 19, 2015 (Updated by DOI on 17 March 2016).

The Nevada Association of Health Plans makes the following suggestions to the March 17 revision of the Regulation.

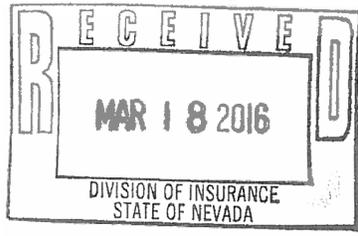
In Section 10, creating the Advisory Council consisting of nine persons with representation from carriers, providers and consumers. The Association recommends that no fewer than 4 members represent the carriers as they have the expertise and responsibility to build the networks and file the information; that staggered terms of 3 years be set; and, in the event of a vacancy, the vacancy be filled by someone from the same representation group.

In Section 13, delete the first sentence and insert in lieu thereof "At least once a month the provider directory must be updated to include each provider of health care who has left the network plan."

Section 14 sets 3 and 10 day timeframes in which to comply with a change in network plans. The Association believes these timeframes are not realistic and would suggest they be increased to 15 days and 30 days respectively.

The Association commends the Division for its hard work in trying to reach consensus on this very difficult issue of network adequacy and looks forward to working with the Division and stakeholders as this concept continues to develop.

Respectfully submitted,



Tomas Hinojosa, MD, President
Weldon Havins, MD, President-Elect
Mitchell D. Forman, DO, Immediate Past President
Howard I. Baron, MD, Secretary
Steven Parker, MD, Treasurer
G. Norman Christensen, MD, Rural Representative
Wayne C. Hardwick, MD, AMA Delegate
Florence Jameson, MD, AMA Delegate
Peter R. Fenwick, MD, AMA Alternate Delegate

March 18, 2016

Commissioner Barbara Richardson
Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Commissioner Richardson:

The Nevada State Medical Association (NSMA), the Nevada Osteopathic Medical Association (NOMA) and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. The comments herein address the draft dated March 17, 2016, that was circulated with the Second Amended Notice of Intent to Act Upon Regulation and Hearing Agenda (the "March 17 draft").

We thank the Division of Insurance for its efforts in the promulgation of this regulation over the last two years. NSMA, NOMA and their partners have and will continue to be active participants in this regulatory process. Through our letters and testimony, we've established a clear record of our position relative to defining an adequate network and ensuring that those who issue coverage under your jurisdiction provide adequate networks to Nevada patients.

Although the March 17 draft does not address all of our concerns, NSMA, NOMA and their partner specialty medical societies view this draft as a very important step forward in this process. As such we support the March 17 draft as written. We are particularly supportive of the creation of the Council, as defined in Section 4 and established in Section 10, and of the provisions in Section 9 balancing the federal standards issued by the Centers for Medicare and Medicaid Services of the United State Department of Health and Human Services as a baseline with the potential need for additional or alternative recommendations made by the Council.

We also support the steps the Division has taken to ensure that the rule-making process is open and available for public comment.

With these critical pieces included in the regulation, we recommend passage of the March 17 draft. It is a step in the right direction on the vitally important topic of patient access to quality health care.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to be 'TH' with a long horizontal stroke extending to the right.

Tomas Hinojosa, MD
President
Nevada State Medical Association

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

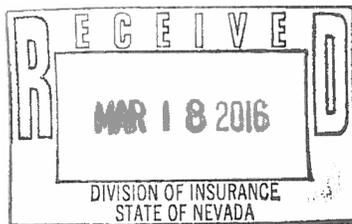
A handwritten signature in black ink, appearing to be 'AR' with a long horizontal stroke extending to the right.

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Sue Dummar

From: Alexia M. Emmermann
Sent: Friday, March 18, 2016 3:37 PM
To: Sue Dummar
Subject: FW: suggested language for patterns of care and access plans for section 12.3

Importance: High



-----Original Message-----

From: Glenn Shippey
Sent: Friday, March 18, 2016 2:45 PM
To: Alexia M. Emmermann; Betsy Gould
Subject: FW: suggested language for patterns of care and access plans for section 12.3
Importance: High

From: Heinze, Scott [Scott.Heinze@uhsinc.com]
Sent: Friday, March 18, 2016 1:03 PM
To: Glenn Shippey
Cc: Lisa Foster (lfnevada@sbcglobal.net); Woodley, Charles
Subject: suggested language for patterns of care and access plans for section 12.3

Hello Glenn, In the last meeting, we talked about possibly including language in the network adequacy regulation concerning the access plan and patterns of care. Since we had to do that in TX for our FMM network adequacy, I thought they might have had the language. Below is that language. In the meeting, I suggested that it might be valuable to talk about the patterns of care and the access plan, borrowing from the language below, in section 12.3. This language was taken from:

Date: February 29, 2016

From: Center for Consumer Information and Insurance Oversight (CCIIO),

Centers for Medicare & Medicaid Services (CMS)

Title: 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Here is the CMS language found in the 2017 final notice to issuers:

As in past years, in addition to permitting issuers to add additional providers, we will use a justification process when CMS determines that an issuer's network is inadequate under the reasonable access review standard. The justification process requires that QHP issuers detail patterns of care and other relevant information that explain why the issuer provides reasonable access to enrollees in the identified area(s). The justification must specifically address how issuers meet the reasonable access standard, despite not meeting the time and distance standards.

If you have any questions, please give me a call and thanks for all your hard work.

Scott

Scott Heinze, MHA
Senior Director of Business Development and Government Affairs

Prominence Health Plan
1510 Meadow Wood Lane
Reno, Nevada 89502

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scott.heinze@uhsinc.com<mailto:scott.heinze@uhsinc.com>

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