The Virginia AAHAM Insider

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

Summer 2015 Volume 35 Issue 1

The President's Message

Greetings Virginia AAHAM Members and Friends!

The days are getting hot in Virginia and the activity at your local AAHAM office has been just as hot! We're coming off a busy spring season, holding our Charlottesville meeting in March and our Payer Summit with HFMA in April.

Using Constant Contact, we put our Bylaw changes out to a vote by our members, and thanks to all of you who responded, all of the measures were passed and will be implemented immediately. Also, updated versions of our Bylaws will be available on the website soon in our Member Information section. This area requires a User ID and Password. Members may contact any board member for access to this area of our website.

We also provided our Annual Survey of the Members to solicit feedback on chapter operations. We loved the feedback that we received for how valuable it is, but we would welcome additional feedback from those that have not had the opportunity to respond. The survey is still available and we would welcome your input. Please take our survey soon, if you cannot locate it or did not get it, you may contact me at david.nicholas@rmccollects.com and I will send you a link to the survey.

We continue to be proud of our newly certified members of the chapter. We had several folks from around the state pass their CRCS, CRCP or CCT exam in May. Please see our list that's contained within the newsletter to get the full detail on who those folks are and send them a big congratulations for all their hard work!

Our Certification Scholarship program has been activated and I'm pleased to report we will have two folks taking the exams in August using our scholarship. They are Lori-Ann Davy who will be taking the CRCS and Christine Lang who will be taking the CRCP exam. Please send them good luck to be two of our newly certified this summer.

Are you thinking about or planning to take a certification exam sometime in the near future? The next exam period for AAHAM after August is the November period which runs from the 9th thru 20th. Deadline to register for that exam is September 1st. We still have funds available in the Scholarship program so consider applying and registering by the cutoff date. Have you considered taking the CRCE exam but had reservations? Watch for information coming out soon that may give you a special incentive to go ahead and get that done this November. Stay tuned for our latest Certification Incentive Program!

I'd like to remind you all that the Virginia Chapter of AAHAM has study manuals available for loan on a first come first serve basis. If interested, contact Leanna Marshall, CRCE-I at 434-293-8891 or 434-962-8508 for more information and to reserve your copy today. Leanna also provides free certification training programs for AAHAM members.

We have two more conferences scheduled for this year. They are the Fall Regional meeting in Warrenton Virginia on October 9th, and the Annual Meeting in Williamsburg Virginia from December 2nd thru 4th. Please visit our website at www.vaaaham.com and click on Calendar of Events to watch for agenda's and registration information.

Have a wonderful summer and I look forward to seeing everyone soon!

David

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

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2nd Place Winner for Excellence in Journalism

2014-2015 National Journal Award!

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ACA AT A GLANCE

Things to keep in mind as you explore the depths of the ACA are the *origins of the law*, *how it affects us today*, and *where it's headed tomorrow*

Staying abreast of the ACA requires constant vigilance and continuous learning, even as we celebrate the fifth anniversary of the law. Aspects of the law affect the past, present, and the future in ways that we already know, in news ways we're still learning, and in many ways we can't anticipate. Things to keep in mind as you explore the depths of the ACA are the origins of the law, how it affects us today, and where it's headed tomorrow.

The most immediate goals of the ACA were to increase accessibility to affordable health insurance options, and to control rapidly growing health care costs. To achieve these goals, the law employs a mixture of mandates, subsidies, tax credits, and penalties to increase coverage of the uninsured, spur health care innovation, and provide for new payment models to reward quality of care and improved health care outcomes. A secondary goal, and one that is now taking shape, is improving health care delivery through payment and delivery reforms.

Health Care, Then.

Between 2008 and 2013, the market was fraught with health care woes; national health spending increased from $2.2 trillion in 2007, to $2.4 trillion in 2008. By 2018, national health spending was expected to reach a whopping $4.4 trillion, and comprise just over one-fifth (20.3 percent) of the Gross Domestic Product (GDP). In addition to rising costs, the number of uninsured or underinsured Americans was also rising. On the cusp of the passage of the ACA, over 41 million people were still without coverage. These two factors drove one of the largest health care overhauls in history: the ACA.

Health Care, Now.

ACA passage was the first step towards increasing access to and coverage of millions the "un" and "under" insured Americans that contributed to the rapidly increasing costs of health coverage. A number of provisions in the ACA provide for increased availability of health insurance options:

- Insurers can no longer deny consumers coverage based on a pre-existing condition;
- Insurers can no longer charge women more for coverage;
- Children/young adults can remain on their parents' insurance until they're 26 years old;
- Most plans include free preventive services and comprehensive coverage guarantees; and
- Consumers can apply for Advance Premium Tax Credits (APTC) and Cost-Sharing Reduction (CSR) subsidies

Still, health care costs are rising. The national medical bill may be back to growing faster than GDP. After five years of historically slow growth, new data shows U.S. health care spending accelerated significantly in 2014. In fact, health spending increased by 5% last year, compared to 3.6% in 2013. If confirmed by the final tally, health care spending in 2014 would mark the biggest jump since before the recession.

