The Virginia AAHAM Insider

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

The President's Message

Whatever you are, be a good one" Abraham Lincoln

Dear friends and colleagues,

Fall is upon us and that means pumpkin spice, boots, campfires, children back in school, and preparing for the upcoming holidays.

We just met in person in Fredericksburg and the agenda was phenomenal! Our 2nd VP has done an amazing job and we appreciate the hard work her team has undertaken to make sure we stay on top of the latest trends and technology.

We have some upcoming events that we are so excited about! Our virtual certification webinars start on 9/30 so please be sure to register for these free sessions. Patient Access is on 9/30. Accounts Receivable Management is on 10/7. Credit and Collections is on 10/14 and we wrap up with Billing on 10/21 and 10/28. Earn your CEUs!

ANI is in Baltimore 10/12-10/14/2022 and our 40th Anniversary Celebration of Virginia AAHAM will be in Williamsburg from 11/30-12/2/2022. Be sure to register and we cannot wait to see you in person!

Covid is still here and now the flu is also. Remember to mask up if you have symptoms, wash your hands, and protect yourself to stay healthy.

Here are some tips: 1) Get some activity every day 2) Increase your fruit and veggie intake 3) Get more sleep 4) Prioritize your mental health 5) Drink water instead of sugary drinks

Until next time my friends…be safe and stay healthy!

Sincerely,

Pam Cornell, CRCE

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management
The Premier Organization for Revenue Cycle Professionals

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

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In Memoriam……

Saul David "Jack" Pustilnik, CRCE

(July 11, 1971 – August 6, 2022)

Jack was a dedicated and active member of the Virginia Chapter of AAHAM for a number of years. He earned his Certified Revenue Cycle Executive certification in April 2009 and served as Second Vice-President in charge of Education from 2012 to 2013.

Jack worked tirelessly to support the chapter. He once assisted a colleague in applying for benefits when she was faced with debilitating health issues. This is just one example of his servant nature.

His devotion did not go unnoticed, and he was recognized by the Virginia AAHAM Board on several occasions as follows:

2010 & 2011 – The Leanna T. Marshall, CRCE Chapter Award – given to an individual who has been a member for two years or more and who has excelled in service to the Chapter.

2012 – President's Award – given to an individual by the Chapter president for outstand service to the Chapter.

2013 – Forrest Perrin, Jr. CRCE Award – given to a member with 10 or more years of service to the Chapter and to recognize that member who excelled in service, dedication, and the promotion of their Chapter and the profession of healthcare administration management.

Jack was a beloved member of the Virginia Chapter who always brought with him an infectious smile, an upbeat outlook on life and a listening ear.

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

Fall 2022 Conference!

The Virginia Chapter of AAHAM
2022 Fall Regional Conference

Mary Washington Hospital
1301 Sam Perry Blvd
Fredericksburg, VA 22401
Fick Center (540) 741-1100

8:30 - 9:00	**Registration and Continental Breakfast**
9:00 - 9:15	**Opening Remarks & Updates** Pam Cornell, CRCE-I, MHA, President, VA Chapter of AAHAM
9:15 - 9:30	**AAHAM National Updates** Lisa A. Laudeman, CRCE-I CRCE-P, National First Vice President, AAHAM
9:30 - 10:30	***Clearing the Hurdles of Medicare Secondary Payor and Third Party Liability*** Kevin Willis, Claim Services, Inc.
10:30 - 10:45	**Break & Corporate Partner Networking**
10:45 - 11:45	***Optimizing Your Revenue Integrity Program: Objectives, Strategies, Staffing, and Performance*** Caroline Znaniec, Managing Director, Protiviti
11:45 - 1:00	**Lunch & Corporate Partner Networking**
1:00 - 2:00	***IT's all about the Baseballs*** Paul Leary, CEO, Credit Control Corporation
2:00 - 2:45	**Payer Panel** Moderated by Pam Cornell, **Payer Participants:** Palmetto GBA – Kathy Boehm CareFirst – Chris Hundall United Healthcare – Alexa Strube Cigna – Audrey Thompson & Catina Yates
2:45 - 3:00	**Break and Donation Presentation**
3:00 - 4:00	**Payer Panel Continued**
4:00 - 4:15	**Door Prizes and Closing Remarks**

We reserve the right to cancel or re-schedule a program because of an insufficient number of registrants or other unforeseen circumstances, or to close registration when a program is oversubscribed.

The Virginia AAHAM Insider
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Pictures.. Fall Conference!

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Virginia Hospital Advocate Newsletter

What's Happening in Richmond?

