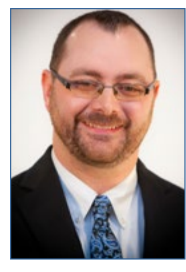
The NorEaster

SPRING 2024



President's Message

I hope you all found time to enjoy our Northern New England Winter, weather it be outside on the slopes or inside spending time with family and friends. Spring is officially here and hopefully spring weather will follow and we can all find time to enjoy it.

It is hard to believe that it has been a few months since our last in-person event which was our Co-Sponsored Event with the Northern New England ACHE Chapter in partnership with University of New Hampshire. This was a great event filled with great Education by speakers from all three states. This was a good opportunity for our two chapters to connect and also connect with the Health Management and Policy students from UNH. It is great to connect with these students and talk HFMA with them to try to get them more involved with our Chapter. This event was well received by both Chapters and we will probably be making it an annual event.

Our most recent in-person meeting was the Annual Conference which was held in beautiful North Conway, NH at the North Conway Grand Hotel on March 28th and 29th. We started the day with a keynote speaker and then a DEI Panel Discussion followed by a Presentation on a Chargemaster Optimization and finished the day with a Cocktail Reception and Cornhole Tournament. We held our Awards Dinner and Chapter Officer Induction for 2024-2025 Chapter Year. Day two kicked off with Shawn Stack from HFMA National providing a Policy Update followed by a 340B Presentation, much more Education and finished the conference with a networking session with the Health Management and Policy students from UNH. It was a great conference with record attendance!

Please also remember that there are many ways you can get more involved with our great chapter. There are the following committees; Education, Sponsorship, Scholarship, Membership/Volunteer/Certification, and Social Event/Social Media. We are also looking at succession planning for our Board and Leadership positions. I know what you are thinking, I don't have time to volunteer with the Chapter. You may be wrong, and it is always worth a quick discussion. There is no better time to get involved than now.

Thank you all for being part of our chapter and everything you do for our chapter.

As always please feel free to reach out if you have any questions, ideas, or concerns. I am here to support and serve you and would love to connect.

Zachary Colby

President, Northern New England Chapter, HFMA

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NEWSLETTER POLICY

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The Newsletter is published four times a year. Our objective is to provide members with information regarding chapter activities as well as ideas to help the individual in the performance of his/her duties. ***Opinions expressed in articles or features are those of the authors and do not necessarily reflect the views of the Healthcare Financial Management Association, Northern New England Chapter or the editor.***

UNH student members attend Annual Conference

"I had an exceptional and insightful experience at the HFMA 2024 conference in North Conway last week. I recognize that not many college students have the opportunity to attend such high-level conferences and engage with industry leaders. During the event, I had the privilege of networking with numerous influential figures in the field. The atmosphere was welcoming, and everyone demonstrated patience and willingness to assist us students. They generously offered advice and expressed interest in maintaining connections with us in the future, for which I am deeply grateful.

Moreover, the conference provided me with valuable insights into the industry and potential career paths. Overall, I believe students should seize the opportunity to participate in such events and leverage them to expand their professional networks!

Thank you once again for this amazing opportunity!"

—Deluna Darmawan (HMP '24)

"During the two-day annual HFMA conference with the Northern New England chapter, I had the opportunity to engage with an array of brilliant speakers who shared insightful perspectives on healthcare-related topics and emerging trends. The event expanded my understanding of various areas of healthcare that were previously unfamiliar to me. The conference also provided me with invaluable networking connections that I would not have accessed without the HFMA."

— Alexa Hayden (HMP '25)

"The conference proved to be a valuable experience for me as a student. Connecting our classroom learning directly to industry practices through the insightful presentations was incredibly beneficial, particularly as we prepare for our upcoming summer internships. Engaging with professionals and gaining insights into their work experiences and educational journeys was truly enlightening. This aspect of healthcare often receives limited attention, making such opportunities all the more vital. Despite the size of our major, the wealth of resources available to us for career guidance is impressive. It's for these reasons that we hold these opportunities to expand our knowledge in such high regard."