One way to attempt to control these rising costs? Improving health care delivery. To continue to slow the growth of health care spending, the ACA provides for health care delivery provisions that mandate health care delivery reforms meant to simultaneously decrease health care costs, *and* increase quality of care.

As the range of benefits continues to increase, as well as the availability of access to care, there exists a renewed focus on more efficient, cost-effective, delivery of care. Looking forward, the drivers of these improvements include:

The Affordable Care Act: Past, Present, and Future

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Health Delivery & Payment Reforms to Control Cost

- Bundled Payments for Care Initiative
- Accountable Care Organizations (ACOs)
- Evidence-based practices
- Narrow networks
- Hospital Value-Based Purchasing Program (VBP

Better Care: Improving customer service and satisfaction by identifying and managing needs and expectations;

Healthy People/Healthy Communities: Improving the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care;

Affordable Care: Reducing the cost of quality health care for individuals, families, employers, and government by making processes more lean, efficient, and standardized, and by incorporating resource stewardship in all decision-making; and

Sharing Information: More effectively generate, capture, and transfer knowledge and improve internal and external communications.

Together, these drivers focus on "patient-centered care," an increasingly influential health care term that includes better care initiatives and affordable care initiatives. To ensure that newly insured individuals and their families are receiving the quality of care they deserve, at a price they can afford, requires focused attention on simultaneously improving quality processes and decreasing costs.

To affect this goal, many providers are focusing on payment reform and delivery reform, including reducing harm caused in the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Of note, delivery reforms will likely occur regardless of the successes of any of the payment reform initiatives; these are the drivers of patient-centered care, which will increase costs to providers if they do not successfully pilot and implement proper payment reforms.

Health Care, Looking Forward.

In addition to the payment and delivery reform vehicles, **three major issues will shape health care moving forward**

#1 Enrollment.

Enrollment numbers will have an enormous impact on how successful the ACA is in 2015 and beyond. Of the roughly 11 million people who enrolled in state or federal Marketplaces in 2015, about 4.2 million were auto-renewals or renewals, indicating that roughly half of all 2015 enrollees kept their 2014 Marketplace insurance plan.

Still, the Congressional Budget Office (CBO) estimated in April, 2014 that Marketplace enrollment would hit 15 million in 2015; significantly higher than the 11 million actually enrolled. These expectations were mitigated in November 2014, when HHS indicated that CBO's initial assumptions inflated the number of enrollees; the actual target being somewhere between 9.0 and 9.9 million enrollees, nearly 4 million less than the CBO projected.

February 2015 Open Enrollment Stats

- **11.4 million** were enrolled in Marketplace coverage
- **$268** was the average monthly tax credit
- **87%** Marketplace consumers qualified for tax credits
- **25%** increase in issuers competing for business in the 2015 Marketplace, as

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For small businesses, the enrollment numbers are a mystery, despite delaying implementation until November 15, 2014. SHOP coverage is available to employers with 50 or less full time equivalent (FTEs) employees, and will expand to cover employers with 100 or less FTEs in 2016. In exchange for signing up, employers qualify for tax credits that lower their share of employee premiums.

#2 Disappearing Subsidies?

Sworn in on January 6, 2015, the 114th Congress marked a drastic shift in the makeup of the legislative branch. For the first time since 2007, Republicans control both the House and the Senate during the last two years of the Obama Administration.

What does that mean for health care? Perhaps indicative is H.R.132 - Obamacare Repeal Act, introduced in the House the very day of their swearing in. The purpose? The law repeals ACA, effective as of their enactment, and restores provisions of law amended by the Act. Although it sounds ominous, the House has voted well over 50 times to repeal the bill, and it wasn't a surprise to anyone that it passed with flying colors in the House in early February of this year.

The main difference this year, as opposed to the past seven years and 50-something other attempts, is that the Republican Senate majority may decide to call up the bill, a move the Democrat-controlled Senate refused to do prior to the 2014 elections. While there is a slim possibility that the Senate will hear and pass the bill, Presidential veto is almost a certainty, meaning that a clean repeal is highly unlikely. Still, it marks a significant presence of lawmakers and constituents that want to repeal the law, and end the subsidies.

Perhaps more threatening is the health care case the Supreme Court of the United States (SCOTUS) heard in March. SCOTUS announced in December, 2014 that it will hear arguments in *King v. Burwell*, a case that turns on the interpretation of one of the most influential health care laws passed in the United States, the Patient Protection and Affordable Care Act (ACA).

Specifically, SCOTUS will decide whether the Internal Revenue Service may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the Patient Protection and Affordable Care Act.

King v. Burwell—what's on the line?

More than half of the individuals who purchased Marketplace coverage will lose their subsidies, resulting in a 43% hike in rates, and a 68% drop in enrollment.