New Laws Go Into Effect

VHHA continues to work closely with legislators, stakeholders, and hospital members to monitor the implementation of new laws approved by the General Assembly and signed by Governor Youngkin. To learn more about news laws that impact hospitals and health care providers, visit this **link** [nam04.safelinks.protection.outlook.com] to access a report summarizing many of those state laws. VHHA is also engaging with state agencies and stakeholders through participation on various work groups charged with developing policies, best practices, and recommendations regarding pressing issues in health care. Representatives from the Association are involved in groups working on issues related to maternal health, intimate partner violence, continuity of care, prior authorization, and alternative transportation for patients with a behavioral health diagnosis. The work of these groups will help inform future legislation and public policy.

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

Virginia Hospital Advocate Newsletter

What's Happening In Washington, D.C.

The Inflation Reduction Act

Debate and action on contentious or controversial legislation is not common in summers prior to congressional midterm elections. This year is an exception to that rule. The 117th Congress in recent months debated and passed significant legislation, including the amended Inflation Reduction Act (IRA) of 2022 (H.R. 5376 [nam04.safelinks.protection.outlook.com]) approved by the U.S. Senate on August 7. The legislation incorporates several provisions addressing some of the top domestic policy priorities of congressional Democrats and President Joe Biden. Included in the bill are significant reforms impacting the prescription drug industry. Beginning in 2026, Medicare will be able to negotiate drug prices for 10 high-cost drugs. The bill also specifies that in 2025 Medicare beneficiaries will be guaranteed a $2,000 annual cap on out-of-pocket drug expenses. The IRA also places a $35 monthly cap on the price of insulin. The legislation also includes a three-year extension of Affordable Care Act (ACA) subsidies and an extension of American Rescue Plan health insurance subsidy enhancements through 2025. The amended version of the IRA now moves to the House of Representatives, where they is expected to pass the measure, advancing it to President Biden's desk.

The Bipartisan Safer Communities Act

In response to mass shootings across the nation this year, Congress also took action to pass the Bipartisan Safer Communities Act (S. 2938 [nam04.safelinks.protection.outlook.com]) that is widely seen as the first meaningful legislation on gun safety in two decades. In addition to regulating the purchase and sale of firearms, the legislation provides funding to states to implement extreme risk protection order programs, drug courts, and community violence intervention programs. The bill also allocates $250 million to the Community Mental Health Block Grant, which will allow states to expand access to mental health services.

The Save Rural Hospitals Act

VHHA and other state hospital associations are working with congressional partners to advance the Save Rural Hospitals Act (S. 999 [nam04.safelinks.protection.outlook.com]) sponsored by U.S. Senator Mark Warner of Virginia. The bill would establish a national area wage index floor for Medicare of and in the process elevate more than 800 hospitals to sustainable funding levels. Under the current system, declining Medicare payments result in hospitals having less money to pay employees, which can lead to lower wages. The legislation would waive the requirement that new Medicare spending is budget neutral – benefiting all hospitals rather than requiring high-wage facilities to offset inadequate reimbursements for low-wage hospitals. The Senate version of the legislation is currently pending in the Senate Committee on Finance. The House version (H.R. 4066 [nam04.safelinks.protection.outlook.com]) is before the Subcommittee on Health of the House Committee on Commerce and Energy.

The Virginia AAHAM Insider
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Virginia Hospital Advocate Newsletter

VHHA ALERT
Urgent News for Hospitals and Health Systems

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 or 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]

Thank you for supporting Virginia hospitals!

VHHA's Advocacy Team works hard to keep you up to date with the latest health care policy and politics news. We love to hear from our members and supporters!

Julie Dime, Vice President of Government Affairs, jdime@vhha.com

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The Virginia AAHAM Insider
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How to Improve Point of Service Collections!

KeyBridge
Medical Revenue Care™

Patient financial responsibility for healthcare costs has grown rapidly over the past few years, rising from 5% to 35% in two decades. Today, patients are now the third-largest payer behind Medicare and Medicaid.

This increase in responsibility can be challenging for healthcare providers when it comes to collecting revenue. However, it is also challenging for patients. High-deductible health plans continue to drive patient financial responsibility increases as they make patients more financially accountable for healthcare.

A 2017 study showed that most hospitals were only collecting from 35% of their patients, which accounted for just 19% of patient financial responsibility. Yet, in the same study, 90% of practices agreed that point-of-service patient collections were crucial to a successful healthcare revenue cycle.

There are many things healthcare providers can do to increase collections from patients and ensure patients are seen, despite their level of coverage.

Casey Williams, Senior Vice President of Patient Engagement for RevSpring believes patient engagement "comes through a culture of improvement and innovation that is measured." He believes focusing on specific outcomes for patients is the "lifeblood of engagement."

