The Virginia AAHAM Insider

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

The President's Message

""When you reach the end of your rope, tie a knot in it and hang on." ~ F. D. Roosevelt

My Dear Friends & Colleagues:

Resilience is certainly the word of the year, the word of the pandemic. I, for one, did not expect to still be masking, social distancing and seeing increases in COVID-19 positive cases eighteen months in…yet here we are hanging on.

If COVID has done nothing else, it has undoubtedly made each one of us value what is most important in life, because it can all go away in an instant.

I was saddened to have to change our September conference to a virtual option, however we took the safest road possible to ensure the health of our members. I cannot thank our Board enough for their commitment to continuing the good work they have always done and that is to bring valuable education to you, our members. Our Education Committee, fearlessly led by Pam Cornell, has been turning on a dime throughout the course of the virus. Always doing so with a focus on how we can best get this done virtually. I applaud them for their resilience.

You are all dealing with the pandemic in similar ways. Many are faced with staffing shortages, full hospital beds and remote working, while caring for children who may or may not be learning remotely. Staffing shortages are everywhere. And we deal with everything in our own ways. You may feel like you are at the end of your rope. When that happens, reach out to a friend, or loved one to talk about it. Take time off from work and go hiking, take a walk, listen to music, sit outside at a winery, enjoy the sunshine. We all need to embrace ourselves and each other during these difficult times.

I miss seeing you all and am hopeful that we can pull off the Williamsburg December meeting in person! Until then, be safe and reach out if you need to talk.

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

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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Notice of Elections of Officers of The Virginia Chapter of AAHAM for the Two-year Term Beginning January 1, 2022

Your vote is very important, so watch for the ballot and participate in this important event in the life of The Virginia Chapter of AAHAM. Be sure not to miss this important opportunity to vote for your 2022-2023 AAHAM Chapter Officers.

Guided by the Chapter By-Laws and Regulations, the Nominating Committee will follow established nominating and voting procedures. The President of the Chapter has appointed a Nominating Committee. The Committee will nominate persons for the offices of President, First Vice President, Second Vice President, Secretary, and Treasurer. The Committee will also nominate any member who is qualified to hold office for nomination endorsed by a minimum of ten members in good standings.

The Committee will report the names of the candidates for nomination to the President by October 1, 2021; and ballots will be sent to members on October 15, 2021. Voting will be open until November 15, 2021. The elected officers will take the oath of office at the Annual Meeting in December in Williamsburg.

Members in good standing have the right to vote with the exception of Student Members or Retired Members who are not an appointed board member. All ballots will have provisions for write-in votes for each office. Election of the nominees shall require a simple majority of those voting.

Additional information regarding nominations and voting can be found in the Chapter By-Laws and Regulations available in the Member Information on the Members-Only section of the Chapter website.

The Virginia Chapter of AAHAM 2021 Nominating Committee:

David Nicholas, CRCE, Chairperson

Leanna Marshall, CRCE, Member

Michael Whorley, CRCE, Member

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Virginia Hospital Advocate Newsletter

What's Happening In Richmond

July: Special Session on ARPA Funds Scheduled

Governor Ralph Northam has announced that August 2 is the start date of the forthcoming legislative special session. Both chambers of the General Assembly will meet in person in the Virginia Capitol for the first time since March 2020, as the executive order declaring a public health emergency expired today (July 1). The scope of the session will be limited – lawmakers will only consider the allocation of federal funds from the American Rescue Plan Act (ARPA), as well as potentially the appointment of judges to court vacancies.

Virginia's share of the ARPA funds is approximately $4.2 billion. State officials have made it clear that the funds should be used for one-time expenses that the General Assembly will not be obligated to fund in the future. Virginia has until 2024 to spend the funds, so the General Assembly is not required to allocate all of the money this year.

VHHA's priorities for the special session include funding to support the behavioral health workforce, offset the substantial expenses hospitals incurred during the COVID-19 response, and restore funding for Intimate Partner Violence (IPV) services at three of Virginia's Hospital-Based Violence Intervention Programs (HVIPs).

August: Special Session on ARPA Funds in Progress

The Virginia General Assembly convened on August 2 for a special session to allocate funds the state received via the federal American Rescue Plan Act (ARPA). The funds amount to $4.3 billion total, though citing concerns about the spread of the delta variant, Governor Ralph Northam and Democratic leadership have suggested they would like to save between $800 million and $1 billion for future use. Virginia has until 2024 to spend the funds.

The ARPA legislation defined broad parameters for use of the funds, and Governor Northam has prioritized several areas for significant, one-time investments, including broadband access, school improvement, and unemployment funding.

VHHA submitted, and continues to advocate for, several health care requests, the most significant being funding for hospitals' pandemic-related expenses and VHHA members' proposals to expand behavioral health care capacity. However, Democratic leadership in the General Assembly have indicated that they are not inclined to add funding not already included in the Governor's introduced budget.

In response to the admissions closures at five of Virginia's state psychiatric hospitals, Governor Northam has proposed funding to help alleviate the immediate crisis, including higher wages and bonuses for employees of those facilities and money to hire contract staff. While VHHA supports those initiatives, the Governor's proposed budget fails to recognize the significant role of private hospitals, and the challenges they share with the state facilities. VHHA is in communication with the administration and DBHDS to try to secure funding for members' proposals.

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What's Happening In Richmond

September: Special Session on ARPA Funds in Progress

The Virginia General Assembly convened in a special session in early August to allocate Virginia's share of federal funds from the American Rescue Plan Act (ARPA), amounting to approximately $4.3 billion. Lawmakers largely left intact Governor Ralph Northam's initial spending proposal, focusing on public school infrastructure, air and water quality, broadband access, and support for small businesses. They also left almost $1 billion unallocated for future use.

In response to the current behavioral health crisis, Governor Northam and lawmakers also allocated funding to reduce the pressure on state psychiatric facilities, including funding for increased wages and contract staff to bolster the workforce at state hospitals.

The final spending bill did not expressly include funding for VHHA members' nine behavioral health care proposals, though it does leave flexibility for DBHDS to partner with community hospitals.

Lawmakers wrapped up their immediate business on August 10, though they did not adjourn sine die, which means they may be called back into session with 48 hours notice at the request of House and Senate leadership.

On August 18, Governor Northam addressed the House and Senate Money Committees to provide an update on the revenue forecast. The Governor shared that the state has experienced growth of 14.5 percent compared with the expected 2.7 percent and will likely have 15 percent in reserves by the end of his term (end of 2021). The state is currently running a $2.6 billion surplus, of which the Governor said he intends to devote some of those funds to pandemic recovery, state police salaries and the state's struggling behavioral health system in his upcoming budget which he will release on December 16, 2021.

Inpatient Behavioral Health Admissions in Virginia

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) announced in July that five state psychiatric facilities would temporarily suspend admissions due to staffing deficiencies. The inpatient bed shortage, coupled with increased demand for behavioral health services induced by the COVID-19 pandemic, has led to a system-wide behavioral health crisis in Virginia. Since then, VHHA members have offered multiple partnership opportunities to open additional beds in community hospitals, contingent on state funding for the requisite infrastructure changes and workforce demands.

VHHA has also convened behavioral health stakeholders to identify and develop strategies and recommendations to address the current crisis and advocate collectively at state level. These stakeholders include: the Virginia Association of Community Services Boards, Virginia Association of Chiefs of Police, Virginia Sheriffs' Association, Virginia College of Emergency Physicians, and NAMI Virginia. The stakeholder work group is in communications with DBHDS to work toward immediate solutions to the current crisis, as well as long-term reforms for the overall behavioral health care system in Virginia.

Kurt Hooks, Ph.D., CEO of Virginia Beach Psychiatric Center and Chair of VHHA's Behavioral Health Committee, recently appeared on VHHA's Patients Come First podcast to address the current state of behavioral health care in Virginia, as well as opportunities for reform. Listen to the podcast here.

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What's Happening In Washington, D.C.

U.S. Supreme Court Upholds Affordable Care Act for the 3rd Time

On June 17, the United States Supreme Court, in a 7-2 decision, rejected a legal challenge to the Affordable Care Act initiated by Texas and several other Republican-led states. SCOTUS ruled that the Republican states lacked standing, or the legal right to sue. This case marks the third time that SCOTUS has upheld the law.

The initial landmark legislation, passed in 2010, included an individual "mandate," or tax penalty on individuals who did not seek insurance coverage. Two years later in its first major ruling on the law, SCOTUS affirmed that the mandate is constitutional because the U.S. Congress has the authority to levy taxes. In 2017, under the Trump Administration and Republican majorities, Congress lowered the tax penalty to $0 while leaving in place language about the mandate, leading to this most recent case.

Texas and other Republican-led states alleged the ACA was not constitutional because the mandate was no longer a tax penalty and therefore not within Congress's authority. Rather than rule on the merits of the case, SCOTUS decided that the states lacked legal standing, because they could not demonstrate how they have been harmed as a result of the tax penalty being effectively eliminated. The result of that decision is that ACA will remain in place, and any future challenges or reforms to it are likely to be legislative rather than legal.

VOCA Fix Act Signed Into Law, Maternal Health Bills Moving through Congress

President Joe Biden has signed the VOCA Fix Act to rebuild the Victims of Crime Act (VOCA) Crime Victim Fund that supports costs associated with caring for survivors and their families, including medical expenses and wraparound services. Several Virginia hospitals in high-need areas receive these VOCA grants through the Virginia Department of Criminal Justice Services (DCJS) to maintain HVIPs that not only treat victims' trauma, but help provide short-term safety and long-term solutions to prevent recurring violence. VHHA sent letters to Virginia Senators Mark Warner and Tim Kaine strongly urging support of this legislation.

