The Virginia AAHAM Insider

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

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Dear friends and colleagues:

Can you believe we are already almost halfway through 2022? Children are out of school. Pools are open. Gardens are growing. Soon we will be celebrating July 4th!

We have a lot of exciting things happening in AAHAM, both nationally and statewide. We have events that are coming up and I would love to see you there in person!

While I'm writing this, we have the following dates planned:

6/15/22-Washington Nationals Ballpark

6/21-6/22/22-Legislative Day

9/14- The Virginia Fall event will be held in Fredericksburg at the Fick Center (please note it's on Wednesday this year)

10/12-10/14/22- ANI is in Baltimore

Finally, our Winter conference is in Williamsburg at Kingsmill from 11/30-12/2

Being a part of the national AAHAM Board is so rewarding. Our membership numbers have increased and there are a lot of changes that continue with certification to make it easier for you to stay certified. Joining at the National level will help you with education and maintaining your certification.

A survey will be coming out in the next couple of months. Please take the time to complete it so that we know how we can best meet your needs.

Please don't hesitate to reach out to me directly if you have any questions or ideas on how to improve the experience or if you would be interested in serving on a committee.

I love this quote by Condoleezza Rice. YOU can do great things!

"The essence of America—that which really unites us—is not ethnicity, or nationality or religion—it is an idea—and what an idea it is: That you can come from humble circumstances and do great things." Condoleezza Rice

Sincerely,

Pam

Pam Cornell

FACEBOOK.COM/VAAAHAM
LINKEDIN: The Virginia Chapter of AAHAM
INSTAGRAM: VAAAHAM

17th Annual Legislative Day…

Mary Prendergast, Tom Perrotta, and Pam Cornell supporting Virginia Chapter of AAHAM!

Coming Back Together!! June 21-22, 2022 Hyatt Regency Washington on Capital Hill Washington, D.C.

Healthcare Professionals Night at the Park!

June 15, 2022

5:30 PM-10:00 PMET

Nationals Park Stadium

1500 South Capitol Street, SE

Washington, 20003

Please join us for a night at the park, in collaboration with these healthcare groups:

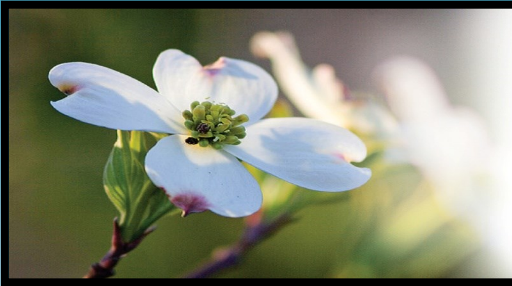
VA-DC HFMA, VA AAHAM, VA HIMSS, NCHE, NAHSE and the DC Chapter of Women in Healthcare

Healthcare Professionals Night at the Park

Nationals Park Stadium | 1500 South Capitol Street, SE | Washington, DC 20003

Scoreboard Pavillion, Section 242

Wednesday June 15, 2022, 7:05 game, any who want to meet prior for networking we will have some food and drinks at 5:30 pm.



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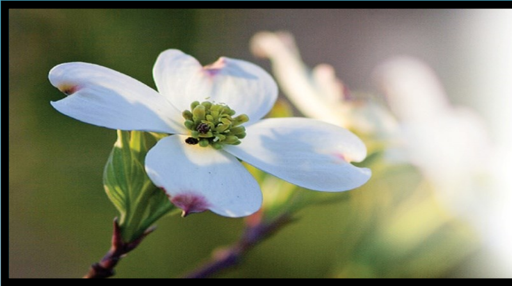

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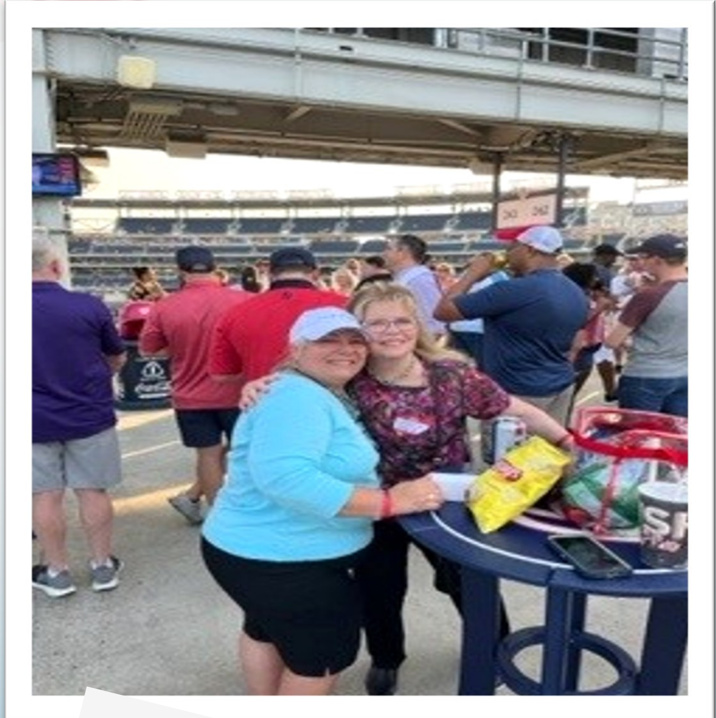