This is a big deal...theoretically.
If the IRS final rule is invalidated, and tax credits are no longer available in the states that have (or had) federal exchanges, more than half of the 7.3 million people who purchased ACA-compliant insurance plans and received subsidies are no longer entitled to them.

Expectations are that those currently covered would drop coverage and avoid the tax penalty, leaving more uninsured and fewer individuals in the exchange which, in turn, could increase costs for those who retain coverage, resulting in significant increases in insurance rates.

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According a recent RAND study, premiums would increase as much as 43% and enrollment would drop as much as 68%, resulting in more than 11 million Americans losing their health coverage. Based on a Kaiser Foundation analysis of Congressional Budget Office estimates of Marketplace enrollment, 13 million Americans could be denied financial assistance to help pay insurance premiums for plans purchased in the Affordable Care Act's federally operated insurance exchanges in 2016.

It is possible that a decision from the Supreme Court would cause many states to create their own exchanges to protect their citizens. As many as 11 states - Arkansas, Delaware, Illinois, Iowa, Maine, Mississippi, New Hampshire, New Mexico, North Carolina, Pennsylvania, and Virginia – would set up their own exchanges if necessary.

Our prediction? The Supreme Court will uphold the IRS rule and find some creative solution to save the Accountable Care Act from itself and spare the Court from political attacks and reputational harm.

#3 New Models of Care and Associated Reimbursement Mechanisms.

As health care markets continue increasing the range of benefits available to consumers, access to efficient, cost-effective, quality delivery of care is becoming a priority. Ensuring that newly insured individuals and their families receive the quality of care they deserve, at a price they can afford, requires focused attention on simultaneously improving quality processes and decreasing costs.

The ACA lays a foundation for increasing the use of bundled payments to bridge the risk gap between fee-for-service (FFS) and capitation payment models. In January 2013, Centers for Medicaid and Medicare (CMS) announced the first participants in the Bundled Payment for Care Initiative (BPCI), which was designed to produce higher quality and more coordinated care at a lower cost, by transferring financial risk to providers and grouping facility and physician reimbursements into a single payment for an episode of care. The traditional FFS approach, by which providers and hospitals are individually reimbursed for their services, often results in fragmented care with minimal coordination across providers and health care settings. Ideally, with bundled payments, providers become responsible for validating the appropriateness of a payment, and must use proper financial accounting techniques to allocate each payment to a billed charge.

The shift away from FFS also encourages lower-cost services and the increasing use of telehealth. Looking ahead, telemedicine will most assuredly be a large part of the future of efficient health care management in America, evidenced in a report from Foley & Lardner, LLP:

- 9 out of 10 providers are moving forward with telemedicine projects, distance-based care programs, and 84% say that meaningful telehealth services will be central to the success of their organization;
- 64% already offer remote patient monitoring services;
- 54% already offer store and forward technology.
- 52% offer real-time interaction capabilities;
- 41% said they do not get reimbursed at all for telemedicine; and
- 21% claimed they get lower rates from managed care for telemedicine compared to in-person care

Despite underwhelming reimbursement rates for telemedicine, hospitals, physicians, and patients recognize the promise of using information technologies to provide clinical health care at a distance. It helps eliminate geographic barriers and can improve access to medical services that would often not be consistently available in rural communities.

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Closely tied to offering patient-focused medicine and convenient alternatives, are new incentive-based payments that require providers to report quality measures and costs to determine value-based, or high-quality, payments. ACA is shifting the national health-care system from one based on sickness and disease, to one focused on prevention and wellness. These FFS alternatives affect provider rate-setting and rate capture activities nationwide, and include value-based purchasing, bundled payments, Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMH), and incentive-based quality payments. Historically, reasonable charges relied heavily on external data pricing sources from CMS and commercial claims databases; now, more than billable charges, reimbursement requires quality and cost data.

Identifying and understanding these models within the scope of the ACA is daunting. New ventures and arrangements constantly evolve across the enterprise based on geographic regions and costs associated with delivering medical care, administering pharmaceuticals, and rendering supplies. In certain markets where value-based models are more prominent, FFS payments no longer suffice as the singular benchmark for determining market rate pricing comparisons.

Daunting Payment Reforms

Identifying and understanding payment and delivery models within the scope of the ACA is daunting. New ventures and arrangements constantly evolve across the health enterprises .

As the prevalence of bundled and packaged services continues to expand, it becomes even more important to ensure charge structures and charge capture activities are optimized. In a major paradigm shift for private sector providers, ACA is also using Population Health Management to drive reimbursement for Integrated Care Systems. Population Health Management has to do with the organization and management of the health care delivery system in a manner that makes it arguably more clinically effective, more cost effective, and safer.

For example, integrated care system reimbursement relies on rigorous population health management decision support, and private sector providers use population health management solutions to integrate patient data from disparate sources, using it for proactive application of strategies and interventions to defined groups of individuals, across the continuum of care, in an effort to improve the health of the of those individuals at the lowest necessary cost.

Conclusion.