— Maddy MacLeod (HMP '25)

"I am grateful to have had the opportunity to attend the Northern New England HFMA Annual Conference held in North Conway. There were captivating discussions and very well-spoken panelists. The conference began with Vic Suarez speaking on navigating Healthcare 3.0 into the 21st century which I found incredibly valuable and have great interest in following. From his military career to discussing Warp Speed, I learned a lot from this presentation. I found discussing industry insights and strategies on maximizing 340B savings which was a new topic for me, very intriguing. Other discussions included the panelist' DEI Journey, answers to questions to assist with payer audits, and more. The DEI Journey stood out to me as each of their organizations are engaged in more projects than I was anticipating. Cristina stated how she works on care coordination and understanding the "why"

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intrigued me and then further discussion on how 1 in 12 Americans have some type of medical debt. The key takeaway for me was that DEI is that everyone and everything is diverse in their own way. Examples I would not have thought of, such as medical debt are a large part of the valuable lessons I am happy to be taking away with me. I am grateful for the opportunity to attend this conference and network with so many healthcare professionals. I truly value all the advice given to me."

— Shayla Davis (HMP '24)

Volunteer Award Recipients

Annual Meeting and Conference | March 28-29 | North Conway, NH

Mark Bonica, Bronze Award

Wendy Dumais, Gold Award

Eric Walker, Medal of Honor

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Artificial intelligence (AI) trends, potential, and considerations for healthcare organizations

Chris Mouradian, Healthcare Senior Manager, BerryDunn and Christopher Ellingwood, IT Assurance Principal

AI in healthcare is here. While it's the early days and there is a lot still to figure out in terms of accuracy and risk, it's undeniable that AI has huge potential in solving some of healthcare's greatest challenges.

AI to help alleviate staffing shortages

A February 2023 report to the US Senate drafted by the American Hospital Association painted a startling, though not new, picture of the healthcare staffing shortage: "The result of mounting pressures on the healthcare workforce has created a historic workforce crisis complete with real-time, short-term staffing shortages and a daunting long-range picture of an unfulfilled talent pipeline." While this report focused on providers such as physicians and nurses, hospitals nationwide are struggling with filling positions across the board. There are just not enough people to fill the need—now and for the foreseeable future.

AI has the potential to address this critical staffing shortage in a number of ways. The area where most people think of AI efficiencies is in administrative tasks. These, as anyone in healthcare knows, abound in the daily work.

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Reducing the administrative burden on clinicians means more time with patients, and more patients that can be seen. In this scenario, it's also possible that this reduced administrative workload will reduce burnout, improve the clinician experience, potentially keep more clinicians in the field—and encourage more to join. This, in turn, can reduce recruiting and retention costs and costs associated with outsourced and travel staff.

It has been shown that nurses can spend up to 35% of their time on data entry, documentation, and charting. Generative AI can assist in these tasks, freeing up nurses for direct patient care.

Risks to consider: The biggest risk here is the protection of personal health information (PHI). Safeguards need to be in place to remain Health Insurance Portability and Accountability Act (HIPAA) compliant. Common AI platforms are often hosted by third-parties, or are open-source systems that require proper due diligence to help ensure that any PHI in AI systems is secured. Often, medical billing systems contain PHI that is overlooked as a risk for HIPAA compliance, but can easily result in large scale breaches. Using AI to help with such administrative tasks will save time, making sure that the correct IT controls are put in place and are frequently evaluated for operating effectiveness.

AI to improve patient experience and outcomes

An added benefit of using AI for administrative tasks and reducing the workload on providers is that patients will have better experiences when providers have better experiences. Patients will, theoretically, have more time with their providers and more focused attention. Another way AI can help with patient experiences and outcomes is through AI diagnostic and image-interpreting tools.

With AI's ability to sift through and analyze huge amounts of data, it can assist doctors in diagnosing patients and even predict what illnesses a patient is likely to develop—in some cases, with life-saving results. A March 2023 article in the Wall Street Journal reported that AI was able to diagnose sepsis in hospitalized patients two hours earlier on average than humans, which reduced the sepsis mortality rate by 18%.

AI is also proving to be adept at analyzing images. Using Natural Language Processing (NLP), AI can provide high-quality analysis of X-rays and MRIs, leading to precise early diagnoses. GE Healthcare reported a 30% increase in speed and enhanced image quality using this technology.