Bipartisan maternal health legislation, supported by dozens of national health care and provider organizations including the American Hospital Association, has been passed by committees in the U.S. Senate and House of Representatives. The Maternal Health Quality Improvement Act would authorize grants to develop and disseminate best practices to improve maternal health quality and outcomes; accredited health professional schools to train health care professionals about perceptions and biases that may affect maternal health care; perinatal quality collaboratives to improve perinatal care and outcomes for pregnant and postpartum women and their infants; and states and trial organizations to provide integrated health care services to pregnant and postpartum women. The bill also includes provisions to improve rural maternal and obstetric care data collection and care networks, telehealth resources and training.

September VHHA Update

Legislatively, the United States Congress has been laser-focused on infrastructure bills, though Democrats and Republicans disagree over how broad the legislation should be; Democrats favor including supports for families, workers, and climate change resilience in the final package, while Republicans, and some centrist Democrats, are determined to limit the scope to physical infrastructure.

VHHA is monitoring the legislation and its potential impacts on Virginia's health care system.

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Virginia AAHAM State Legislative Day

With Featured Content Regarding Balance Billing Regulations

Virginia AAHAM Hosts First State Legislative Day

By: Linda Patry, CRCE, President Virginia AAHAM

The Board of Directors for Virginia AAHAM have long considered hosting a State Legislative Day. For various reasons, the idea was always well-received, however we were not able to bring the event to fruition, not until this year.

On Friday, September 24, 2021, on what should have been our first 'live' conference in a year and a half, we met virtually with representatives from the Bureau of Insurance to discuss the new Balance Billing Law. Thanks go out to Austin Hale, our Legislative Chair, for helping us to turn that goal into a reality.

The meeting was well-attended and our speakers were well-prepared to address our questions. We want to thank Julie Blauvelt and Van Tompkins of the Bureau of Insurance in Virginia for graciously accepting our invitation to speak.

The idea of hosting a State Legislative Day came about as a result of our chapter being involved in, and active with the annual National AAHAM Legislative Day event hosted in Washington, DC every spring. That event has brought about a number of positive changes to various legislative issues facing the healthcare industry such as: the Telephone Consumer Protection Act (TCPA), Prior Authorization, No Surprise Act, 340B, Unique Health Plan Identifier, RAC Audits and HIPAA Standardization, to name a few.

As AAHAM members, we have witnessed the successes that have come about as a result of the national lobbying efforts. We are pleased to have been able to host this State event as a platform to have our questions answered and to present our concerns. This is not something that many AAHAM chapters have undertaken. We are fortunate to have been able to get this first ever Virginia State Legislative Day on our list of accomplishments and look forward to coordinating future State Legislative Day events.

Special Report Content on Surprise Billing

By: Natalie Hefner, CRCE, Secretary Virginia AAHAM

As Chairperson of the Virginia AAHAM Publications Committee, I am pleased to provide our membership with relevant content pertaining to the Virginia Balance Billing Regulations and future federal mandates surrounding Surprise Billing. There's a lot of food for thought and opportunities for providers to enhance their processes surrounding the Virginia Balance Billing regulation to maximize reimbursement. Tammy Tipton, President of Appeal Solutions has graciously provided our membership a custom article which is accompanied by a Request for Negotiation letter template with 5 wonderful tips for ways providers can review their internal balance billing compliance and strategy. We are sharing two articles written by Nick Hut, senior editor with HFMA on the regulations restricting surprise billing and the administrative requirement scenarios providers could soon face. Speakers George Buck and Leslie Bender had some great updates on Regulation F Compliance. I encourage all Revenue Cycle leaders to educate their staff to thoroughly on the many regulation compliances and take advantage of opportunities to negotiate with out-of-network payers.

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5 Tips for Success with the Virginia Balance Billing Law

Virginia SCC Representatives Answers AAHAM Questions on Balance Billing

By Tammy Tipton

Successful implementation of the recently enacted Virginia Balance Billing law is a current challenge for Virginia AAHAM members. However, balance billing success might also be a factor in improved patient relations and more predictable out-of-network reimbursement.

Virginia State Corporation Commission (SCC) representatives presented a question-and-answer session at the Virginia AAHAM State Legislative Day and Fall conference held September 24, 2021 in order to assist providers with the law's provisions. The numerous questions posed reflect the various challenges providers face with balance billing compliance and financial strategy.

As follows are some tips for reviewing your internal balance billing compliance and strategy along with information covered by the insurance bureau representatives during the presentation.

Tip 1 – Review Your Out-of-Network Patient Disclosure Process for Compliance with the Patient Notification Requirements

The new law requires providers to notify consumers about balance billing protection for out-of-network services. The notification must include information on how consumers can determine if they are protected from balance billing, when they can be balance billed, and what to do if they are billed too much.

Julie S. Blauvelt, Deputy Commissioner of its Life and Health Division, said that procedures should be in place to ensure disclosures are made. The law anticipates that most disclosures will be made electronically, via websites, electronic health records and email. However, in situations where a consumer does not have access to such electronic options, Blauvelt stated mailing a disclosure to a physical address would satisfy the disclosure requirement.

Blauvelt also clarified that enforcement of the law falls under the Virginia Health Department. However, the SCC has been tasked with compliance investigations and would report lack of compliance to the Health Department.

The SCC website provides a model for patient notification.

Tip 2 – Review Billing System Out-of-Network Payment Identification for Accuracy and Efficiency

Prompt identification of claims which fall under the law is critical to many aspects of provider compliance and implementation.

Under the law, carrier must pay providers within 30 days for out-of-network emergency care claims and certain non-emergent claims billed in relation to care sought at an in-network facility. Once the claim is paid, it is important for providers to promptly identify the potential impact of the balance bill provisions. However, prompt identification is complicated by a number of factors. Providers should review internal

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processes for identifying claims which fall under the law and how such claims are routed for review. Some of the claim identification challenges that were discussed at the meeting include the following:

- The new balance billing law does not apply to Medicare, Medicaid, and Federal employee claims. Further, the law does not apply to self-funded group health plans unless those plans opt-in. A list of plans that have chosen to opt-in is available on the State Corporation Commission's (SCC) Bureau of Insurance (Bureau) website. ERISA self-funded plans that do not opt-in are not subject to the law and patients can still be balance billed. Therefore, providers must review the opt-in status to determine balance billing options or, alternatively, options to pursue negotiation and arbitration for claims of opt-in plans.
- Tight negotiation and arbitration deadlines force providers to quickly identify claims paid under the law which providers want to contest. The SCC representatives confirmed that many arbitration requests are rejected as past the arbitration filing deadline (see Review Tip 3). Therefore, it is important to quickly identify claims which fall under the law. Sources of failure to identify such claims may be related to internal challenges such as delayed posting/review and lack of knowledge regarding applicable claim types to carrier-generated challenges such as discrepancies in claim payment date/receipt and poorly worded explanations of benefits that make it difficult to determine copay, out-of-network adjustment and insurance type (fully insured vs self-funded).
- Denied claims do not fall under the law. SCC representatives emphasized that the law only applies to covered claims. Therefore, providers are encouraged to review routing processes to make sure that denied claims are still sent for collections when appropriate.

Tip 3 – Review Effective Claim Payment Negotiation Tracking and Strategy

Once a claim payment is identified as under the bill's protection, providers must quickly accept the payment or initiate negotiation with the carrier. A key intent of the Virginia Balance Billing law is to force providers and carriers to negotiate reimbursement on applicable out-of-network claims.

"The goal is to get providers and carriers to come to agreement," said Blauvelt.

The amount the health insurer pays the facility or provider must be a "commercially reasonable amount" based on payments for the same or similar services in a similar geographic area. According to the SCC presentation, providers who feel they have been paid incorrectly should seek information from carriers during negotiation about how rates were calculated.

"It is a legitimate question for providers to ask of the carriers," said Blauvelt. "We do think that presenting information on how these amounts are arrived at is part of a good faith negotiation."

The law specifies that negotiations should be both initiated and conducted within the 30 days after receipt of payment or notification of payment. However, SCC Representative Van Tompkins, who also participated in the presentation with Blauvelt, said that the parties can request a second 30-day extension and those are typically granted.

To assist AAHAM members with making written negotiation requests under the Virginia law, please see the sample letter accompanying this article.

Tip 4 – Review Effective Arbitration Strategy

If the health plan and the provider cannot agree on the amount, either party can start the arbitration process. However, Blauvelt also noted that many carriers have an appeal process which should also be pursued.

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Often, the provider may be in a situation at the end of the negotiation period where they have not received any response to either a negotiation request or a carrier appeal.

"There is no requirement for us that the carrier needs to respond to negotiation before the provider submits to arbitration. Don't let the arbitration timeline pass you by while you wait for the carriers to respond to a negotiation request," Blauvelt said.

According to the law, arbitrators will choose between the two parties' settlement offers giving consideration to the following three factors:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable;
2. Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the service;
3. The arbitrator may also consider other information that a party believes is relevant as part of their original written submission, including data sets developed pursuant to § 38.2-3445.03 of the Code of Virginia. The arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

The Virginia commercially reasonable payments data set is available at www.scc.virginia.gov/pages/Balance-Billing-(1) and is annually updated based on the medical consumer price index.

Blauvelt indicated that of the arbitration decisions made thus far, the majority have been in the carrier's favor. However, the SCC also believe that some carriers have updated payment levels on certain claims as the result of unfavorable decisions.

Tip 5 – Collaborate with AAHAM Colleagues

Balance billing disclosure requirements, out-of-network claim tracking, reimbursement negotiation and arbitration efforts add to the complexity of treating patients. Keep in mind that all providers are also refining internal processes in response to the law. Your colleagues are a source of information on how technology can be utilized, how reimbursement has been impacted and how negotiations and arbitration requests are going. Also, it may be helpful to review your out-of-network case mix and speak with colleagues who have gone in-network with the same carriers. Find out is what the pros and cons of going in-network might be from both our current standpoint and information provided by other providers.

Both Blauvelt and Tompkins also encouraged AAHAM members to sign up for update notifications to the SCC Balance Billing web page.