As the Supreme Court stews over *King v. Burwell*, newly-elected governors will embrace policy and state-based market strategies for improving quality, and reducing the cost of health care using value-driven modes. The drivers of health care cost growth are complex and the effects multifaceted; no single driver is responsible for the nation's high and rising health care costs. Likewise, no single policy solution will adequately meet this challenge. Only by continuing to innovate and evolve, can we keep up with the fast-paced health care world post-ACA.

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About the Authors

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Endnotes

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Healthcare providers interested in cost savings and other benefits are converting to electronic payments at a steady clip. In 2014, the ACH Network moved more than 149 million healthcare Electronic Funds Transfers (EFTs), transferring about $876.6 billion in claim payments from health plans to providers. During the same period, it is estimated that the healthcare industry saved approximately $295 million by using the healthcare EFT standard and Electronic Remittance Advice (ERA).

But what if a provider has received an EFT payment with no corresponding ERA and doesn't recognize the sending organization? How is the sender determined? Unfortunately when a provider does not receive the associated ERA and cannot recognize the originator of the transaction, the provider must follow-up with the bank and the health plan—often with numerous phone calls.

Populating the Company Name Field of the CCD+Addenda

For the healthcare EFT standard CCD+Addenda, the *NACHA Operating Rules* require that "the Company Name field must contain the name of the Health Plan originating the CCD, or, where an organization is self-insured, the name of the organization's third-party administrator that is recognized by the Healthcare Provider and to which the Health Care Provider submits its claim."

Using the name of the clearinghouse or vendor instead of the health plan or third-party administrator does not comply with the requirements of the *NACHA Operating Rules*. If the originator of the healthcare EFT standard transactions is not populating the company name field in accordance with the *NACHA Operating Rules*, the provider's financial institution can file a Report of Possible Rules Violation through NACHA's National System of Fines.

The goal of the National System of Fines is to ensure compliance with the *NACHA Operating Rules* and to have all parties correct possible formatting errors. If corrections are not made and the originator is found to be in violation of the *NACHA Operating Rules,* fines can be levied against the Originating Depository Financial Institution (ODFI), which may then pass those charges along to the originator. Fines range from $1,000 to $500,000, depending on the classification and severity of the violation.

Determining the Payment Originator

In those instances when the company name field is not populated correctly and the name of the originator of the CCD+Addenda is unknown, some financial institutions recommend that providers contact NACHA directly for assistance. However, as the rulemaking body for the ACH Network, NACHA is not a payments processor and does not possess detailed information on individual payments. NACHA staff does not have access to any information that can identify the originator of the healthcare EFT transaction and will recommend that the providers contact their financial institution for assistance.

How to Identify Who Sent Your Healthcare EFT Payment

Here are some helpful tips for healthcare providers that need to work with their financial institution to identify the EFT originator:

- Contact your financial institution and give them the account number, the deposit date, and the amount of the transaction.
- Advise the bank that you need assistance in identifying the originator of the transaction.
- Ask the bank to contact the ODFI of the transaction.
- The bank will need to give the ODFI the ACH trace number of the transaction (which is different from the TRN Reassociation Trace Number) to receive the name of the originator and a contact phone number.

The 2013 CAQH U.S. Efficiency Index estimates that the healthcare industry can save $1.98 per claims payment using the healthcare EFT standard and ERA, thanks to the automated reconciliation of the payment with the ERA and the auto-posting of both the EFT and ERA.

It is important to both health plans and providers that the originator of the healthcare EFT is easily and correctly identified in the healthcare EFT standard format and that associated ERA or explanations of benefits are sent in a timely manner to eliminate the need for manual intervention and time-consuming follow-up.

Priscilla Holland, AAP, is Senior Director of Healthcare Payments at NACHA – The Electronic Payments Association

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Managing Risks in a Rising Interest Rate Environment

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Since late 2007, the Federal Reserve (Fed) has used aggressive measures to keep interest rates low, inflate asset prices and stimulate the economy. Even though the Great Recession officially ended in September 2009, these monetary policies effectively remain in place today. Recently, however, the narrative has shifted from "if" to "when and how aggressively" rates will rise. Nonprofit organizations with investible assets and long-term debt should view this as an opportunity to manage interest rate risk.

Interest Rates Should Rise . . . Eventually

Fed policy and world events have resulted in historic lows for both short-term and long-term interest rates over an extended period. The capital markets, with guidance from the Fed, are now anticipating a deliberate approach to raising the Fed Funds rate—beginning with an increase from the current level of 0% to 0.25%. Contemporaneously, there is an expectation for long-term rates to increase as well, reflecting an improving economy and mild inflation.

Many nonprofit organizations have embraced the ability to borrow during this time of low interest rates. Confronted with the likelihood that interest rates will be higher in the future, borrowers should review whether or not existing policies and procedures for managing interest rate risk are being followed. If guidelines are silent on the matter, a plan suitable for the organization's long-term goals and objectives should be swiftly adopted.

