AAHAM
American Association of Healthcare Administrative Management
MN Gopher Chapter

Gopher Tracks

Payer Panel Pics

Article Highlights

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President's Message

Heather Rickgarn

As we near the end of the year, I look back on all that AAHAM has been able to provide to its members. I have been honored to serve as your Chapter President for the last three years and look forward to my final year in the President's role.

For 2022, we have a lot to look back on as positives for the Minnesota Chapter. We have been able to offer free webinars to our members on a wide range of topics. We had a very successful Payer Panel in September and are actively planning a solid lineup of speakers for March, 2023. We had fantastic representation at this year's Legislative Day and were able to educate our congressional legislators on critical issues to the healthcare industry. We continue to provide state-specific AUC updates along with certification content to keep you updated on industry changes.

Finally, we had an excellent turnout for this year's election, to which we welcomed some familiar and new faces to the board. As we look to 2023, we as a board look forward to continuing to serve you, our chapter members. We indeed couldn't do what we do without your continued support. To a wonderful new year, thank you for all you do!

Sincerely,

Heather

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H.R. 3173, Medicare Prior Authorization

H.R. 3173, Medicare Prior Authorization

Insurers offering Medicare Advantage plans requiring prior authorization would have to establish an electronic authorization program and meet new standards for decision timing and transparency under a modified version of H.R. 3173.

The Health and Human Services Department would have to approve the electronic authorization programs and would also set time frames and transparency requirements for prior authorization decisions for Medicare Advantage plans.

Medicare Advantage plans allow individuals to obtain coverage normally provided through Part A (hospital) and Part B (medically necessary and preventive services) from approved private insurers.

MA plans, like other insurance plans, often require health care providers to obtain prior authorization for certain medical treatments before they can treat patients. In a September 2018 report, HHS' Office of Inspector General found that MA plans overturned 75% of their denials for preauthorization — raising concerns that some MA beneficiaries and providers were initially denied services and payments that were
medically necessary.

"When seniors need critical medical care, doctors and other health care providers should be spending their time working with patients instead of going back and forth on requests that should be electronic, standardized, and eventually automated," said bill sponsor Rep. Suzan DelBene (D-Wash.) in a May 2021 news release. The bill would create "sensible rules for the road and will offer transparency and oversight to the prior authorization process," she added.

HHS would have to provide for the transfer of $15 million from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare and Medicaid Services Program Management Account for fiscal 2022 to carry out the measure.

Prior Authorization Requirements

Medicare Advantage insurers that impose prior authorization requirements would have to establish an electronic preauthorization program within three plan years of the bill's enactment that would provide:

Real-time decisions if the request is submitted with the documentation required by an MA plan.

Secure electronic transmission of a request and any health claims attachment that comply with applicable technical standards set by HHS and any other requirements to promote the standardization and streamlining of electronic transactions. A fax, electronic form, or proprietary payer portal that doesn't meet HHS standards wouldn't be

H.R. 3173, Medicare Prior Authorization

treated as an electronic transmission.

HHS would have to announce the items and services for which prior authorization requests are regularly approved and update the list at least every two years.

HHS would also have to conduct a rulemaking to determine what constitutes a real-time decision based on current medical practice, technology, and health care industry standards — though it could be no longer than seven days after a prior authorization request.

MA insurers could request a delay in issuing a real-time decision on a prior authorization request of as long as 72 hours after receiving the request, or 24 hours in cases where a delay could seriously jeopardize a beneficiary's life. The department would have to finalize any additional requirements to streamline electronic transmission
by July 1, 2023.

Other Provisions

Transparency: The measure would require MA plans to annually submit to HHS a list of the items and services that required prior authorization in the previous plan year.
Plans would also be required to provide information on preauthorization requests submitted, approved or denied as well as decisions that were delayed or appealed.

The bill would also direct plans to submit information on:

The average and median time between a request and a decision.
Information on when medical professionals, in the course of providing previously authorized surgery or services, must seek additional prior authorization.

Artificial intelligence, machine learning, or any technology specified by the HHS the plan used to make decisions.

Grievances received related to a prior authorization requirement.