About the Author:

Tammy Tipton is the President of Appeal Solutions. For the past two decades, she has been training patients and healthcare organizations on how to effectively appeal denied claims via her website AppealTraining.com. She has published two books on appeals and countless articles. Prior to starting her own company, she worked as a paralegal and journalist.

Sample Letter Developed by Appeal Solutions / AppealTraining.com is on the next page.

Sample Letter

Request for Negotiation under Virginia Balance Billing

Developed by Appeal Solutions/AppealTraining.com

Contact Tammy Tipton, Appeal Solutions, at 888-399-4925 with any questions.

Date

Carrier Name

Carrier Address

RE: (Insert Claim identification details)

Dear Carrier,

According to the explanation of benefits, your company appears to have issued payment under the Virginia Balance Billing law requiring carriers to calculate certain claims using a “commercially reasonable” payment calculation. We wish to negotiate the reimbursement rate applied to this claim.

As you are likely aware, the Virginia Balance Billing law, § 38.2-3445.01, "Balance billing for certain services; prohibited," requires carriers to calculate certain out-of-network emergency claims based on the median in-network contracted rate for the same or similar service in the same or similar geographical area. This law also applies to certain out-of-network non-emergency claims related to care sought from an in-network provider. In order for us to determine benefit accuracy, please provide any fee schedules and applicable modifiers, coding methodologies and bundling processes used to calculate benefits. If your company utilized published data sets and/or coding guidelines to review the claim, please provide the publisher, product name and version of any data set/guideline used so that we may assess the applicability to this claim. Further, non-standard, payer-specific coding edits should be explained in detail with a related clinical and/or coding rationale.

This information will assist us in reaching a negotiation offer to settle this claim prior to arbitration. If information is not provided, your failure to disclose benefit calculation information may influence our decision to proceed with arbitration as outlined in Virginia § 38.2-3445.

Thank you for your prompt written response.

Closing Text,

Customization This Letter For Success With The Following Documentation:

Attach Published Pricing/Data set information to Support Billed Charge

Cite Published Coding information to Support Coding

Cite Historical Payment Information specific that that code/carrier

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Regulation F Debrief for Virginia AAHAM

September 24, 2021 By: Natalie Hefner, CRCE as Presented By: George Buck and Leslie Bender

George Buck

Consultant,
ARM Industry

Leslie C. Bender

Senior Counsel

Privacy, Data Security, and Consumer Financial Protection

On September 24, 2021, Virginia AAHAM welcomed George Buck and Leslie Bender to speak at our State Legislative Day about Regulation F. Regulation F implements the Fair Debt Collection Practices Act (FDCPA). This rule governs certain activities by debt collectors and among other things, clarifies the information that a debt collector must provide to a consumer at the outset of debt collection communications and provides a model notice containing such information. Deadline for compliance for the Final Rule is November 30, 2021. The Consumer Financial Protection Bureau (CFPB) encourages the industry to come into compliance earlier but safe harbors and/or rebuttable presumptions begin November 30, 2021.

§1006.2(b) Attempt to Communicate is any act to initiate a communication or other contact about a debt through any medium. A Limited Content Message (LCM) is an attempted communication but it is not a communication. Although industry had requested it, the CFPB did not make the LCM formula for communicating available for email or text—only voicemails. Attempts to Communicate apply to electronic communication, but is not counted as part of a call frequency. "A ringing phone is an attempt to connect. A single ring makes it count, even if it is a ringless drop", said Bender. Attempts can still be the basis of an FDCPA claims under §1692d, e or f.

§1006.2(j) Limited Content Message pertains to a voice mail message that includes all required content: Business name (as long as the name itself does not suggest in debt collection business); Request consumer reply to message; The name of one or more natural persons to whom the consumer can reply at office of the debt collector; and The telephone number to respond.

§1006.6(d)(4) & (5) describes Email and Texting are Permitted under Certain Restrictions. With every email or text response, confirm that you have consent to continue to email or text in the future. Buck recommended "Refresh the training of any consumer facing employee to listen for)or if processing mail—read for) any communication preferences or revocations or changes of them. Every email and text must include an opt-out or unsubscribe and you must act on that immediately."

For full details on this presentation, visit the Members-Only portion of the Virginia AAHAM Member website.

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Government Agencies Issue the First Set of Regulations Restricting Surprise Billing

July 1, 2021 By: Nick Hut, Senior Editor with HFMA

- **A new rule implementing the No Surprises Act establishes various consumer billing protections for out-of-network care.**
- **The rule sets out the formula for determining provider payment rates when out-of-network care can't be balance-billed.**
- **Providers will be prohibited from balance-billing patients in many scenarios and face administrative requirements concerning notification.**

In a development that many healthcare stakeholders have awaited for months, four federal agencies on July 1, 2021 released new regulations prohibiting surprise billing in various scenarios. An interim final rule with comment period implements some aspects of the No Surprises Act, which was passed as part of an expansive 2020 year-end legislative package. The provisions will take effect for health insurance plan and policy years that begin on or after Jan. 1, 2022. Requirements that apply to providers and facilities also start Jan. 1.

"These interim final rules implement provisions of the No Surprises Act that protect participants, beneficiaries and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills when they receive emergency services, nonemergency services from nonparticipating providers at participating facilities, and air ambulance services from nonparticipating providers of air ambulance services, under certain circumstances," the rule states.

An "interim final rule with comment period" is issued when departments can't release a proposed rule within the stipulated timeline. The rule can still be subject to change based on stakeholder feedback. A 60-day comment period for the new rule will begin after its publication in the *Federal Register*.

Still to be addressed in regulations later this year are several key aspects of the No Surprises Act, including a new federal arbitration process for instances when providers and health plans don't agree on an out-of-network payment amount.

In addition, some regulations pertaining to transparency and the patient-provider dispute resolution process are still pending, as are enforcement procedures.

The basics of the new rule

As summarized in a news release from the U.S. Department of Health and Human Services, which joined the Departments of Labor and Treasury and the Office of Personnel Management to publish the new regulations, the 411-page rule includes bans on:

- Surprise billing for emergency services, coverage for which cannot be subject to prior authorization or consideration of network status
- Out-of-network cost-sharing rates for emergency and some nonemergency services
- Out-of-network charges for ancillary care provided at an in-network facility
- Other out-of-network charges in the absence of advance notice

Calculating cost sharing and out-of-network payments

For all emergency services as well as for some nonemergency services furnished by out-of-network providers at in-network facilities, cost sharing will be limited to in-network levels and must count toward deductibles and out-of-pocket maximums. The same is true for air ambulance services. In addition, balance billing by providers is prohibited in those situations.

The rule specifies that a patient's cost sharing in those scenarios must be calculated based on the following mechanisms, in order:

- An applicable All-Payer Model Agreement that has been established by the Center for Medicare & Medicaid Innovation (as in Maryland and Vermont).
- An amount established by state law

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- The lesser of the billed charge or the median contracted rate of the insurer, i.e., the *qualifying payment amount*

With balance billing largely prohibited, providers will be paid for out-of-network services based on an applicable All-Payer Model Agreement or state law, and in the absence of those, an amount agreed to with the insurer. If an amount can't be negotiated, the yet-to-be-detailed arbitration process will apply.

The rule establishes a comprehensive process for consumers to file complaints with federal agencies regarding violations by both insurers and providers.

Keeping consumers informed

Protections that limit cost sharing and prohibit balance billing may not apply to post-stabilization services when different conditions apply, nor to many nonemergency services performed by out-of-network providers at in-network facilities. In those types of situations, the patient can still be balance-billed if the provider follows prescribed notice-and-consent procedures.

However, the notice-and-consent option isn't available "in certain circumstances where surprise bills are likely to occur, such as for ancillary services provided by nonparticipating providers in connection with nonemergency care in a participating facility," the rule states.

One administrative requirement established by the rule is to post information on a public website and provide a one-page notice to patients regarding the balance-billing prohibitions implemented by the rule and by state regulations. The information must include how to contact state and federal agencies about potential violations. Health plans similarly must publicize the relevant information for their members.

A "model disclosure notice" is being issued as an option for providers and insurers "to reduce burden and facilitate compliance with these disclosure requirements," the rule states.

In general, the regulations are not meant to "universally protect individuals from every high or unexpected medical bill," the rule adds. "For example, an individual may be enrolled in a group health plan or health insurance coverage that provides little or no coverage for their particular healthcare condition or the items and services necessary to treat that condition."

New Rule Describes the Penalty Associated with Regulations On Surprise Billing

September 14, 2021 By: Nick Hut, Senior Editor with HFMA

- **A new rule from HHS sets forth the maximum penalty for violations of patient-billing regulations that take effect Jan. 1, 2022.**
- **Enforcement starts at the state level and could carry implications for out-of-state telehealth providers.**
- **The rule describes aggravating and mitigating factors in the determination of penalties for violations.**

Healthcare providers could face penalties of up to $10,000 for each violation of regulations that prohibit surprise billing of patients starting in 2022.

The penalty amount and related procedures were confirmed in a newly issued proposed rule, the bulk of which pertains to insurers and air ambulance providers.

All providers will want to take note of the proposed enforcement procedures associated with the new regulations, which were established by passage of the No Surprises Act in late 2020. A previously issued interim final rule with comment period will implement core provisions of the law, including restrictions on out-of-network cost sharing and balance billing, along with the notice-and-consent procedures required to bill patients for out-of-network care.

Comments on the newly proposed rule are due 60 days after the rule's publication in the *Federal Register*, which likely will happen within the next week.

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With Featured Content Regarding Balance Billing Regulations

Enforcement will start with the states

As with other sets of healthcare regulations, such as HIPAA, provisions are supposed to be enforced at the state level. “If HHS determines that a state has failed to substantially enforce an applicable provision, HHS enforces that provision in the state,” the proposed rule says. Research posted by the Commonwealth Fund shows 33 states have comprehensive or partial surprise-billing protections.

