GOPHER TRACKS

PRESIDENT'S UPDATE

KRISTINA GURSKY CRCR, CRCP
VICE PRESIDENT OF HEALTHCARE STRATEGY AND CONTINUOUS IMPROVEMENT AT IC SYSTEM

Greetings All!

2024 is here, and as is often the case, the new year brings us new changes. This particular letter is a bittersweet one to write today, as it will be my last communication to all of you as your Chapter President. I have accepted a position on the National AAHAM team as the Government Relations Chair, and as such, am resigning as Gopher Chapter President. It was an incredibly difficult decision to make, but I am so grateful for the support of the Gopher Chapter leadership team to help with the transition.

As I reflect on 2023 and what we accomplished, I'm grateful for the work of the team that made a number of things possible. Hopefully you were able to join us at either the March or November conferences that were held, or participated in a webinar with us. Our team worked really hard to bring you quality content at a reasonable price. We know the budget challenges so many of you are facing and appreciate your involvement with AAHAM despite such challenges.

The team has already been hard at work planning out 2024 events. For example, we've got a fabulous three-part webinar series coming up with topics for customer service challenges, front office tips for success, and patient billing advice. These will occur monthly February-April. Stay tuned to future emails from AAHAM and like us on LinkedIn to ensure you're getting all the information on when these take place. Be sure to pay attention to what the national AAHAM team is up to – we're also hard at work there to bring you quality content and education, including multiple webinar opportunities, Legislative Day, and of course the ANI.

With the deepest gratitude I have, thank you all for allowing me to serve as your President in 2023. It has been an absolute honor. I have been humbled and grateful by all the work the team beside me has done, and cannot wait to see what else the leadership team has in store for the future!

Respectfully,
Kristina

ELECTION RESULTS

The votes have been tallied and the results are in! The Minnesota AAHAM Gopher Chapter is please to announce its newly elected officers and board members.
A sincere thank you goes out to everyone who submitted nominations and cast votes.

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KRISTINA GURSKY

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CALEB CHARON

SECRETARY
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BOARD MEMBERS
RICHARD ROGERS
RANADENE TAPIO
JAMIE WEAPPA

CONGRATULATIONS AND WELCOME TO THE LEADERSHIP TEAM!

2023 PRESIDENT'S AWARD

KRISTINA GURSKY CRCR, CRCP

Each year, the Chapter President has the wonderful honor of bestowing the President's Award to one deserving member of the Chapter. This year, I am honored to announce the 2023 President's Award Winner for the Gopher Chapter of AAHAM is our own First Vice President, Mr. Caleb Charon!

Throughout 2023, Caleb went above and beyond in his duties. From creating great agendas for our March and November conference, coordinating presentations, updating LinkedIn, helping the leadership team organize content with DropBox, and so much more, he has been nothing short of an amazing asset to the chapter.

Caleb—for all you do, your hard work is deeply appreciated. Congratulations on this well deserved accomplishment!

My deepest thanks,
Kristina

CONGRATULATIONS CALEB!

2023 PRESIDENT'S AWARD RECIPIENT

CERTIFICATION INFORMATION

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H.R. 5378, HEALTH-CARE PRICING PACKAGE

PASSES HOUSE UNANIMOUSLY

BY PAUL MILLER, MILLER/WENHOLD CAPITOL STRATEGIES—DECEMBER 2023

• Medicaid Hospital Payments: This bill would eliminate $8 billion in annual cuts to DSH payments until fiscal year 2026. The payments are intended to offset the cost of uncompensated care for hospitals that serve large numbers of low-income and uninsured patients.

• The cuts, which were included in the Affordable Care Act (Public Law 111-148) in anticipation of falling uninsured rates, have been continuously delayed and are now set to take effect Jan. 20 and run through fiscal 2027.

• Provider Pricing: Starting Jan. 1, 2026, hospitals and ambulatory surgical centers would have to disclose prices for at least 300 common services to patients, including the gross charge, discounted cash price, and insurer-negotiated costs for each service.

• HHS would have to establish a uniform method for providers to compile prices and make them public in a machine-readable format. HHS could impose civil penalties on providers that don't comply with the rules and would be required to maintain a website detailing each hospital's compliance.

• The measure would also require laboratories to disclose prices for clinical diagnostic lab tests starting in 2026. Imaging services providers would have to disclose prices starting in 2028. Both would have to disclose the discounted cash price, or gross charge if there is none, and insurer-negotiated prices in a machine-readable format, and would be subject to civil penalties for noncompliance.