The measure would allow MA plans to offer additional information on the percentage and number of requests denied because they didn't demonstrate that a patient met specified clinical criteria for items and services.
Plans would also have to provide their policies on prior authorization requests and criteria used to make prior authorization decisions to health care providers or suppliers seeking to contract with the plan. Enrollees could also request decision-making criteria.

HHS would have to publish all prior authorization data and decision-making criteria on the Centers for Medicare and Medicaid Services website broken down by individual plan levels.

MA plans would have to comply with transparency requirements within four plan years of the bill's enactment.
Enrollee Protection: The bill would direct HHS to conduct a rulemaking to set requirements for Medicare Advantages plans to ensure they:

Adopt transparent prior authorization programs developed in

H.R. 3173, Medicare Prior Authorization

consultation with enrollees and participating health-care providers.

Allow for waivers or modifications of preauthorization requirements based on provider compliance with evidence-based medical guidelines.

Annually review the items and services for which it requires prior authorization while considering stakeholder input.

MedPAC Report: The Medicare Payment Advisory Commission would have to report to Congress with an analysis of the use of prior authorization, including relevant statistics on appeals and overturned decisions and recommendations to improve electronic preauthorization programs.

Group Positions

The bill is SUPPORTED by 500 organizations, including AAHAM, AARP, American Medical Association, Better Medicare Alliance, and the Regulatory Relief Coalition.

Previous Actions

DelBene introduced the bill, called the "Improving Seniors' Timely Access to Care Act," on May 13, 2021. It had 311 cosponsors, including 180 Democrats and 131 Republicans, as of Sept. 12. The bill was referred to the House Ways and Means and the Energy and Commerce committees, which haven't considered it, though the Energy and Commerce Subcommittee on Health plans to hold a markup Sept. 14.

The Ways and Means panel approved a similar bill (H.R. 8487) — also introduced by DelBene — by voice vote on July 27. The version of H.R. 3173 reflects what was approved by the committee.
Sen. Roger Marshall (R-Kan.) introduced a companion (S. 3018) to H.R. 3173 in October 2021 that was cosponsored by 21 Democrats and 19 Republicans as of Sept. 12. The Senate Finance Committee hasn't acted on the measure.

Prospects

House leaders listed H.R. 3173 for consideration as soon as Sept. 14 under suspension of the rules. A two-thirds majority would be required for passage.

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AAHAM Government Relations Monthly Town Hall Discussions

Legislative Currents

AAHAM Government Relations Monthly Town Hall Discussions

The AAHAM Government Relations Committee would like to hold monthly calls with Chapter Presidents, Chapter Government Relations Chairs and Members who are interested in becoming active in AAHAM's legislative healthcare reform initiatives. What happens in Washington usually starts back home in your states.

These calls will generate discussions on what is happening in Washington and will enable intel to be shared on what is happening across the country at the state level. These sessions will be focused on healthcare issues that are taking place. These calls will also serve as an opportunity to use this information as a grassroots blueprint to utilize in your own chapter.

The next call is tentatively scheduled for scheduled for Tuesday, January 17, 2023, at 4:30 PM EST.

Subsequent calls in 2023 will be on the 4th Tuesday of the month at 4:30 PM EST.

Legislative Currents

In The News

- Apple, Google Distribute Podcasts That Spur Anger at Hospitals
- Long Covid Eases With Time, But Disables Millions, Study Shows
- Employers Target Expensive Surgeries to Cut Health-Care Costs
- Pfizer Says Booster Lifts Antibodies for Omicron Variants
- Gene Variant Tied to Better Covid Shot Response, Study Says
- USDA Extends Access to Baby Formula for Low-Income Families

Legislative/Regulatory

- IRS Moves to Expand Obamacare Subsidies to Families
- Trump-Era Health-Care Worker Conscience Rule Cases Still on Hold
- Medicaid, Telehealth Fallout: Ending Covid Emergency Explained
- Medicare Drug Negotiation and Rebate Group Formally Organized
- Covid Public Health Emergency Gets Last-Minute Extension by HHS

Legal

- San Francisco, State, Feds Reach Deal Over Safety Net Hospital
- ACLU to Argue Against First-in-Nation Transgender Care Ban

