The Virginia AAHAM Insider

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

Fall 2017 Volume 44 Issue 1

The President's Message

Greetings Virginia AAHAM Members and Friends!

As we say so long to September we witnessed a rocky month of weather, both here and around the country. The hurricanes of the month devastated many communities and have left millions dealing with loss and even rebuilding from scratch all that they once had. Our hearts and best wishes go out to all who have been affected by these tragedies. The Virginia Chapter of AAHAM will be holding a fund drive to support victims of these storms. Please stay tuned for more details coming out soon. We are happy to be closing the books on September and looking forward to a beautiful October and coming holiday season. I'm sure we could all use and appreciate it.

Thank you to all who attended our Fall Regional Conference at Mary Washington Hospital. It was our first year back there after several years in Warrenton and it was a great success. We had more than 70 of our friends and colleagues attend this fun and information packed day. It was topped off with our Payer Panel at the end of the day, and even though some of our carriers had to drop out at the last minute, it was still a great success with those that attended. Many great questions were answered by our experts from Medicare, Medicaid and Carefirst BCBS. I want to thank the Education Committee, the Presenters and Corporate Partners who helped make this a great day for all!

I will say so long for now and ask that you please mark your calendars and plan to attend our 35th Annual Meeting which will be held again this year at Kingsmill Resort and Spa in Williamsburg December 6th thru the 8th. This location was popular with our attendees last year, and we know it will be again this year. Keep a watch out for the agenda and registration information that will be published soon. All of us on the Board hope to see you there!

Have a wonderful Fall season everyone and I look forward to seeing you at our Annual Meeting in Williamsburg, if not sooner!

David

David Nicholas, CRCE-I
President, Virginia Chapter of AAHAM

Inside this issue:

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

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Facing the Next Set of Hurdles in Claim Processing

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Wow, I thought that we had a break in claim processing. Now we are facing the next set of hurdles that really require some great thought processing within your own revenue cycle regarding the operational and systematic response to the new data collection activities. You may have addressed them already but in case you have not, here are some of the considerations to pursue.

1.New Medicare Patient Numbers: the new law requires the Centers for Medicare and Medicaid Services (CMS) to remove Social Security numbers from all Medicare cards by April 2019. A new unique Medicare number will replace the current Health Insurance Claim Number (HICN) on the new Medicare cards. This is to protect people with Medicare from fraudulent use of Social Security numbers, which can lead to identity theft and illegal use of Medicare benefits. The transition period will start April 1, 2018 and run through December 31, 2018. However, your systems must be ready to accept the new Medicare number (which is called the Medicare Beneficiary Identifier or MBI) by April 2018 for transactions such as billing, claim status, eligibility status and interactions with the Medicare Administrative Contractor contact centers. NOW, what set of hurdles will we face?????

A. How about the simple fact of our Medicare population? Will they care both cards? Will they know the difference? Will you need to know the old number as a reference to their accounts during the transition? Will this new "Identifier" of numbers and letters completely confuse many of our patients? What will happen if they forget their new card for the first time? How do you register them? Will the physician's office be able to help since that may be their first experience?

B. Can we help simplify this situation? We know they will be getting information via mail from CMS explaining this new situation but most times our population is more confused from these letters. Maybe we can provide some additional guidance to our population by:

- Offering some educational sessions in the hospital to further explain the new cards and what they should do with them AND do not throw away the old card yet!
- Speaking at local senior citizens meetings or conducting your own speaking engagements in the community.
- Visiting nursing homes and senior living facilities, especially after the cards have been mailed, to address the change and work with the administration there to gather the new card information prior to their use of your facility.

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Facing the Next Set of Hurdles in Claim Processing

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- Create a flyer to simply explain the new card and the reason and the new process of presenting both their cards at their first medical experience.
- Working with physician offices with the flyers and educational sessions schedule

2. System issues for acceptance of the new card information: the new card represents some system changes in EVERY system in your facility and/or physician practice. Some systems may be able to handle this change and some systems may need a major re-write. In fact, some systems may not be able to make this change at all. Also, ALL your supporting systems must make this change also. So, if you are using any "add-on", "bolt-on", third party system, the change must be made including the interface connections. As we know, the current HICN number is the social security number with a letter at the end, the new MBI consist of 5 numeric fields – 4 alphabetic fields – 2 alpha-numeric values.