Strengthening point-of-service patient collections is key to recouping payment for healthcare services and improving healthcare revenue cycle management.

Train Front End Staff To Engage Customers About Payments

No matter the industry, talking about money owed can be difficult and uncomfortable. However, studies have shown that only around 57% of providers discuss a patients financial responsibilities

The Virginia AAHAM Insider

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How to Improve Point of Service Collections!

Engaging customers so they know what they owe is crucial. Front end staff should be trained to have conversations about payments with patients. Training staff on patient responsibility is important and allows them to feel comfortable navigating difficult conversations.

Front end staff can also ask patients how they will pay, rather than if they will pay. Even a simple shift in language can shift the expectations of the customer.

Better front end staff education can boost point of service collections by focusing on ensuring staff:

- Understand how patient responsibilities are calculated
- Know what information is needed to process a claim
- Understand how co-pays and deductibles work
- Learn what other front end responsibilities employees manage
-

Not only is staff training necessary for their confidence. Patients are more likely totrust a transparent healthcare organization that provides them with precise information.

Bring Revenue Cycle Management Functionality Into The Front Office

Along with additional training, front end staff can benefit from having access and training in revenue cycle management functions that traditionally live in the back office.

A lack of communication between the point of service staff and the back office can lead to communication breakdowns and siloed patient information. In addition, when staff are only familiar with their area of the revenue cycle management process, payments or errors that lead to delays can slip through the cracks.

Many staff are only familiar with a singular role they perform, whether scheduling, registration, or billing. By requiring staff to perform patient financial checks upfront, healthcare organizations can create a more seamless revenue cycle management system.

With patient registration and eligibility verification moved to the front end, staff can check that their insurance covers patients before seeing a doctor. Then, providers can share this with patients before they come in for their appointment. This way, patients are aware of where their insurance ends and their personal financial responsibilities begin.

The Virginia AAHAM Insider

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

How to Improve Point of Service Collections!

:, Having the appropriate information in the system, staff can calculate accurate payment estimates at the point of service and submit cleaner claims. In addition, precise information provides the groundwork for claims to be billed and collected quickly and efficiently.

Introduce Customer Friendly Payment Options

Although patient financial responsibility is increasing, healthcare organizations are still in the business of customer service. This means that if patients are frustrated with providers who lack the technology or service they expect they will seek out a better experience at a competing hospital or clinic.

Healthcare organizations also need to understand that placing barriers between patients and payments only harms their bottom line.

For patients, credit cards, smartphone payment, and online payments are par for the course in other service industries. Healthcare organizations should do everything they can to bring new technology into their systems and make the barrier to payment easier.

Manual payment methods are slow and make it difficult for point of service staff to collect on the full amount of services rendered. Some healthcare organizations only allow patients to make payments during business hours or only accept certain types of payments.

Many patients take care of the bills outside of work hours, or just can't find the time in their day to spend half an hour on the phone organizing a payment. A report by Instamed revealed that 70% of patients preferred to pay by electronic payments such as credit cards or online.

Additionally, roughly half of the respondents said they would consider changing providers if it meant they could pay by their preferred method.

Increase Price Transparency To Help Patients

For many patients, a lack of transparency is what is preventing them from paying up. Healthcare organizations are rarely forthcoming with the cost of their healthcare service costs upfront. In no other industry are consumers expected to pay a bill without having any idea of the cost beforehand.

The Virginia AAHAM Insider

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

How to Improve Point of Service Collections!

Healthcare providers need to have clarity within their own organization of what their costs are and detailing this information clearly on a patients bill. Far too often, providers are unable to clarify what services rendered were when a patient has an enquiry about their bill. Providers should be able to complete price estimates for patients when asked.

One way to provide this information with patients without taking up precious time from the point of services staff is to display it on the website. Just as patients budget for things like groceries and car servicing, being able to accurately budget and plan for medical expenditure is important. In fact, this is no longer a nice-to-have.

With the passing of the Hospital Price Transparency rule, hospitals must publish machine-readable files online that outline their payer-negotiated payment rates and must provide patients with a tool to search and view the prices of their medical services.

Create a Patient-Centric Collections Strategy

To truly improve the customer experience and collect revenue at point-of-service, healthcare organizations need to develop a collections process that focuses on the customer as an individual. Every patient has a different financial situation and providing a strategy for payment that caters to them is paramount.

Mr. Williams says, “Engaging the patient in the right way, through the right medium/technology and presenting the right message” drives the best outcomes for both patients and providers.

That said, healthcare providers should start by focusing on collecting payment no later than at the time of service. With the majority of providers still collecting payment after service is delivered this will be a big shift for many.