Around the States

- New Jersey: Health-Care Hikes Foist $350 Million 'on the Backs' of Towns

https://www.aaham.org/Portals/5/Files/Advocacy/Oct142022.pdf

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Payer Panel Pictures


Revenue Cycle
Solutions


Helping
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lost
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Apple, Google Distribute Podcasts That Spur Anger at Hospitals

In January, the staff of Mercy Hospital in Coon Rapids, Minnesota, was flooded with tens of thousands of angry phone calls, all with the same concern. Calling in from as far away as Australia, the people were worried that an unvaccinated Covid-19 patient was getting a lower level of care and wanted to ensure he would be transferred elsewhere.

Mercy eventually transferred the patient to a Texas hospital. But in the meantime, administrators increased security, and the staff had to set up a new phone system so that unrelated inquiries about patient care could still get through, according to a person familiar with the matter. Tensions grew among staff, who feared that they were going to continue being targeted by furious callers no matter what they did, the person said.

The source of the outrage was a popular podcast called The Stew Peters Show, which, after hosting the patient's wife, asked its listeners to call the hospital and apply "social pressure," alleging that Mercy was treating the unvaccinated patient unfairly while pushing back against the idea that a Covid-19 vaccine could have helped with severe illness from the virus. At the time, Mercy was dealing with one of the pandemic's worst surges of Covid-19 in the state. All beds at Mercy's intensive care unit were in use back then, according to data gathered by USA Today's network of local newspapers.

It's one of several podcasts, distributed through major platforms such as Apple Inc. and Alphabet Inc.'s Google, which have encouraged listeners to direct anger at health-care workers, according to new research from the Tech Transparency Project. In an published Thursday, the nonprofit group also documented the spread of monkeypox conspiracies and a large volume of Covid-19 misinformation through audio content. The research, based on a collection of 401 episodes TTP gathered that aired between February 2020 and June 2022, underscores the extent to which misinformation and provocation can proliferate on podcasts, which are distributed to millions using platforms operated by tech giants — often with little content oversight. Apple's podcast guidelines state that the company prohibits "content that may lead to harmful or dangerous outcomes," while Google says it won't promote podcasts that include "harassing" and "hateful" content, or podcasts that depict "deceptive practices." But the companies continue to distribute such podcasts, even when competing platforms have removed them.

Apple distributing such podcasts "shows how the company's lofty talk about corporate responsibility often fails to translate into concrete actions in how it runs its business," the Tech Transparency Project said in its report. "In the case of podcasts, Apple is allowing a huge body of misinformation about the coronavirus to reach its listeners, endangering the public at large." Four episodes that encouraged directing anger at healthcare workers, despite being removed from Spotify were still distributed through Apple Podcasts and Google Podcasts, according to TTP. The Stew Peters Show, a program hosted through a service called Podbean and that has ranked as high as No. 48 in Apple's most popular US political podcasts in September, according to data from Chartable, was behind three of the four documented incidents. In one case,

the wife of the unvaccinated patient at Mercy Hospital joined Peters on a January episode. She played the recording of a call in which doctors informed her of their decision to remove life support. At the time, she pushed back against the idea that a Covid-19 vaccine could have helped her husband. "These people are cold-hearted," Peters said in response. "Cold-blooded killers are what they are."

He then encouraged listeners to call up the hospital. When the episode was posted on Apple Podcasts, the description included individual workers' names and phone numbers, which TTP says violates Apple's rule to prohibit content that is "likely to humiliate, intimidate, harass or harm individuals or groups." Apple Podcasts declined to comment. A Google spokesperson said its podcast product crawls and indexes audio content hosted on third-party servers and the open web. "Like Search, our systems are designed to surface high quality results and we have established policies against recommending content containing harmful misinformation," they added. The episodes flagged by Bloomberg are not recommended by Google Podcasts.

Allina Health, which oversees Mercy Hospital, said in a statement that privacy laws prohibit it from commenting on the care provided to specific patients. But a spokesperson added that the company "has great confidence in the exceptional care provided to our patients, which is administered according to evidence-based practices by our talented and compassionate medical teams." In another episode that same month, Peters called medical staff a "coronavirus death cult" and encouraged listeners to "flood" a Virginia hospital's phone lines. During a third episode in January, he called a pediatrician a "murderous tyrant" while simultaneously promoting an unproven "Z-Stack Protocol" from Vladimir Zelenko to protect against Covid-19 vaccines that become "self-spreading bioweapons threatening the purebloods."