N	A	AN	N	A	AN	N	A	A	N

N = numeric; A = alphabetic; AN = alpha-numeric

For example: 1EG4-TE5-MK73

This new number is not only confusing to the Medicare beneficiary but may be confusing to some programmers, especially if some things are "hard coded". Now let's think of some ways to handle this in different type situations:

- If the original system build accepts alphanumeric fields already, great…should not be too big of a problem.
- If the current system cannot change the existing acceptance field for the Medicare number, then a problem exists. There can be options but with each option there is a multitude of other interfaced systems that must be addressed.
- Do we have to resubmit older claims with the new number or can we stay the same?
- Can you build a cross-reference table reflected both the new and the old number?
- Can the cross-reference table be shared with other departments? Outside physician offices? Outside Lab companies?
- How will you handle any "off-line" systems that use the Medicare number but cannot handle the multitude of alpha-numeric fields?

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Facing the Next Set of Hurdles in Claim Processing

- Beware of new software companies claiming to provide a solution to this or other connected problems.
- An inventory of ALL systems must be made and then determined if they use the Medicare number for any data gathering AND then address any specific issue.
- Data intake must be examined for compatibility with your new re-write.
- Immediate action should be take on your transaction program for the 837 and 835. If the government starts only using the MBI and no reference to the HICN on claims, how will you identify the payment for old claims and then bill secondary, if available?
- Don't forget that in setting up this new MBI, in the alphabetic character fields (A), they do not us S, L, O, I, B, Z.
- Oh, Medicare Advantage and Prescription Drug plans will continue to assign and use their own identifiers on their health insurance cards.

You need to form a "short-term" committee, including some Medicare patients, and openly discuss all the potential complications and solutions to this transition. This group should comprise IT staff, department users (Lab, Rad, PT, etc.), Medicare billing staff, Medicare people, large physician practice staff, Compliance, and anyone else you believe could be beneficial to the discussion. Outcome solutions should be addressed immediately. Some members, such as department users and physician offices, may realize that their internal systems must be addressed as well.

DO NOT LET YOUR VENDORS SAY, "THEY HAVE THE WHOLE THING TAKEN CARE OF" unless you are part of their solution group AND test the H… out of it long before April 2018.

Good Luck Jumping the Hurdles!

Sincerely,

Rob Borchert

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Medical Claim Insurance Recovery

P | S

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Houston, TX 77024
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The Secret to Cash Reconciliation

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While collecting cash is vital, reconciling cash is an important function for both Finance and Revenue Cycle operations which often goes overlooked. Historical underinvestment in cash reconciliation has led to a number of highly manual solutions that require resources and still have significant risks of failure.

In running a hospital revenue cycle, plenty of attention is paid to collecting patient information; managing the pricing and charge description masters; and, of course, watching the AR. If done well, many of the factors of a great revenue cycle result are present. However, there is one that is often overlooked: cash reconciliation.

Even when claims are being paid, failure to appropriately reconcile cash can cause hours of rework, headaches with a variety of stakeholders, like cash posters, follow up staff, and finance (not to mention auditors!), as well as create uncertainty about whose cash is whose. Especially in more complex operating environments, where payers often mingle physician and hospital payments in combined remits, and where overlapping relationships between hospitals and their affiliated or owned physician groups create confusing cash flows, *reconciling cash is a critical process than can easily go wrong*.

A modern, effective, and efficient cash reconciliation process tracks by deposit and utilizes technology to ensure clarity in the relationship between the cash you have in your bank and the cash you say you have in your GL and PAS systems.

