The Virginia AAHAM Insider

A Newsletter by and for the members of the Virginia Chapter of AAHAM

The President's Message

"When I was a boy and I would see scary things in the news, my mother would say to me, "Look for the helpers. You will always find people who are helping." ~ Fred Rogers

My Dear Friends and Helpers:

First let me start by saying that I pray you are well and taking good care of yourselves and your families, while staying at home as much as possible. I know that many of you must be at work because you manage teams that are patient facing. Thank you for your service to your teams and to your patients.

If any of us had been told a year ago that in 2020 we would be cancelling Legislative Day, our conferences and countless other events due to a world-wide pandemic, we would not have believed it, yet here we are! This is an unprecedented time for all of us and we must rise to meet the challenges as they present themselves.

As you may be aware, we postponed our Charlottesville conference to June 26th. I want to thank our Board of Directors for acting swiftly to ensure that arrangements and speakers were notified and rescheduled. As a result of their good work, we did not lose any deposit monies and we are pleased about that. We will keep you updated on this new date as COVID19 continues to unfold before us.

We were able to meet the March 31st deadline for submission of the Chapter Excellence-Operations Report, although the deadline has been indefinitely lifted by the National AAHAM office. This was the right decision, as many chapters were struggling to meet the deadline, as well as competing priorities.

If you need anything at all, please reach out to a colleague, a board member or me. We are all in this together and together we will persevere and be better than we ever were. I may be reached at Linda.Patry@mwhc.com or 540-741-1591. Be well, be safe and I look forward to seeing you again very soon.

Yours in AAHAM,
Lin
Linda M. Patry, CRCE-I
President, Virginia Chapter of AAHAM

Inside this Issue:

The Virginia Chapter of AAHAM
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Virginia Hospital Advocate Newsletter

2020 General Assembly Session

The 2020 Virginia General Assembly session kicked off Wednesday 1/8/20! This year is considered a "long" session, and is scheduled to last 60 days in order to give the legislature time to produce the Commonwealth's two-year budget. Here are some key dates on the calendar:

Wednesday, Jan 8 - First Day of Session

Tuesday, Jan 14 - Hospital Lobby Day

Tuesday, Feb 11 - Crossover Day (The last day for bills to be heard in their chamber of origin [House or Senate] before they must cross over to the opposite chamber. Any bill not passed by its originating chamber by this day is no longer active for this session.)

Saturday, March 14 - Sine Die (scheduled adjournment of the regular session)

Wednesday, April 22 - Reconvened Session (aka "Veto Session." On this date, the General Assembly returns to Richmond to consider amendments to, or vetoes of, any legislation passed during the regular session.)

Make sure you're signed up for VHHA's Hospital Grassroots Network to stay informed about critical hospital and health care-related legislation!

What's Happening in Washington, D.C.

Prior to the Christmas recess, Congress passed a $1.4 trillion spending package to fund the federal government through FY 2020. The package included several important provisions supported by hospitals and health systems such as: an additional delay of the Affordable Care Act's Medicaid Disproportionate Share Hospital (DSH) cuts through May 22, 2020; funding for community health centers; an extension of funding for children's graduate medical education ($340 million); and the CREATES Act, which will reduce barriers to bringing generic drugs to market. Importantly, the legislation did not include harmful provisions related to surprise billing or health care cost transparency that some legislators were pushing to finalize last year. By extending the DSH cuts and other health care programs until May 22nd, Congress is setting up a potential must-pass health care package later this spring.

Regarding surprise billing, leaders on the House Energy and Commerce (E+C) and Senate Health, Education, Labor, and Pensions (HELP) committees announced an agreement on the Lower Health Care Costs (LHCC) Act prior to the recess. According to summaries of that deal, the legislation includes the median in-network rate as the benchmark for settling surprise billing disputes and most, if not all, of the troubling transparency-related provisions that were included in earlier versions of the bill. Additionally, the legislation includes an option for arbitration for any claim in excess of $750, a provision that was added to E+C's proposal last summer but was not included in earlier versions of the LHCC. Following the announcement of the deal, the House Committee on Ways and Means announced the broad principles underlying a surprise billing proposal it plans to introduce in early January. That proposal would ban balance billing in the same situations as the LHCC, but would not impose a benchmark rate according to a high level summary released by the committee. Insurers and providers would negotiate their own payment rates and proceed to arbitration if an agreement can't be reached. These two competing proposals will dominate much of the health care policy discussion as we head into 2020

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Virginia Legislative Leader Spotlight

Senator Louise Lucas

President Pro Tempore of the Virginia Senate and Chair of the Senate Education & Health Committee

D-Portsmouth

Senator Louise Lucas is a trailblazer in the Virginia Senate. She was elected to the Senate in 1991, and previously served on the Portsmouth City Council from 1984-1991. She was recently appointed the first woman and first African-American person to serve as the President Pro Tempore of the Virginia Senate. She will proudly resume wielding the gavel as Chair of the Education & Health committee this week.