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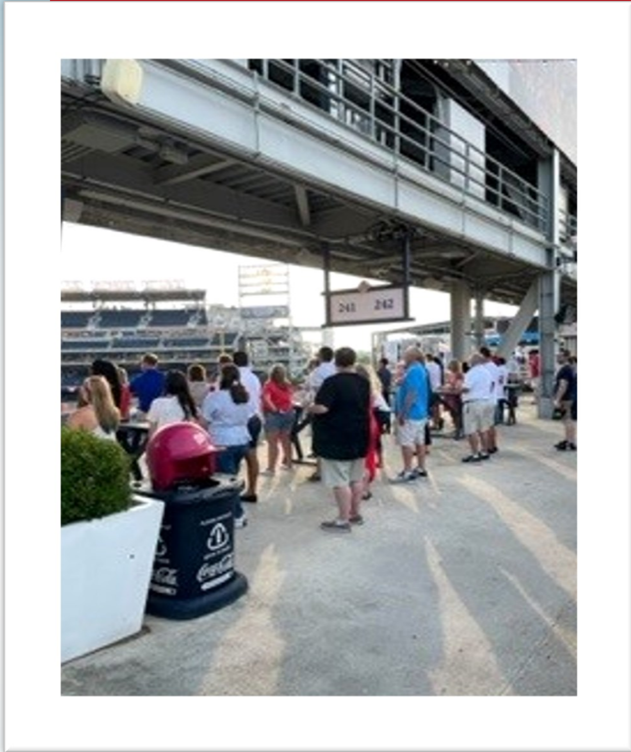

Virginia Hospital Advocate Newsletter

Happy Spring from your VHHA Government Affairs Team! As part of our goal to keep you informed about VHHA's advocacy work, we want to let you know that our team has undergone some internal changes in the past month. Kathryn Gilley, our former Director of State and Federal Policy, has joined the National Alliance for Mental Illness. While we will miss her dearly as part of the team, we are delighted that we have the opportunity to work closely with her in her new position as we continue efforts to strengthen Virginians' access to behavioral health services. We are also excited to share that W. Davis Gammon, who supported our advocacy work at the General Assembly session in 2022, has joined our team full-time as Director of Policy and Legislative Affairs after previously being on loan to us from the VHHA Foundation. Speaking of the General Assembly, the state legislature recently returned to Richmond in late April for the reconvened session to consider gubernatorial legislative amendments and vetoes. We have also commenced the annual HosPAC giving campaign and we are keeping our fingers crossed that legislators will reach a compromise to complete their work on the two-year state budget. If you haven't already, please remember to join the Hospital Grassroots Network [nam04.safelinks.protection.outlook.com]to stay informed about Virginia hospital and healthcare advocacy initiatives.

As always, VHHA will strive to keep you informed about issues affecting the health care delivery system at the national and state levels. Please feel free to contact us at any time with questions or comments.

- The VHHA Government Affairs Team

Virginia Hospital Advocate Newsletter

What's Happening In Richmond

On April 27, 2022, the General Assembly reconvened to consider Governor Glenn Youngkin's vetoes of, and amendments to, legislation approved during the regular legislative session this winter. Resolving those policy issues was overshadowed that day by partisan infighting among Democrats in the House of Delegates where a parliamentary maneuver was employed to remove Delegate Eileen Filler-Corn (D-Fairfax County), a former House Speaker, from her role as caucus Minority Leader. Delegate Charniele Herring (D-Alexandria), the former Majority Leader, survived a caucus vote by the caucus to remove her as Democratic Caucus Chair. The caucus did not hold a vote to select a replacement for Filler-Corn – Delegate Don Scott (D-Portsmouth) has declared his candidacy for that position – and a date for such a vote has not been set though one is expected the weeks ahead.

Governor's Vetoes

All 26 of Governor Younkin's vetoes were sustained, though not without some pushback on several vetoes of legislation that received bi-partisan support during the regular session. One of the bills vetoed by Governor Younkin, HB 573 sponsored by freshman Delegate Nadarius Clark (D-Chesapeake) would have reduced the statute of limitations for medical debt collection actions to three years, two years fewer than the standard statute of limitations for health care service contracts.

The Governor also vetoed HB 675 sponsored by Delegate Patrick Hope (D-Arlington County), which sought to eliminate the authority of a health carrier to adjust premium rates based on covered individuals' tobacco use. Under current law, a health carrier may charge premium rates up to 1.5 times higher for a tobacco user than for a non-user.

Governor's Amendments

VHHA-supported legislation, HB 264 sponsored by Delegate Chris Head (R-Botetourt County) and SB 369 sponsored by Senator Richard Stuart (R-Westmoreland County), allows for out-of-state licensed professionals to practice in a hospital, licensed nursing facility, or dialysis facility on a temporary basis as necessary to respond swiftly to rapid increases in demand even when a state of emergency has not been declared. The Governor added an emergency clause to the bill making the bill effective immediately upon his signature. The amendment was unanimously adopted

Another VHHA-backed bill, HB 900 sponsored by Delegate John Avoli (R-Augusta County) and SB 130 sponsored by Senator Barbara Favola (D-Arlington County), codifies the authority given to the State Health Commissioner in Executive Order 52 (2020) to temporarily extend the bed capacity of hospitals and nursing homes. This legislation removes the need for a formal state of emergency declaration to be issued in order for the Commissioner to exercise those powers. The Governor amended the bill by adding language that is consistent with the criteria specified in previous executive orders related to additional bed capacity to ensure that health care providers have the ability to safely staff services across existing hospitals and nursing homes. The amendment was adopted unanimously and the bill has an effective date of July 1, 2022.

Virginia Hospital Advocate Newsletter

What's Happening In Richmond

VHHA requested, and the Governor agreed to add an emergency clause to HB 745 sponsored by Delegate Rob Bell (R-Albemarle County), which allows a person who has graduated from an accredited respiratory therapy education program to practice with the title "Respiratory Therapist," "License Applicant" or "RT-Applicant" until the individual has received a failing score on any examination required by the Board of Medicine for licensure, or six months from the date of graduation, whichever occurs sooner. The amendment was adopted unanimously and is effective upon the Governor's signature.

One additional item of interest is SB 192 sponsored by Senator Monty Mason (D-Williamsburg), which sought to amend the qualification requirements for local health department directors to provide that a person may be a local health director if that individual possess a master's or doctoral degree in the area of public health and has at least three years of professional experience in a full-time position in either a public health agency or public health-related position, or is otherwise qualified for the position as determined by the Commissioner of Health. Currently, only a person who is a physician licensed to practice in the Commonwealth may be a local health director.