To avoid unreconciled cash, organizations should understand the causes of the problem, avoid the common mistakes in cash reconciliation, and focus on adding one simple – though potentially hard to execute – element: *track cash by deposits.*

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The Secret to Cash Reconciliation

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The Problem

When hospitals were all one entity and had straightforward relationships with a small number of payers, cash reconciliation faced one relatively simple problem: checks and remittances often arrived at different times.

That disconnect, along with potential delays in cash posting processes, meant that cash in the bank had not necessarily been posted against the claims it had paid.

Then the problem became slightly more acute when cash was received near the end of one month but the remittance was received or posted in the following month. The imbalance of postings and deposits could be resolved with a simple comparison – so Finance knew whether the cash associated with payment on an account had been deposited.

However, as hospital and payer environments became more complex, so did the cash posting and reconciliation process.

- Owned physician groups generally received separate remittances, but payers often combined payments, delivering one check with a series of remittances.
- Hospital based billing arrangements added another layer of complexity, and a proliferation of payers with a variety of payment methods – including bundled payments and various quality or population health focused methodologies – created a new set of challenges.
- Even the common factors of secondary or tertiary payments caused additional complexity in the cash posting process.

The Secret to Cash Reconciliation

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More recently the consolidation of administrative functions, including the growth in RCM outsourcing functions, has added yet another layer of complexity. For example, if a hospital has moved from posting patient payments itself to doing so in some centralized function, it is commonly the case that payments can get batched up ways that may make reconciliation more difficult.

With more entities *sending* cash, *receiving* cash, and *posting* cash, reconciling payments has become more challenging. A single deposit may consist of multiple payments – and those payments likely consist of multiple batches, in multiple systems.

Responses

The constant flow of payments (including takebacks) and remittances led hospitals to implement a variety of tracking mechanisms – but the cash reconciliation processes can be shockingly rudimentary.

A Case in Point

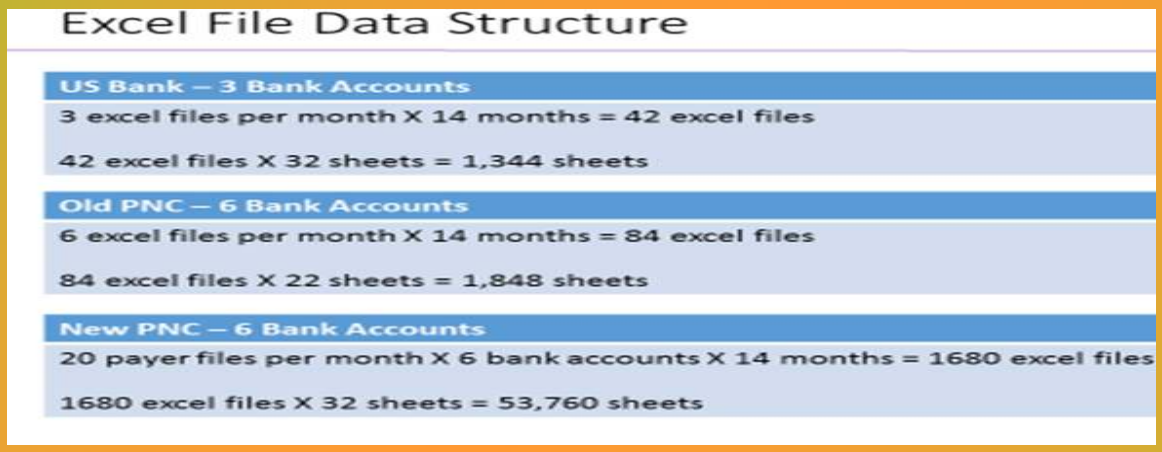
> For example, in one hospital we worked with, the revenue cycle department had used a highly manual, paper based system to tie out deposits and postings. The process was so manual and antiquated, the revenue cycle department had to contact multiple office supply vendors looking for a supplier of carbon paper, a key element in their reconciliation process!