A key point in the proposed rule is that a state’s enforcement of surprise-billing regulations can apply to providers that offer telehealth services to residents of that state “even in circumstances where the provider or facility is located in a different state.”

“While many states require licensure of out-of-state telehealth providers furnishing care to individuals within the state, HHS understands that this is not always true, and that many states have relaxed licensure requirements in response to the COVID-19 public health emergency,” the proposed rule adds. “HHS seeks comment on whether the approach taken in this proposed rule presents challenges with respect to providers or facilities furnishing telehealth services.”

Factors in determining the penalty amount

Enforcement at the federal level will fall under the purview of CMS. If a violation of the new billing regulations is alleged, “CMS would consider all relevant documentation provided when determining whether to impose a civil money penalty, including information from the complainant, provider or facility,” the proposed rule states.

If CMS decides a penalty is called for, it would evaluate various factors when determining the amount. Aggravating factors, which could result in a maximum or near-maximum penalty, include evidence of a pattern of violations; significant financial harm inflicted on the affected individuals or health plans; and failure to provide documentation of corrective steps.

The penalty amount could be reduced by mitigating circumstances, including an absence of previous complaints and steps already taken to adjust business practices to comply with the regulations. The penalty could be canceled if the violation was unintentional and the provider withdraws the inaccurate bill and reimburses the affected plan or enrollee for the erroneous amount, plus interest at a rate determined by the HHS secretary.

An exemption to the penalty could be extended to providers that are dealing with financial hardship arising from extraordinary circumstances such as a natural disaster or — as has been an issue for the last 18 months — a public health emergency.

Procedures for assessing a penalty

Under the proposed rule, CMS would notify providers of an alleged violation in writing, including a description of any complaints and supporting information, along with the proposed penalty.

The notice would include instructions on how the provider can respond and would describe the provider’s right to a hearing. At the hearing, the provider could be represented by counsel, present witnesses and cross-examine witnesses. The notice also would state that failure to request a hearing within 30 days of receipt allows CMS to implement the proposed penalty “without right of appeal.” However, any final decision on a penalty could be challenged in U.S. appellate court.

If a penalty is issued, CMS would notify certain organizations, including the state or local medical or professional association, the state health department, the appropriate state or local licensing agency and the applicable utilization and quality control peer-review organization. Penalties cannot be issued if more than six years has elapsed since the time of the alleged violation.

More about the new rule and what’s to come

The proposed rule has many provisions that apply specifically to providers of air ambulance services and to health plans. See this fact sheet for a summary.

Still pending are regulations to establish the arbitration process that will be used to determine health plan payments for out-of-network care if the parties can't agree during negotiations.

The Virginia AAHAM Insider
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National Patient Account Management Week: October 18-24, 2021

Moayad Zahralddin, Operations & Membership Director National AAHAM

National Patient Account Management Day was established on October 18, 1989 by a proclamation from the U.S. Congress when AAHAM (then AGPAM) sought to officially recognize healthcare administration management throughout the country. The 2021 National Patient Account Management Day will be part of a week-long celebration, October 18-24,by hospitals, physician offices and others involved with patient account management to recognize and honor the individuals engaged in healthcare administrative management.

The 2021 theme is “Building a Better Future Together.” This is a special week to honor those special people involved in healthcare administrative management; for managers to honor the individuals on their staffs, for the public to become aware of the profession, and for each of us to recognize our colleagues and ourselves. There are numerous opportunities for you to gain recognition for your department or office. Submit an article on our profession to your chapter or company newsletter. Local newspapers often have sections that highlight important dates and celebrations. Create an informative display describing the work, growth and/or evolution of the department or spotlighting the department’s employees. Some departments celebrate with decorations, contests, treats and create elaborate themes to get office/hospital-wide involvement. By supporting PAM week, you show your healthcare administrative management team that you appreciate their hard work. A recognition program implemented during this special week is an excellent way of increasing hospital and office morale and expanding knowledge of our profession.

We hope you have a truly rewarding and successful Patient Account Management Day and week! For more information please contact Moayad Zahralddin at the National Headquarters at 703-281-4043 ext. 4 or moayad@aaham.org.

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National Patient Account Management Week: October 18-24, 2021

We Asked our Members: How Do YOU Celebrate?

At Mary Washington, pre-COVID, we hosted a Patient Accounts Week breakfast meeting in our Fick Center. Our cafeteria catered a hot breakfast and we provided a full agenda that included: Epic training presentation, Contracting update, VP of Revenue Cycle review of metrics, recognition of Associates with Patient Accounts Oscars in various categories and we usually ended up with a game of some sort. The remainder of the week was filled with food and gifts from our vendor partners. - Linda Patry, BA, CRCE, Director Patient Financial Services Mary Washington Healthcare.

At Mercury Accounts Receivable Services, we are firm believers in celebrating all who work in the Revenue Cycle, including us vendors who work with our partner providers, as we make a difference in their A/R. To that end, MARS has helped our providers celebrate their Revenue Cycle staff by sponsoring a lunch during PAM week. For our own team, we have celebrated with a catered lunch and sent gift cards to our remote staff for a lunch treat also!
-Natalie Hefner, CRCE Project Manager, MARS

At Augusta Health, we put together prize baskets, had cake & punch and/or snacks one day, and had management make breakfast another. Last year since it was during Covid times—we still did prize baskets. We actually Face-timed the people who won who were working at home so that they were still able to pick their prize baskets! One day we had lunch catered with sandwiches, etc., outside and we set up a "drive by" social distancing lunch for people to enjoy. - Amy Beech, CRCE Patient Financial Services Manager Augusta Health

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The 3-Question Rule

Justin Bariso, Principal, EQ Applied

Justin Bariso, Principal, EQ Applied

Years ago, I was watching an interview with comedian Craig Ferguson, when he gave some very sage advice:

There are three things you must always ask yourself before you say anything.

- Does this need to be said?
- Does this need to be said by me?
- Does this need to be said by me, now?

Ferguson jokes it took him three marriages to learn that lesson.

Before you dismiss this as too simple, think about how this rule could very quickly make for:

- Shorter emails and meetings at work
- A kinder and gentler home
- Less harmful, stupid, or regrettable comments on social media

With enough practice, it only takes a few seconds to mentally go through these questions.

And since I've learned this rule, I use it almost every day of my life.

For example:

When someone cuts me off in the supermarket, without realizing it, and I feel like giving them a piece of my mind.

- *Does this need to be said? Ummm…probably not.*

When someone tries to provoke a fight with me on social media and I'm tempted to say something snarky or waste time going back-and-forth. . .

- *Does this need to be said? Definitely not.*

When I get home from work and want to tell my wife something came up and I have to cancel our dinner plans for the weekend, but I see right away she's had a horrible day.

- *Does this need to be said? Yeah, definitely.*
- *Does this need to be said by me? Sure.*
- *Does this need to be said by me, now? Nope. Better wait until she's in a better mood and I've got a plan to make it up to her.*

See how it works?

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The 3-Question Rule

Justin Bariso, Principal, EQ Applied

The Lesson

This quick mental dialogue is a lifesaver. It helps me to avoid saying something I'll later regret.

At the same time, it doesn't discourage me from speaking up when appropriate. There are times when the answer to all three questions is a resounding yes—even when what I need to say isn't comfortable (for me or the recipient).

When those times come, the 3-question rule can help you to be assertive when necessary and speak with confidence, like this:

A teammate is late to a meeting—for the third time in a row. This can't continue.

- *Does this need to be said? Yup.*
- *Does this need to be said by me? Sure 'nuff.*
- *Does this need to be said by me, now? You better believe it—but of course, in an emotionally intelligent way.*

But what if you have the opposite tendency? What if you naturally hesitate to voice your opinion?

In that case, the last thing you want to do is discourage yourself from speaking up. So, instead of using the 3-question rule you might use a single question:

If I don't say this now, will I regret it later?

In fact, you could probably benefit from using both methods, at different times. So, the next time you're tempted to say something too quickly, stop! Take a few seconds, and follow the 3-question rule. Because those few seconds could make all the difference.

Try This

Take some time to ponder your personal communication style. Do you tend to put your foot in your mouth, agree too quickly to commitments, or otherwise say something you later regret? Or do you tend to stay silent, later wishing you had expressed yourself?

Then, look for opportunities to follow the 3-question rule by asking yourself:

- *Does this need to be said?*
- *Does it need to be said by me?*
- *Does it need to be said by me now?*

Or:

- *If I don't say this now, will I regret it later?*

In summary

By using the 3-Question Rule, you will:

- Save yourself from saying things you later regret
- Increase the value of what you say
- Speak with more confidence

The founder of EQ Applied, Justin Bariso helps organizations and individuals develop their emotional intelligence. His thoughts on leadership and EQ draw over a million readers a month, and his book, EQ Applied: The Real-World Guide to Emotional Intelligence, shares fascinating research, modern examples, and personal stories that illustrate how emotional intelligence works in the real world.

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Medicaid Before, During, and After the COVID-19 Public Health Emergency

Shanna Hanson, FHFMA, ACB

Remember when there wasn't a pandemic? COVID-19 has rocked our world and has left its mark on a new generation. It has also shape-shifted the Medicaid program. States will need to figure out how to return Medicaid to the pre-COVID-19 program it was. What does that mean for payors, providers, and beneficiaries? This article takes a look at Medicaid before, during and after the COVID-19 Public Health Emergency (PHE) to increase your understanding and help you sleep better at night.

Medicaid Before

FMAP

Medicaid is a voluntary program for states. All 50 of the United States plus the District of Columbia have chosen to participate in Medicaid. The federal government shares the expense of each state's Medicaid program on a percentage basis through what is called the Federal Medical Assistance Percentage (FMAP). There is an established FMAP for each state.