TTP said episodes of The Stew Peters Show are routinely removed as newer ones are added on Apple and Google Podcasts, where the show's archive only goes back to May. The group included text descriptions and screenshots of the episodes on Apple Podcasts in its report. Bloomberg reporters verified the quotes by listening to the episodes available on Peters's show archive on his website. "Our efforts have always been about saving lives," Peters said in an interview. The show has been mischaracterized, he added, and "has never harassed anybody. We want to hold to account these death panels." He later added, in an email: "I categorically reject that I, Stew Peters, or anyone at the Stew Peters Network has harassed ANYONE, at ANY TIME."

A separate Podbean-hosted podcast, SGT Report's The Propaganda Antidote, has been banned by Twitter and YouTube but remains on Apple and Google Podcasts. Since January, according to the TTP's report, show host Sean Turnbull mentioned one pediatrician 13 times on his show who he says concealed the Covid-19 vaccine's effects on pregnancies. On a livestream, he also showed a picture of her face along with information on her workplace, including its address and phone numbers. Bloomberg reporters watched a copy of the livestream and verified TTP's findings. A Podbean spokeswoman said she wasn't aware of any reports made about SGT Report's or Stew Peters' show.

TTP also collected a number of examples in which several popular podcasts spread unverified origin stories about the monkeypox virus. In a May episode of The Stew Peters Show, Peters stated that "globalists were plotting the course of a monkeypox outcome at this exact time a year ago." In a June episode of The Highwire with Del Bigtree, the anti-vaccine activist Del Bigtree pushed the notion that monkeypox is a tool by governments to oppress their people. Bigtree's show is hosted on Spreaker, an IHeartMedia-owned platform. There is no evidence of a global conspiracy to plan the monkeypox pandemic. "When monkeypox came along I simply warned my audience to keep an eye on the coverage," Bigtree said in response to TTP's report. "I hypothesized that the same tech and pharmaceutical industries, along with world and federal agencies may attempt to use the 'opportunity' provided by the monkeypox outbreak to try again to install vaccine mandates, cell phone tracking systems, and other familiar Draconian measures."

Francesco Baschieri, head of Spreaker parent company Voxnest, said because of the large number of shows that use Spreaker as their hosting tool, including Bigtree's, the team, "obviously cannot preemptively check each and every new episode for all of these violations. But we do react strongly when we become aware of them."

He said the team is looking into whether Bigtree's monkeypox statements violate its terms, which don't allow podcasters to publish content that harms others.

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Long Covid Eases With Time, But Disables Millions, Study Shows

Long Covid eases with time, according to a study that found about 1% of coronavirus patients had persistent symptoms for a year or more. In the first rigorous assessment of the magnitude of long Covid on a global scale, researchers found 6.2% of people who had Covid-19 in the pandemic's first two years experienced at least one of three main groups of symptoms three months later. Of those patients, 15% were still afflicted after a year, they found. Although the probability of having chronic health problems from Covid is relatively low, the vast number of cases – at least 670 million worldwide – leaves a substantial burden of disability, said Christopher Murray, director of the Institute for Health Metrics and Evaluation at the University of Washington, where the study was conducted.

Long Covid's effects are, on average, similar to what occurs after a moderate-to-severe traumatic brain injury or complete deafness, said Theo Vos, a professor of health metrics sciences at the university, who led the study. The study, published Monday in the journal JAMA, helps explain why as many as 4 million Americans have dropped out of the workforce in the wake of the pandemic and why long Covid may cost $3.7 trillion in the US alone. More than 94 million cases and 1 million Covid deaths have been reported in the US, where the coronavirus infected almost 42,000 people a day on average in September. The research is based on data from 1.2 million Covid patients in 22 countries gathered from 54 studies and two medical record databases, including from the US Veterans Affairs health system. More than 200 ailments have been linked to long Covid, but the study in JAMA collated information on three common clusters of symptoms. It found that three months after a coronavirus infection, 3.7% of patients had ongoing respiratory problems, 3.2% had persistent fatigue with bodily pain or mood swings and 2.2% had cognitive problems, after adjusting for their health status before Covid.