Most hospitals have advanced past 1950s typewriter based technology and use some version of an excel spreadsheet or access database to reconcile cash. However, the many-to-many relationships inherent in tracking batches and payments can make the process difficult to track. Too often, hospitals literally give up, accepting that their reconciliation efforts will fall a few thousand (or a *few hundred thousand*!) short of fully reconciling and they accept the risk and costs of not being fully reconciled. And even where tracking is attempted, the effort is overwhelmingly tedious.

The Secret to Cash Reconciliation *Continued on next page*

Another Case

Another hospital we helped attempted to track payments and reconcile via excel spreadsheets. Daily deposit sheets were kept for each day and separate workbooks for each payer. Furthermore, separate accounts were maintained for various facilities and for the associated physician groups, meaning the number of worksheets quickly ballooned into the *tens of thousands.*



While cumbersome, the process worked….as long as it worked. If a deposit was entered incorrectly or if someone needed to find a historical deposit, searching through dozens of files and thousands of worksheets was theoretically possible, but functionally impractical.

The Solution

Well-intentioned, well-meaning, and even well-informed efforts to reconcile cash have generally led the industry to incomplete and cumbersome outcomes that reduce, but do not the eliminate, the risk of failed cash reconciliation. Our experience tells us that one simple concept can fix those problems: ***tracking by deposit***.

The Secret to Cash Reconciliation

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If an organization tracks by deposit, it can reduce the many to many relationships that result from the complex posting world in which most providers operate. Tracking by deposit creates a data structure like this:

Deposit	
4/1/2016	5,000.00

Payments	
3/26/2016	2,500.00
4/1/2016	2,500.00

Batches		
4/8/2016	Athena	$2,500.00
4/8/2016	EPIC	$2,000.00
4/8/2016	Medipac	$500.00

The deposit amount becomes the source of truth and cash, after all, is the ultimate truth in the revenue cycle. The deposit can be split into the various accounts where the cash belongs and can be posted into whatever systems or batches are appropriate. This layout also quickly highlights any unposted or unreconciled amounts, allowing staff to resolve those exceptions quickly.

While creating and managing a database of this structure is a viable option for reconciling cash, it does have some limitations. For example, it requires a significant amount of data entry, and entails all the risks associated with manual keystrokes.

The answer? Automation, building a relational database for all transactions. When deposits are matched with batch and transaction files from your Patient Accounting System, we have seen that automation can reconcile 90%+ of the deposits, creating a worklist for those that fail the auto-reconciliation process. A relational database can also allow users to easily search for specific deposits or transactions and quickly see the activity (or lack thereof) associated with those items.

The Secret to Cash Reconciliation

Along with streamlining and automating the reconciliation process, by creating a central repository for data related to the cash posting process, managerial insight is provided into staff productivity and cash posting backlogs. Neither excel spreadsheets nor carbon paper based processes can equal that kind of insight.

Conclusion

While there is variation in performance levels of most revenue cycle functions, the performance level in cash reconciliation is uniformly poor, or at least rudimentary. Antiquated tools and complex environments lead to unwieldy and often ineffective solutions that can provide inaccurate outcomes and create audit risk for hospitals.

Tracking by deposit is one way to minimize cash reconciliation problems. By utilizing automation, a comprehensive view into cash posting and provide real managerial insight can be created, solving many challenges and promoting the truth.

Tyler Kurasek is a principal at Colburn Hill Group, www.colburnhill.com. Tyler's experience includes years of providing analytical insight and operational improvements for healthcare systems; he is also the inventor of a Software as a Service (SaaS) application which allows hospital and physician groups to manage deposits, posting, and reconciliation of insurance and self-pay cash.

Election....

Notice of Elections of Officers of The Virginia Chapter of AAHAM

for the two year term beginning January 1, 2018

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 2018-2019 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 1st 2017; and, ballots will be sent to members on October 21st 2017. Voting will be open until November 15th. The elected officers will take the oath of office at the Annual Meeting December 7th in Williamsburg.

Members in good standing have the right to vote.

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 Handbook on the members only section of the Chapter website www.vaaaham.com.