• Health Coverage: Starting in 2026, group health plans would have to disclose the amount of money a participant or beneficiary would have to spend out-of-pocket on a specific item or service when requested. The information would have to include in-network rates; the maximum coverage amount for out-of-network services and any additional charges for which the patient may be liable; cost-sharing amounts from deductibles, copayments, or coinsurance; and any coverage limitations or requirements under the plan.

• Health plans would be required to maintain a self-service tool online to provide the requested information in real time.

• Group health plans would also have to make rate and payment information public each month, including in-network rates for services and drugs, the average amount paid for drugs dispensed to in-network providers, and amounts billed by out-of-network providers.

NEW CMS PRIOR AUTHORIZATION RULE TAKES EFFECT

BY ANDREW CASS—JANUARY 2, 2024

A new CMS rule aiming to streamline Medicare Advantage and Part D prior authorizations took effect Jan. 1.

CMS issued the final rule in April. It requires that coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary, according to a CMS fact sheet.

It also requires coordinated care plans to provide a minimum 90-day transition period when a beneficiary undergoing treatment switches to a new MA plan. During this period, the new plan cannot require prior authorization for the active course of treatment.

To ensure prior authorization is used appropriately, CMS is requiring all MA plans to establish utilization management committees to review policies annually and ensure consistency with traditional Medicare national and local coverage decisions and guidelines.

The rule also requires that approval of a prior authorization request for a course of treatment must be valid as long as medically reasonable and necessary "to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history and the treating provider's recommendation."

TWO BIG INSURERS TAKE SMALL STEPS TO EASE PRIOR AUTHORIZATION BURDEN

BY KEVIN B. O'REILLY—SEPTEMBER 2023

The country's No. 1 health insurer, UnitedHealthcare (UHC), and another insurance giant—Cigna Healthcare—recently announced tentative steps to reduce the volume of care-delaying, time-wasting prior authorizations they require.

Starting this month, several UnitedHealthcare plans will start eliminating the prior authorization requirement for many procedure codes that the insurer says account for nearly 20% of its overall prior authorization volume. The company also said that next year it will implement a "gold card" program allowing those who qualify to follow a "simple administrative notification process for most procedure codes" instead of prior authorization. Cigna, meanwhile, said it is removing nearly 25% of medical services from prior authorization requirements.

The insurers' efforts "begin to reduce the overwhelming volume of prior authorization requirements that are threatening patients' health and wasting valuable health care resources," said AMA Immediate Past President Jack Resneck, MD.

"The actions taken by UHC and Cigna appear to be a step in the right direction and in line with components of the consensus statement to improve the prior authorization process, which was agreed to by insurers in 2018," added Dr. Resneck, a San Francisco Bay Area dermatologist. "As we evaluate the real impact of these changes, we remain cautiously optimistic that patients and physicians will begin to feel some relief from the prior authorization burden under these plans."

The UHC and Cigna announcements come after years of apathetic or ineffectual follow-through by health insurers on mutually accepted prior authorization reforms, with many other insurers failing to make the agreed upon changes, as demonstrated in the most recent AMA survey of physicians. Dr. Resneck said the AMA is "careful not to confuse positive developments with major progress," noting that "prior authorization remains a major obstacle to timely and necessary care for our patients and an overwhelming burden to physicians."

UHC's recent implementation of an advance-notification program for nonscreening gastroenterology endoscopies supports the AMA's cautious response. While the program only requests that physicians submit supporting documentation to the insurer and does not result in medical necessity denials, it still increases administrative hassles for practices.

Moreover, UHC will be using the data from this program to determine eligibility for its gold-carding program in 2024—suggesting that these endoscopy services may be added to the insurer's prior authorization list.

While payers often claim that prior authorization requirements are used for cost and quality control, an overwhelming majority of physicians report that the protocols lead to unnecessary waste and avoidable patient harm. One-third of the 1,001 physicians surveyed by the AMA in December reported that prior authorization has led to a serious adverse event for a patient in their care.

More specifically, the AMA survey found that these shares of the physician respondents reported that prior authorization led to:

- A patient's hospitalization—25%.
- A life-threatening event or one that required intervention to prevent permanent impairment or damage—19%.
- A patient's disability or permanent bodily damage, congenital anomaly or birth defect, or death—9%.

That's why regulatory and legislative actions at the state and federal levels are needed.