It's not uncommon for Covid patients to experience persistent symptoms for a month, but most have fully resolved or diminished significantly after three months, said Sarah Ryan, a doctor at Columbia Primary Care in New York. Ryan, who has been caring for long Covid patients for more than two years, says that in her experience "a handful" have severe problems a year after their infection. "But the good news for the public is that they're a small minority," she said.

The risk of getting durable long Covid symptoms increases with the severity of the acute infection, the study in JAMA found. The average duration of long Covid was nine months for people who were hospitalized for the coronavirus, compared with four months for people who fought off the virus at home. Among patients older than 20 who caught Covid three months earlier, persistent symptoms occurred in 10.6% of women and 5.4% of men. It's not known yet what causes long Covid, though several risk factors are associated with the condition, said Michael Peluso, an infectious diseases physician-scientist at the University of California, San Francisco, who's been studying Covid's lingering effects in patients since March 2020.

"Women tend to be more affected than men," Peluso told a university forum on Thursday. The probability of developing long Covid is higher among people who are "middle age, rather the extremes of age," those with pre-existing medical conditions and obesity, and in individuals with lower socioeconomic status and poorer access to health care, he said.

The latest analysis accounts for Covid cases through the end of 2021, before

omicron variants fueled an unprecedented surge in infections. UK data suggest the hyper-infectious omicron clan of strains is much less likely to cause long Covid than the delta variant that preceded it. Long haul symptoms aren't the only health threat to Covid survivors. Diabetes and life-threatening conditions including heart attacks, stroke and kidney damage are more common in Covid patients than those who avoided the pandemic disease.

"The pandemic will raise the baseline risk of disease and disability to a new level," said co-author Ziyad Al-Aly, chief of research and development at the Veterans Affairs St. Louis Health Care System, whose own studies have led to important early findings about long Covid.

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AAHAM Certifications

What is the AAHAM CRCE (Executive) certification?

Executive Certification is an extensive online proctored exam directed to all senior and executive leaders within the healthcare revenue cycle industry, to help equip them for strategic management of the business. This certification possesses the highest level of difficulty combining content knowledge of the business with critical thinking and communication skills.

What is the AAHAM CRCP (Professional) certification?

Professional Certification is an online proctored exam directed to supervisors and managers in the revenue cycle industry, to validate their knowledge and skills. This certification is for the individual who desires confirmation and recognition of their expertise and/or for those who aspire to the executive level certification.

What is the AAHAM CRIP (Revenue Integrity Professional) certification?

The Revenue Integrity Professional (CRIP) is an online proctored exam directed to anyone in the revenue cycle industry to help ensure that facilities effectively manage their charge master, and bill and document appropriately for all services rendered to a patient. This certification requires an in-depth, working knowledge of various revenue cycle areas and proper skill sets needed to increase revenue and reimbursement for facilities. It also ensures that proper charging takes place to maintain compliance within the insurance payer programs.

What is the AAHAM CRCS (Specialist) certification?

Specialist certification is an online proctored exam that tests the proficiency of staff involved in the processing of patient accounts and to prepare them for the many details needed to perform their daily job duties.

What is the AAHAM CCT (Compliance) certification?

Compliance certification is an online proctored exam that thoroughly tests competencies in healthcare compliance for all staff involved in the processing of patient accounts. It is intended to meet the annual employee compliance training requirements and to support individuals with professional compliance responsibilities in both institutional (hospital, health system) and professional (physician, clinic) settings.