But patients are no longer only owing small portions of the overall payments. If providers don’t focus on a more patient-centered strategy they risk doing damage to their bottom line and ultimately to patient satisfaction.

With just a 30% chance of collecting payments from patients after they leave their appointments, providers need to prioritize point-of-service strategies to secure their bottom line.

The Virginia AAHAM Insider

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

How to Improve Point of Service Collections!

To improve point-of-service collections, healthcare organizations can:

- Collect or arrange for payment no later than the time of service.
- Offer multiple ways to pay such as automated phone systems, online payment portals, digital payment tools, and FSA/HSA cards.
- Use communication tools for payment notifications customized to each patient's preferences.
- Leverage propensity-to-pay analytics to inform the financial conversation and identify options such as financial assistance or charity care.
- Provide flexible payment plans.
- Create statements that are clear, concise, and easy to understand.
- Ensure all departments are following the same collections practices to create a consistent patient financial experience.

Ask Your Patients How To Best Serve Their Needs

Ultimately, there is no one-size-fits-all model for collecting revenue from patients. What is effective is reviewing and monitoring what is working and refining what isn't. One place that healthcare providers can begin is by asking their own staff and their patients what is and isn't working.

Start by asking internal staff what parts of the revenue cycle management process are creating friction. Whether it's collecting payments on time, integrating patient communications or driving patient satisfaction, your internal staff are good indicators of the gaps that are in your processes.

Set up monitoring of the following areas as you work towards improving the revenue cycle management process:

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

How to Improve Point of Service Collections!

- **Self-payment collections**: Measure pre-service, time of service and post service. By focusing on improving the first two (through front office tasks, increased price transparency, and customer-friendly payment options) post-service payments should drop.

- **Patient satisfaction**: keep a record of patient satisfaction both clinical and financial, specific by issue or complaint. This will give you a good indication of areas to improve. If patients complain about not being able to pay bills by their preferred methods,or not being able to understand their bills, mark these complaints as areas for improvement.

- **Cost of collection**: Providers lose money by bills going further through the revenue cycle. Collecting earlier in the revenue cycle is cheaper and allows for more costs to be recovered. Developing a more patient-centric model should help improve the cost of collection.

- **Bad debt metrics**: Identify problematic areas via bad debt trends. Identifying the gaps could be as easy as training staff to ask for payment at the time of service.

Once again, Mr. Williams believes focused outcomes are the key to patient engagement. And that mentality starts before patients walk through our doors. What outcomes are you driving? Everyone in your entire organization engages patients on some level. It is critical to meet the patient where they are with the best possible communication methods possible. Machine learning and predictive analytics can be deployed to understand these outcomes even before a patient is seen can dramatically increase yield, reduce unneeded costs and drive up patient satisfaction.

If you have any questions or comments about this article, please reach out to Susan McDonald: smcdonald@keybridgemed.com

The Virginia AAHAM Insider

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The No Surprises Act…..

The No Surprises Act (NSA), signed into law in December 2020, is meant to help protect patients from financial hardship due to surprise medical bills. Such bills are often the result of patients receiving emergency or nonemergency services from providers that don't participate in their health plan's network. Patients become aware of an issue only when they're hit with a hefty bill for those services, which their health plan won't cover. Meeting the requirements is an arduous task for most healthcare providers and facilities.

The pressure is on for providers and facilities to stay on top of the evolving requirements, and ideally to get ahead of them. Providers and facilities should not underestimate how much time and effort will be needed to meet the demands under NSA, particularly when it comes to understanding how to navigate the dispute resolution process when the qualifying payment amount (QPA) is not agreed upon, when scenarios do permit balance billing, and gathering information from co-providers and co-facilities to create good faith estimates (GFEs).

Understanding the NSA and its requirements is an important starting point for healthcare providers and facilities preparing to comply with the law. With that in mind, the following is a high-level overview of two key parts of the NSA — prohibitions on balance billing and GFEs.

Part I — Prohibitions on Balance Billing

Balance billing refers to billing a patient for an unexpected balance — aka "surprise billing." Under the NSA, hospital facilities, emergency departments (including freestanding ones), ambulatory surgery centers, urgent care centers (those licensed to provide emergency services), air ambulance services and providers servicing the facilities mentioned are prohibited from billing patients more than the in-network cost-sharing amounts for surprise medical bills. The NSA also requires private health plans to cover out-of-network claims and apply in-network cost-sharing.

The Virginia AAHAM Insider

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

The No Surprises Act…..