The Governor recommended amending the bill to remove the added criteria language in the bill for hiring a health director but did not remove the language allowing the state to hire anyone deemed "otherwise qualified by the Commissioner." The Governor's amendment was rejected on a party line vote. Based on that outcome, the Governor has several legal options: he can sign the legislation as passed by the General Assembly, veto the bill, or allow the bill to become effective without his signature.

Biennium Budget Update

Budget negotiations remains underway with the expectation that the General Assembly will reconvene to vote on the budget prior to the end of May.

The two lawmakers leading the negotiations, House Appropriations Committee Chairman Barry Knight, (R-Virginia Beach) and Senate Finance Committee Chairwoman Janet Howell (D-Fairfax County), have each publicly stated that progress is being made. VHHA staff remain in frequent communication with legislative budget negotiators regarding our budget priorities and will provide updates to the hospital community as more detail become available.

Behavioral Health

The legislative Behavioral Health Commission (BHC) held its first meeting on Tuesday, April 26, 2022. The newly formed Commission replaces the Deeds' Commission and was established to be a permanent entity that will address the needs of Virginia's behavioral health system and the individuals it serves.
BHC Commission Members include: Senators. Creigh Deeds (Chair), Emmett Hanger, George Barker, Barbara Favola, Monty Mason and Delegates Rob Bell, Emily Brewer, Patrick Hope, Vivian Watts, John Avoli, Tara Durant, and Sam Rasoul.
Nathalie Molliet-Ribet has been hired as the Commissioner executive director and has been in that role since February 10, 2022. The BHC is also expected to hire two policy analysts, with plans in place for a Commission website to be up and running this month.
2022 BHC Workplan includes:

Virginia Hospital Advocate Newsletter

What's Happening In Richmond

- Develop of a five-year strategic plan (goal is to be more proactive and maintain focus on the system).
- Identify key BH metrics.
- Address HB 2047 and SB 315 (from the 2021 Session) – criminal proceedings; consideration of mental and intellectual condition, etc.
- Address SB 198 (from the 2022 Session) – disposition when a defendant is found incompetent; involuntary admission of the defendant.
- Create a workgroup to consider DBHDS restructure – this is a priority for the BHC with a report due by November 2022.

Address Problem Gambling and Treatment Fund (required by budget language).
DBHDS Commissioner Nelson Smith Provided an Update on the Agency's "North Star Strategic Plan"
DBHDS Priorities and North Star Plan:

- Workforce – recruitment, retention, engagement
- Expand Continuum of Care
  - Project BRAVO
  - Less reliance on inpatient care
  - Fully fund STEP-VA
  - Improve crisis system
- Improve Services, Programs, and Business
  - Modernize systems and process

Virginia Hospital Advocate Newsletter

What's Happening In Washington, D.C.

In April, Congress did not act to remove Medicare sequestration cuts from federal spending legislation. Federal legislation approved last year prevented Medicare rate reductions from occurring all at once by establishing a delayed rollout schedule. As of April 1st, a 1% sequester cut has taken effect with another cut likely coming in July. Please refer to the Medicare Physician Fee schedule for more information on these rate changes.

In the past month, the nationwide Test to Treat initiative was rolled out. The program will give individuals a way to rapidly access free lifesaving treatment for COVID-19 by offering access to testing – two who test positive will receive appropriate treatment – and receiving a filled prescription from a qualified health care provider all in one location. These "One-Stop Test to Treat" locations will be available at hundreds of locations nationwide, including pharmacy-based clinics, federally-qualified health clinics (FQHC), and long-term care facilities. Individuals will also be able to receive testing and treatment from their primary health care providers who can appropriately prescribe oral antivirals at locations where they are being distributed.

While vaccination continues to provide the best protection against COVID-19, therapies are now available to help treat eligible people who become ill with the virus. The Biden-Harris Administration has invested in a number of COVID-19 treatments, including two oral antiviral pills – Pfizer's Paxlovid and Merck's Molnupiravir – that can help prevent severe illness and hospitalization when taken soon after symptom onset. Supplies of these treatments are being distributed Test to Treat sites each week.

Virginia Hospital Advocate Newsletter

Join the Hospital Grassroots Network!

Sign up for the VHHA Hospital Grassroots Network to join our **rapid response network** that helps legislators understand the importance of a pending health care vote of issue.

The Virginia Hospital Advocate newsletter will also help keep you updated on key issues so that you're informed and ready to respond when an urgent action alert is issued.

Register online today! [nam04.safelinks.protection.outlook.com]

Support Dedicated Legislators through HosPAC!

HosPAC is VHHA's political action committee. HosPAC provides organized, effective political action by supporting candidates who will work to improve quality health care through policies that recognize the importance of Virginia's hospital and health systems.

To contribute,
please visit www.VAHosPAC.com [nam04.safelinks.protection.outlook.com]

Is Your Patient Financial Experience Losing Your Customers?

Patient financing is a critical part of delivering a positive healthcare experience for customers and is directly linked to retaining their loyalty. Yet, many healthcare organizations don't measure the impact the financial experience has on customers.

The financial experience is the final perception that customers are left with after seeking medical care. This means that even if the patient has experienced standout service throughout their medical journey — from booking an appointment, visiting the healthcare practice, waiting for their appointment, and being seen by a healthcare professional — their financial experience is the final opportunity to make a good impression.

A poor financial experience can prevent customers from returning. 65% of patients would change providers based on being able to pay using their preferred payment method.
Cultivating a positive financial experience for patients takes commitment. Healthcare providers need to create a seamless, accurate, and consistent experience the entire way along the patient journey. Studies show that it can take up to two years to build customer loyalty so providers need to be ahead of the curve and implement changes as soon as possible.

Tena Hoxsie, Vice President of Patient Financial Experience for Metro Health, says, “A patient's perception of a wonderful clinical experience declines when their financial experience is negative.” In other words, a poor financial experience can lead to patients choosing care with other organizations.

Understand the patient financial experience

Before you can change the patient's financial experience for the better you need to properly understand it. Revenue cycle teams and point of service staff are at the front lines of the patient experience. Spend time with these members of staff to get a thorough understanding of the policies and approaches to the financial journey.