TWO BIG INSURERS TAKE SMALL STEPS

(CONT)

“The AMA is committed to right sizing this bloated process,” Dr. Resneck said. “In line with the consensus statement, the AMA is urgently working on all fronts for further reductions in prior authorization volume, as well as other critical steps, including protections for patient continuity of care, gold-carding programs for physicians, and improved transparency and automation.”

This summer, the powerful House Ways and Means Committee advanced provisions that would help bring badly needed reforms to the prior-authorization process within Medicare Advantage. The provisions hew closely to the Improving Seniors’ Timely Access to Care Act.

The House Ways and Means Committee passage came on the heels of a bipartisan, bicameral letter to HHS and the Centers for Medicare & Medicaid Services (CMS) urging the agency to finalize a pending federal regulation that would overhaul prior-authorization requirements within Medicare Advantage.

Ultimately, 61 Senators cosigned the letter, along with 233 House members. The AMA helped spearhead support for the letter, and the AMA’s Physicians Grassroots Network and Patients Action Network worked to ensure a robust number of members of Congress cosigned this important communication to CMS.

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NO MORE SURPRISE MEDICAL BILLS:

BIDEN ADMINISTRATION ISSUES NEW SURPRISE BILLING RULEMAKING PROPOSING BATCHING AND PROCEDURAL CHANGES TO ARBITRATION PROCESS UNDER NO SURPRISES ACT

CAROLINE TURNER ENGLISH, ALISON LIMA ANDERSON, D. AUSTIN RETTEW, DAVID S. GREENBERG, JACK R. BIERIG AND APHRODITE KOKOLIS OF ARENTFOX SCHIFF LLP – DECEMBER 2023

On October 27, the US Departments of Treasury, Labor, and Health and Human Services (the Departments) issued new proposed rules intended to revamp the negotiation and arbitration proceedings established under the No Surprises Act (the Act). Under the proposed rule, the Departments would permit broader batching of eligible claims and implement additional changes to the Open Negotiation and Independent Dispute Resolution (IDR) processes established under the Act.

As background, Congress passed the Act to prevent "surprise" medical bills – bills patients receive when they are forced to obtain emergency care at an out-of-network facility or non-emergency care from an out-of-network provider at an in-network facility. Rather than billing patients for unpaid charges, out-of-network health care providers instead may engage in a "baseball style" arbitration process with insurers to determine the appropriate out-of-network reimbursement rate for the services rendered. Under that process, an independent dispute resolution entity (IDRE) selects one offer – either that of the provider or the insurer. As detailed previously, health care providers have already mounted numerous successful legal challenges to various aspects of the Departments' prior rulemaking implementing the Act. With this new round of rulemaking, the Departments are seeking to adjust several prior portions of the rules that were previously struck down in court.

Broader Batching Permitted

In one of the most highly anticipated aspects of the rulemaking, the Departments have proposed several revisions to the batching regulations that permit parties to submit multiple claims together for a single adjudication. Under the Act, parties may "batch" claims together so long as the services were rendered by the same provider, within the same 30 business days, were paid for by the same payer, and were related to the treatment of a similar condition. Under prior rulemaking, the Departments had taken the position that services were "similar" only when billed under the same service code. However, following a Texas federal district court's ruling striking down those regulations, the Departments issued this new round of rulemaking in an attempt to allow for broader batching. Of note, the Departments have proposed:

- Continuing to allow parties to batch all services billed under the same service code, whether a current procedural terminology (CPT) code or another type of code.
- Allowing parties to batch services billed with comparable codes across different coding systems.
- Allowing parties to batch all services billed for the care of one patient on the same claim form (i.e., batching by single patient encounter).
- For certain specialties (i.e., anesthesia, radiology, or pathology and laboratory services), allowing batching of services billed under codes from the same CPT code section or group.
- Notably, the Departments have also proposed limiting the total number of claims a party may submit in a batch to 25 line items per dispute.

While the Departments have indicated some positive departures from their previous same-service-code-only approach, the new proposals would still impose significant administrative hurdles for providers seeking to use the arbitration process under the Act, particularly ancillary providers whose singular claims may be too small to make arbitration worthwhile unless they can be batched together. For example, anesthesia providers have urged the Departments to permit batching based on anesthesia conversion factors (i.e., the same per-unit reimbursement rates sought for timed anesthesia services). While the new proposed regulations have not implemented that approach, the Departments have requested comment from stake-

NO MORE SURPRISE MEDICAL BILLS (CONT)

holders, so the ultimate framework for future batching remains in flux.