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National AAHAM Quick Links

e are the most common pages with information you would need to link to:

Membership - http://www.aaham.org/JoinNow.aspx
Certification - http://www.aaham.org/Certification.aspx
Legislative Day - http://www.aaham.org/LegislativeDay.aspx
The ANI - http://www.aaham.org/AnnualNationalInstitute.aspx
The infohub - http://www.aaham.org/InfoHub.aspx
The National Calendar - http://www.aaham.org/Events.aspx (Please don't forget to send me any upcoming meetings for me to post there)

o, if you've missed any of the emails going out to the membership, all the current news and immediate coming events can be found on the aaham homepage.

ayad Zahralddin
erations & Membership Director

Public Health

medicalbeat.net

James Whelan MD

In a remarkable memoir about a remarkable man (Oblivion, a Memoir), the Colombian writer Hector Abad tells of his father's passion for sweeping intercessions that would improve the health of the entire population far more than conventional curative medicine. Hector Abad Gomez was a physician who courageously took up the banner of public health in mid-20th century Colombia with notable success, amid opposition from conventional health care. He also became a prominent spokesperson for the poor and downtrodden, and this advocacy eventually cost him his life.

Gomez is the father of public health in Colombia and his writings tell the story of a man who probably saved more lives by his unswerving efforts to bring public health measures to a country with a population in woeful need of basic healthcare.

He believed in the power of education and public works to improve hygiene and had much success in generating measures to help all people, not just the rich, who were uniquely able to enjoy the benefits of modern medicine. He pushed for universal pasteurization of milk (simple boiling), which eliminated a form of tuberculosis. He said having drinkable water for the entire population saves more lives than sophisticated medical interventions, as so much disease in undeveloped countries is the product of unsafe water and poor sanitation. He highlighted the devastating effects of malnutrition. Anticipating the eradication of smallpox and the elimination of polio in countries with effective public health, he noted the power of vaccines, which have saved the lives of millions (maybe billions) worldwide,

Public Health in the United States

The public health measures cited above are so common and elementary in the United States that we can forget their power. But it was not that long ago that we resembled Columbia in the 1950's.

Congress created the US Public Health Service in 1912, authorizing it to investigate tuberculosis, hookworm, malaria, leprosy, sanitation, water supply, and sewage disposal. Johns Hopkins University founded the first school of public health in 1916. Today, the public health establishment includes multiple agencies, including the National Institutes of Health, the Federal Drug Administration, the Center for Disease Control, the Health Resources and Services Administration, and a few more.

The reach of these agencies is broad, and, with some occasional but important glitches, they have had a profound positive effect on the health of the US population. One public health official estimated, perhaps somewhat immodestly, that public health added 25 years to the life expectancy of the average American between 1900 and 2000.

This assertion is not hard to believe when some great public health successes are highlighted. These include a 90 percent reduction in deaths due to motor vehicle travel since 1925, despite a phenomenal increase in vehicular traffic. Between 1980 and 1995, work-related deaths decreased by 28 percent. The US enjoys a water supply that is virtually free of microbial contamination. In 1900, tuberculosis killed 194 people per 100,000 in the US. In 2020, it was .2 per 100,000. Malaria does not exist in the US, except in people who contract the disease in other countries and then travel to our country. HIV/AIDS has gone from a 100 percent fatal disease to a chronic one. And tobacco! In the 1960's, between 40 and 45 percent of adult Americans smoked cigarettes. Today, that figure is an astounding 13 percent. It goes on and on.

Comparisons

Countries with developed public health systems like the US enjoy a level of safety that should be a model for so-called third world countries. Today, 2195 children per day die of infectious diarrhea worldwide, primarily because of contaminated water supplies. Deaths from diarrhea in the US average about 300 per year.

In the handling of the Covid-19 epidemic, public health in the US, particularly the CDC, has come under much criticism, a lot of it merited. On the other hand, successes like the Covid-19 vaccines cannot be ignored. Based on research that was years in the making, the US produced the world's best Covid vaccines almost within a year of the identification of the virus.

The Take Home

In the US, we see stupefying advances in medical technology almost weekly. But none of it approaches the impact on well-being that public health has had. The United States Public Health Service is the crown jewel of American healthcare. Dr. Gomez knew what he was talking about.

Medical Debt

medicalbeat.net

James Whelan MD

In 2010, Congress passed the Affordable Care Act (aka, "Obamacare") and President Obama signed it into law. One of the main provisions related to Medicaid. This is a program that provides medical insurance for people with incomes at or below 138% of the poverty line. It is a joint program between the federal government and each state, with the feds matching state expenditures dollar for dollar.