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Is Your Patient Financial Experience Losing Your Customers?

Historically, revenue cycle management has been designed to effectively deal with insurance claims, not patient collections. With patients now responsible for more payments than ever, there may be holes in the revenue cycle that lead to frustration for your patients. Ms. Hoxsie suggests when a patient is informed upfront of their financial obligations and understand their payment options, their experience is positive — even if they have financial liability for services rendered.
With this in mind, go over every part of the patient experience with a critical eye. Here are some questions to consider:

- Is accurate demographic and insurance information collected at the first point of contact?
- Do you offer pre-service estimates?
- Are your bill statements clear, well designed, and easily break down services owed?
- Is communication clear, frequent, and timely before and after a patient's appointment?
- Are there multiple ways to pay including directly after the appointment and online?
- Is it easy for customers to reach out to ask questions about their billing statements?
- Is it easy for customers to provide feedback?

While according to a 2017 report from the Center of Healthcare Quality & Payment Reform 70% of patients find their medical bills confusing. If your healthcare organization has a 'one-size-fits-all' policy for any parts of the billing process, it's probably a good time to expand your offerings.

Measure what is and isn't working

The best way to get definitive data on what is and isn't turning customers away is to simply ask. There are multiple ways healthcare providers can do this, from surveys, to focus groups or online panels. If you provide an online payment option, consider adding in the ability for patients to rate their financial experience and leave any feedback online.

If customers can pay after their appointment, a simple check-box customer experience survey may be enough to measure the areas customers would like to see improvements in. Healthcare providers should continue to measure customer satisfaction after new ideas and changes have been implemented to make sure it is improving.

Is Your Patient Financial Experience Losing Your Customers?

:Develop an end-to-end patient financial journey

A Connance study found that among patients who had rated a hospital's billing process well, 85% would recommend the hospital, and 95% would return for future services. Developing an end-to-end patient financial journey is worth it to retain current customers and attract new ones. Think about the financial interactions that patients have with your system.

Understanding that the financial side of your business is also responsible for upholding the standards of your practice as a 'brand.' Identifying touchpoints that customers have with the financial side can help to discover areas to improve that experience.

Providers still have a lot of changes to make before the healthcare industry can be as consumer-friendly as retail. Creating a more transparent, flexible financial experience will go a long way to giving patients the innovative, customer-centric experience they are looking for.

As deductibles continue to rise, so too will the need for consumers to be able to accurately plan and manage their finances. Healthcare providers who can understand and deliver a super financial experience to patients will be light years ahead of their competitors and see the results in their own bottom line. Providing a billing process that is barrier-free, easily understood, and patient-centric will help deliver an excellent patient financial experience.

Avoiding Five Common Financial Assistance Program Pitfalls

Some may argue that the biggest pitfall of hospital financial assistance programs is that many in the general population are unaware of their existence in the first place. That may be true, but lack of awareness is not the only problem.

Hospitals are pillars of their communities, integral to the fabric of society. But, like every other institution, hospitals face challenges with things like budget decisions and staffing issues. Trust is key, and it needs to be reciprocal.

We, the community, want to receive the best care possible, and hospitals want to provide that care. They don't want to be in the bill collection business any more than patients want to be in the medical debt business.

Hospital financial assistance programs can go a long way toward making life easier for all parties. But awareness of these programs is paramount. Here are five easily avoidable pitfalls that commonly plague hospital financial assistance programs.

1. Don't create an over-complicated application form

The longer something is, the less likely someone is going to read it. Keep financial assistance applications closer in size to a blog post than, say, *War & Peace*. One or two pages is sufficient, and don't waste space on instructions.

Limit the questions to only those that directly impact eligibility and those that help you receive reimbursement. For example, ask for assets information so you can claim Medicare bad debt reimbursement due to indigence.

Avoiding Five Common Financial Assistance Program Pitfalls

2. Don't include outdated or irrelevant questions

It doesn't take long these days for things to become outdated. Everything evolves, so constantly re-using the same application form from years past just doesn't cut it.

Information like the make, model and value of your vehicle, your monthly expenses, and whether or not you are a US citizen don't belong on the application. Also, formerly applicable questions may reference programs that have expired. Keep everything up to date.

3. Don't install too many steps on the sliding scale

Calculations of the federal poverty line are not precise, and too many discount percentages only serve to complicate matters for patients. Don't forget: These patients are in the hospital for a reason. Adding headaches and complications to these situations should be the last thing anyone wants to do.

Keep it to three simple steps. 1. You have free care up to X%. 2. You have a _% discount from X% to Y%. 3. You have a _% discount from Y% to Z%. No surprises.

4. Don't sabotage eligibility requirements

Follow the American Hospital Association's patient billing guidelines. Patients are eligible for free care up to 200 percent of the federal poverty line.

And if you consider assets, limit the request to non-retirement liquid assets and non-primary residence real estate.

Avoiding Five Common Financial Assistance Program Pitfalls

5. Eligible patients don't know financial assistance is available

Being 501(r)-compliant isn't good enough. Hospitals need to make it easy and inexpensive to connect patients to financial assistance. Make paperless and self-serve options the standard. Ask yourself at each step, is this user-friendly for the patient and user-friendly for hospital staff.

Finally, please don't fear "leaving money on the table" with patients eligible for financial assistance. I used to work in collections. Trust me, your hospital isn't going to lose any revenue by promoting financial assistance, and you will be a much greater corporate citizen as a result.

Medical billing is a two-way street, and it doesn't have to be the road to ruin. Helping and enabling patients to pay their bills is good for them and the hospital. After all, what's better than a clean bill of health, and a clean bill?

Nick McLaughlin is CEO and Founder of Breez, a company committed to eliminating medical debt by streamlining hospital financial assistance programs.

Is My Collection Agency Prepared for Regulation F?

How has Regulation F changed the Validation Letter to Consumers?