VHHA honored Senator Lucas for her leadership in both 2017 and 2018 as a HosPAC Healthcare Hero honoree.

"Education & Health is the one committee that I have served on since I first became a member of the Senate in 1992, and it's the one committee I will never give up. That's because education and health care are hot-button issues that are important to me, my constituents, and the people of Virginia. I'm looking forward to assuming the Chair again, and I believe in my heart of hearts that we're going to get a lot of good things done."

Delegate Mark Sickles

Chair of the House Health, Welfare & Institutions Committee

D-Fairfax County

Delegate Mark Sickles was elected to the House of Delegates in 2004, and was recently appointed to Chair the Health, Welfare & Institutions (HWI) Committee in the upcoming session. He also serves on the powerful budget-writing House Appropriations Committee, as well as the House Privileges & Elections Committee. Delegate Sickles served as House Democratic Caucus Chair from 2011-2014, and is highly respected by his colleagues on both sides of the aisle.

VHHA honored Delegate Sickles for his leadership in both 2017 and 2018 as a HosPAC Healthcare Hero honoree.

"Over my 16 years on HWI, I have enjoyed working with Virginia's hospitals on many different health care issues. As Chairman, I hope to continue our productive relationship by rolling up my sleeves to improve the quantity and quality of our overall health care system at costs we can afford going forward."

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Health System

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Our Basics are being tested! From BARC to CRAB

Rob F Borchert, CRCE-I, SME, MBA

I'll bet you are scratching your head wondering what BARC and CRAB mean. Good question and I will be very "clear" in their meaning. In fact, I have generated a table to better explain them.

LETTER	INITIAL MEANING		LETTER	TODAY'S MEANING
B	Billing		C	Compliance and Coding
A	Admissions		R	Revenue Integrity
R	Receivables		A	Patient Access
C	Collections		B	Patient Financial Services

Many years ago, one of my first clients formed a weekly group of representatives from the different functional areas to meet and align its function with the major project that we were performing. This Chief Financial Officer (CFO) called together those "functions" that were key to working together in order to achieve the expected outcome of the project. For those of us that have been around awhile, these are very recognizable areas and there has typically been much discussion between them (if not blame when things went wrong).

We all know that these are basic functions of the Revenue Cycle and have always represented a very valuable (though not recognized a lot) asset to the operations of any hospital, health system, ambulatory care center, nursing home, etc. The interesting part is that these functions, although the names may have changed over time, are still vital to every organization. As I talk about "back to the basics and the basics are being tested", I want to focus on the key elements of each one and the "connection" between each one to provide the Revenue Cycle with the *best practice* associated with your organization. We all know that there are *best practices* in each area and we also know that these practices are not cut and dry and meant to be directly implemented. We each have our own "personality" within the Revenue Cycle and we each have our own set of personnel and personalities that work in these functions. So we know that, sometimes, these personalities can be a hurdle to jump over or workaround to meet the objectives of a *best practice*.

B. When we talk about billing/patient financial services, we are talking about a group of individuals who have been trained in the various aspects of bill completeness, accuracy and generation. There are various aspects to this valuable function and the intricacies of knowledge required has typically formed this area into some specialization due to the multitude and variety of government and third-party contracts.

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Yes, we have tried to build our technology to support these various contracts but there still needs to be some oversight or there will be a large percentage of denials and underpayments associated with each bill. If one were to identify the "source" of the various elements required to complete each bill, one would become aware that approximately 96% of the data required comes to the bill from outside sources. Think about it…

Access/Admissions/Registration – whatever you call it – provides a great deal of information to the billing process. Correct demographic information assures that this bill belongs to the correct person. It assures that the insurance information is accurate and that any other associated information (e.g. 'date of occurrence for an Emergency patient) is completed to meet certain insurance requirements. The date of admission to the hospital (especially from out of the Emergency Room) must also be accurate for the billing process. So many little things that sometimes a computer program does not pick up, but a trained biller will and hopefully before it goes out the door.

