

December 3, 2018

Division of Financial Regulation
Department of Consumer and Business Services

Via Electronic Submission

Re: Department of Consumer and Business Services Proposed Rule – Out-of-Network Reimbursement Rate (836-053-1600 to 836-053-1615)

MEDNAX, Inc. (MEDNAX) welcomes this opportunity to offer comments on the Proposed Rule establishing reimbursement rates for out-of-network services provided at in-network health care facilities. In Oregon, MEDNAX includes twenty one neonatologists and eight pediatric intensivists who provide services in the neonatal intensive care unit and pediatric intensive care unit within Portland, Oregon.

As a national medical group, MEDNAX is comprised of the nation's leading providers of neonatal, anesthesia, teleradiology, maternal-fetal and pediatric physician subspecialty services. MEDNAX's physicians and advanced practitioners are reshaping the delivery of care within their specialties and subspecialties, using evidence-based tools, continuous quality initiatives and clinical research to enhance patient outcomes and provide high-quality, cost-effective care. MEDNAX, through its affiliated professional corporations, provides services through a network of more than 4,100 physicians in all 50 states and Puerto Rico. MEDNAX includes neonatal physicians who provide services at more than 400 neonatal intensive care units, and collaborate with affiliated maternal-fetal medicine, pediatric cardiology, pediatric critical care and other physician subspecialists to provide a clinical care continuum. MEDNAX is also the nation's largest provider of newborn hearing screens. MEDNAX established its anesthesiology service line in 2007 and includes more than 3,425 anesthesiologists and advanced practitioners who provide anesthesiology to patients in connection with surgical and other procedures as well as pain management. vRad, which MEDNAX acquired in 2015, provides teleradiology services through a network of more than 725 radiologists located in all 50 states.

In response to the proposed regulation, we make the following comments and recommendations:

Regarding Anesthesia-related reimbursement formula, the proposed rule sets the base units as the number of units published in the Center for Medicare and Medicaid Services' (CMS) CY 2018 Physician Fee Schedule Final Rule as of January 1, 2018. We recommend modifying this proposal to instead reference the American Society of Anesthesiologists Relative Value Guide (ASA RVG), which is more appropriate and standard for use by commercial carriers for anesthesia services.

Regarding Anesthesia Modifier Adjustments, for those Modifiers not explicitly listed in the proposed rule, i.e., QZ and AD, we understand the intent to be that it will be reimbursed at 100% of the full case rate, with no additional deductions. If indeed that is the intent, we recommend adding language to that effect to specify that if a Modifier is not listed, then it shall be reimbursed at 100% of the full case rate, with no additional reductions.

Regarding Labor Epidurals (CPT 01967), we recommend the addition of language specifying that labor epidurals are included in Anesthesia-related claims.

Regarding Non-Anesthesia reimbursement, we are concerned with the reference to the allowable amounts paid by the insurer for commercial claims. Without further definition or guidance, and in referencing the All Payer All Claims Database, the insurers, on their own, set the reimbursement amount, as allowable, without negotiation with providers. Crucial to our ability to continue to provide high-quality services to patients, is the ability to negotiate with insurance plans for fair reimbursement.

Due to the emergent and urgent nature of the services we provide, we deliver care to *all* patients without regard to their ability to pay. Because hospital-based physicians cannot “opt-out” of seeing hospital patients, health plans will have little incentive to negotiate fair reimbursement rates, particularly since the provider has lost the ability to bill the patient for their services. Payors must be incentivized to negotiate fair rates for out-of-network services provided, particularly under emergent and urgent conditions, and also to be incentivized to enter into fair contracts to avoid out-of-network services in the future.

Rather than be dependent upon allowable rates previously set by insurers as a ceiling for out-of-network reimbursement, we encourage the consideration of using claims data from an independent nonprofit database resource, such as FAIR Health. We believe that using FAIR Health provides a more accurate representation of market-level costs and fair reimbursement than setting rates as allowable amounts.

As an alternative, reimbursement could be set as some percentage above the allowable amount in order to provide an incentive to negotiate a fair contract to be in-network for future services provided, or even as a percentage of billed charges to ensure consideration of provider cost of care.

In addition, we recommend including an opportunity to appeal out-of-network reimbursement, whether through informal dispute resolution, or a more formal arbitration process.

We support the effort to protect the citizens of Oregon. Whether a provider is out-of-network by design or initiated by the health plan, physicians and insurance companies must be incentivized to negotiate fair reimbursement. As physicians, we want to participate with health plans and typically use great efforts to contract with each of the payors. Providers believe there are considerable advantages to participating in contracts. In those instances when out-of-network situations occur, fair reimbursement for physicians must be incentivized and protected.

Thank you for the opportunity to provide feedback. If you have any questions or would like to discuss further, please feel free to let us know.

Sincerely,

Sean Mercado
Regional Director, Managed Care