The Virginia Chapter of AAHAM 2017 Nominating Committee:

Linda McLaughlin CRCE-I, Chairperson

Leanna Marshall CRCE-I, Member

Michael Whorley, CRCE-I, Member


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Hospital Spotlight.....

LewisGale Medical Center
HCA Virginia Health System

Lewis Gale Medical Center

Lewis Gale Medical Center is located in Salem, Virginia. It is one of 4 hospitals that are part of the Lewis Gale Regional Health System. The Lewis Gale Health System consists of 4 hospitals, 6 outpatient centers, 2 cancer centers and over 700 physicians. The Salem area hospital is a 521 bed private, community based facility. They began in 1909 as a 26-bed facility. In 1968, they joined forces with Hospital Corporation of America (HCA).

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Certification… why bother?

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

Benefits of obtaining AAHAM certification:

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

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

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

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

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

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

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

Leanna Marshall, CRCE-I

PFS Consultant

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Charlottesville, VA 22902

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

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Certification

2017 Certification Schedule:

November 6-17, 2017
November 2017 Exam Period

December 15, 2017
Registration deadline for March 2018 Exam Period

Newly Certified….

First Name	Last Name	Certification	Facility
Rylee	Adkins	CRCS-I	Mary Washington Healthcare
Stacy	Anderson	CRCS-I	Mary Washington Healthcare
Brigette	Bardeaux	CRCS-I	Mary Washington Healthcare
Johnathan	Belhumeur	CRCS-P	Inova Health Systems
Sunee	Bunyasrie	CRCS-I	May Washington Healthcare
Geoffrey	Carter II	CRCS-P	Inova Healthcare Services
Diane	Clarkin	CRCS-I	Mary Washington Healthcare
Patrcia	Deacon	CRCS-I	Centra Health
Julissa	Durand	CRCS-I	Mary Washington Healthcare
Amy	Garnett	CRCS-I	Mary Washington Healthcare
Stephanie	Hilgris	CRCS-P	Mary Washington Healthcare
Devorah	Kapololu	CRCS-I	Chesapeake General Hospital
Linda	Koonce	CRCS-I	Chesapeake General Hospital
Dana	Mims	CRCS-I	Mary Washington Healthcare
Renee	Morris-Taylor	CRIP	Southside Regional Medical Center
Jenna	Newsom	CRCS-I	
Stephanie	Roelfs	CRCS-P	Fauquier Hospital
Leslie	Rosbolt	CRCS-I	Inova Health
Minoo	Salahy	CRCS-I	Fauquier Hospital
Tamira	Smith	CRCS-I	
Deborah	Sullivan	CRCS-I	Mary Washington Healthcare
Robin	Waybright	CRCS-I	Mary Washington Healthcare

Congratulations!
We are proud of you!!

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Looking for a Financing Solution: It Pays to Keep Your Options Open

Antelope Valley Healthcare District (AVHD) and Tri-City Healthcare District (TCHD) are similar in many ways.

- Both organizations are a political subdivision of the State of California with elected boards.
- One facility is in northern Los Angeles County and the other is in northern San Diego County.
- Both own and operate medium-sized hospitals with similar revenue bases.
- Both hospitals anticipate future capital needs related to seismic requirements in California.

However, the credit profile and financial needs for the two organizations are very different. Therefore, when the two organizations looked to refinance their existing debt, the solutions were unique.

AVHD's primary asset is a safety-net hospital located in Lancaster, California, with a facility originally built in 1955. The hospital was renovated and expanded several times over the years, and it now has 420 beds. While the hospital has historically performed well financially, other challenges had adversely affected the hospital's credit rating. In addition, the organization was obligor for several different bond issues, which created an administrative burden. Furthermore, the terms of the bond issuances created uneven debt payments including a $55 million bullet maturity due in 2017.