If implemented, these proposals would become effective on the later of August 15, 2024, or 90 days after the effective date of the final rules.

Open Negotiation and IDR Procedural Changes

The Departments have also proposed significant modifications to the provisions of the regulations governing the mandatory open negotiation process that precedes the initiation of arbitration under the Act. Notably, the Departments have proposed:

- Requiring parties to conduct open negotiations through the online portal operated and maintained by the Centers for Medicare & Medicaid Services (CMS). Currently, the portal is used solely for the arbitration process following claim negotiation.
- Requiring the initiating party to include additional information with its negotiation notices, including more details about the disputed items or services.
- Requiring the non-initiating party (usually the insurer) to file a response within 15 business days of receiving the initiating party's open negotiation notice.

Currently, the negotiation process, which must be exhausted during a short window prior to arbitration, has operated between the parties only and has not proved as successful as the Departments would like. The Departments believe that implementing additional information-sharing requirements in the negotiation period will lead parties to resolve more claims prior to initiating arbitration, thereby reducing the backlog of claims currently pending in the arbitration process.

Additionally, the Departments have proposed hefty modifications to the rules that govern the arbitration process following the negotiation period. Notably, the Departments have proposed:

- Requiring the Notice of IDR Initiation (the opening of an arbitration) to include additional information, most of which would be identical to the requirements for the open negotiation notice.
- Requiring the non-initiating party (usually the insurer) to furnish a written response regarding claim eligibility within three business days of receiving the Notice of IDR Initiation.
- Implementing a preliminary three-business-day selection window in which the parties could negotiate regarding IDRE selection, followed by a final selection window in which the IDRE would undergo conflicts screening.

If implemented, these proposals would all become effective on the later of August 15, 2024, or 90 days after the effective date of the final rules.

Administrative Fees Revised

Finally, the Departments have proposed modifications to the non-refundable administrative fee parties must pay to access the Act's arbitration proceedings. Initially, this fee was set at $50. Following CMS's unexpected increase of the fee to $350 in late 2022, providers filed a separate lawsuit in a federal district court in Texas, resulting in those fee provisions being struck down. In September 2023, a separate round of rulemaking set the administrative fee at $150, effective in 2024.

In the latest set of new proposed rules, the Departments have now proposed:

- Implementing a tiered fee structure under which initiating and non-initiating parties would pay different portions of the $150 fee depending on the overall value of the dispute and whether the case is ultimately deemed eligible for arbitration by the IDRE.
- Requiring payment of the administrative fee within two business days following IDRE selection.
- Requiring parties to submit the administrative fee directly to CMS, as opposed to remitting the payment to the IDRE assigned to the case (who previously paid it over to CMS).

NO MORE SURPRISE MEDICAL BILLS
(CONT)

If implemented, these proposals would become effective for disputes initiated on or after January 1, 2025.

Looking Ahead: Notice and Comment Periods and Partial Resumption of Arbitrations

The proposed rule is currently undergoing review during a notice and comment period, and the Departments are accepting comments on the proposed regulations. Meanwhile, two of the Texas federal district court's previous orders, which struck down portions of the Departments' previous rulemaking, have been appealed. The Fifth Circuit is slated to hear oral arguments in the first case in February 2024. This case challenges the Departments' regulations governing how IDREs must weigh the various statutory factors that determine the out-of-network reimbursement rate. Various physician groups and others have argued, and the Texas federal court agreed, that those regulations improperly give primacy to one factor — the Qualifying Payment Amount (QPA), calculated exclusively by the insurer — over the other mandatory factors.

The particulars of the arbitration process under the Act remain far from settled. Accordingly, while the regulatory dust settles, health care providers should consider filing comments on the portions of the rules most impactful to their practices. While the Departments consider comments and finalize their rulemaking, providers should continue filing open negotiation notices and timely initiating all eligible claims for arbitration in accordance with the existing regulations.