Note that in the table above, the corresponding box is "compliance and coding". Something that over the years was not fully recognized but today is not only a component of complete billing but a mandate. Compliance to all the elements of 'proper and accurate' billing is one area, but coding is a key element for not only proper billing but more importantly proper payment. Years ago, coding [Health Information Management, HIM] was looked upon as something that was nice to gather, and they would never state or admit that they were part of the billing process. Well, today, one could easily address the fact that this department, HIM, are performing a key task that directly effects the outcome of the bill submission. Since 1982, when inpatient DRGs (Diagnostic Related Group) was implemented by the federal government and then adopted by the insurance industry, coding has become a vital part of the reimbursement structure of our industry. Over the years, the development of various reimbursement strategies based on coding information has expanded into outpatient surgery, outpatient ancillaries, physician practices, nursing homes, etc. And over the years, the federal government and insurance companies have used coding to not only identify services but require certain diagnosis codes to be present before permission was granted to perform the service. For inpatient coding, there has been much discussion and contract negotiation over the reimbursement between the "principal" diagnosis or reason for admission and the "primary" diagnosis where the majority of services are performed. As an example, if someone was admitted to the hospital for a broken leg but the patient also is an insulin dependent diabetes person with some heart conditions. The "principal" diagnosis is broken leg BUT the majority of services will be for the maintenance of the diabetes and heart conditions.

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These codes reflect the "primary" services rendered to the patient. Another example for today's situation is that there are three (3) basic codes for "coronavirus" [B34.2; B97.2; B97.29] which reflects the principal reason for the admission to the hospital. However, we know that many of these patients have additional health issues that must be addressed also. These complications will also be coded and defined as primary diagnoses not principal.

A Admissions/Access is the start of the *best practice* process. Whether the patient or physician's office calls to make an appointment or the patient physically presents themselves, the beginnings of the gathering of all critical information starts. Whether a patient is ambulatory, outpatient or inpatient, the gathering of data begins and the training for patient access staff is also critical to assure the correctness and completeness of information. Whether it was years ago or even today, the Patient Access area is one department that has the highest percentage of turnover as well as the highest percentage of part-time staff. The main reasons, after study, are that in this, typically, 24/7 day department, the amount of pressure associated with the collection of the patient information, the maintenance of required information that each registrar must know, the high volume of part-time staff and the problem of keeping everyone trained can be overwhelming to some people. The most successful 'maintenance' program associated with the Patient Access department has been to "pair up" people for the sharing of knowledge and training support. Whether the pairing is with a new person and an established person or whether it is with different shift personnel for the ability to call others for information, this program appears to be beneficial for most organizations.

With this department, which includes all inpatient and outpatient registration sites, being so vital in the Revenue Cycle process, it is important that there be regular communication with other departments. This department needs to have access and communication with the ancillary areas, patient financial services and ever Health Information Management. These lines of communication should be more than weekly or regular meetings; they should consist of contact people in these other departments for clarification and completeness of data. For instance, some registration processes include the scheduling of ancillary tests and therefore would require information pertaining to the number of staff available to care for/be with while waiting for a blood draw or a radiology procedure. Sending patients into an unknown area and to sit alone or with other 'nervous' patience is not the best practice in focusing on good patient care. Many organizations use volunteers to bring/escort patients to ancillary areas but, again, to just leave them there without some contact with the ancillary staff is not best practice.

Within the actual registration process, many areas scan the patient's information such as drivers license and insurance card. This is a good practice and should be aligned with insurance verification. Insurance verification is not just finding out if the patient is a member of that insurance plan BUT more importantly, is the service to be provided covered. Are there pre-requisites associated with the service requested? Are there any co-payments to be collected NOW? These are just a few of the many necessary tasks associated with this department. But each one is vital.

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R. Receivables/Revenue Integrity may seem like they do not actually fit together but they do actually in their associated names. For your receivables to be accurate, your revenue must have integrity. Let me explain. We all know what receivables are…they are the unpaid claims awaiting some form of payment from the government, insurance company or individual. They are typically based on the date of discharge from the completion of services rendered to a patient. They typically take 5 or more days to generate a bill that would then move into receivables. Receivables are a measurement that many 'administrators', especially chief financial officers, watch carefully. When receivables begin to 'age' into categories beyond 60 to 90 days, many administrators worry about the collectability of such outstanding claims.