TCHD's primary asset is a 397-bed acute care hospital in Oceanside, California, which originally opened in 1961. TCHD also has an auxiliary campus in Carlsbad, California. TCHD's capital structure was less complicated than AVHD, but TCHD's existing debt was put in place when the district was in a relatively weaker financial position. In the last two years, the hospital's financial position and managerial structure stabilized, and TCHD was in a position to refinance its debt. The primary goal was to find a long-term financial solution with a financial partner that could accommodate future capital needs.

Multi-Tracking for Optimum Capital Solutions

Neither AVHD nor TCHD were considered investment grade organizations by the credit rating agencies, but both districts had credit and market characteristics similar to low investment grade hospitals. Furthermore, a very favorable bond market made public bond issuance a viable option. Considering the financial profiles and goals, the boards and management at both hospitals saw the benefit of a multi-track financing approach. Both hospitals' investment bankers worked to develop a process to pursue tax-exempt bond financing, as well as the Federal Housing Administration (FHA) Sec. 242 program. The benefits of the multi-track approach include:

- The risk of changing capital markets is mitigated. The timing to make a decision regarding a structure and lock in a rate is deferred so that the borrower can take advantage of the best option.
- If FHA approval or the ability to sell bonds becomes questionable, the project team maintains other viable options.
- Having multiple options allows a board to choose a structure that best meets long-term goals, even if price is similar.
- The project team can take advantage of overlap of analytical and legal work. Even though FHA and tax-exempt bonds are very different structures, the credit review and much of the legal due diligence is similar.

Looking for a Financing Solution: It Pays to Keep Your Options Open

When using the multi-track approach, the logical starting point is the longer lead time option, which is usually the government agency program (FHA 242 in this case). Both AVHD and TCHD submitted preliminary review requests to the HUD's Office of Hospital Facilities and received positive feedback. The next step in the FHA 242 process called for a pre-application meeting at The U.S. Department of Housing and Urban Development (HUD) headquarters. While feedback was generally positive, there were certain unique challenges for each district with respect to FHA 242 program requirements. However, the project teams methodically proceeded with the next stage of the FHA process: preparation of the FHA 242 firm application. At this point, the project teams began preliminary work necessary for a tax-exempt bond issue. Fortunately, the firm application is a credit request package that includes much of the same due diligence necessary for a tax-exempt bond issue.

The Roads Diverge

As mentioned above, a primary emphasis for AVHD was cleaning up its capital structure, especially the need to reamortize a Series 2002 Bond issue, which had a $55 million bullet maturity due in 2017. For AVHD, timing and certainty of execution were key considerations. In early 2016, the FHA 242 process stalled because of management changes at the hospital, but the district remained in good financial condition. Fortunately, 2016 was a very favorable time for the tax-exempt bond market, as a strong economy, a lack of supply for tax-exempt securities, and an aggressive fixed income pricing environment presented an attractive pricing opportunity. In early 2016, the hospital's investment banker developed a pricing scale for a proposed approximately $130 million bond issue and simultaneously held discussions with investors that might be interested in securities issued under an FHA insured mortgage scenario.

The estimated interest rate for the FHA 242 scenario was 4.85%, while the initial bond pricing scale showed an all-in true interest cost (TIC) of 5.0%. The FHA 242 loan program is limited to 25-year amortization, while the Series 2016 tax-exempt bonds would be limited to final maturity in 2046 (30 years), because of Internal Revenue Service (IRS) rules. Given the similarities in debt service, the remaining question related to covenants. One of the most attractive features of the FHA 242 program is the limited financial covenants, while public bond issuances tend to have covenants dictated by the strength of the market. In 2016, the fixed income environment presented an opportunity to structure bonds without onerous financial covenants. Of course, a fixed income bond offering would have liquidity and debt service coverage requirements, but the market allowed for favorable negotiations of financial measures and limitations.