Risks to consider: As with any technology, results depend on the quality and quantity of data that is being analyzed. Patients may also feel uncomfortable being diagnosed by AI. Any diagnosis should be verified by a human and any technology should be thoroughly vetted and tested prior to use. There is a particular risk when using AI in emergency room situations, where the treating physicians may not have the patient's full medical history for backend algorithms to consider. This could result in a misdiagnosis. However, in a clinical setting, the results of AI diagnosis tools are close to the accuracy rate of a doctor (about 90%). The biggest challenge to the medical profession will be getting patients to trust the use of AI. In a study by Harvard Business Review, surveys showed that patients felt

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their medical conditions were unique and overwhelmingly preferred meeting with a doctor versus being diagnosed by AI.

AI and revenue cycle optimization

At BerryDunn's Hospital Summit in October, audience members were asked where they saw AI having the greatest impact in the next five to 10 years. The top answer, with 35% of votes, was in the revenue cycle area. According to a recent article published by the Healthcare Financial Management Association, there is the potential for $9.8 billion in savings by automating revenue cycle functions. Many organizations are already using Robotic Process Automation (RPA) to aid in their revenue cycle functions. Many are now adding predictive analytics and automation using AI.

AI tools can help revenue cycle operations in a number of ways. One example is using AI to prompt providers on when and how best to document. It can also be used in medical coding to suggest appropriate codes based on relevant clinical data. One hospital reports that they've saved over $1 million using AI in their revenue cycle.

Risks to consider: As with most AI tools, the biggest risks are related to data privacy, security concerns, and concern about the accuracy of data. Like any investment an organization makes in technology, new systems need to be fully vetted and tested, and organizations must follow proper change management practices so that the new technology is properly designed and implemented. Rushing to implement AI may result in incorrect outputs and increase the organization's risk exposure.

The healthcare industry is already a front-runner in using AI and there's an exciting future ahead. Risk management is key to launching any new technology and particularly AI. Organizations should prioritize the following: Inventorying all uses of AI at the organization, having clear policies and procedures in place, and doubling down on compliance.

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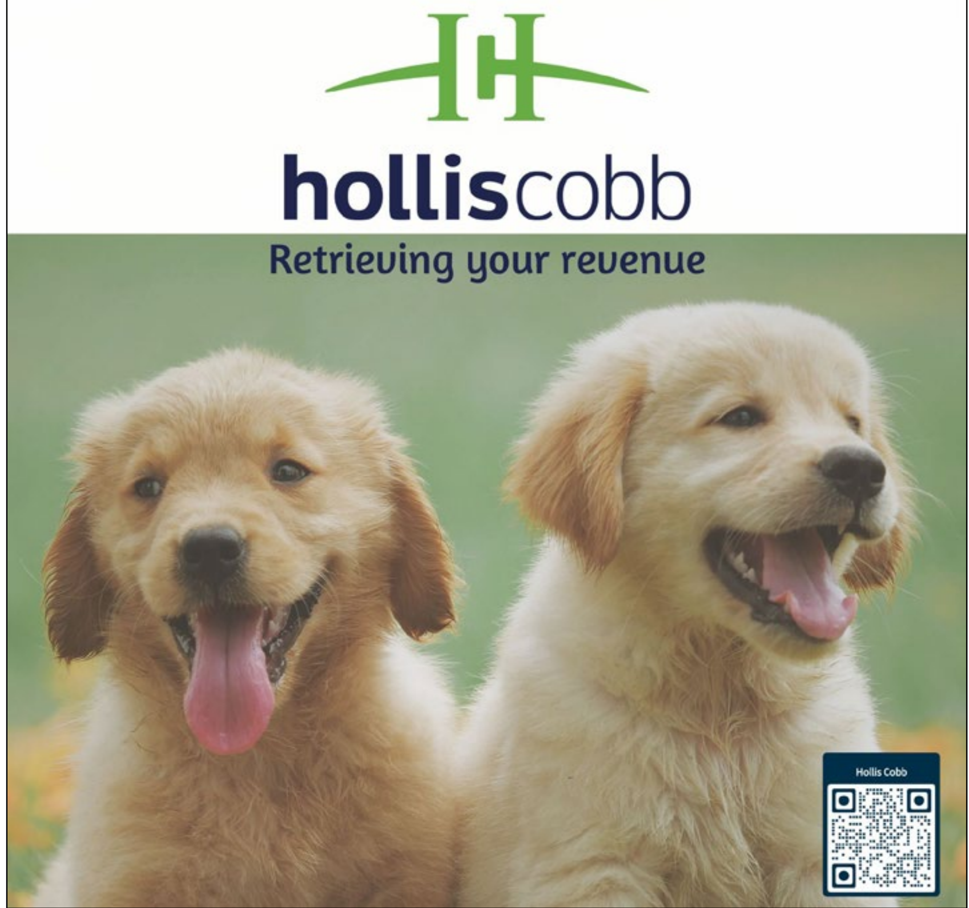