Aside from the billing staff, there, typically, are a group of people who focus on collecting these receivables. If it is also the responsibility of the billing staff, then the allocation of time must be allowed for the billers to do such follow-up. It is a fact that most submitted bills are paid, without challenge, in 30 to 45 days. The question is "are they paid correctly?" Is it underpaid?

This is where the question regarding the integrity of the revenue comes into play. Yes, there are many reimbursement situations today where the payment is based on the DRG but in order to properly track and monitor the revenues from each department and the costs associated with these departments, a true picture of revenue must be captured. Revenue integrity is more that just keeping the chargemaster correct, it is assuring that each service is properly identified and charged to the appropriate patient as well as validating the contractual obligations associated with those claims that are not paid by diagnosis. Capturing charges is certainly the function of the various clinical areas through order entry and/or service validation but assuring that each of these clinical areas are accurate and complete is (or should be) one of the functional outcomes of Revenue Integrity. This type of function further assists with all third-party contract negotiations since Revenue is also directed into the chart of accounts in the general ledger by payor (hopefully your finance department does this). By the combination of maintaining a proper chargemaster; assuring that all clinical areas assign the full service charges to each patient; the gathering of third-party revenue in the general ledger; and the associated function of cost accounting, the recognition of a true receivable is valid for the organization.

C. Collections/Compliance and Coding: I know that it appears that I have addressed these issues above but here I would like to further address the overall importance of focusing on the basics within a *best practice* arena. I know that this is under the "C" category, but it would not be fair to leave out another important element in Basics…denials. Yes, denials will always be with us but with our focus on "the basics", we can both reduce denials and collect on denials quickly. Validation of processes, for me, is one of the most critical functions of Compliance. Not only that we comply with rules and regulations but, more importantly, we perform the *best practice* function within each department. Collections is nothing more that capturing (collecting) the appropriate reimbursement for the proper services rendered to the patient. This collection process applies to all payors, government, insurance companies, and individuals. This collection process is based on Revenue Integrity and proper Coding in all cases.

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This collection process can be somewhat easy if all the elements of contractual obligation are present and all elements/services are properly documented. Even collecting from individuals is easier when the services rendered are clear, correct, appropriate for the level of care and therefore explainable to the individual.

So now can you see how the concept of BARC transformed into the concept of CRAB. In fact, BARC spelled backwards is CRAB. The point of this article is that in these advanced but troubling times, the basics of Revenue Cycle Management hold true. The need for each of us to recognize our role in the Revenue Cycle and also recognize our interactions with others in the Revenue Cycle will give us strength to continue doing our role in bringing care to patients. Yes, we bring care to patients in the fact that the Revenue Cycle provides the necessary financial support to allow all caregivers to continue their actions in supporting the health and welfare of each and every patient.

If you have any questions regarding this article, please feel free to contact me via email or phone. Thank you for being part of the Revenue Cycle.

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CMS in 2020: New and Existing Rules That Affect Organizations

Bradley Granger, Chris Walski

Along with perennial concerns like staffing and overall population health, the regulatory environment is an omnipresent consideration for health care organizations looking to thrive, improve and grow. Nowhere does this concern manifest more clearly than in reimbursement and payor structures, which largely includes policies and rules put in place by the Centers for Medicare and Medicaid (CMS). Even as certain subsets of the care spectrum adjust to CMS changes, such as the transition to a Patient Driven Payment Model (PDPM), hospital facilities have had their own set of guidelines to adjust to and work within. In this article, we take a look at some recent and underutilized CMS programs and look ahead to proposed rule changes that could affect organizations.

Proposed and Implemented Policies for 2020

Among potential new rules from CMS in 2020 are those on the outpatient payment system, Medicare physician fee schedules and payments related to treatment of patients with renal failure.

An important topic included in these, which has been the subject of much recent discussion, is price transparency. Importantly, the rule would stipulate that negotiated rates for hundreds of popular services would need to be transparent. This has received some pushback in the industry, but has the backing of the current White House administration. “Hospitals will finally have to make their real, negotiated prices known to patients, enabling patients to shop among providers,” Department of Health and Human Services Secretary Alex Azar said in 2019.

This is in addition to the list price of a service, which also must be made publicly available. This is a large shift for some providers, and may alter negotiation relationships as the market adjusts to the new transparency requirements.