Asset-Liability Management

Asset-liability management is a critical component of financial risk management. Despite the relationship between these components of the balance sheet, organizations often manage assets and liabilities without any consideration of the other. A systematic approach of integrating debt and investment policies helps organizations avoid many adverse consequences (e.g., diminished access to capital, higher borrowing costs, or limited liquidity) that compromise the ability to fulfill its mission.

A sound investment policy expressly states objectives while taking into account an organization's overall obligations, including liquidity requirements and spending policy. The investment policy should implicitly align the mission, objectives and all policies of an organization while explicitly referring to any outstanding debt obligations. Ideally, the implicit portion would survive the natural turnover of committee and board members. However, any aspect of the investment policy related to debt should be revisited regularly and, if appropriate, revised to reflect any modifications in structure and terms.

Nonprofit organizations have access to capital from five sources. Internal sources include operations (free cash flow after debt service), monetization of assets, and existing cash and investments. External sources include benefactors and debt. Debt provides the most immediate access to significant sums. As such, nonprofits must establish, maintain and protect a strong credit profile.

Managing Risks in a Rising Interest Rate Environment *Continued on next page*

Nonprofit organizations have access to capital from five sources. Internal sources include operations (free cash flow after debt service), monetization of assets, and existing cash and investments. External sources include benefactors and debt. Debt provides the most immediate access to significant sums. As such, nonprofits must establish, maintain and protect a strong credit profile.

A debt policy sets forth guidelines an organization uses to govern the amount and types of debt to which it will become obligated. Effective implementation considers industry standards and market dynamics as well as the actions necessary to realize the dual objectives of low cost and maximum flexibility. Factors should include: impact on credit rating, overall capital planning, affordability, borrowing capacity, use of cash, length of debt, type of structure, variable rate exposure, use of derivatives, refinancing, credit enhancement, method of sale and investment of proceeds.

A well-conceived asset-liability management plan provides guidance in any rate environment. Unfortunately, it is often disregarded when interest rates are low and credit is widely available. Furthermore, operational discipline fades with reduced borrowing costs and healthy investment gains, putting greater reliance on access to cheap capital.

Interest Rate Risk Management Strategies

Comprehensive debt policies inherently contain guidance (e.g., affordability, capacity, term, structure) for managing interest rate risk. Furthermore, rating agencies and the capital markets provide additional advice (e.g., net variable rate exposure should not exceed 25% of all outstanding debt). The following are some of the more common mitigation techniques:

Long-Term, Fixed-Rate Financing

Probably the most traditional method utilized by nonprofit organizations is the issuance of fixed rate bonds. However, while this method fixes borrowing costs, it also "locks in" a borrower's credit profile. Thus, if the credit profile subsequently improves, significant costs would be incurred should the borrower want to restructure its debt to realize a lower rate.

Some programs, such as those administered by the U.S. Department of Housing and Urban Development (HUD), do not have risk adjusted pricing. Thus, if a borrower qualifies, there is a strong incentive to pursue this financing option. HUD happens to be a very attractive alternative for those organizations seeking nonrecourse, low-cost, fixed rate permanent debt without financial covenants—*especially when there is consensus that interest rates will rise*.

Another consideration for longer term debt is the challenge of realizing low-risk interest rate arbitrage. Historically, nonprofit organizations had an opportunity to achieve tax-free investment returns in excess of borrowing costs. Match funding at the short

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Another consideration for longer term debt is the challenge of realizing low-risk interest rate arbitrage. Historically, nonprofit organizations had an opportunity to achieve tax-free investment returns in excess of borrowing costs. Match funding at the short end of the yield curve usually offers the best opportunity for arbitrage. Seeking investment returns in excess of borrowing costs at the long end of the yield curve should be addressed in the investment policy as match funding is generally not feasible and potentially exposes the organization to greater risk.

Mid-Term (Five-, Seven-, and 10-Year) "Fixed" Rate Debt

Mid-term debt is a common funding structure wherein bonds are directly purchased by a commercial bank. However, it should be noted the debt is not as much fixed as it is subject to reset in the future. As such, borrowers are exposed to renewal risk in the form of both interest rate (overall market rates) and credit (a weaker financial profile or less appetite in the market for its sector). This option should be viewed relative to the overall economic cycle, rate expectations and existing credit profile.

Variable Rate Debt with a Fixed Payor Swap

This is another method of funding wherein debt, which is reset weekly or monthly, is directly placed with a commercial bank. The borrower manages its variable rate exposure through a swap agreement by exchanging obligations with a counterparty that accepts variable rate risk while the borrower makes a fixed payment for the term of the contract (Figure 1).

Swaps are generally for the same term as mid-term "fixed" rate debt. As such, borrowers have the same renewal risks listed above. Furthermore, borrowers are often frustrated when interest rates do not rise after executing a swap. This perception of having paid more than was necessary characterizes the risk mitigation effort as a trade. As such, borrowers are encouraged to document the reason for entering into such a structure (e.g., following asset-liability management plan) in order to reduce the effect of buyer's remorse.