Processing Standards

State Medicaid programs are held to federal standards when it comes to eligibility processing. State-based exceptions may apply, but generally the following holds true:

- **Applications**: A state has 45 days to determine an applicant's eligibility for a family-related Medicaid program or 90 days for a disability-related program.
- **Verifications**: The caseworker verifies eligibility, either electronically or by requesting supporting documentation.
- **Redeterminations**: Once eligible, a Medicaid beneficiary typically has 10 days to report a change in circumstances after which the caseworker completes a redetermination of eligibility.
- **Renewals**: An eligibility review is required on an annual basis.

If a Medicaid beneficiary becomes ineligible, states are required to review eligibility for all applicable Medicaid programs before discontinuing coverage. Medicaid beneficiaries typically go on and off the program, and in and out of state managed care programs. This is called churn.

Medicaid During

Public Health Emergency (PHE)

The COVID-19 pandemic has lived through two Presidential administrations, Donald Trump and Joe Biden. The United States Department of Health and Human Services (HHS) former Secretary Alex Azar first declared a PHE effective January 27, 2020. The current HHS Secretary Xavier Becerra recently renewed the PHE through approximately October 20, 2021.

The declaration of a PHE allows states flexibility they would not otherwise have. The Medicaid eligibility verification process, for example, may allow for self-attestation in lieu of supporting documentation if information cannot be secured electronically.

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Virginia received approval for its title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) VA-20-0001. This amendment provides temporary adjustments to the following, effective January 1, 2020 through the duration of the PHE:

- Waive requirements related to timely processing of applications and renewals;
- Delay acting on changes in circumstances affecting eligibility, other than changes related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid;
- Provide an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status as long as the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period; and
- Waive cost-sharing for all services.

FMAP and Continuous Medicaid Eligibility

The Families First Coronavirus Response Act (FFCRA), a stimulus package, was passed into law on March 18, 2020. Section 6008 of the FFCRA, amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, increased a state's FMAP by 6.2 percentage points if a state maintains "continuous eligibility" for their Medicaid beneficiaries, until the end of the month in which the PHE expires. All 50 states and the District of Columbia have agreed to the continuous eligibility provision.

Processing Standards

With few exceptions, Medicaid beneficiaries are remaining enrolled in the program, even if a change in circumstances has made them ineligible. Redeterminations and renewals have halted in many states.

As of March 2021, total Medicaid/CHIP enrollment grew to 81.7 million, an increase of 10.5 million (14.7%) from enrollment in February 2020. In Virginia, Medicaid/CHIP enrollment increased 17.6%, to 1,678,670 for the same time period. Churn has all but ceased. Providers are seeing less uninsured, and Medicaid managed care rosters have increased.

Medicaid After

Public Health Emergency (PHE)

President Biden has stated he plans to renew the PHE through the end of the year and give states 60-days' notice before the end of the final renewal period. The PHE is renewed in 90-day increments so the "end of the year" would take us through roughly January 20, 2022. Continuous eligibility, then, could cease effective January 31, 2022.

Processing Standards

The Centers for Medicare and Medicaid Services (CMS), under the Trump Administration, issued State Health Official (SHO) letter SHO #20-004 on December 22, 2020 to guide states in resuming normal operations after the PHE ends. Page 22 notes four key areas of eligibility and enrollment actions states will need to address:

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1) processing applications, 2) completing verifications for individuals enrolled based on self-attested information, 3) acting on changes in circumstances, and 4) completing renewals.

The Biden Administration issued SHO #21-002 on August 13, 2021, updating the original guidance in two key areas:

1. Extends the timeframe from 6 to 12 months for states to complete verifications, redeterminations and renewals, and
2. Requires states to complete a redetermination of eligibility after the PHE for all beneficiaries prior to taking any adverse action.

FMAP

The 6.2 percentage point FMAP increase expires at the end of the calendar quarter in which the PHE ends. If the PHE ends roughly January 20, 2022, the end of the calendar quarter would be March 31, 2022. States will be faced with ineligible Medicaid beneficiaries on their rosters that they are no longer receiving extra money for, although the regular FMAP will apply.

Summary

SHO #20-004 asks states to adopt one of four risk-based approaches to prioritize actions for Medicaid beneficiaries who are most likely no longer eligible for coverage. States have 12 months to reprocess their eligibility. Additionally, any beneficiary losing coverage must be reviewed for other programs including, but not limited to, electronic referral to the Marketplace. This will help to prevent a "renewal bulge" by evening out future annual renewals, ease the administrative burden on states and beneficiaries, and minimize churn.

Shanna Hanson, FHFMA, ACB is Manager of Business Knowledge at Centauri Health Solutions. In her role, she is responsible for researching and reporting to executive staff on all legislative and environmental changes and trends impacting the company's health care markets, services and product development initiatives. This includes strategic knowledge leadership for the company on national health care reform and the Affordable Care Act; she has researched health care reform and the ACA for many years. Prior to her present role, Shanna served 14 years as Human Arc Midwest Operations Leader for its Medicaid eligibility enrollment services. She is a Past President of the Healthcare Financial Management Association's (HFMA) Heart of America Chapter and earned the designation of Fellow of the Healthcare Financial Management Association (FHFMA). Shanna holds the organization's Certificate of Advanced Technical Study in Mastering Patient Financial Services as well as the Founders Medal of Honor Award. She is a recognized industry writer and speaker on health care and related topics, conducts webinars, and was a frequent HFMA HERe blog contributor. Shanna holds a BS degree in business from Oklahoma State University (Stillwater, OK) and several certifications including Master Team Facilitator, Integrative Health Coach, and Toastmaster's Advanced Communicator Bronze.

Centauri Health Solutions works with healthcare payors and providers to improve the lives of their members and patients through compassionate outreach, sophisticated analytics, and data-driven solutions. Our reimbursement-focused services and unparalleled expertise lead to more accurate payment rates; a reduction in uncompensated care; transparent provider pricing; and referral management and analytics.

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"Where Should I Put This Check?"

James A. Bush, PhD, MHA
Principal Product Trainer, nThrive
Adjunct Professor of Healthcare Sciences

After months of planning, implementation calls, configurations, and budget approvals, you finally got the go-ahead for your new system to go live. Few on your team will understand the exhaustive person-hours you've dedicated to the success of this project. Few will know the technical complexities of the projects, the dodging of physical barriers to meet leadership's expectations. Not to mention the office politics that went into the selection of this new system. What you thought would be cheers and praises of admiration for all your hard work are literal eye rolls, deep sighs, and whispers of defiance. You've probably even heard "I'm not doing that" or "we could have kept the old system." Baffled by the team's response, you think: How could anyone hate this new system? It's completely automated, increases productivity, reduces denial rates, and shoots glitter!

James Bush, PhD, MHA

What you are experiencing is not just another "Negative Nancy or Nathanial." Their response directly results from the failure to apply the Change Management process effectively at some level. The goal for any successful product implementation is to get full adoption from all stakeholders at every level of the organization. While there are numerous Change Management models, they all agree on one part: the people element. Most models suggest that consistent communication happens at all levels and that all stakeholders' roles be considered in the overall plan. You would be surprised at the number of times I have visited a facility to conduct end-user training only to find out the users had no idea of a new solution and had no idea of the project in question. According to sources, the average new solutions implementation cost upwards of $100K - $200k on average, not including the additional cost of system maintenance. For facilities to truly get a return on their investment and truly see positive trends in their revenue cycle, everyone needs to be on board with the new process.

While visiting a facility in Texas, I encountered a new Director of the Revenue Cycle with a significant problem on her hands. Her front desk staff approached her with a simple question, "*Where should I put this check?*", a payment from a patient. The new Director questioned the front desk staff about the current process. The staff informed her that they simply accept the payment from the patient and stuff them in a lockbox under the desk. They were coming to her because they had no idea what happens to the box or who was responsible for making the nightly deposits from it. I'm sure you can imagine the disbelief in the Director's face as she discovered that the lockbox had not been open in over three years and contained thousands of expired checks and now lost revenue to the facility. Through investigation, the Director found that the person responsible for this part of the process was under the impression that her duties of manually depositing patient payments nightly were no longer needed. The facility got a new system that accepted and processed electronic payments and the employee didn't understand her role in the process. This process error is just one example of how communication of a new process failed to reach all the stakeholders and ultimately cost the organization revenue.

"...you can imagine the disbelief in the Director's face as she discovered that the lockbox had not been open in over three years and contained thousands of expired checks and now lost revenue to the facility…"

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According to the Fox Group, a healthcare consulting firm, it is estimated that 20% of software implementations are deemed failures across the industry. Additionally, untrained staff was listed as the top 5 challenges hospital revenue cycle management leaders faced in 2019. According to a Harvard study, the root cause of resistance is that the employee identifies with and truly cares for the organization. People fear that the organization or job they identify with will no longer be the organization they value after the change. The study concluded with participants' support for change being higher when the vision of continuity accompanied the vision of change. According to McKinsey & Company, "70 percent of change programs fail to achieve their goals, largely due to employee resistance and lack of management support." Ultimately, your team members' buy-in is what drives the success of your new change initiative.

"People fear that the organization or job they identify with will no longer be the organization they value after the change."

Combating employee resistance may seem like an insurmountable task but it can be done. Communication is critical, whether it's implementing a new revenue cycle management solution or something simpler like an internal procedural change of who deposits checks. The decision of a new system lies in the hands of the executive leadership team, however, don't underestimate the power of including individuals from all levels of the organization. Inclusion should not only occur in the middle of the project or tail end but in the planning and kick off. This inclusion will drive early acceptance of the new solution and often illuminate potential changes to the solution or project plan that project leaders did not consider. Secondly, don't forget the importance of having project ambassadors. Every great team has its very own set of cheerleaders. As cheerleaders, they not only report back the tone of the organization, they assist in building excitement for the new solution. Lastly, you can never communicate enough with your team. Communication can come in more than just the form of weekly project e-mails. Creating small focus groups or even "lunch & learn" can be a great way to communicate the new vision of the project, inspire adoption, and achieve ROI. As a final thought Fall is a great time for Follow Up on those new process or systems you have already implemented. You never know, you may find a lock box full of expired checks!