Price transparency is an area that has been challenging for many hospitals to implement effectively. The complexity of negotiated insurance rates with hospitals makes it difficult to meet the disclosure requirements while providing published information that is meaningful to individual patients, making it an area of concern in 2020 and beyond.

Implementation of Existing Policy

Amidst changes, it is important to remain mindful of existing rules that affect reimbursements. An estimated $563 million in Medicare payments is expected to be withheld in fiscal year (FY) 2020 under the Hospital Readmissions Reduction Program[1]. This number is based on readmissions data from July 2015 to June 2018. The need for operational efficiency and strong partnerships to reduce readmissions is a frequent goal related to quality of care, but high readmissions also levy a heavy collective financial toll on organizations that struggle to maintain acceptable levels.

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CMS is also implementing a final rule issued in 2019 that will update Medicare payment policies for hospitals under the Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2020. Several areas are affected under this rule, including the pipeline for development of new approved technologies, increasing payment ratios related to technological add-on services, and another increasing the accuracy of wage index calculations that affect payments to rural facilities.

Technology and Payment

While technological infrastructure is generally framed as having the potential for long-term cost reduction, there are generally upfront costs associated with the transition to new services. In certain cases, however, CMS will provide support for eligible services. The Medicare Shared Savings Program (MSSP) is one example of how payment guidelines are pivoting to account for an increasingly tech-dependent health care landscape. With the intent of transitioning accountable care organizations (ACOs) to a mindset of value over volume, the program supports such services as remote monitoring of physiological parameters (weight, blood pressure, etc.) through apps or smart watches, as well as clinician-to-clinician consultations that help to share information and practices among and between health systems. Documentation guidelines can vary state to state, making education crucial to maximizing the monetary benefit.

Additionally, CMS has also finalized Medicare Advantage plans to cover telehealth without regard to the classic rural telehealth restrictions beginning in 2020[2]. This has implications for urban and larger hospital systems, in addition to rural facilities that have been able to benefit from this rule for some time.

Focus on Innovation

The CMS Innovation Center was established under the Affordable Care Act and acts as a pipeline for new policies and procedures. The program recently transitioned leadership and has received endorsements from Washington. While the number of rules adopted from the program since its inception is comparatively low, as testing of payment and delivery models are refined, it is likely more will find their way to official policy.

Beyond 2020

The regulatory and legislative wheel does not stop turning, and announcements have already been made about impending changes to Medicare Advantage payment plans that will not take effect until 2021. While this particular rule would only adjust an existing rule instead of creating a new one, it is a sign that the next wave of adjustments is never far off. Most rules will not require wholesale changes to operations or payment structures. However, staying abreast of the latest information to understand which rules affect your organization will continue to be the most proactive approach to gauging risk and opportunity.

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Innovation will be a key to hospital success in the future. Not only is there a focus on innovation by CMS, but newer, non-traditional organizations like CVS, Amazon, and Walmart have set their sights on changing the health care delivery model. Given these external pressures, hospitals will need to adapt and innovate to maintain market share and support their relatively high capital costs.

Transforming health care to maintain or improve quality of care while lowering costs is the holy grail of clinical and operational success. ACOs and the processes that define them through CMS provide an opportunity for standardization of best practices. This ongoing process is a vital way forward for many organizations. Close attention to the CMS system can thus yield valuable insights for prioritizing change in the years to come.

To see what projects are currently in the pipeline at the CMS Innovation Center, check out its website.

[1] Rau, J. (2019, October 1). New Round of Medicare Readmission Penalties Hits 2,583 Hospitals. Retrieved from https://khn.org/news/hospital-readmission-penalties-medicare-2583-hospitals/

[2] HealthLeaders Media Staff (2019, April 22). CMS EXPANDS RECOGNITION OF TECHNOLOGY-ENABLED SERVICES. Retrieved from https://www.healthleadersmedia.com/innovation/cms-expands-recognition-technology-enabled-services.

Bradley Granger

Bradley Granger is a vice president, operational and clinical underwriting with Lancaster Pollard Mortgage Company, a financial services firm based in Columbus, Ohio, that specializes in providing capital funding to the health care and senior living and sectors. LPMC is a division of ORIX Real Estate Capital, LLC. Securities, Investment Banking and Advisory Services provided through OREC Securities, LLC, Member FINRA/SIPC.