Here are three scenarios where an individual would be likely to receive a balance bill for care:

- Receiving emergency services from an out-of-network provider or out-of-network emergency facility
- Receiving covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network healthcare facility
- Receiving covered air ambulance services provided by an out-of-network provider of air ambulance services

To determine the applicability of the NSA and the ability to balance bill, the following information is required:

- **Service need:** Is the service emergent or not?
- **Type of facility:** Is the facility included in the NSA provisions?
- **Network status:** Is the facility/provider in or out-of-network?
- **Type of service:** Is the service provided "ancillary" (for example, the presence of an assistant surgeon during a procedure)?

In some limited situations, known as "notice-and-consent exceptions," the NSA allows for out-of-network providers and facilities to seek written consent to voluntarily waive their protections against balance billing when services include post-stabilization or nonancillary, nonemergency services.

When an exception doesn't apply, an emergency facility or provider can't bill an individual for an amount exceeding in-network limits or hold an individual liable for paying an amount exceeding in-network limits. In-network limits are determined by the payer through an all-payer agreement, equivalent state law, or the calculation of a QPA.

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

The No Surprises Act…..

Table 1. NSA Part I: Scenarios for Emergent Services

Service	Network Status			Reimbursement			Notice-and-Consent Exception
	Facility	Provider	Ancillary	Facility	Provider	Ancillary	
Emergent	INN	INN	INN	C	C	C	N/A
	INN	INN	OON	C	C	QPA	
	INN	OON	INN	C	QPA	C	
	INN	OON	OON	C	QPA	QPA	
	OON	INN	INN	QPA	C	C	
	OON	INN	OON	QPA	C	QPA	
	OON	OON	INN	QPA	QPA	C	
	OON	OON	OON	QPA	QPA	QPA	

Key:
INN – In-network status
OON – Out-of-network status
C – Contractual Rate

QPA – Qualifying Payment Amount
N/A – Not Applicable

Table 2. NSA Part II: Scenarios for Non-Emergent Services

Service	Network Status			Reimbursement			Notice-and-Consent Exception
	Facility	Provider	Ancillary	Facility	Provider	Ancillary	
Non-Emergent	INN	INN	INN	C	C	C	N/A
	INN	INN	OON	C	C	QPA	N/A
	INN	OON	INN	C	QPA/ N&C	C	Permitted for OON Provider
	INN	OON	OON	C	QPA/ N&C	QPA	Permitted for OON Provider
	OON	Non-emergent services provided at an OON facility are not protected under the No Surprises Act					

Key:
INN – In-network status
OON – Out-of-network status
C – Contractual Rate

QPA – Qualifying Payment Amount
N/A – Not Applicable

The Virginia AAHAM Insider

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

The No Surprises Act…..

Part II – Good Faith Estimates (GFE) for the Uninsured

Under the NSA, providers and facilities must provide uninsured or self-pay patients with a GFE that includes expected charges for:

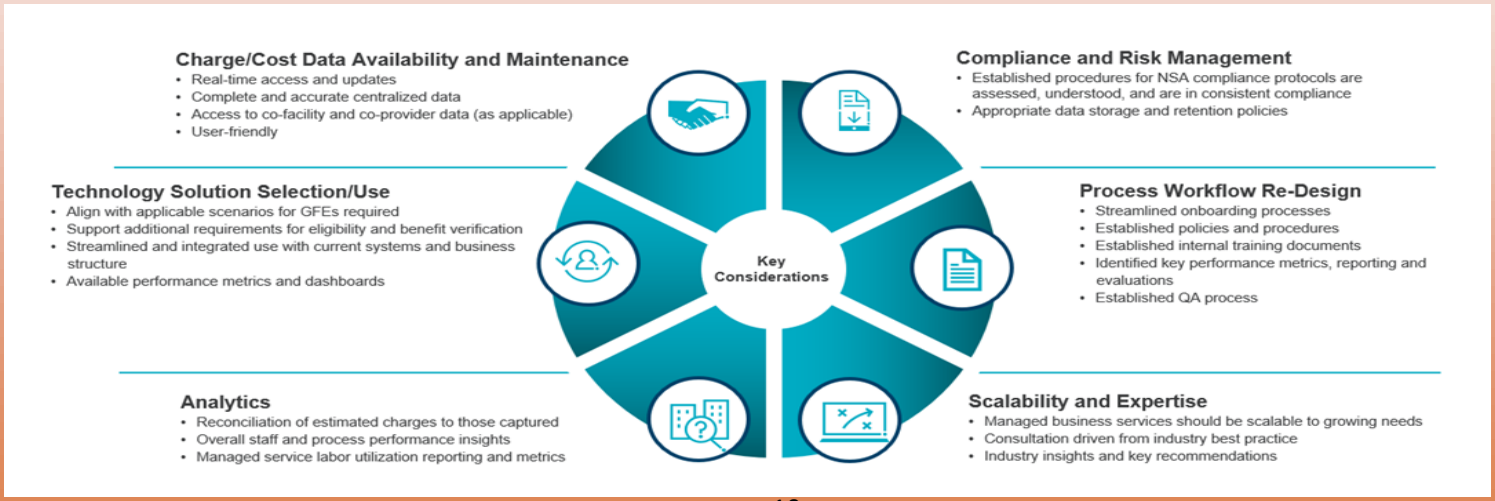
- Scheduled or requested items and services
- Items and services reasonably expected to be provided along with a primary item and/or service