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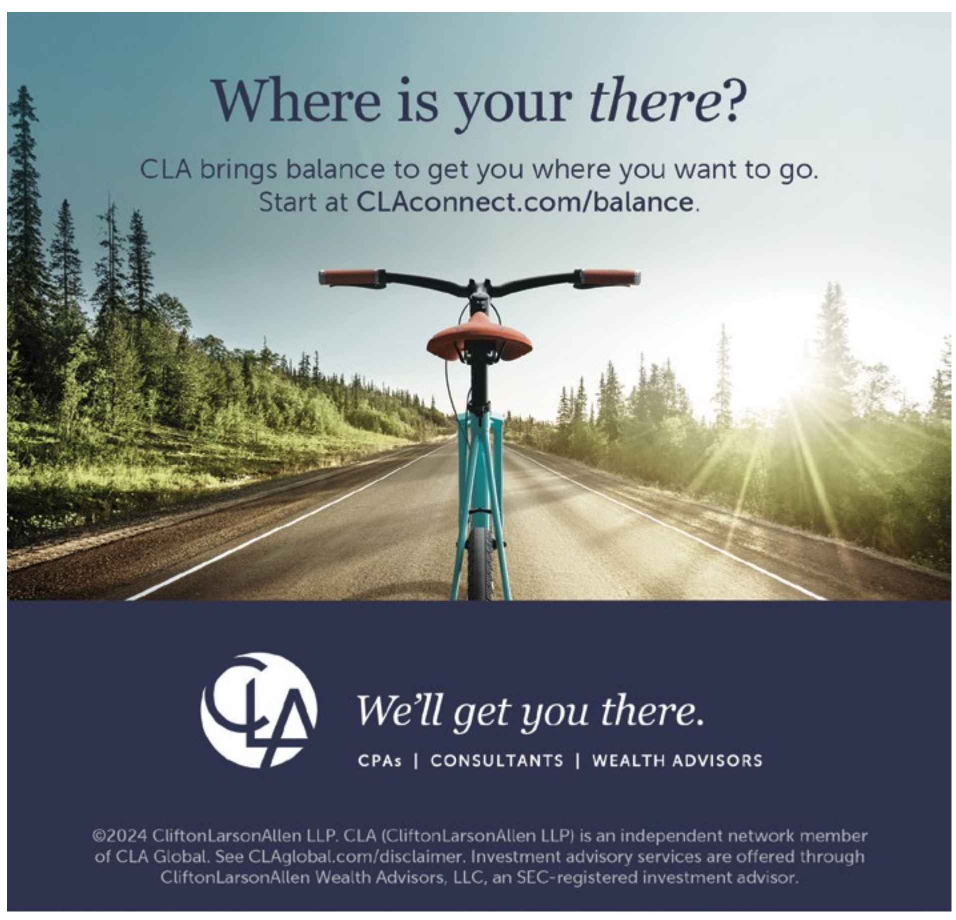
2023 Revenue Intelligence Data and Insights Report that includes insight and recommendations to help build a future-proof revenue cycle that adapts and thrives in a challenging market. Dozens of industry experts are quoted in this report that includes data-backed insights specifically geared toward improving and mastering the RCM process, from scheduling and pre-registration to managing denials and collecting patient payments.



Medicare Advantage challenges for hospitals: Five strategies for reducing revenue loss

Denny Roberge, Principal - Revenue Cycle Lead, BerryDunn
Debralee Dorain, Senior Reimbursement Manager, BerryDunn
Brittney Brinker, Revenue Cycle Manager, BerryDunn
Regina Alexander, Principal – Compliance Consulting, BerryDunn
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With the rapid growth of Medicare Advantage (MA) plans in the last several years, many hospitals are struggling to effectively manage the financial and operational challenges of these plans, including:

- ***Increased denials of Medicare Advantage claims***
- ***Confusion between Medicare, supplemental Medicare plans, and Medicare Advantage (Part C) plans, and what each cover***
- ***Extra burden of "shadow billing" inpatient claims and leaving potential reimbursement off the table if not done correctly***
- ***Compliance risk, including the risk for Medicare fraud***

This year, over 30 million people—more than half of those eligible for Medicare—have a MA plan. Medicare Advantage plans are inherently more complex than traditional Medicare, and many hospitals simply don't have the appropriate processes in place to manage their nuances. However, by implementing the best practices outlined below, hospitals can decrease their Medicare Advantage risks.