"Creating small focus groups or even "lunch & learn" can be a great way to communicate the new vision of the project, inspire adoption, and achieve ROI."

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Case Study: Managing Patients, Payments and a Pandemic

By Deirdre Ruttle, Chief Marketing Officer, InstaMed, a J.P. Morgan company

The COVID-19 pandemic has accelerated demand for contactless experiences that are both digital and convenient across the entire range of patient interactions. However, one of the strongest preferences expressed by healthcare consumers – for online systems to receive and pay bills – has been largely unmet because of legacy mechanisms that require patients to interact with staff and decipher often-confusing paper statements.

These outmoded procedures can jeopardize patient loyalty through friction in the payment journey. Indeed, 56% of consumers would consider switching healthcare providers for a better healthcare payments experience. The disconnect between patient preferences and the actual payment experience is wide. More than 70% of consumers prefer an eStatement versus only 29% who actually get their medical bills that way, while 67% would rather pay these bills online.

It's imperative that the industry address the payment disconnect with patients through a reimagined payment experience that is intuitive, secure and easily accessible. Systems and experiences should allow patients to quickly and efficiently pay balances.

This article will examine how a Chicago-based billing service, Revenue Integrity Management Services (RIMS), answered demand for convenient payment options with a quick-pay option for online payments that resulted in a 250% increase in online payments over its previous system.

Complex systems result in low usage

The provider customer is a 150-provider pediatric surgical practice that offers its families access to an online portal where they can communicate with providers, view test results and manage their appointments. However, in late 2019, the practice's payment systems had no connection with that online portal.

The disparate systems were highly inconvenient for patients who were forced to use a separate billing portal to pay online. Additionally, the process to set up an account on the billing portal was so complex it required staff intervention – creating more manual work for RIMS staff. Families calling to set up an account on the portal often ended up paying the bill with a credit card over the phone, rather than going through the longer process of setting up an online account.

A self-service online payment option was needed to give families the convenience they needed and reduce unnecessary work for RIMS staff.

Quick-pay option leads to surge in online payments

RIMS implemented a quick-pay option for online payments at the start of 2020. The new payment channel was first promoted by including the URL on all billing communications, including statements and pre-collection letters. Additionally, staff encourages families to pay their balance online rather than taking a payment over the phone. The results were dramatic. A majority of families began using the new channel to pay their balances, resulting in a 250% increase in online payments for the RIMS client.

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Case Study: Managing Patients, Payments and a Pandemic

By Deirdre Ruttle, Chief Marketing Officer, InstaMed, a J.P. Morgan company

COVID-19 pandemic causes unprecedented disruption

The disruption caused by the March 2020 COVID-19 pandemic cannot be overstated, particularly for healthcare-related businesses. During the COVID-19 pandemic , billing services struggled to move business operations to an entirely remote workforce to securely manage client payments. This transition included quickly equipping staff with all the tools needed to securely conduct billing and collections processes entirely from home.

For RIMS, leadership had to make the transition to remote workforce within a matter of days. In the case of the pediatric surgical client, the transition was significantly eased by the quick-pay online option. In fact, the system was so successful that April 2020 saw the highest level of patient payments in the company's history.

Overcoming continuing hurdles

The transition to a remote workforce had to happen quickly in March, but the repercussions continued long after the initial change. RIMS leadership and staff worked diligently to minimize any potential operations disruptions and ensure payment collections continued.

Once again, the quick-pay site was crucial to collections for clients. Rather than taking credit-card information over an unsecure phone line, all staff directed patient families to the secure online payment site. In the midst of the COVID-19 pandemic, families valued the priority RIMS gave to the privacy and security of payment Information.

The client appreciated that the new payment tool included a robust reporting tool, allowing RIMS to quickly produce detailed reports, including daily summaries and payment trends. Indeed, the client found that online payments increased 45% over previous months due to the new channel.

Looking ahead to more self-service options

Although the quick-pay online channel was intended to solve a usability issue for the client's families, it became an important tool to transition RIMS staff to an entirely remote workforce during the COVID-19 pandemic. This led to the company experiencing higher than normal payment levels despite the pandemic.

RIMS is exploring ways to offer other self-service options, including automated payment plans, to further empower clients to connect with patients for payments.

Download the free Trends in Healthcare Payments Annual Report for an insider look at industry data, stakeholder sentiments and the type of healthcare payment experience consumers want: ***www.instamed.com/trends***

Deirdre Ruttle is Chief Marketing Officer, InstaMed and Head of Wholesale Payments Healthcare Marketing, J.P. Morgan Chase & Co.

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An Interview with Medicare Administrative Contractor Palmetto GBA: MACtoberfest®

Natalie Hefner, CRCE, Palmetto Provider Outreach & Education Advisory Group (POE-AG) Member

The Virginia Chapter of AAHAM is dedicated to providing its membership with important regulatory updates. As a long time member of Palmetto GBA's Provider Outreach & Education Advisory Group, I can tell you first hand that this Medicare Administrative Contractor (MAC) matches this dedication to educate providers on important topics and changes. I am grateful to have had the opportunity to interview the JM MAC, Palmetto GBA and hope each of you will **register** for their biggest provider education conference of the year, **MACtoberfest®, October 19-21, 2021**!

Q. **How did MACtoberfest® come about?**

A. *The Palmetto GBA MACtoberfest® Symposium originated in 2009 and was expanded to include all Palmetto GBA jurisdictions as a yearly event. This two- to three-day event, our largest of the year, spotlights targeted education and includes key operational areas and partnerships. MACtoberfest® offers multiple tracks with sessions targeting one or more lines of business—Medicare Part A, Part B and Home Health and Hospice.*

Q. **Who are some of the key players that put MACtoberfest® together?**

A. *MACtoberfest® is coordinated by Palmetto GBA's Provider Outreach and Education department (POE), and the key players are Susan Pendley, Provider Customer Service Program (PCSP) Director and AB MAC Deputy Program Manager, and Belinda Marin, Provider Outreach and Education and PCSP Manager.*

Among our key operational area managers presenting sessions this year are EDI Operations Manager Kim Campbell on Electronic Data Interchange (EDI); Provider Enrollment Manager Randi Heyward on Provider Enrollment; Home Health and Hospice RN Medical Review Manager Sheri Mertins, RN, MSN-NL, on Medical Review; and Jurisdiction M Provider Contact Center Director Kelly Temple on Medicare Appeals.

Other sessions will be presented by POE Clinical Education Consultants including Charles Canaan, Sandra Booker, April Gause and Judy Brown. There will be special partnership sessions with CGS DME Contractor and Dr. Bill Rifkin of MCG Health.

Q. **How many providers do you estimate have attended MACtoberfest® in the past? How many providers is Palmetto GBA expecting to reach this year?**

A. *2020 was our first virtual MACtoberfest® due to the Novel Coronavirus pandemic. It was attended by 5,465 providers, more than doubling our live and in-person 2019 MACtoberfest® Symposium. Registration is now open, and we hope this year's attendance exceeds last year's. Provider feedback has indicated that the virtual conference provides an opportunity for those who would ordinarily be unable to travel to an in-person conference to attend virtually from their homes or offices.*

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An Interview with Medicare Administrative Contractor Palmetto GBA: MACtoberfest®

Q. **What is something providers would be surprised to know about MACtoberfest®?**

A. *Most people probably don't realize that Palmetto GBA has service-marked the word "MACtoberfest®. That makes our event unique in that respect. We also start planning the event a year in advance with the help of focus groups, feedback from our POE advisory group, and data analysis reports.*

Q. **Do MACtoberfest® presenters have a favorite part of the event?**

A. *Our presenters enjoy the question and answer sessions the most. It allows them to interact with the attendees, to get to know them on a personal level and gauge their level of participation. In our in-person MACtoberfest® symposiums, we favored the one-on-one time we were able to spend with our providers.*

Q. **Who should attend?**

A. *Because of the diversity in the topics we offer, attending MACtoberfest® provides a benefit to individuals across the Medicare provider spectrum: coders and billers; office and account managers; physicians, physician assistants and non-physician practitioners; utilization review nurses and RNs; compliance personnel; clinical and support staff; and even an organization's senior leadership, including CEOs and CFOs will benefit from what MACtoberfest® has to offer.*

Q. **Without selling trade secrets, how does Palmetto GBA coordinate an event of this magnitude!**

A. *Organizing a symposium from the ground up requires a tremendous amount of forethought and data-gathering. The entire POE staff is actively involved in the preparation of the MACtoberfest® project plan. We plan a year in advance for the optimum date, location (prior to pandemic), topics and logistics. We are constantly collaborating with our internal operational areas for the most critical education topics. POE also collaborates with other Medicare contractors, as well as state and federal organizations to establish partnerships for the benefit of our provider community.*

Q. **Name three reasons providers should participate in MACtoberfest®?**

A. *The primary reason providers should participate in MACtoberfest® is to learn more about Palmetto GBA, their Medicare Administrative Contractor, and how they can interact with us to ensure proper billing and coding of their claims. MACtoberfest® also instructs providers to be Medicare-compliant by learning about pertinent and sometimes critical Medicare updates. But most of all, we want our providers to have a voice and use essential Medicare information to succeed in business!*

Q. **How can providers submit questions to be addressed during the event?**

A. *Providers have the opportunity to ask questions during the individual sessions. Palmetto GBA utilizes a user-friendly web platform which features an "Ask a Question" chat function. Participants are able to type in their questions and session facilitators can respond during the session.*

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An Interview with Medicare Administrative Contractor Palmetto GBA: MACtoberfest®

Q. **Name the main takeaways Palmetto GBA would like providers to have after attending MACtoberfest®, knowing that all education will be on demand.**

A. *We pride ourselves on preparing you to understand and comply with Medicare's operational processes, policies, new initiatives, and billing procedures. We want you to successfully manage and bill the Medicare program correctly, avoid billing errors, and be Medicare compliant.*