A. *Validation Letter Format*: Regulation F has dictated the required language in the initial validation letter sent to all cosumers in the form of a template. The validation letter must include the following information:

1. Consumer Name

2. Phone Number

3. Address

4. Original Balance

5. Date of Service or Delinquency

6. Applicable Additional Charges

7. Payments Received

B. *Required Dispute Options on Validation Letter*:

»This is not my debt.

»The amount is wrong.

»Other (please describe on reverse or attach additional information).

C. *Validation Period:* The Validation Letter contains a statement that debt is valid unless the consumer disputes it in writing within 30 days.

Is my collection agency prepared for Regulation F?

The Consumer Financial Protection Bureau (CFPB) implemented new rules, known as Regulation F, in 2021. The rules require collection agencies to obtain additional information from creditors sending past-due accounts for collection.

Regulation F has impacted the collection industry and raised many questions about what comes next, especially among creditors who use collection agencies to recover their past-due accounts. Below, we summarize some of the most common questions about Regulation F.

Is My Collection Agency Prepared for Regulation F?

What is required before a collection agency can credit report?

Regulation F requires the following information before collection agencies can credit report. Without it, a collection agency cannot credit report, which could significantly impact the ability to recover revenue.

A. Standardized validation letter required before credit reporting can take place

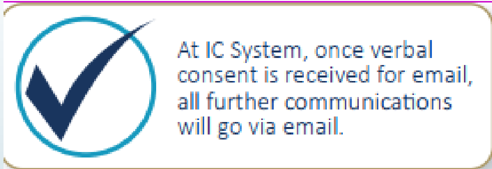
B. Credit reporting cannot begin before 40 days

C. ***Information required to credit report:***

1. Full Name

2. Address

3.Social Security Number (or DOB if no SSN is available)



What is required for email and text consent?

Debt collectors must have procedures to reasonably confirm and document it had consumer consent to communicate by sending an email or text to an address or phone number. Regulation F strictly describes how debt collectors may obtain and document the requisite consent.

A. ***Why does an agency need consent?*** **Consent is required to avoid a third-party disclosure under Regulation F and, in the case of texting, to ensure the consumer knows they may inherit some expense when receiving text messages.**

B. ***How does an agency capture consent?*** **An agency may gather passthrough consent from the creditor or directly from the consumer. Regulation F has strict requirements to obtain valid consumer consent.**

Is My Collection Agency Prepared for Regulation F?

How frequently can a collection agency communicate with a consumer under the new rules?

Regulation F allows debt collectors to contact consumers seven times within seven consecutive days; however,a debt collector must not call a consumer for seven consecutive days after having had a telephone conversation with the consumer in connection with the collection of the debt.

A. *What controls should an agency have in place?*

To comply with calling restrictions, your collection agency should have automated controls.

B. How does an agency optimize its seven attempts?

Agencies may take different approaches to their collection strategy.

Regulation F is for collection agencies.

Why should my business care about Regulation F?

The CFPB expects creditors and service providers to ensure the compliance of its vendors and subcontractors. If a collection agency is in violation of state or federal regulations, such as Regulation F, regulators may question the creditor's oversight.

Consumers may also bring litigation if they perceive a violation of state or federal law. Most debt collection lawsuits involve the consumer and the debt collector or collection agency.However, the original creditor could be asked to give testimony or evidence. In some cases,there may even be some legal liability and associated costs when responding to a consumer lawsuit.

Ensuring your collection partner is compliant with all state and federal regulations, including requirements enacted by Regulation F, will protect your business from potential legal liability.

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www.icsystem.com

Does the Revenue Cycle Ever End?

What Can We Measure?

Have you ever asked that question? Have you ever thought about it? In our mind, the Revenue Cycle is a continuous, (sometimes ever growing), experience like a 'life cycle'. While this may be true, we recognize that there is an end to a 'life cycle' and we can even measure a 'life cycle'. So what about the 'revenue cycle'?

If we break down the revenue cycle into components, we find that there are many components that will never end as long as we have people who need help with their health issues. As part of the full recognition of serving (helping) people with health issues, we acknowledge them through registration. We register people not just to collect their domestic and financial information but, more importantly, to gather their basic information regarding the key health issue that they are presenting to us for help. Whether in a physician's office or a hospital setting, we intrinsically 'know' that a person presenting with certain identifiable issues will require blood work or another lab test or an x-ray or …

Although, we in registration can not write the order to the clinical future, we know what needs to be done and that we are gathering the 'vital' information about the patient so that the services needed will be performed, tracked and follow-up based on the registration data. If there is any kind of measurement here, it will be the collection of the most patient information possible to provide the next step in the revenue cycle with key data for providing the most appropriate clinical service to enhance the patient's health. We, in registration, usually don't hear about the quality of our work in providing the key data for the next patient care service; rather we sometimes hear about the 'missing' elements that we 'should have' collected from the patient. Well, we are human and can only document what the patient tells us when we ask. Have we ever measured the total number of registrations throughout the healthcare facility or office to the identified 'errors' for a set period of time? If the average physician's office registers 30 patients per day per physician or medical staff visit and there is recognition of 'say 3' identified errors over a 30 day period…that is 3 errors for 600 registrations or .05% of the total (one physician office). If multiple physicians, the error rate could be 5 per 1200 or 1800 or 2400 registrations (for a 4 physician office that is .0005% of the total). I would say that is pretty good! How would you measure it?

Does the Revenue Cycle Ever End?

What Can We Measure?

Now in a healthcare facility situation, like a hospital or hospital network, the number of registrations throughout the complex could be 5 to 10 times the number from a physician's office. Remember, a healthcare facility is usually a 24/7 situation for patient care. Now, we know there are metrics that have been established in many of these situations and, again, it is a metric based on the number of 'errors' found in the registration process over a period of time. There is even further recognition that the error rate is different between 'regular' registration and Emergency Department registrations due to the historical level of 'confusion' found in the Emergency Department. Now I know you can all look up the different metrics for a registration area, so I won't bother to indicate the various percentages for 'best practice'. The fact of the matter is that there is recognition that errors can and do occur in the process of registration. If we basically relate to the indicators above ranging from .05% to .0005% and even consider the number of registrations to be 2400, the error rate would be 12 (.05) or 1.2 (.0005). I point this out because most metrics would indicate a general registration error rate of 2% and an emergency room registration rate of 5%. This would mean that for the same 2400 registrations in the general category, there would be 120 errors and for the emergency room, there would be 48 errors. Now, let's do a reality check. If that many errors occurred during any registration process of 2400 patients, the revenue cycle would be in a chaotic mess. The fact of the matter is that registration does a great job but no one really recognizes this when the overall metric is under the goal metric. What a shame that we do not measure and post the 'great numbers' rather then focus on when (if ever) the goal is not met.