1. Optimize your Electronic Health Record (EHR) to decrease Medicare Advantage denials

As with any insurance, you should understand the patient's covered benefits well before they walk in the door. Collecting correct information at the time of scheduling is essential. In addition, for non-scheduled encounters, it is also essential to gather the correct information so that you can get the "prior auth" after the fact but within the specified time frame. Educating your patient access staff is essential. This is true for all plans, but since Medicare Advantage is often confused with traditional Medicare (by patients and providers alike), it's even more important.

Most hospitals and provider groups leverage an eligibility and benefits tool that verifies coverage. These tools are often fully integrated into the EHR system. Revenue cycle leaders must

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- **Charge Master Reviews**
- **Revenue Integrity Audits**
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Effective January 1, 2024, CMS deleted HCPCS G2066 for the technical component of cardiac device interrogation, adding the technical component for this service to existing CPT codes 93297 and 93298. However, CMS failed to make these codes payable under the OPPS. This has caused a considerable amount of confusion.

On February 9, 2024, the Federal Register published a correction notice to the OPPS Final Rule, in which they have called this an inadvertent error that will be corrected. CPTs 93297 and 93298 will be payable under the OPPS. Expect to see a revision to Addendum B with updated status indicators for these codes.

For further details and clarification regarding this update, we recommend referring to the specific page (81669) of the Federal Register.

Jon Menard, CPC, COC, CHFP
Principal, Integrated Revenue Integrity

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ensure these tools are configured correctly and staff understand how to interpret the results. For example, running eligibility on a patient with Medicare will return an active result regardless of whether they have a Medicare Advantage plan or not. Patients must be eligible for Medicare in order to have a Part C plan. Most of the query responses do contain the additional information that the patient has a Part C plan and many EHRs can alert the user regarding this information.

We recommend:

- ***Ensuring that staff members understand how the benefit verification vendor and EHR handle responses from traditional Medicare when the patient has an Advantage Plan***
- ***Optimizing your EHR and workflow to manage these exceptions***
- ***Training patient access staff around understanding responses and appropriate workflow***
- ***Developing accompanying standard operating procedures and quick reference guides***

2. Avoid authorization-related denials from Medicare Advantage

Authorization-related denials are a significant concern with Medicare Advantage. Two issues collide to form the perfect storm: Traditional Medicare does not require authorizations, and Medicare Advantage plans typically have stringent authorization requirements. The following is an example of a revenue cycle pain point that we see far too often:

The patient schedules an appointment and states that they are "on Medicare," so they are registered with traditional Medicare. The patient needs an expensive procedure, and following Medicare rules, the staff believes no authorization is required. Approximately three weeks after the procedure, the hospital receives a denial stating the patient has a Medicare Replacement Plan. The accounts receivable staff member then bills the replacement plan, and now 60 days or so after the procedure, a second denial is received for no authorization. The claim will now get sent back to patient access and "ping-pong" around the revenue cycle. The ultimate result is most likely a write-off as most Medicare Advantage plans do not allow for retroactive authorizations after this much time has passed.

The revenue loss due to the volume of this type of scenario can be staggering, but with tools and training, it can be nearly 100% avoidable!

On a related note, there is a new bill being introduced in the US Senate, the Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act, that is looking to ensure MA plans maintain accurate provider directories. This could be another tool that the frontline staff uses to identify traditional Medicare participants from MA plan participants. Asking "How did you find us today?" for new patients may solicit additional helpful information.