Q. **How can providers register for MACtoberfest®?**

A. *MACtoberfest® registration is now open. Simply, go to Jurisdiction M Part A - MACtoberfest (palmettogba.com) to register for each session you would like to attend. View our video invitation here!*

Sessions will include:

Submitting Claims Electronically: EDI Options and Tools	**Part B Medicare Updates**	**Comprehensive Error Rate Testing: Paving the Way to Excellence and Ensuring Successful Outcomes**
OPD PA Cervical Discectomy & Spinal Cord Stimulators	**Remittance Advice Overview**	**Learn about the Railroad Medicare Program with a Spotlight on Medical Review**
Observation Care and Admission Decisions: Reducing Payer-Provider Friction	**Provider Enrollment**	**DME/HHH Guidance for Ordering Providers**
Hyperbaric Oxygen Therapy (HBO)	**Medical Review Updates**	**Did You Know? (Tips & Reminders for Accessing and Using Palmetto GBA Resources**
Quarterly Medicare Updates	**Timely Topics**	**Let's Avoid Claim Overlaps**
Jurisdictions J and M Appeals Overview		

Thank you, Palmetto GBA, for your time and fantastic responses! VA AAHAM Members should be reminded that they earn 1.0 unit for each hour in attendance at an educational program or class related to the healthcare field. I hope you all visit the MACtoberfest registration page to preview the sessions and sign up today. There truly is something for everyone! For more information on Palmetto GBA Events and Education, please visit their Learning and Education Page. Providers are encouraged to sign up for Email Updates to receive up to date news and information.

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Does the Revenue Cycle Ever End? What Can We Measure?

Rob Borchert, S.M.E., MBA, CRCE, FHFMA
Principal, Federal Advisory Partners
rob@bpa-consulting.com

Does the Revenue Cycle ever end? 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 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 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, etc.

Although, registration staff cannot 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 the services needed will be performed, tracked and followed 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 3 identified errors over a 30-day period, that equals errors for 600 registrations or .05% of the total (in one physician office). If measuring 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?

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 than a physician's office. Remember, a healthcare facility is usually a 24/7 situation for patient care. 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 registrations and Emergency

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Department registrations due to the historical level of "confusion" found in the Emergency Department. I know you can look up the different metrics for a registration area, so I won't bother to indicate the various percentages for best practices. 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 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. 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 than focus on when (if ever) the goal is not met.

Now, I know 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, can 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 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, 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? 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.

The 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

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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.

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? 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 really 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 a certain dollar amount, 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)

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- 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 that may have occurred before I started looking at the function. I may find out that no one has ever questioned the function and the common answer to my question is "we have always done it this way!" 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 or listen to a different station on the radio. At work, ask to work a different set of accounts or even learn another aspect of the Revenue Cycle. There is an old expression I remember from my childhood, "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 still 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? Becomes 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 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 the only reason why I bill and collect monies is so that these "other functions" can provide quality healthcare to our patients. 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?

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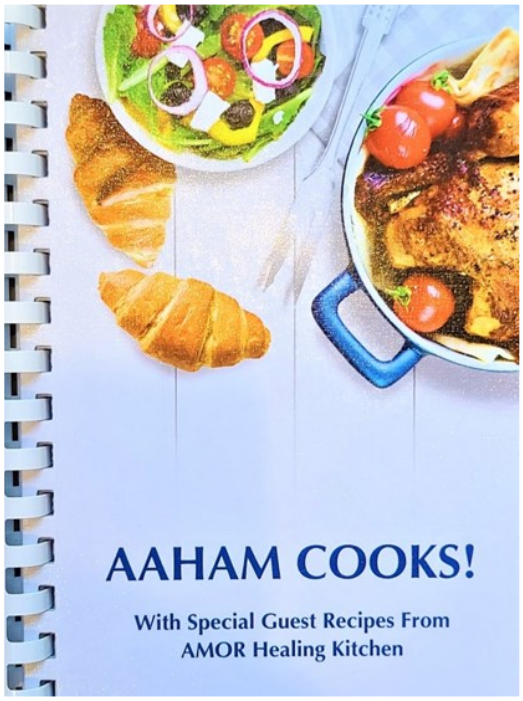
VA AAHAM Charitable Contribution: AMOR Healing Kitchen

The AMOR Healing Kitchen is based in Charleston, South Carolina. They make and deliver nutritious, healthy food, using seasonal organic ingredients sourced from local and surrounding area farms, made with love by youth volunteers. On a weekly basis, Kitchen Mentors teach AMOR's Teen Chefs culinary skills who prepare delicious, nutritious meals for people undergoing or recovering from medical treatments such as Cancer, Diabetes, and HIV. These meals are delivered to those in need by AMOR's Delivery Angels every Friday. The Virginia Chapter of AAHAM, along with other National AAHAM chapters, have created a cookbook to support this wonderful organization. The cookbook features a selection of AMOR Healing Kitchen's recipes. There have been over 200 cookbooks books sold with a net profit of over $10,000. It was a fun project and the cookbook is great.



How did AAHAM Become Involved?

It was a beautiful day in the Fall of 2020 when Pete Ash reached out to several AAHAM colleagues to "plant a seed" about a challenge that would benefit the AMOR Healing Kitchen. You see, HFMA had made a field trip to the kitchen in Charleston, South Carolina to help prepare food as part of a community service project. That is when our HFMA colleagues met Maria Kelly and fell in love with AMOR Healing Kitchen and its mission. A few emails, a resounding "yes, let's do it!" and an idea was all it took to begin creating the AAHAM Cookbook. It was so much more than a book. It became a labor of love to support AMOR, as well as a respite from COVID, isolation, social distancing and masks. The collaborators met almost weekly to plan every step, to fundraise and solicit recipes. Seven AAHAM Chapters joined forces and crossed borders during a pandemic to bring the cookbook to fruition. Members and friends of the Carolina, Georgia, Pennsylvania Keystone, Maryland, Philadelphia, Pennsylvania Three Rivers and Virginia Chapters of AAHAM along with AMOR's own Marie Kelly and her culinary staff shared their most prized recipes. They filled the cookbook with their favorite meals and also included touching stories, funny anecdotes and family memories to support AMOR Healing Kitchen.

Purchasing Details

With the holidays approaching, now is the perfect time to order your AAHAM Cooks! cookbook for you and your friends & family. This well-rounded cookbook not only features some of AMOR Healing Kitchen signature dishes; it is also packed full of delicious recipes, fun photos, and helpful tips! **The cookbooks can be purchased at AMOR Healing Kitchen's website.**

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Upcoming Events

Virginia AAHAM

- **October 5-7, 2021 The 2021 AAHAM ANI** will be held virtually. The Annual Business Meeting and Awards Showcase is October 5, 2021 from 2:00-3:00 EST. Attend every day or just one day and earn your AAHAM CEUs. Register today!
- **October 6, 2021** Wine Wednesday at King Family Vineyard, Crozet, Virginia. VADC HFMA and VA AAHAM will join together to celebrate "in person" events.
- **October 18-24, 2021** National Patient Account Management Week
- **October 19-21, 2021** VA AAHAM Supports **Palmetto GBA's MACtoberfest®**
- **October 28, 2021** Jeopardy! Certification Game 12:30-1:30
- **October 2021 VA AAHAM Fall Certification Webinar Series**

Friday, October 1, 2021	Patient Access
Friday, October 8, 2021	A/R Management
Friday, October 15, 2021	Credit & Collection
Friday, October 22, 2021	Billing: Part 1
Friday, October 29, 2021	Billing: Part 2

Earn AAHAM CEU's by attending a certification webinar. **Register today!**

- **November 30, 2021-December 3, 2021 VA AAHAM Annual Winter Conference** Join us in-person at Kingsmill Resort in Williamsburg, Virginia and Earn AAHAM CEU's! *Please watch for updates on our **website** and by email.*

Upcoming Certification Exam Dates and Registration Deadlines

Certification Exams are now available each month.

- October 18-22, 2021 October 2021 Exams
- November 15-19, 2021 November 2021 Exams
- December 13-17, 2021 December 2021 Exams

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JEOPARDY!

Natalie Hefner, CRCE with Leanna Marshall, CRCE Retired

The Virginia AAHAM Executive Board is continually finding creative ways to promote certification. When the pandemic hit and in-person conferences were cancelled, we knew the outreach had to change. Certification Chair, Leanna Marshall shares how she took a creative leap of faith and teamed up with some spectacular AAHAM Members to keep the spirit of certification alive with a fun, fresh look on a Jeopardy Game!

Q: How did the idea of a Jeopardy game come about?
A: The board was reviewing the requirements for Chapter Excellence and one of the questions posed is, "How do you promote certification?" Normally I have the certification wheel at meetings but since we couldn't have meetings I told Linda Patry I had a suggestion to do a Jeopardy game.

Q: Who are the key players in organizing this?
A: They key players were Timothy Breen, David Nicholas, Linda Patry, Tom Perrotta, Michael Whorley and myself. I asked Timothy to set up game like the real Jeopardy on website and I would come up with the questions for Jeopardy, Double Jeopardy and Final Jeopardy. I also contacted the people to be the contestants. Tom got the sponsors to donate gift cards in the amounts of $125, $75 and $25. David and Linda were the score keepers.

Q: Where do the questions come from?
A: I make up questions from the CRCE study manual.

Q: What part of planning the Jeopardy games were the most fun?
A: Most fun for me was seeing the presentation of the final results.

Q: How do you think people benefit from the Jeopardy certification event?
A: It is fun but very educational and will help people who are thinking of taking the exam.

Q: What are you looking forward to most for the next event?
A: I look forward to having other AAHAM Chapters involved.

Join us **October 28, 2021** as Virginia defending champion Katie Adams, CRCE (Virginia) takes on Theresa Johnson, CRCE (North Carolina) and Marina Himes, CRCE (Maryland)!