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Variable Rate Debt Naturally Hedged

Naturally hedging variable rate debt means match funding investible assets with the debt. Historically, nonprofit borrowers could rely on this strategy to mitigate interest rate risk and even present an opportunity to realize interest rate arbitrage. That is, the nonprofit organization borrows at tax-exempt rates while investing at higher taxable rates. The debt is "naturally" hedged. Counterintuitively, higher borrowing costs (i.e., increase in short-term rates) creates opportunities for greater investment returns. With taxable rates near zero—as is the present case—there is no interest rate arbitrage opportunity.

Variable Rate Debt Unhedged ("Buy Term, Invest the Difference")

Some nonprofit organizations are comfortable budgeting the cost of debt at a certain level (e.g., 6%). Such borrowers will issue variable rate debt and set aside the difference. If handled with appropriate discipline (i.e., not appropriated for other purposes), these funds can be used to cover the cost of debt when it exceeds the budgeted rate.

Interest rate risk management strategies offer protection from capital market volatility. Properly structured to reflect an organization's goals and objectives, techniques can help moderate any negative impact from rising interest rates. Furthermore, because of the difficulty in predicting the direction of interest rates, nonprofit boards should avoid evaluating strategies in isolation and measure effectiveness relative to the entire organization, especially as it relates to facts and circumstances present at the time a decision was made.

The possibility of rising interest rates should remind nonprofit organizations to review policies and procedures used to manage assets and liabilities. Implementing interest rate risk management strategies that effectively integrate debt and investments should enhance financial viability as well as ensure long-term stability. Additionally, this is also a time to review operational efficiency and address any excesses that are sustainable only with cheap debt and investment returns. The Fed has made its intentions known and the opportunity is now for nonprofit organizations to strategically plan for success in a rising rate environment.

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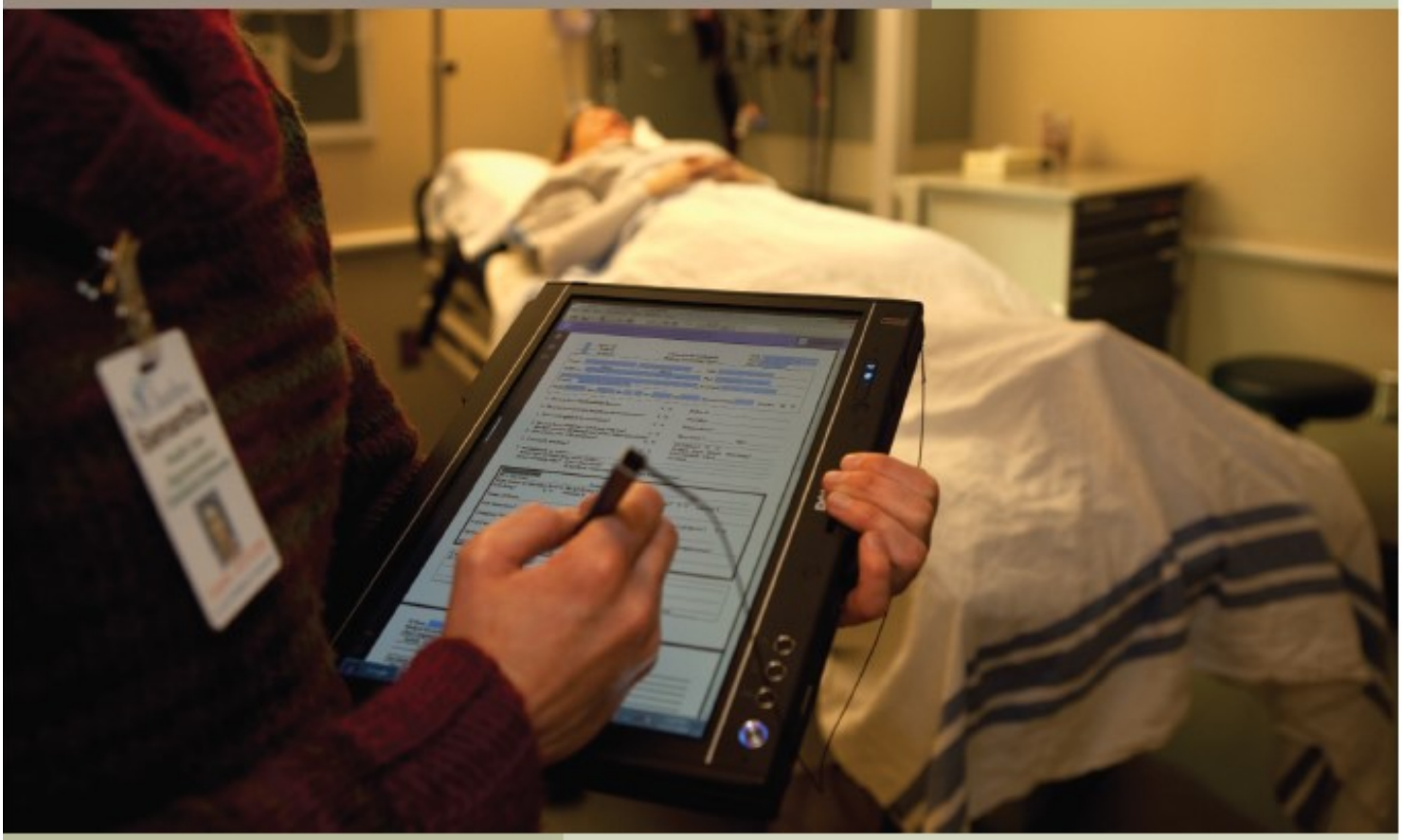