However, in 2014, the year that Obamacare was implemented, the federal government began to pay 100% of the cost of new Medicaid enrollees in states that accepted the new benefit. States that embraced the program are "expansion states" and those that did not accept the expanded Medicaid benefit are "nonexpansion states."

Results

Expansion states that engaged the new Medicaid benefit in 2014 have experienced a 44% reduction in average per capita medical indebtedness compared to nonexpansion states. The regional breakdown was stark: in the Northeast, mean medical debt is now $167, whereas in the South, it is $616. In 2015, across the entire country, 23.8% of the population reported past due medical debts. The figure in 2020 was 17.8%.

Nor are the benefits limited to a reduction in medical debt. In expansion states, access and use of medical care increased.. Food and housing insecurity decreased. Medical outcomes, especially in maternal and fetal health, improved. Racial disparities in medical insurance diminished. And aggravated assaults went down.

A Ways to Go

At the time of implementation of Obamacare, 24 states opted out of the new benefit. To date, 11 states remain nonexpansion states, nine of which are in the South along with Wyoming and Wisconsin. Six states (Maine, Utah, Idaho, Nebraska, Oklahoma, and Missouri) have skirted their recalcitrant state governments and obtained the expansion benefit by means of state referenda.

There is much to be done. In 2020, 66.5% of bankruptcies were directly caused by medical expenses. Although the 8.6 % of medically uninsured Americans is at an all time low, this statistic could be easily reduced. If all of the states that have opted out of Obamacare's Medicaid expansion were to join in, an additional 3.7 million Americans would gain medical coverage.

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Notice of Proposed Rulemaking

AUC Update

Dave Haugen

FYI – The federal Centers for Medicare & Medicaid Services (CMS) has recently issued two notices of proposed rulemaking (NPRM) of possible interest. CMS is seeking public comments on both of the NPRM. The AUC will not be submitting comments but members and interested parties are encouraged to review the NPRM and to submit their own comments if desired and as instructed in the NPRM. In addition, other organizations such as WEDI (named in the HIPAA law as a formal advisor to the federal Health and Human Services (HHS) Secretary) are hosting informational sessions regarding the NPRM and will likely be submitting comments.

Notice of Proposed Rulemaking (NPRM) CMS-0056-P: Administrative Simplification: Modifications of Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Standards; and Adoption of Pharmacy Subrogation Standard
What This Proposed Rule Would Do

This proposed rule, if finalized, would modify the currently adopted National Council for Prescription Drug Programs (NCPDP) D.0 standard to the Telecommunications Standard Implementation Guide Version F6 (F6) and Batch Standard Implementation Guide Version 15, and adopt the NCPDP Batch Standard Subrogation Implementation Guide Version 10. The proposed rule would also broaden the applicability of the Medicaid pharmacy subrogation transaction to all health plans. To that end, the rule would rename and revise the definition of the transaction and adopt an updated standard, which would be a modification for state Medicaid agencies and an initial standard for all other health plans.

Public Comment Period

There is a 60-day public comment period for this rule, which closes on January 9, 2023. Instructions for submitting comments can be found at Notice of Proposed Rulemaking (NPRM) CMS-0056-P.

Notice of Proposed Rulemaking (NPRM) CMS–0057–P: CMS Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

CMS proposes to modernize the health care system by requiring certain payers to implement an electronic prior authorization process, shorten the time frames for certain payers to respond to prior authorization requests, and establish policies to make the prior authorization process more efficient and transparent. The rule also proposes to require certain payers to implement standards that would enable data exchange from one payer to another payer when a patient changes payers or has concurrent coverage, which is expected to help ensure that complete patient records would be available throughout patient transitions between payers.

CMS proposals include requiring implementation of a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standard Application Programming Interface (API) to support electronic prior authorization, as well as requirements for certain payers to include a specific reason when denying requests, publicly report certain prior authorization metrics, and send decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests.

In addition, this proposed rule would add a new Electronic Prior Authorization measure for eligible hospitals and critical access hospitals under the Medicare Promoting Interoperability Program and for Merit-based Incentive Payment System (MIPS) eligible clinicians under the Promoting Interoperability performance category.