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Q: Who thought of involving other AAHAM Chapters?
A: Pete Ash made the suggestion of getting other chapters involved. He recruited Maryland and I contacted Theresa Johnson of N.C. Katie Adams will represent the Virginia Chapter since she is our current winner.

Q: Describe something that has surprised you about the Jeopardy event.
A: Something that surprised me was how willing the contestants were to be on the event. We have a lot of smart people in the chapter but some people are afraid they would be embarrassed if they didn't know the answers! We received a lot of great comments about the game. Past contestants include: Mark Morhack (the first winner), Katie Adams (winner of second and third Jeopardy), Pam Cornell, Susan McDonald, Linda Patry, Karen Thomas and Deanna Almond.

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Spotlight: The AAHAM Certified Revenue Cycle Specialist

The **CRCE** exam is intended for revenue cycle staff with responsibilities in patient access, billing, account resolution, denial management, collections, cash posting, customer service, and self-pay collections. The exam focuses on knowledge required in revenue cycle functional areas including registration (front desk), billing, and credit & collections. Although Specialist Certification is not a pre-requisite for Professional level certification, it is designed as a rung on the AAHAM certification ladder to the Professional certification for those interested in pursuing the next level in their career path Visit the AAHAM Certification webpage for more information.

About the AAHAM CRCS Exams

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

Exam Overview

The exams are two hour, online, proctored exams that requires working knowledge within focused areas of the revenue cycle, including relevant regulations and acronyms, and comprised of three multiple-choice sections.

Eligibility

The CRCS exams are available to individuals involved in the management of healthcare patient accounts. Membership in AAHAM is not a requirement, although it is encouraged. One-year employment in the healthcare revenue cycle is recommended to successfully complete the exam.

AAHAM CRCS Sections

Sections included in the exams include:
CRCS Sections
1. Patient Access/Front Desk
2. Billing
3. Credit & Collections

Exam Format

Examinees must initially sit for all three sections, which contain questions in a multiple-choice format. Each section of the AAHAM CRCS exam is graded separately and all three sections must be passed with a score of 70% or greater to earn the CRCS certification. If only one section is failed, a retake of that section is permitted. If more than one section is failed, a retake of the full exam is required.

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Recently Certified in Virginia

VA AAHAM would like to congratulate those who earned the following designations this summer. Congratulations to:

Certified Revenue Cycle Specialist

Steven Perini, CRCS
Sydney Birckhead, CRCS
Elissa Engler, CRCS
Dalia Faris, CRCS
Windy Rowland, CRCS
Katya Sepkowski, CRCS
Juana Vann, CRCS

Certified Revenue Cycle Professional

Kelli Cefalu, CRCP

Certified Compliance Technician

David Partridge, CCT

Congratulations!

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Brenda Chambers Certification Scholarship Program

Virginia AAHAM has earmarked funds for the AAHAM Certification Programs. The money is to be used by Virginia AAHAM National members who wish to apply for these funds to pay for the testing fee at AAHAM and will be applied on a first come first serve basis. Once these funds run out, money won't be available until 2022. This scholarship is meant for people that are truly interested in becoming AAHAM Certified but would have difficulty paying for it on their own and are not receiving funds from their employer for this purpose. This would be for any of the AAHAM Certification programs that AAHAM offers (CRCS, CRCP, CRIP, CRCE or CCT). In order to qualify for reimbursement of the expense of taking the exam you should meet these simple requirements:

- Be a member in good standing with both Virginia AAHAM and National AAHAM for 2021 if taking one of the Professional Exams: CRCP, CRIP or CRCE
- Be a member in good standing with Virginia AAHAM as a State Only member for 2021 if taking one of the Technical Exams: CRCS or CCT
- Be someone who is not receiving reimbursement from their employer for the exam fee
- Must register for and take exam of one of these programs in 2021: CRCS, CRCP, CRIP, CRCE, CCT. Visit www.aaham.org to view exam schedule and register
- Must reside in or be employed in the Commonwealth of Virginia
- To apply, Contact David Nicholas, Chairperson of the Board VA AAHAM **HERE**

Virginia AAHAM will reimburse your expense for your registration if you have a need and request it. **Once these funds run out then the program will automatically end, so please don't hesitate to register and apply for these funds if you need them!**

Writers Wanted!

Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent! *Submission deadline for the Winter Newsletter is December 10, 2021.*

Submit articles or, express interest in participating on the Virginia AAHAM Publication Committee **HERE**.

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2021 VA AAHAM Membership Application

We are growing!

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!

National AAHAM would like for you to know the 2022 membership renewal invoices have been mailed. As a thank you for your membership, they are continuing the "pandemic dues renewal discount" of $188, payable in one lump sum by 12/31/21. They are mindful of the times we are in and understand you may be struggling and wondering how to pay for your dues. If you are unable to take advantage of this discount, AAHAM does offer payment plans to help ease the dues burden Please contact the AAHAM National Office if you would like more information about these options.

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Dr. Steve Sobel

Speaker Extraordinaire!

Dr. Steve Sobel is a nationally adored motivational speaker, humorist, success coach and author. He is the author of The Good Times Handbook-Your Guide To Positive Living and an Exciting Life and numerous DVD and CD programs. He is a former award winning school principal and also teaches p/t at the college level. Steve is also the proud head coach of The Springfield SLAMM, a top men's pro am basketball team, and also works with at risk youth through his basketball program. His work with his presentations has been featured on INSIDE EDITION and he writes for several professional publications and is often on TV and radio. **Dr. Steve Sobel, a frequent AAHAM Chapter Speaker, is making a one time courtesy offer to AAHAM Virginia Chapter members.** Dr. Steve knows this "Powerpack" will make a tremendous difference in your professional and personal lives!

POWERPACK includes:

- Steve's popular book "The Good Times Handbook-Your Guide To Positive Living and an Exciting Life"
- CDs: "Blueprint for Excellence", "Dancing With Wolves-How To Deal Superbly and Creatively With Difficult People", "All You Need To Know About Creative and Potent Leadership" The CD's run about 40-45 minutes-great for drivetime or anytime and sharing with your team at work!
- Courtesy price for "POWERPACK" is $79.00 plus $7.50 p/h. **Must order by October 12, 2021**
- Please order by mailing check or money order to: Dr. Steve Sobel, 400 Blake Street-#2107,New Haven, Ct 06515. Please include detailed contact information.
- You can also order a personalized 20 minute "power moves" CD made especially for YOU for $155.00 plus $4.50 p/h You will need to fill out a brief questionnaire so Steve can personalize the CD for you. Steve will also call you to discuss your "power moves" CD. Makes a tremendous difference in how you approach life's challenges-personally and/or professionally. (He prepares many of these for the top athletes and high performance professionals he does one to one life coaching with-which is also available to you by phone coaching.)

Steve can be reached at Info@DrSteveSobel.Com as well as 413-530-5173 and 413-530-2106 (texting number)
Steve's website is www.drstevesobel.com

Get your **POWERPACK** *today!*

Dr. Steve will be joining VA AAHAM as a keynote speaker in the Spring 2022!

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Virginia AAHAM Executive Board 2021

Chairman of the Board
(Chapter of Excellence Committee)

David Nicholas, CRCE
President, Mercury Accounts Receivables Services

Office: (703) 825-8762

Email: David@MercuryARS.com

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

Linda Patry, CRCE, Director, Patient Financial Services
Mary Washington Healthcare
2300 Fall Hill Ave. Suite 311 Fredericksburg, VA. 22401

Office: (540) 741-1591

Email: Linda.Patry@mwhc.com

First Vice President
(Committee Chairperson: Membership & Chapter Development: Chapter Awareness)

Amy Beech, CRCE
Augusta Health PO Box 1000, Fishersville, VA 22939

Office: (540) 245-7216
Email: ABeech@AugustaHealth.com

Second Vice President
(Committee Chairperson: Education Committee; Government Relations Committee)

Pam Cornell, CRCE
Mary Washington Healthcare

Office: (540) 741-3385

Email: Pam.Cornell@mwhc.com

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(Committee Chairperson: Publications Committee)

Natalie Hefner, CRCE
Mercury Accounts Receivable Services

Office: (571) 620-0141

Email: Natalie@MercuryARS.com

Treasurer
(Committee Chairperson: Vendor Awards Committee)

Jeffrey Blue
UVA Health System
4105 Lewis and Clark Drive Charlottesville, VA 22911

Office: (434) 297-7477

Email: Jrb2re@virginia.edu

Appointed Board Member: SPONSORSHIP COMMITTEE
Thomas Perrotta, Vice President of Client Relations, CCCO

Penn Credit

Office: (888) 725-1697

Email: Tom.Perrotta@penncredit.com

Appointed Board Member: CERTIFICATION COMMITTEE

Leanna Marshall, CRCE, Retired

Charlottesville, VA

Phone: (434) 962-8508

Email: ayden1@embarqmail.com

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Appointed Board Member: FINANCE COMMITTEE CHAIR

Dushantha Chelliah
UVA Health System
2212 Greenbrier Dr. Charlottesville, VA, 22901

Office: (434) 924-9266

Email: DC5P@hscmail.mcc.virginia.edu

Appointed Board Member: COMMUNICATIONS CHAIR

Timothy Breen, CRCE
UVA Health System
4105 Lewis & Clark Drive Charlottesville, VA 22911

Office: (434) 982-6355

Email: tjb8pm@virginia.edu

Honorary Board Member

Linda McLaughlin, CRCE, Retired
Office: (804) 690-7282
Email: Linda.B.Mclaughlin@gmail.com

Honorary Board Member

Michael Whorley, CRCE, Retired
Office: (540) 470-0020
Email: Michael@Whorley.com

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Committee Chairperson LEGISLATIVE Committee

Austin Hale
Tiffany Law Firm

Office: (757) 597-1449

Email: Austin@TiffanyLawFirm.com

Committee Chairperson Student Membership Committee

Mary Prendergast
IC System

Office: (757) 839-6215

Email: MPrendergast@icsystem.com

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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.