Unlike the hospital price transparency rule, GFE requirements aren't limited to certain facility and provider types. They apply to *all* licensed healthcare facilities and providers. Currently the requirement for GFEs is enforceable for the uninsured or self-pay patient population, with anticipated expansion to all patients (insured or not) slated for implementation and enforcement in future rulemaking.

There are also several additional requirements for GFEs, including the provision of a GFE in written form (paper or electronic) based on a patient's requested delivery method and within required time frames, and the use of clear and understandable language in the GFE.

Of the NSA's two key parts, GFE compliance requirements have shown to be the most challenging for healthcare providers and facilities — specifically, the requirement for collecting information from multiple, disparate sources, including co-providers and co-facilities outside of the care network. And while there are technology tools that can help to manage this process, no one solution can eliminate all the manual work and resources involved in gathering the information needed to create accurate and timely GFEs for patients.

Picture 1. Key Considerations for GFE Compliance



The Virginia AAHAM Insider

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

The No Surprises Act…..

NSA Compliance: Strategies for Success

To comply with the NSA, generally, and reduce the risk of bottom-line-eroding billing disputes, providers and facilities should consider effects on people, process and technology.

Table 3. Understanding Effects of the NSA Across NSA Parts I and II

Effect	Consideration	NSA Part I — Balance Billing	NSA Part II — Good Faith Estimate
People	Educate internal and external stakeholders to support simplified and standardized workflows	X	X
Process	Identify scenarios where balance billing is/is not appropriate, including in the provision of ancillary services and post-stabilization	X	
Process	Determine the minimum acceptable Qualifying Payment Amount (QPA) for items and services for out-of-network items and services	X	
Process	Outline processes for initiating open negotiations and dispute resolution processes with payers and patients	X	
Process	Identify out-of-network payers, co-providers and co-facilities, and understand their potential impact to the billing of services, as well as the preparation and monitoring of GFEs		X
Process	Identify data sources for compiling GFEs, reconciling the estimate to actual charges and monitoring accuracy in estimates		X
Technology	Explore the use of technology to automate processes, create documentation, integrate disparate data sets and set up effective communication workflows	X	X
Process & Technology	Monitor successes to identify repeatable best practices and areas for improvement	X	X

The Virginia AAHAM Insider

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

The No Surprises Act…..

Providers and facilities will also need to develop a multidisciplinary group to manage NSA compliance. This team should consist primarily of revenue cycle leadership but may also include stakeholders from customer service, financial advocacy, patient access and managed care. It's essential for providers and facilities to also consider the impact of dedicating staff to this work, as it will take them away from other priorities.

By taking a structured approach to NSA compliance, healthcare providers and facilities will be better positioned to manage the heavy lifting involved in meeting the law's requirements as delayed requirements become enforceable. And by being proactive, they can avoid being "surprised" themselves by a mountain of complex work while facing NSA compliance deadlines. As an immediate starting point, providers and facilities may want to consider working with a third party to help them identify potential obstacles to NSA compliance success, including data integration challenges, ineffective workflows, and potential data security and data privacy issues that may arise when handling sensitive patient data.

Co-Authors

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Price Transparency? People Need A Visual Explanation.

Everybody is talking about "price transparency" and what does it mean? There are multiple interpretations concerning the legislation from the government and therefore multiple applications. The basic questions are fairly simple:

- What is the main purpose of having every hospital post their "prices" on their website?
- Who will go on the website to look up the "prices"?
- Who will understand these prices?
- Who will interpret these prices?
- What does it mean if you have government insurance (Medicare, Medicaid, etc.)?
- What does it mean if you have commercial insurance?
- What does it mean if you have no insurance?
- How does a 'potential patient' put "prices" together to configure what their bill might be?
- How do you compare one hospital to another?

All good questions and maybe, if you are not involved with this transparency process, you should stop reading now!