Chris Walski

Chris works with hospitals and health systems across the country to ensure they are optimizing reimbursement received from Medicare, Medicaid, and commercial payors. He frequently speaks for both the Healthcare Financial Management Association (HFMA) and state hospital associations, such as the Ohio Hospital Association. In these sessions, he has covered a wide range of healthcare reimbursement topics from the basics of Medicare cost reporting to overall reimbursement structure and optimization. He belongs to the AICPA and the HFMA and received his B.B.A. from Alma College and his M.S. degree in accountancy from the University of Notre Dame

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THE ROOT CAUSES OF SURPRISE BILLING AND HOW PROVIDERS CAN HELP

KEN MAGNESS

Sadly, surprise billing (i.e., a patient receiving an unexpected bill for healthcare services) is very much a reality for many patients for a myriad of reasons.

Root Causes

In emergency situations, patients have little say when an ambulance arrives to dictate which emergency department to be rushed to or which doctors provide care. Similarly, patients don't have any say in which ambulance company provides their ride to the hospital. And, even though the hospital is in-network, the doctors providing the care may be out-of-network, resulting in a surprise bill. A study conducted by Yale researchers found that of 1 in 5 emergency visits, patients attended in-network hospitals but were treated by out-of-network physicians.

Undergoing a common surgery provides another opportunity for a patient to receive a surprise bill. A recent study, published in JAMA, found that among commercial-insured patients who underwent common in-network surgery, 20% of these procedures involved out-of-network charges. "These findings suggest that, in surgical settings, the problem of out-of-network billing is not restricted to a single specialty or setting. Surgical care is inherently multidisciplinary and requires a team of clinicians with payer contracts that are rarely intentionally coordinated," researchers said in the study.

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THE ROOT CAUSES OF SURPRISE BILLING AND HOW PROVIDERS CAN HELP

The Narrow-Network Phenomenon

In some geographic markets, the availability of certain specialists may be limited. In other cases, a few providers may enjoy having a monopoly power in particular areas. As a result of these scenarios, insurance plans don't have much negotiating power, so these providers remain out-of-network. When health plans don't contract with these providers, they are 'narrowing the network' of available providers.

Out-of-network providers charge more for their services than in-network, but in the case of anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment. A Kaiser Family Foundation survey showed that 40% of patients have received a surprise bill in the last 12 months and an alarming 67% said that receiving a surprise bill would be a serious cost concern.

Can Legislation Enforce Change?

Not surprisingly, there's no clear answer on what it would take to end surprise billing. Currently, there's no federal law to protect consumers from surprise bills, and there are some state laws, but ultimately the federal law prevails and consumers who get their insurance from employers with self-funded plans aren't protected under state laws.

As consumers are responsible for more and more of their healthcare, the issue of surprise billing is not going to be alleviated. On the contrary, the issue has raised interest at the federal level and prompted a series of federal proposals in the last session of Congress.

What Can You Do?

As a provider, be completely transparent with your patients. If there's a chance an out-of-network provider will be part of their care, inform them ahead of time so they know what to expect. Even if you can't communicate costs or specific details, just simply informing them of the possibility will improve your patient satisfaction.

Second, if you don't have processes in place to provide patients with the transparency they are demanding – around coverage benefits and costs – consider looking into a patient access management platform. The right platform will empower your staff to inform patients up-front while leading to higher patient satisfaction scores and increased reimbursement.

Ken Magness is a focused healthcare professional with more than a decade of experience in helping clients understand the true value of automation in the revenue cycle management process. As the Strategic Initiatives Leader at Quadax, Ken and his team are passionate about connecting with healthcare providers to help them create and leverage the appropriate technology solutions to optimize the revenue cycle process and improve the experience of their patients and staff.

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4 THINGS TO CONSIDER WHEN BILLING CORONAVIRUS PATIENTS

KEN MAGNESS

The healthcare industry has been thrown a curveball with the introduction of the Coronavirus Disease 2019 (COVID-19)**.** Becoming one of the biggest threats to the global economy and financial markets, the monetary impact remains unknown – both on the provider and patient side. HFMA Policy Director, Chad Mulvany, spoke out to provide guidance on the four things health systems should be doing now to keep coronavirus patients satisfied with their experience after they return home.

Get familiar with payer policy exceptions for coronavirus.

America's Health Insurance Plans has compiled a list of what some health plans are doing. Many are waiving co-pays for testing and covering telehealth services. Furthermore, the IRS has said that high-deductible health plans (HDHPs) can pay for testing and treatment without losing their HDHP status. Knowing what payers are doing will make for a more seamless billing experience for the patient, Mulvany said.