Given the exceptionally strong fixed income market and uncertainty of the FHA 242, the project team focused on a tax-exempt bond structure, with a goal to refund all prior issuances. Once the decision was made, execution was quick. The process to develop bond documents and go to market took less than three months. Pricing for the bonds was favorable, with a final all-in TIC below 4.90%, which was equivalent to the interest rate under an FHA scenario at the time. In addition, the financial covenants were loosened and unified. Previously, the District's numerous bond issues had separate covenant reporting requirements, and meeting the liquidity covenant was often a challenge because of the vagaries of government health care reimbursement programs. The new structure provides more flexibility.

Looking for a Financing Solution: It Pays to Keep Your Options Open

For TCHD, timing was less of a driving factor, as the existing debt structure was manageable. However, the board and management recognized an opportunity to improve its financial profile and prepare for capital projects in coming years. One attractive feature of the FHA 242 program is a straightforward process for issuing supplemental loans. That is, gaining approval for the initial FHA 242 loan can be a challenge, but established participants in the program often utilize the FHA supplemental loan program (known as 241) to fund projects in stages. By contrast, the ability to issue future tax-exempt debt in the public bond market is less certain. Market forces dictate pricing and covenants, and there is no guarantee that the appetite for non-investment grade fixed income securities will exist when capital is needed. Both AVHD and TCHD will need capital to meet state-mandated seismic requirements by 2030. However, the needs at TCHD are somewhat more extensive. Therefore, the clarity for future debt issuance offered by the FHA 242 program was an important feature. In addition, TCHD's management and board had experienced first-hand the challenges of issuing debt in an unfavorable environment. Years ago, TCHD was forced to refinance its debt at a time when the market was weak and the hospital was experiencing financial challenges. The resulting structure required TCHD to hold $51 million of cash as collateral.

Based on its expected needs and previous experience, TCHD's management and board worked with its investment banker to patiently proceed with the FHA 242 application. The process was delayed by a peculiar legal issue with a local developer, but FHA representatives worked with the hospital to get comfortable with the solution. In the end, the FHA 242/223(f) loan closed with an excellent rate, and the district now has the long-term capital partner that it was seeking.

The AVHD and TCHD examples demonstrate the value in keeping financing options open as long as possible. Two organizations that are quite similar on the surface can have very different needs and the capital funding solution needs to fit. Furthermore, market conditions can change quickly; the solution that seems best today might not be the best in three to six months. Because non-investment grade tax-exempt organizations are particularly vulnerable to market conditions, boards and management should regularly consult a financial advisor when contemplating a capital funding or refinance opportunity.

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

2017 Membership Application

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

Take advantage of these important benefits…

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Please enter your information below.

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

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

Treasurer, Virginia AAHAM
Linda Conner
2204 Wilborn Ave.
South Boston, VA 24592

-OR-

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

Virginia AAHAM Tax ID: 54-1351774

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The Virginia Chapter of AAHAM Executive Board 2016-2017

Chairman of the Board

(Chapter of Excellence Committee)

Linda McLaughlin, CRCE-I

Director, Director Finance and Governmental Services

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On the lighter side of things.....

Colorful Fall Salad

Prep time	Cook time	Total time
5 mins	1 hour	1 hour 5 mins

A colorful, nutrient rich salad that boasts the flavors of fall! It's a savory dish with the perfect balance of sweet and tart from the pomegranate seeds that will brighten up any dinner!

Author: Sarah @ Bucket List Tummy
Recipe type: salad, appetizer
Serves: 4-6 servings

Ingredients

- 1 large sweet potato, diced
- 2-3 beets, roasted
- 3-4 cups arugula or any green
- 1 pomegranate, cut and seeded
- 1 can black beans
- 1 cup edamame
- 1 avocado (see recipe for dressing below)
- ½ tsp salt, for roasting and to taste
- ½ tsp pepper, for roasting and to taste
- 1 tablespoons olive oil, for roasting

Instructions

1. Wash and cut sweet potato and beets into cubes and roast for 45 minutes to 1 hour on 375. I seasoned with olive oil, salt and pepper.
2. While those are roasting, prepare your salad in a bowl. Add pomegranate seeds, beans and edamame. Add beets and sweet potato when done.
3. Top with additional avocado if desired as well as dressing and enjoy!