Well, if they know you work at the hospital, clinic, doctor's office, etc., you will probably be asked a lot of questions about "price transparency". If you are involved in any way, such as loading the Charge Description Master (CDM) or reading it in regard to billing and reimbursement purposes, then you should read on. Your facility may be "cherry picking" items from the CDM that could cause more confusion and explanation needed. We also have to recognize that the government (Congress) has no idea what a commercial CDM looks like. Remember, they are under their own "plan" and have no real concern about their healthcare coverage. If they had a plan like you and I, there would be a lot more debate on the subject and a much cleaner document as to what is expected in the display of "prices" to the public.

The Virginia AAHAM Insider

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Price Transparency? People Need A Visual Explanation.

What is the main purpose? Well, if Congress thinks that the main purpose of displaying a hospital's prices will cause better competition or marketing among hospitals, they certainly do not understand the healthcare environment. Even within a regional network of hospitals, under the same management, the CDMs can be different. The various sizes and services among these hospitals can cause the "prices" in each facility to be different. The "prices" among large medical centers and small community hospitals in the same geographic area are very different but certainly not because the services are "better" in one than the other. This is what will confuse many potential patients. If they see cheaper "prices" at one hospital versus another, it does not mean that their services are "less professional" than another. This again is another area where it is tough to explain to a potential patient.

So now we have recognized that "prices" will be different from each facility but certainly not due to a professional or quality issue. We know the real reason. CDM prices are usually set based on two simple criteria: one – market pricing, which is done through research of both local, regional and national similar services offered; and two – contracted reimbursement from third party insurance companies, as government reimbursement is set on a different methodology. If you start with the consideration of inpatient pricing, we know that the government reimbursement is based on a 'cost report' that each facility (approved for serving government covered people), submitted annually. These cost reports are analyzed for services rendered to patients in the government programs. Based on this analysis, a dollar figure is established as the baseline for reimbursement. From this baseline, the amount of services ("prices") generated is reimbursed by a single dollar value associated with the patient's diagnosis. Confusing, you bet!

Outpatient services for government patients are also calculated in a special manner and have nothing to do with the "prices" in the CDM. Diagnosis has become a big part of reimbursement in the healthcare environment and just publicly listing "prices" on a website has no real meaning. Some explanation of the differences in reimbursement needs to be published along with "prices". So, as you can see, although public pricing of information may be different for each hospital, the reimbursement, in some cases, may be the same.

The Virginia AAHAM Insider

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Price Transparency? People Need A Visual Explanation.

The average person looking up "prices" on the hospital website can get easily confused. For instance, if the person needs an X-Ray of the chest. Can the person read the physician order and say that it is a two-view x-ray or a four-view x-ray and what is the price difference? If the physician order is for Laboratory services, is the order for a CBC (combined blood count) or a urine test (with or without bacteria study) and how does one find these on the website? If the person knows that they will become an inpatient, how do they know what services will be performed and how do you look any of this stuff up on the website. I could go on but as you can see, the average person will not understand the collection of these "prices" and get more upset in not understanding them and could come into the facility highly stressed (which is another diagnostic condition). They may even call you before they come into the facility and YOU will be the one required to interpret the "prices" and the patient's concerns.

These concerns will probably come from two distinct populations. The first being the greater than 65 who are on a government program (or Part C Advantage program) and have questions concerning both their coverage and the services they might be receiving. This occurs frequently especially when they are having an operation (inpatient). The second population are the younger generation who are very efficient with technology. They have questions about the website and the individual "prices" associated with services. They want to know who to "put a bill together".

This population can need more of an explanation than the over 65 since they are continually seeking knowledge. What is common is that both populations usually do not understand their insurance coverage and what might be their financial responsibility. Financial responsibility is usually the 'bottom line' of any phone conversion or personal visit. This takes patience and if you had any examples (paper) that you could share with them, it would be very helpful.

The last population that will either visit or call is the patient who does not have any insurance. Yes, the self-pay patient who, after looking at the website and the CDM, is very confused about their financial responsibilities. If they visit, there is a wonderful opportunity to explain the process to them and also a way to offer them any financial plans that your facility may have available. In fact, if they call, you should encourage a personal visit to discuss the various possibilities to minimize their anxiety.

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Price Transparency? People Need A Visual Explanation.

Now, how does "price transparency" work in your facility? Have you ever gone online to the facility website and look at what is there for "price transparency"? Is it the full CDM? Is it a partial CDM? Is it clear? It is understandable? What would you do to change it? Some basic questions for you to ask in placing yourself in a patient's position. Does your website give any examples of what a combination of services may look like? Is there any explanation regarding various government programs and commercial insurance coverages? Is there any explanation about deductibles and co-pays? Is there any explanation about inpatient stay? Or ambulatory overnight stay? Or surgical center costs? Or outpatient therapies? Does your website present the best picture of your best services to the public?