Rethink the organization's financial assistance policies.

Many patients are losing work due to closures and restrictions resulting from the coronavirus and won't be able to pay a bill that may not have been a problem a few months ago. It might make sense to extend assistance to people who wouldn't otherwise qualify, Mulvany said. "I don't know if it's reasonable to do, but it's a conversation to have," he said.

Screen patients for financial assistance.

Be sure to communicate all applicable policies and practices for medical account debt resolution and provide financial assistance and/or charity options, if applicable.

Stay current with coronavirus coverage.

The Centers for Disease Control and Prevention has a wealth of information and resources on their website that is updated frequently.

With the uncertainty the coronavirus brings, Quadax understands researching new revenue cycle management solutions or vendors is most likely not a high priority on your list. But, please know, we are committed to serving and helping our clients' billing processes. We hope you all stay happy and healthy!

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Upcoming Events

Join us for our (delayed) Spring Conference and Wine Tour!

- **6/25/20– Wine Tour– 12:30pm-7:00pm**
- **6/26/20 VA AAHAM Spring Conference Charlottesville VA 1901 Emmet St Holiday Inn**
- **9/25/20– Fredericksburg, VA at John F Fick III Conference Center 1301 Sam Perry Blvd Fredericksburg VA 22401**
- **12/2/20-12/4/20– Williamsburg, VA at Kingsmill Resort 1010 Kingsmill Rd Williamsburg, VA 23185**

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A Newsletter by and for the members of the Virginia Chapter of AAHAM

Virginia Certifications from our December Exams!

Nickolas	Frost	Centra Health	CRCS
Emilienne Diane	Touomou Kamga	Inova	CRCS
Tazia	Williams	Inova Health Systems	CRCS

Spring Volume 54 Issue 1

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Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you! Certification is an investment in your personal growth and your professional future.

Benefits of obtaining AAHAM certification:

- Professional development
- Individual enrichment
- Employer awareness
- Recognition by industry and build a network of connections in the elite group that shares your designation
- Personal challenge and satisfaction
- National recognition
- Recognition and access to the positions and promotions you seek and deserve

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

Expertise—you possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination.

Professionalism—your pursuit of excellence supports the quality of service in your career and in the healthcare industry.

CRCE-I & CRCE-P exams are considered to be the best indication of knowledge in our field. Set a goal or make a promise to yourself to pass the exam. It will be gratifying to prove to yourself that you can pass this difficult exam, and that your years of experience and hard work will be evident to all by the CRCE-I/CRCE-P designation after your name.

The webinars that were held on credit & collection; Patient access and Billing are out on the web site.. Also a practice test is out there and the power points from the three webinars are on the web site. You have to be a Va AAHAM member to access this information. If

Study guides are loaned out to members. You do not have to purchase your own study guide.

If you are interested in testing your knowledge and gaining the recognition that comes with certification, contact Leanna Marshall for additional information.

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Virginia AAHAM offers a certification payment reward for passing the professional exam. AAHAM will reimburse the member for the cost of the exam.

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Virginia AAHAM Executive Board 2020

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(Chapter of Excellence Committee)

David Nicholas, CRCE-I

President, Mercury Accounts Receivables Services

Office - (703) 825-8762 Email— David@Mercury.ARS.com

President

(Committee Chairperson: Nominating Committee; Accounts Receivable/Third Party Payer Committee)

Linda Patry, CRCE-I

Director, Patient Financial Services

Mary Washington Hospital

2300 Fall Hill Ave. Suite 311 Fredericksburg, VA. 22401

Office 540-741-1591 Linda.Patry@mwhc.com

First Vice President

(Committee Chairperson: Membership & Chapter Development:Chapter Awareness)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

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Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Pam Cornell, CRCE-I

Manager, Patient Accounts Billing, Follow Up, and Denials

Mary Washington Healthcare

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Virginia AAHAM Executive Board 2020

Secretary

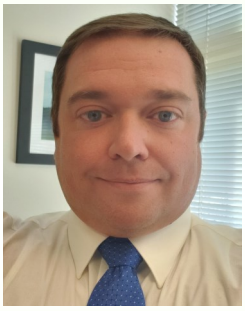
(Committee Chairperson: Publications Committee; Scholarship Committee)