3. Don't neglect "shadow billing" of inpatient claims for MA beneficiaries

On top of the administrative burden of contending with prior authorizations and satisfying the billing requirements of the Medicare

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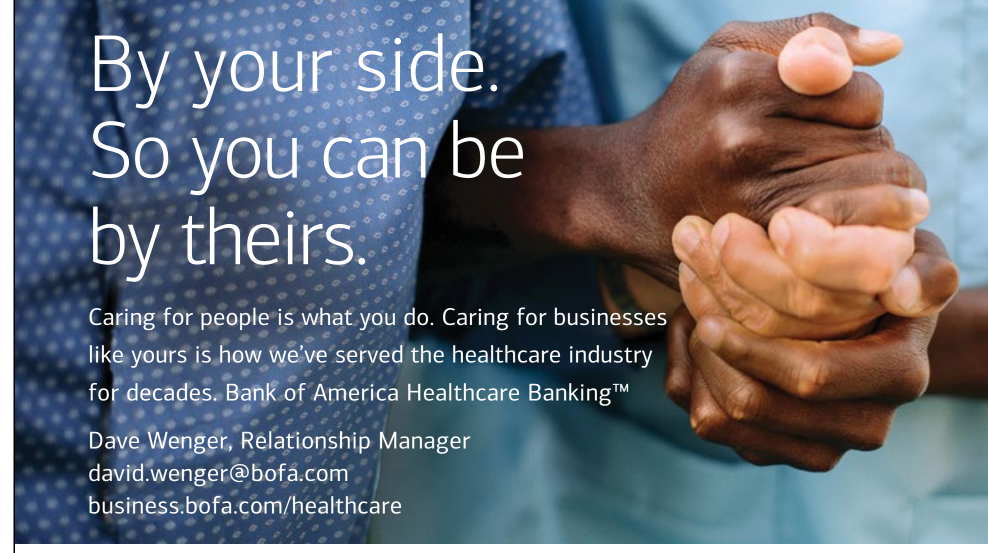

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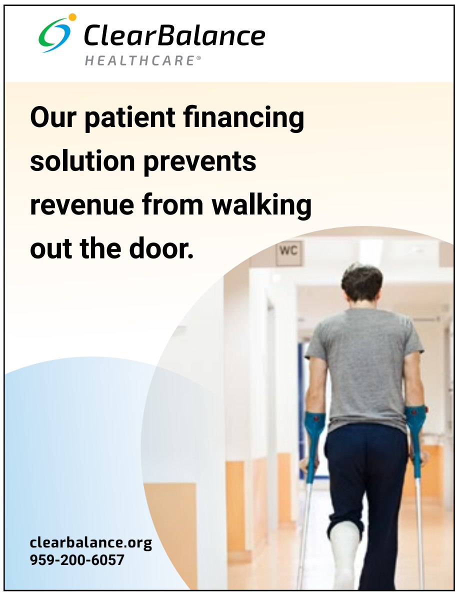

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Advantage plan, hospitals, swing bed units, and skilled nursing facilities are also required to submit no-pay claims to the Medicare Administrative Contractor (MAC) for inpatient services provided to MA patients. This type of duplicate billing is often referred to as "shadow billing" since claims are submitted to both the MA plan for payment and MAC as information-only billing. It's not uncommon for these shadow claims to be overlooked, or not billed to the MAC properly, which results in potential revenue loss or compliance risk related to:

- ***Reimbursement for Medicare's share of indirect graduate medical education or nursing/ allied health education costs. MA plans do not make payments for medical education costs, but the Medicare program will pay teaching hospitals directly for it based on the number of MA patients they serve as determined by shadow claim billing and reimbursed via the annual cost report settlement.***
- ***Hospitals that are eligible for Disproportionate Share (DSH) payments receive additional operating and capital payments intended to offset the financial burden of treating a disproportionate share of certain low-income patients. It's important that MA inpatient days are reported through shadow claims to properly capture days in the SSI percentage used to determine these payments and optimize reimbursement via the annual cost report settlement for DSH.***
- ***Skilled nursing facilities and swing-bed units must submit shadow claims for beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness in Medicare's common working file (CWF).***

We recommend that you periodically review your shadow billing processes to ensure that you're capturing all Medicare Advantage inpatient claims and not leaving any potential reimbursement off the table.