Recipe by Bucket List Tummy at https://bucketlisttummy.com/the-most-colorful-fall-salad/

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National News— www.aaham.org

AAHAM announced a new mid-level certification at the 2014 Annual National Institute (ANI) in San Diego, CA, the Certified Revenue Integrity Professional (CRIP). This certification is intended for individuals in the revenue cycle to help ensure that facilities effectively manage their facilities charge master, and bill and document appropriately for all services rendered to a patient. This certification requires an in-depth, working knowledge of various revenue cycle areas and proper skill sets needed to increase revenue and reimbursement for facilities. It also ensures that proper charging takes place to maintain compliance within the insurance payer programs. With the addition of this new certification, AAHAM now offers a complete career ladder, beginning with the CRCS and culminating with the CRCE.

Visit the website for more information **http://www.aaham.org**

And calendar of upcoming events.

Stay up-to-date on Administrative Simplification and other healthcare Legislative issues of interest by visiting the National AAHAM web site:

https://www.capwiz.com/aaham/home/



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National News— www.aaham.org

The 2017 Annual National Institute will be held at the

Opryland Resort in Nashville, Tennessee

October 18-20, 2017

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Volume 44, Issue 1

Sponsorship

Platinum Sponsorship - $1500

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- **Free Registration at <u>BOTH</u> the May & December educational conference for four (4) sponsor employees**
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Silver Sponsorship - $1,000

- **Exhibit space available at EITHER the May OR December Conference**
- **Half-page ad in ALL newsletters**
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- **Plus much more…….**

The Virginia Chapter of the American Association of Healthcare Management (VA AAHAM) exists to provide or facilitate professional education, promote professional excellence, provide opportunities for sharing management strategies and tactics through professional networking. You and your organization are important to this mission. Virginia AAHAM benefits by drawing on the experience and education that you and your organization can bring to the activities and efforts of our association. Virginia AAHAM's mission. I hope that you will consider supporting Virginia AAHAM this year. —***Dale Brumbach,***

Mark your calendars!

Upcoming VA AAHAM events:

2017 Annual Meeting and Conference, Williamsburg, VA.

35th Anniversary, Dec. 6-8, 2017

Go to our web site for more information and registration:

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

www.vaaaham.com

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Autumn paints
in colors
that summer
has never seen.
cardstore.


Hello
Autumn

Tip 1: Use Fitness to Fight Back – When it comes to exercise and diet decisions, you really want to be proactive and not reactive. Make sure you have a reasonable plan for exercising and stick to it.

Tip 2: Sleep - "You have four times the odds of getting a cold if you get fewer than six hours of sleep a night.

Tip 3: Wash, wash, wash those hands!!

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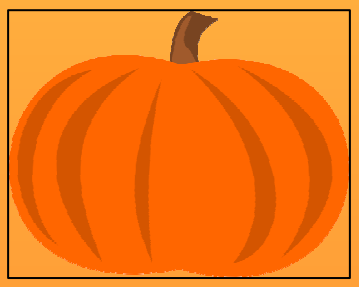

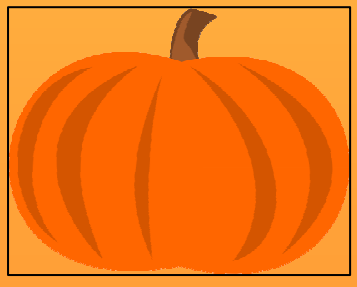

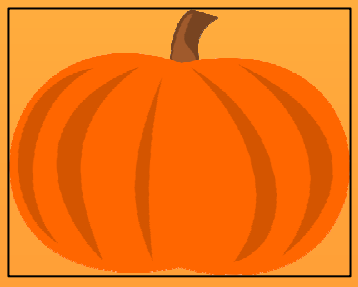

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Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2017. Submit articles to Amy Beech abeech@augustahealth.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

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

Amy Beech, CRCE-I

abeech@augustahealth.com

Sara Quick, CRCS-I,P

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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.

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