Linda Connor, CRCE-I

Manager of Patient Financial Services

Sentara Halifax Regional Hospital

Office: (434) 517-3433 Email: linda.conner@halifaxregional.com



Treasurer

(Committee Chairperson: Vendor Awards Committee)

Manager, Revenue Cycle

University of Virginia Health System

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Charlottesville, VA 22908

434.297.7477 Jrb2re@virginia.edu

Appointed Board Member

(Committee Chairperson, Sponsorship Committee)

Thomas Perrotta

Vice President of Client Relations, CCCO

Penn Credit

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Appointed Board Member

(Committee Chairperson: Certification Committee)

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UVA Health System (Retired)

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Virginia AAHAM Executive Board 2020

Appointed Board Member

(Finance Committee Chair)

Dushantha Chelliah

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Appointed Board Member

(Communications Chair)

Tim Breen

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Appointed Board Member

(Legislative Chair)

Austin Hale

Honorary Board Member

Linda McLaughlin, CRCE-I

Email– linda.b.mclaughlin@gmail.com

Honorary Board Member

Michael Worley, CRCE-I

Office—(540)470-0020 Email—mworley@ntelos.net

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Woodrow Samuel Scholarship

Congratulations to our 2019 recipient, Cecilie Elliott!

Woodrow Samuel Annual Scholarship Application

Purpose:
The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987. The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter, and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization. A maximum of $1,000 scholarship award will be given.

Eligibility:
Eligible nominees must:
- ☐ Be a Virginia AAHAM member or a child of a Virginia AAHAM member as of January 1 of the current year.
- ☐ Eligible nominees can apply for the scholarship award on an annual basis.
- ☐ Members must be employed full time in a healthcare related field and dependents must be enrolled in an accredited college or school.
- ☐ Chapter dues of the member must be paid prior to the acceptance of requested scholarship applications.
- ☐ Classes taken must be taken during the current school year.

Nomination Procedure:
Nominees must:
- ☐ Complete the application form
- ☐ Include at least one letter of reference.
- ☐ Include or attach any documentation you would like to have considered.
- ☐ Include an essay on why winning the scholarship is important.

Submission:

The form will be completed and returned to the address listed at the end of the application. This application will be postmarked no later than January 30th of the year the application is submitted to the Virginia State AAHAM Scholarship Chairman. All application materials and supporting documentation will be reviewed by the Virginia State Scholarship Committee. After all applications are reviewed, the applicant will be notified if they have been selected as a Scholarship recipient by the Chair of the Scholarship Committee.

Please submit all applications to Linda Conner by email at LWConner@Sentara.com or mail the application to Linda Conner, Manager Patient Financial Services-Patient Access, Sentara Halifax Regional Hospital, 2204 Wilborn Ave South Boston VA, 24592 no later than January 31st. Awards will be presented at the March AAHAM meeting to be held in March 2020 in Charlottesville.

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2020 Membership Application

Please enter your data below, and then send this form, along with the $30.00 annual dues to the address below to join or renew your membership with the Virginia Chapter of AAHAM.

Take advantage of these important benefits…

- Problem solving and solution sharing with your associates
- Membership directory
- Reduced fees for chapter education events
- Access and preparation assistance for certification tests that demonstrate your professional skills
- Educational seminars & workshops
- Chapter newsletter
- Interaction & networking with peers

First Name:	Last Name:
Certification:	Employer Name:
Job Title:	Mailing Address:
Day Phone #:	City:
Fax #:	State & Zip Code:
E-Mail:	

MEMBERSHIP RECOMMENDED BY: _____

For additional information contact Linda Patry @ 540-741-1591 or via email at: Linda.Patry@mwhc.com

Please mail the completed form with our dues payment of $30.00 to the following address:

Treasurer, Virginia AAHAM

Jeffrey Blue

Manager Revenue Cycle, UVA Health System

PO Box 800750 Charlottesville VA 22908

-OR-

Take advantage of our online membership application and payment options. Visit our website at http://www.vaaaham.com/Membership_Application.html

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RMC
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Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2020. Submit articles to Linda Conner at LWConner@Sentara.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

This publication is brought to you through the collective efforts of the **Publications Committee**

Linda Conner, CRCE-I

Secretary

What is AAHAM?

AAHAM is a premier professional organization for healthcare administrative management. Our goal is to provide quality member services and leadership in the areas of education, communication, representation, professional standards and certification. Virginia AAHAM was founded in 1982 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a based constituency of healthcare professionals.

I ❤ Virginia