Public Comment Period: There is a 90-day public comment period for this rule, which closes on March 13, 2023. Instructions for submitting comments can be found at Notice of Proposed Rulemaking (NPRM) CMS–0057–P.

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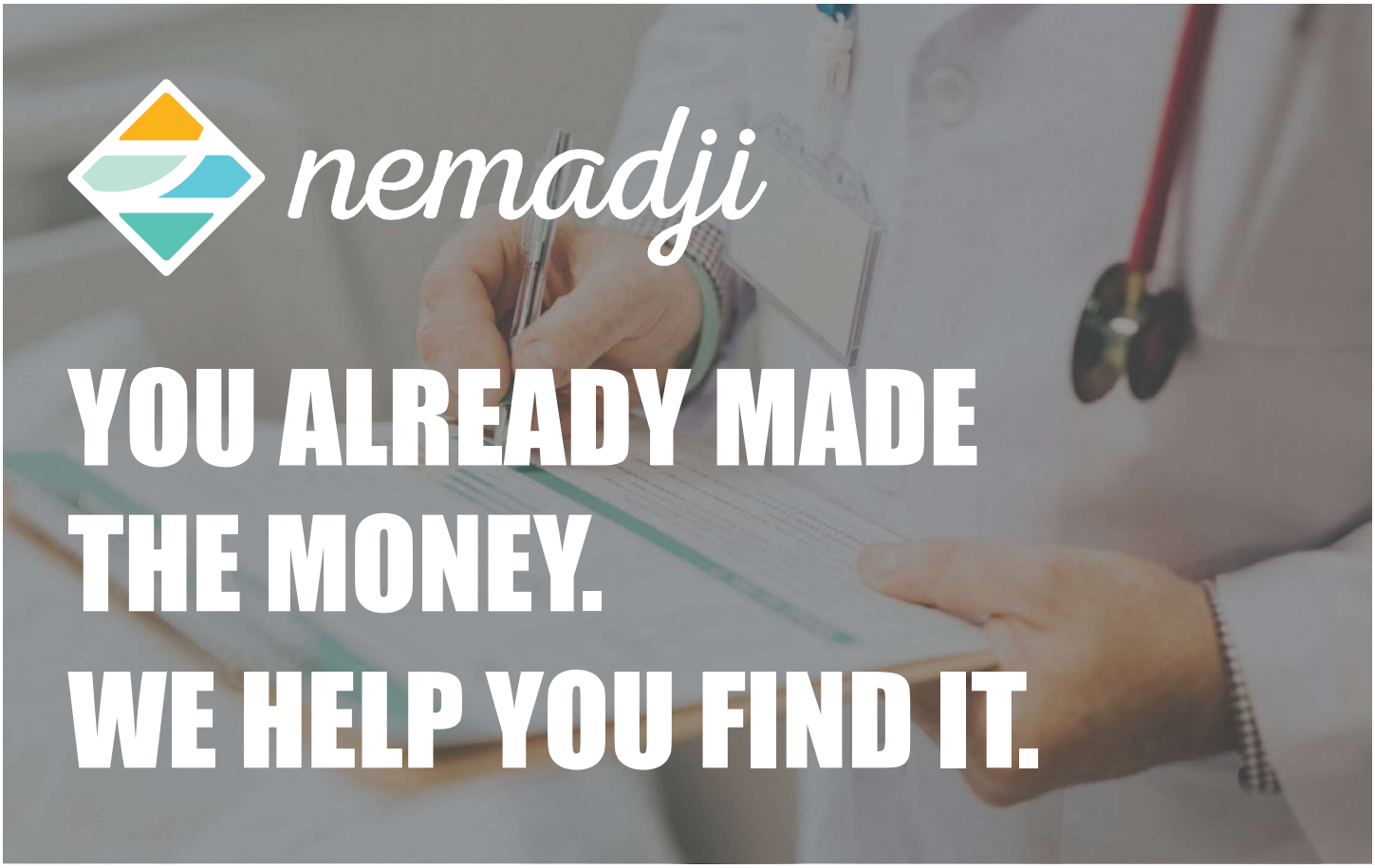

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