Now, I know that I could continue and discuss every sector of the revenue cycle but that might fill the magazine, so I will limit myself to a few of the 'measurable' areas that are familiar to each of us. An area that, I think, has been overlooked is Radiology. Inpatient radiological procedures/exams are usually documented very well and typically align themselves to the proper diagnosis. This is a combination of Health Information Management (HIM), the chargemaster and the choice by the radiological technician. Since the utilization of inpatient radiology procedures/exams are 'summed up' in the billing process, most people do not ask for the detail behind this summary. Any measurement of internal questions or changes is typically bypassed and 'left as they are.'

Outpatient radiology, however, may be a different story. Does the segment of the revenue cycle for radiological procedures/exams end after the order is cut and received by the department? How many times does the 'ordered' test get changed by the Radiologist? Many times the Radiologist believes that there is a better test (procedure/exam) that can be performed to assist the ordering physician, so they go ahead and do something different without contacting anyone about the change. Although, this may be a 'better' procedure/exam, the change can cause havoc for associated departments. Does the changed test meet the 'medical necessity' criteria? Does it directly relate to the stated diagnosis? Does the changed test need 'prior approval' by the third party insurance carrier? Will the ordering physician re-order the original test, thus creating double billing? Is anyone monitoring these changes? Are the changes being made by the 'department' or by one physician?

Does the Revenue Cycle Ever End?

What Can We Measure?

Is there a 'quality assurance' question regarding best practice? As one can see, the revenue cycle does not end but may get more confusing. So, is anyone measuring this situation? Should it be suggested by someone to do an internal audit of the Radiology Department, especially in the outpatient area? Are these changes causing problems in the billing/collection processes? Always a good discussion with the Revenue Cycle Management Team.

Health Information Management (HIM) Department has a primary seat within the revenue cycle. Their role is involved at the very beginning of patient care. Their patient diagnosis for outpatient services designates whether there is prior approval needed or not; whether the requested outpatient service is supported by the stated initial diagnosis; and whether one or more diagnosis is needed for multiple outpatient service requests. For inpatient, the initial diagnosis is critical for two major reasons. First, does the diagnosis meet criteria for inpatient admission, and second, the initial diagnosis is the starting point for the designation of the appropriate Diagnostic Related Group (DRG). From the standpoint of measurement, you probably have plenty of reports regarding diagnosis. Some examples of measurement for quality and best practice are:

- Additional diagnosis that do not relate to the initial diagnosis;
- Distinction between the principal diagnosis (initial) and primary diagnosis (high service rendering);
- Internal choices of DRGs based on various factors;
- Changes of the DRG by third party payors;
- Top diagnoses generated an initial denial from a third party.

There may be other reports that you use for measurement such as most common diagnoses within a medical specialty area or too many 'unidentified' (specific) diagnoses, but you get the idea. One thing that I believe is not used as part of Revenue Cycle Management is historical data from HIM. By this I mean, seasonal reviews of diagnoses to try to prepare for (and care for) the population impact to the health facility or even identify seasonal diagnoses that may provide an avenue for a clinical approach to avoid hospitalizations through outreach programs. Within HIM, I don't think the revenue cycle ever ends.

Now when it comes to the business office and the billing/collections process, do you believe that the revenue cycle ends when you close out an account? Is it that simple? Does it matter how the account is closed? Does it reach a zero balance? Is it written off? What criteria is used to write the account off? Is it turned over to a collection agency and therefore 'ended'? All good questions and all possible scenarios? If you, as a billing/collection person, are responsible for hundreds of accounts, does the revenue cycle end for that one account when it reaches zero or is written off?

Does the Revenue Cycle Ever End?

What Can We Measure?

Is that the end? With the ever-increasing number of accounts added to each person, one probably does not even notice when an account or two goes away. Probably the only noticeable change in numbers is when there is a major write-off of accounts to a collection agency or year-end adjustments. So, can we measure the end of a revenue cycle?

In the billing/collections area, we are usually reviewing 'active' reports regarding the collections or the number of accounts greater than… or working denials, etc. Have we ever stepped out of the daily workload and look at the work from a different vantage point? From a historical standpoint, have we ever analyzed insurance payments from a specific company to see if there are any patterns to their payment/denial history?

- What claims are paid very quickly? What is their diagnosis and services rendered?
- What claims are their initial denials? Are there specific diagnosis or procedures that they deny?
- Are there claims that have required additional data in order to get paid? Can we prepare for that by sending in the initial claim with the historically requested data?
- Do they pay small claims quickly and delay on larger claims?
- Do they pay the physician but initially deny the hospital? (this is key for challenging)
- Are they denying your claims but paying them at another provider? (this involves communications with other facilities/offices in your area)
- Have you found out the criteria they are using if they, historically, underpay a claim? (you can ask them for their protocols since you have a contract with them)
- Are they paying claims that other insurance companies are denying?
- Are they denying claims that other insurance companies are paying?
- Does your Revenue Cycle Management team talk about these issues?

Questions concerning your daily activities is the best way to enjoy what you do. At least, I find that to be very true for me. As I question things that I do on a regular basis, I either find that I am doing the best that I can at this particular time, or I could improve what I am doing by working a different angle. I can talk to others about my tasks and inquire as to various historical practices may have occurred before I started looking at the function. I may find out that no one has ever really questioned the function and the common answer to my question is "we have always done it this way!".

Does the Revenue Cycle Ever End?

What Can We Measure?