FALL PAYER PANEL RECAP

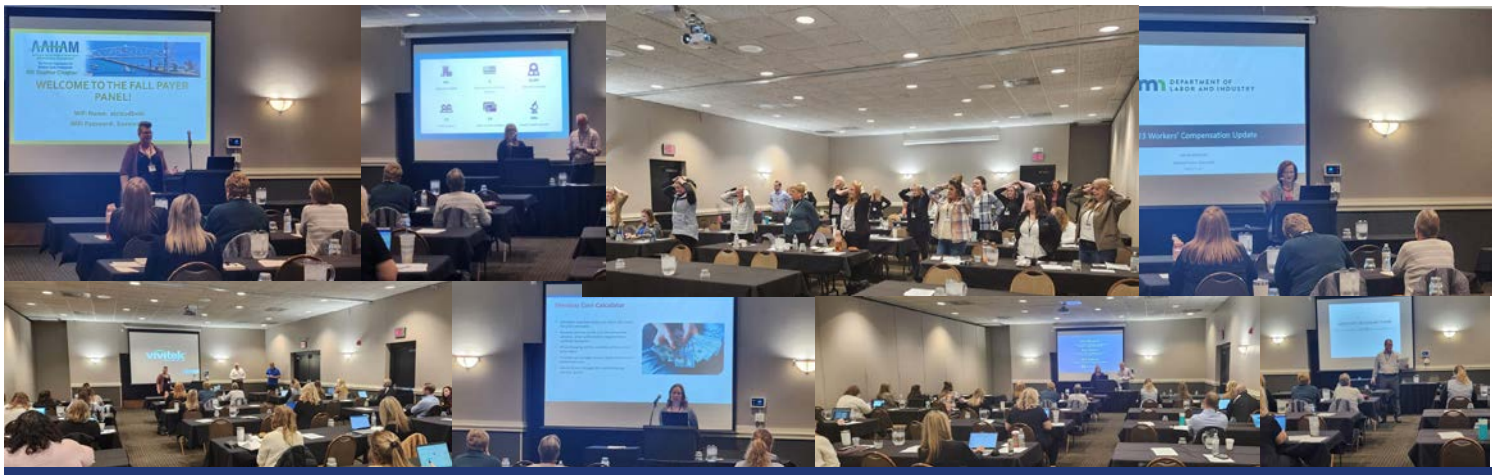
BY CALEB CHARON

The Minnesota AAHAM Gopher Chapter Board and Officers would like to thank everyone that attended the fall payer panel this past November.

We also appreciate the feedback given from attendees. We have decided that for 2024, instead of having a spring and fall conference, we are going to just have a combined larger fall conference for both payer updates and other revenue cycle trending topics.

In place of the spring conference, we are hosting a three-part webinar series hosted by MedCycle Solutions. If you haven't already, be sure to sign-up today! We received a lot of ideas for future speakers and will be bringing some of these topics to our fall conference.

The dates of the conference are in the process of being finalized but watch for a save-the-date in the coming weeks. If you couldn't attend the fall payer panel, but you have ideas for our fall conference, please don't hesitate to reach out to us – we are always wanting to provide education on topics you are interested in.



2024 WILL 'MAKE OR BREAK' MANY HOSPITALS

BY ALAN CONDON—DECEMBER 5TH, 2023

Dramatic margin fluctuations characterized 2022, which was one of the worst financial years for hospitals in decades. Despite a modest positive turning point in 2023 for some hospitals and health systems, 2024 will be categorized as another "make or break" year for a significant portion of the sector, Fitch Ratings said in its annual outlook report.

Nonprofit hospitals are battling an ongoing "labordemic" with widespread staff shortages, intense wage pressure and heightened inflation, according to the report, which pointed to a "trifurcation" of credit quality emerging from these struggles that will likely become more prominent in 2024.

"Much of a hospital's ability to be successful, will depend on their ability to recruit and retain staff in the currently hyper-competitive landscape for personnel," Kevin Holloran, senior director and sector head at Fitch, said in the report.

Fitch projects that most hospitals will fall into the middle of the trifurcation pack with mixed results in the form of lower margins — though not enough to warrant widespread downgrades — and, despite some success in obtaining staffing, a still-heavy reliance on external contract labor.

A small percentage of hospitals will be successful in recruiting and retaining staff while seeing improved patient demand versus hospitals that will struggle to recruit and retain talent while facing volume demand challenges, according to the report. This last group of hospitals will be most vulnerable to rating downgrades in 2024, when bond covenant breaches will be another area of concern. "Second year violations, which would occur in calendar 2024 as fiscal 2023 audits are finalized, may intensify the potential for bondholders to declare an event of default and accelerate payment of bonds," Mr. Holloran said.

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The Officers and Board of Directors would like to express our gratitude to our Corporate Partners for their continued support of our mission. It is through your support that we are able to deliver on our mission of providing top quality educational resources to our members. In addition, your partnership helps our chapter engage lawmakers in the important work of legislation, which impacts our industry on the state as well as national level.

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