In presenting examples of practical questions and practical answers, the visual explanations become "transparent" to the reader. In preparing for these examples and/or updating your website, one needs to review the current and short history (one year) of major services offered. This includes inpatient services (cardiac, cancer, orthopedic, etc.), ambulatory services (minor surgeries performed on an outpatient (overnight) basis, and outpatient services (radiology, laboratory, therapies). With this analysis, one can place clear examples of "pricing" so that a reader would become more knowledgeable in the potential outcome of their service. These examples can also be in a 'take-home' or mailing piece to patients prior to their scheduled service. Price transparency is more that just putting parts of the CDM on display. It is a marketing event to make people comfortable with the professional services that are offered at your facility. Good examples also make good referrals from one patient to another potential patient. It also wards off a large number of phone calls. If you have any questions, please feel free to contact me. Rob Borchert

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

315 345 5208 & rob@bpa-consulting.com

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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

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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?

AAHAM
American Association of Healthcare Administrative Management
The Premier Organization for Revenue Cycle Professionals

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.

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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 staffinvolved 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.

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Recently Certified in Virginia

VA AAHAM would like to congratulate those who earned the following designations in June, July, and September. Congratulations to:

Certified Revenue Cycle Specialist:

Nadine Clark, CRCS

Keyona Dobbins, CRCS

Ashlyn Taylor,CRCS

Falvia Fernandez. CRCS

Certified Revenue Cycle Professional:

Stephen Sutton, CRCP

Certified Compliance Technician:

Brittany Biggs, CCT

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Congratulations.. Scholarship Winners!!!!

VA AAHAM would like to congratulate these two ladies on winning the Woodrow Samuel Annual Scholarship for 2022:

Ayden Knight!!!! Ayden is the granddaughter of Leanna Marshall, Communication chair for Virginia Chapter of AAHAM. Ayden is planning to attend Piedmont Virginia Community College and then transfer to UVA to obtain her nursing degree/ physician assistant! Congrats to Ayden!!!!

Allison Quick!!!! Allison is the daughter of Sara Quick, Patient Accounting Data Quality and Training Coordinator for Augusta Health. Allison is planning to attend Bridgewater College where she is majoring in Biology with plans to become a physician assistant!! Congrats to Allison!!

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!

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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

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Upcoming Events

Upcoming Certification Exam Dates and Registration Deadlines

Certification Exams are now available each month!

- October 17-21, 2022 October 2022 Exams
- November 14-18, 2022 November 2022 Exams
- December 12-16, 2022 December 2022 Exams

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Upcoming Events

Virginia Chapter of AAHAM Free Webinars:

These series provide a great way to learn and study for our exams as well as you can earn CEU's!! Don't miss out on the free education opportunities!

- Accounts Receivable Management– 10/7/2022
- Credit and Collections– 10/14/2022
- Billing– Part One– 10/21/2022
- Billing– Part Two– 10/28/2022

Please visit www.vaaaham.com and register under the Calendar of Events.

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

Upcoming Events

Save the Date:

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.

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Virginia AAHAM Executive Board 2021-2022

Chairperson of the Board
(Chapter of Excellence Committee)

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Mary Washington Healthcare

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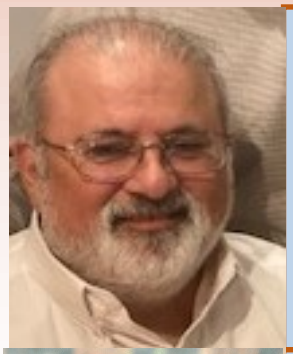

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Penn Credit

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Email: Tom.Perrotta@penncredit.com

Appointed Board Member: CERTIFICATION COMMITTEE

Leanna Marshall, CRCE, Retired

Charlottesville, VA

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Email: marshallleanna86@gmail.com

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Mercury Accounts Receivables Services, LLC

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PUMPKIN SPICE LATTES

Learn how to make a homemade Starbucks Pumpkin Spice Latte so you can enjoy the warm flavors of the fall and holiday season at home!

Author: adapted from www.jennyevolution.com
Servings: 1 Latte

Ingredients

- 1 1/2 tablespoons sugar
- 2 tablespoons pumpkin puree
- 1/2 teaspoon pumpkin pie spice
- 1/2 cup (4oz / 115g) brewed coffee
- 1/2 cups (4oz / 115g) milk

Instructions

1. In a saucepan add in all of your ingredients.
2. Stir and bring the ingredients to a simmer.
3. Take the saucepan off the heat and pour into your mug.
4. Decorate with freshly whipped cream and a sprinkles of pumpkin pie spice or cinnamon. Enjoy!

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

The Virginia Chapter of AAHAM

American Association of Healthcare Administrative Management

The Premier Organization for Revenue Cycle Professionals

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.