We see
proven paths
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and enrollment.

Chamberlin Edmonds® eligibility and enrollment track record is the most productive in the nation. Our custom-tailored services examine the widest spectrum of uninsured and underinsured patients, including inpatient, outpatient and emergency department cases. The advanced technology of our web-based system is built on the unique experience and expertise of the most qualified professionals in the industry – our people. By gathering and analyzing information faster and more accurately, we are even more patient-centric and more effective in securing reimbursement for the hospitals Chamberlin Edmonds serves. For more information, contact Robert Meyer at 800.255.0953, ext. 5108.

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Supplemental Security Income - SSI | State Disability | Charity Care | Crime Victims Assistance

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RYCAN

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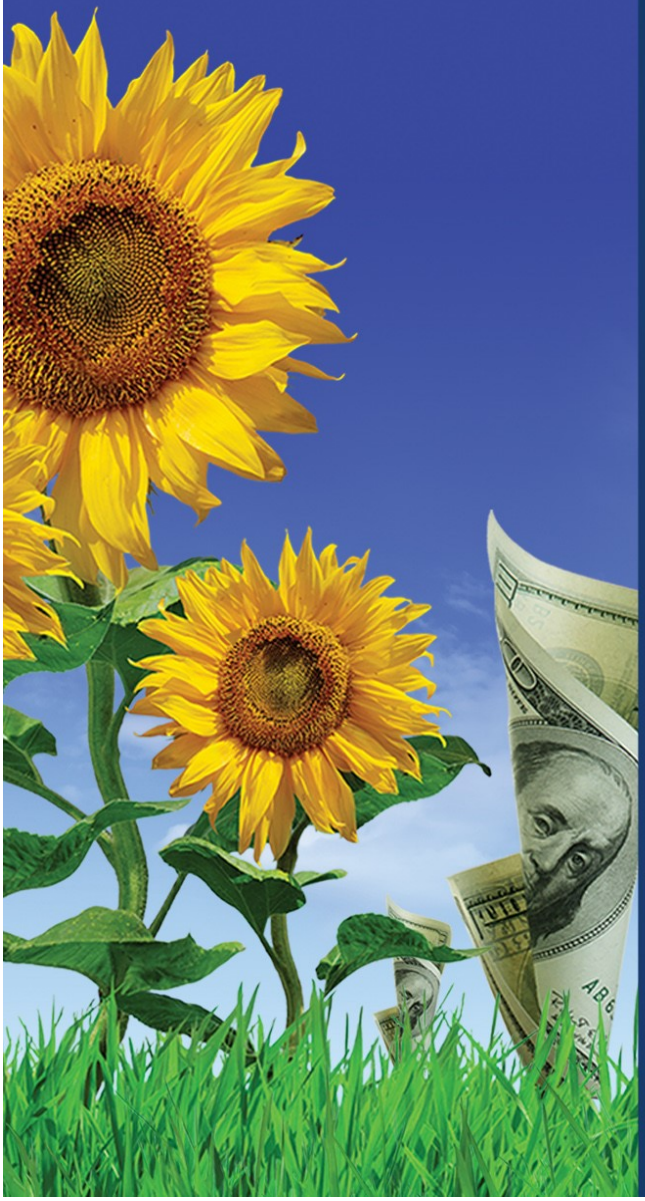

Revenue Cycle Solutions

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- Claim Submission
- ERA Retrieval Services
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- Denial Management
- Audit Management
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www.rycan.com 800.201.3324

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.