In fact, I have a "pin" that says exactly that. Enjoying life, including work, is to venture forth and challenge the activities that one does. Simple examples are shopping at a different grocery store to find out if there are different items or different prices or different varieties of what you may want to buy. Another would be to drive to work a different way (change); or listen to a different music station on the radio. At work, ask to work a different set of accounts or even learn another aspect of the revenue cycle. There was an old expression that I remember early on in my life…"If you are ripe, you get rotten; if you are green, you are growing." For me, this means that if I continue to do my day to day activities without any internal or external challenges, I will grow weary of my functionality and do my job but in a stagnant manner. If I challenge myself (every now and then), I will enjoy my functionality better and grow personally.

So, does the Revenue Cycle ever end? Or what can we measure? Become internal questions for each of us. For me, the revenue cycle does not end but is a challenging experience in any industry. In the healthcare industry, the revenue cycle involves many, many different facets that lead to one outcome…good patient care. Can I know all of these different facets…probably not, but I want to learn more about each facet and how its workings impact my functionality. Do I have to be a surgeon to know that anesthesia is usually involved with this function? Do I have to be a therapist to know that certain diagnoses and conditions will require intervention? The answer is definitely no in each case but to have some basic knowledge of their function will help me better process a claim, talk to an insurance carrier and talk with the patient. Show they (the surgeon and the therapist) know something about my function, definitely. To make that happen is part of my challenge to better perform my functionality. So, I can measure the impact of the revenue cycle on my functionality by the way that I grow into an enhanced knowledge of the fullness of the revenue cycle. The functions outside of billing/collections should recognize that the only reason why I bill and collect monies is so that these "other functions" can provide quality healthcare to our patients. So we each have a personal measurement to enhance and enjoy our own functionality. By the way, this whole measurement process applies to all facets of the revenue cycle not just billing/collections. So you now have the challenge, what are you going to do about it?????

Rob Borchert, S.M.E., FHFMA, CRCE-I

The Virginia Chapter of AAHAM Publications Committee is Seeking Committee Members!

No Experience Necessary!

As a member of the publication committee, you can earn AAHAM CEU's while collaborating with other Chapter members, vendors, and authors.

Writers Wanted!

Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent!

Submit articles or, express interest in participating on the Virginia AAHAM Publication Committee. Contact Amy Beech for information!

abeech@augustahealth.com

AAHAM Certification Options:

The AAHAM Certified Revenue Cycle Executive

The AAHAM Certified Revenue Cycle Professional

The AAHAM Certified Revenue Integrity Professional

The AAHAM Certified Revenue Cycle Specialist

The AAHAM Certified Compliance Technician

What are the AAHAM Exams?

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 are the AAHAM Exams?

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.unts and to prepare them for the many details needed to perform their daily job duties.

Recently Certified in Virginia

VA AAHAM would like to congratulate those who earned the following designations in April and May. Congratulations to:

Certified Revenue Cycle Specialist:

Nidia Dence, CRCS
Jianna Estoesta, CRCS
Terri Gay-Bryant, CRCS
Tionna Harrison, CRCS
Damien Howell, CRCS
Tonoa Romney, CRCS
Taja Smith, CRCS
Kelly Wimer, CRCS

Certified Revenue Integrity Professional:

Stephan Sutton, CRIP

Certified Compliance Technician:

Claudia Galiatsos,CCT

CONGRATULATIONS VIRGINIA CHAPTER!

Virginia AAHAM received recognition for

Stellar Membership Numbers with

over 200 Members in 2021!

2022 VA AAHAM Membership Application

We are thrilled to be growing the Virginia Chapter of AAHAM. Visit our online membership application and payment options 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
- Educational seminars & workshops, conference presentation materials
- Membership directory
- Chapter newsletter
- Reduced fees for chapter education events
- Interaction & networking with peers
- Preparation assistance for certification tests that demonstrate your professional skills
- Certification Training webinar slides and recordings

Join VA AAHAM Today!

Upcoming Events

2022 Annual National Institute

The 2022 AAHAM ANI will be held at the Hilton Inner Harbor in Baltimore, Maryland October 12-14, 2022.

- Attend vibrant educational sessions on career-focused topics
- Learn new techniques
- Acquire new skills
- Obtain best practices
- Earn 20 CEU's
- Connect with colleagues and expand your network

Upcoming Events

Upcoming Certification Exam Dates and Registration Deadlines

Certification Exams are now available each month!

- July 25-29, 2022 July 2022 Exams
- August 22-26, 2022 August 2022 Exams
- September 19-23, 2022 September 2022 Exams
- October 17-21, 2022 October 2022 Exams
- November 14-18, 2022 November 2022 Exams
- December 12-16, 2022 December 2022 Exams

Upcoming Events

Save the Date:

September 14, 2022, Mary Washington Flick Center Fredricksburg, VA.

November 30-December 2, 2022– Annual Conference, Kingsmill Resort Williamsburg, Virginia

Please be sure to watch out for email blasts with registration details for Virginia AAHAM's next Conference! As always, you can view our Events page on our website for upcoming events.

Virginia AAHAM Executive Board 2021-2022

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(Chapter of Excellence Committee)

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Appointed Board Member: **CERTIFICATION COMMITTEE**
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Appointed Board Member: FINANCE COMMITTEE CHAIR
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Appointed Board Member: COMMUNICATIONS CHAIR
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A Newsletter by and for the members of the Virginia Chapter of AAHAM