4. Stay on top of best practices for Critical Access Hospitals receiving Medicare cost-based reimbursement

For Critical Access Hospitals (CAHs) that receive cost-based reimbursement from Medicare, there's an additional layer of revenue risk related to the proliferation of MA plans. MA plans typically pay CAHs' based on a factor of their Medicare rates, which are based on the CAHs allowable costs. However, unlike traditional Medicare, MA plans do not retroactively settle payments based on actual allowable costs from its annual cost report filing. This means that a CAH is not actually paid its allowable cost to treat all Medicare beneficiaries, only those that are enrolled in traditional Medicare, which is a shrinking population. The Medicare Cost Coverage Ratio (the proportion of allowable costs that

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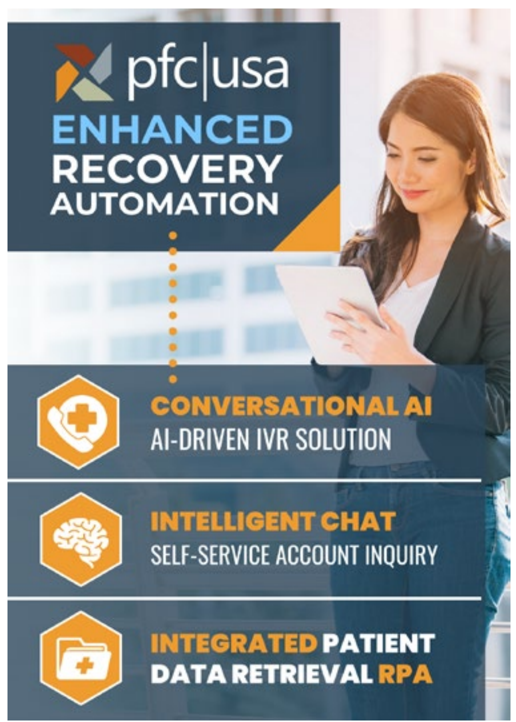

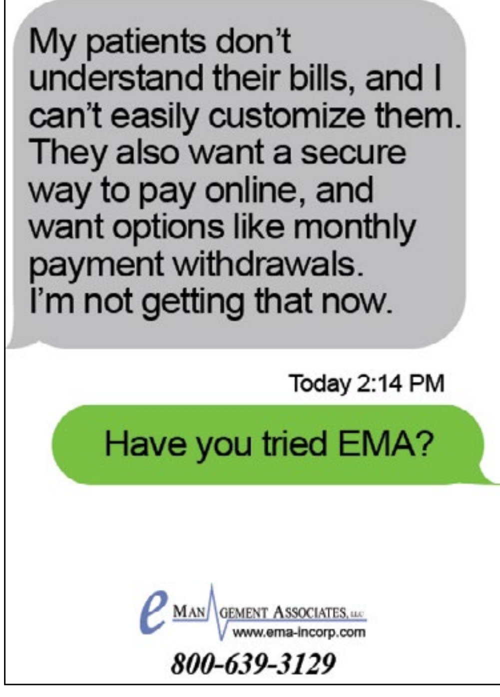

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are reimbursed by Medicare) for CAHs throughout the United States shrunk by nearly 15% from 2018 to 2022 and is expected to continue to shrink as participation in MA plans grows. This puts a CAH's cost-based reimbursement at risk.

A CAH may be underpaid or overpaid by a MA plan throughout the year if its interim Medicare rates are not close to its actual allowable costs. We recommend that CAHs take the following steps to mitigate revenue loss and receive payments from MA plans that are reasonably close to their actual allowable costs.

- ***Regularly estimate Medicare cost report settlements (ideally every month, but at least quarterly). If necessary to incorporate operational changes, prepare an interim cost report to provide a more accurate estimate.***
- ***Establish a threshold for your settlement estimate that would trigger you to request an interim rate adjustment.***
- ***Send Medicare rate letters to all MA plans as soon as possible after you receive them so the MA plan can update their payment rates.***
- ***If you've made significant investments or operational changes that would have an impact on your costs, don't wait for your annual cost report filing to see the impact.***
- ***Consider submitting an interim rate review to incorporate these changes into your Medicare and MA rates in a more timely fashion.***

5. Understand your obligations at the time of contracting and enrollment

As mentioned previously, many of the MA products are included as part of a commercial contract. While not inherently "bad," it is important that each provider organization is clear about the differences in plan administration (authorizations, formularies, panel closure notifications) that may cause workflow changes for the staff to ensure revenue integrity and the rates. Typically, a small percentage of MA plans are reimbursed on "Medicare Plus." However, this percentage varies greatly, as do the payer policies. Several MA plans are introducing value-based programs. It is very important for each organization to understand the obligations clearly before engaging in these programs.

While the MA plans may look like they are part of the commercial agreements, the enrollment process for these plans is reliant on the completion of the traditional Medicare enrollment. Far too many times, we have seen providers forget to go back to the commercial plan to ensure that the provider has been linked to all of the products, again resulting in denials.