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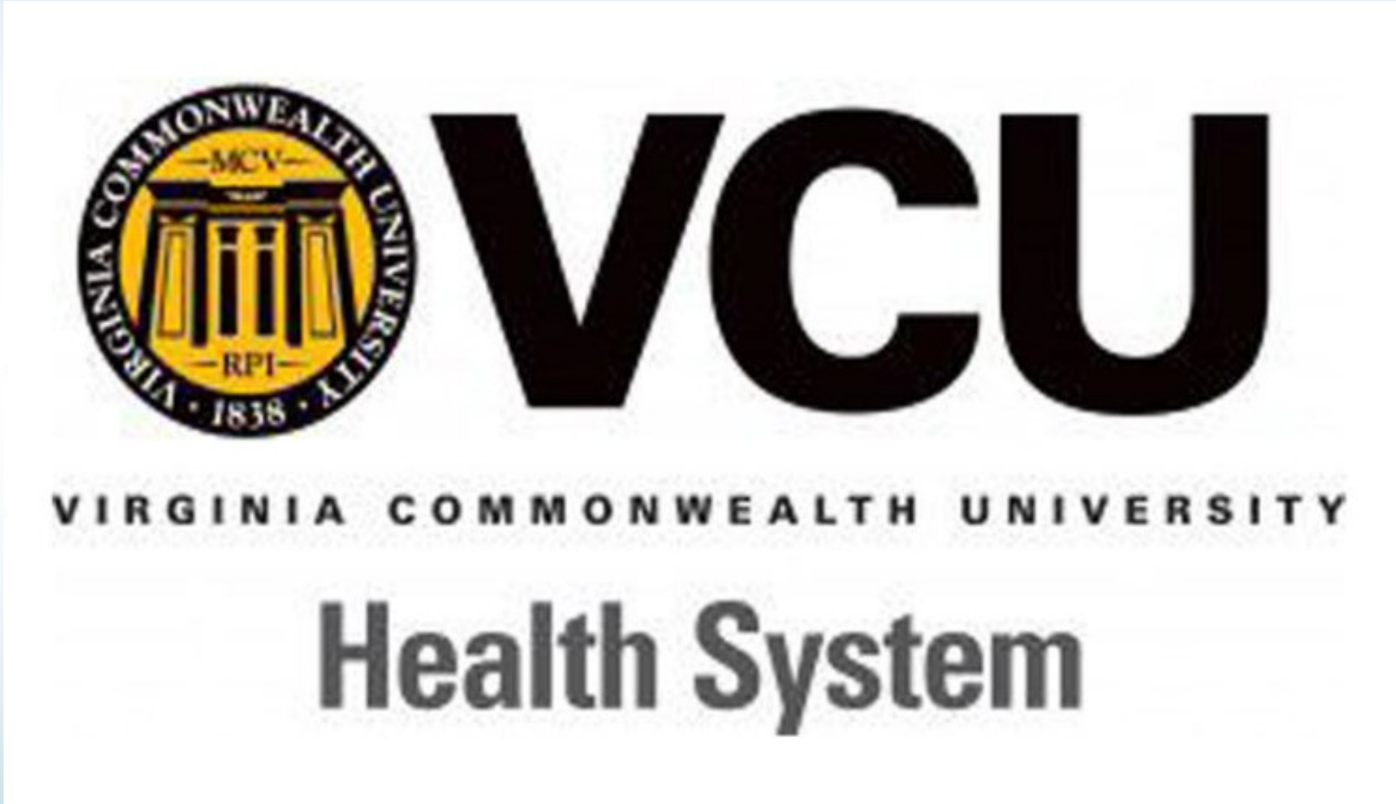

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Sweet Summer Recipes

Strawvocado Smoothie

Yield: 5 Servings (8 oz.)

Ingredient	Weight	Measure
Almond Milk		1 cup
Apple Juice		1 cup
Vanilla Greek Yogurt		1 cup
Simplot Simple Goodness™: Sliced Strawberries with Sugar 1/30lb		1 cup
Ice, Cubed		1 cup
Simplot Harvest Fresh™ Avocados: Avocado Pulp, Frozen 12/1lb		1/2 cup

Preparation Instructions:

Step 1
Combine almond milk, apple juice, yogurt, strawberries, ice and avocado pulp in blender. Blend until smooth and pour into 5 glasses.

Ingredients

- 4 oz cream cheese, softened
- 4 oz cool whip
- 1/4 cup powdered sugar
- 1/2 tsp vanilla
- 2 slices watermelon
- 1/2 cup sliced strawberries
- 1/2 cup sliced peaches
- 1/2 cup sliced kiwi
- 1/2 cup blueberries

Instructions

1. Beat the softened cream cheese.
2. Mix in the cool whip.
3. Stir in the powdered sugar and vanilla.
4. Spread 1/2 cup of the cream cheese frosting on each slice of watermelon.
5. Top with sliced fruit.

A little summer fun!!

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U Q E Z J Y L A V E X S T F L
N O I T A C A V L G A C Y Q O
Q X D C C T G T T G A K V P L
Z T F U P F S U N F L O W E R
H O Q Q T A C A O X A D Q H X
H E A T C I I Q L T Q U C N Y
B V B D Q C N A E O H A V W F
F A N P D E C S M P E V L U S
G A S K B C I F R B O P A W K
S N V E A R P C E C G O I N O
F S I S B E L J T D F M L D G
U I O T W A K J A X M Q E B F
A I Y S A M L F W I V N A F G
I T A C E O H L N G D B Y V F
T F Z C G K B G O V W N P Y C
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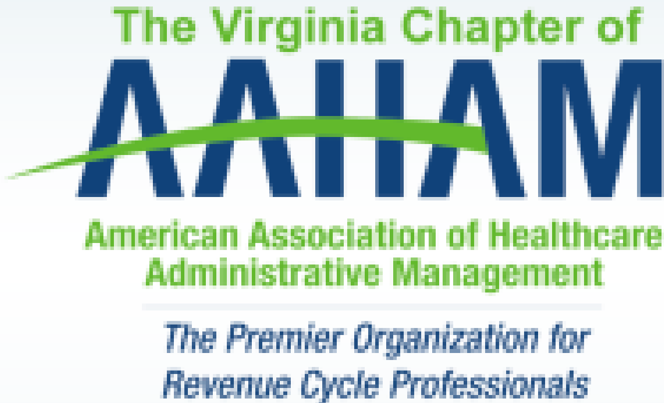
BEACH	PICNIC	SANDCASTLE
BASEBALL	VACATION	HEAT
ICE CREAM	SUNFLOWER	BOATING
SWIMMING	WATERMELON	POOL

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



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.