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

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Charlottesville, VA 22902

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

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

Newly Certified…

First Name	Last Name	Certification	Facility
Jill	Booth	CRCS-P	Augusta Health
Natalie	Campbell	CRCS-I	UVA Medical Center
Maria	Campos	CRCS-I	Inova Health Systems
Betty	Collier	CRCS-I	Mary Washington Healthcare
Jennifer	Dennis	CRCS-I	Mary Washington Hospital
Tina	Grim	CRCS-I	Mary Washington Healthcare
Jessica	Hitt	CRCS-I	Augusta Health
Connie	Layne	CRCS-I	Centra Health
Sherry	Lewton	CRCS-I	Medicorp
Patricia	Litchford	CRCS-P	Centra Health
Migzailie	Mendez	CRCS-I	Inova Health Systems
Vanessa	Miller	CRCS-I	UVA Medical Center
Deborah	Mitchell	CRCS-P	Augusta Health
Amanda	Salik	CRCS-I	Mary Washington Healthcare
Amy	Schuler	CRCS-I	Mary Washinton Healthcare
Olivia	Solomon	CRCS-I	UVA Medical Center
Wendy	Tanner	CRCS-I	Centra Health
Christine	Taylor	CRCS-P	University of Virginia Health System
Debra	Troutman	CRCS-I	Centra Health
Melissa	Worley	CRCS-I	Centra Health
Silvia	Zamudio	CRCS-I	Inova Health Systems
Terry	Zatrepalek	CRCS-I	Centra Health
Donna	Darconte	CRCP-I	Fauquier
Belinda	Schultz	CRCP-I	Fauquier
Lisa	Tantillo	CRCP-I	Fauquier
Charlotte	Brooks	CRIP	Carilion Clinic

Congratulations!
We are proud of you!!

Certification

2015 Certification Schedule

June 1, 2015 - Registration deadline for August 2015 Exams
August 10□21, 2015 - Exam period
September 1, 2015 - Registration deadline for November 2015 Exams
November 9□20, 2015 - Exam period
December 1, 2015 --Registration deadline for February 2016 Exams

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

2014 Membership Application

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

Take advantage of these important benefits…

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

Please enter your information below.

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

MEMBERSHIP RECOMMENDED BY: _____

For additional information contact Chris Fisher @ 540-332-5030 or via email at: cfisher@augustahealth.com

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

Treasurer, Virginia AAHAM
Dushantha Chelliah
2212 Greenbrier Dr
Charlottesville VA 22901

-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

Medical Claim Insurance Recovery

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9821 Katy Freeway, Suite 850
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C. 713.252.4876 F. 713.470.7243

The Virginia Chapter of AAHAM Executive Board 2014-2015

Chairman of the Board

(Chapter of Excellence Committee)

Linda McLaughlin, CRCE-I

Director, Director Finance and Governmental Services

VCU Health System

PO Box 980227, Richmond, VA 23298-027

Office—(804)828-6315 Fax—(804)828-6872

President

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

David Nicholas, CRCE-I

Director of Operations RMC, Inc.

Office - (703)321-8633 Fax- (703)321-8765

Email— **David.Nicholas@RMCcollects.com**

First Vice President

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

Chris Fisher, CRCE-I

Patient Access Coordinator

Augusta Health

PO Box 1000, Fishersville, VA 22939

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Amanda Sturgeon, CRCE-I

Director of Payer Relations

500 Hospital Dr., Warrenton, VA 20186

Office phone—(540)316-4313 Email—sturgeona@fauquierhealth.org

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

PO Box 1000, Fishersville, VA 2293

The Virginia Chapter of AAHAM Executive Board 2014-2015

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Dushantha Chelliah

2212 Greenbrier Dr.

Charlottesville, VA, 22901

Office - (434)924-9266

Appointed Board Member

(Committee Chairperson: Finance Committee; Constitution & By-Laws Committee; Historical Committee)

Brenda Chambers, CRCE-I, CCAM

Revenue Integrity

HCA - RSSC Capital Division

7300 Beaufont Springs Drive; Boulders VIII – 2nd Floor;

Richmond, VA 23225

Office—(804)267-5790 Fax—(804)267-5791

Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall. CRCE-I

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Honorary Board Member

Michael Worley, CRCE-I

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

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

Appointed Board Member

(Committee Chairperson: Communications Chair)

Katie Creef, CRCE-I

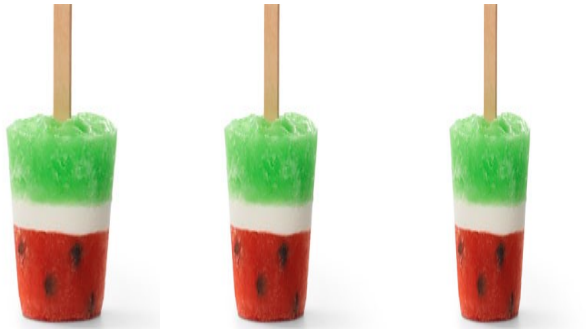
Director of Patient Accounting

Augusta Health

P.O. Box 1000

Fishersville, VA. 22939

On the Lighter Side...by Sara Quick



Watermelon Pops

1 cup sugar, divided

1 3oz pkg lime Jell-O

2 cups boiling water

Ice cubes

1 cup cold water, divided

1 3oz pkg strawberry Jell-O

3 tbsp. semi-sweet choc. chips

4oz cream cheese, softened

1 ½ cups thawed cool whip

- **Prepare lime Jell-O according to directions. Refrigerate 25min. Prepare strawberry Jell-O & omit the refrigeration step. Pour into 16 (3oz) paper cups. Freeze 20min, then stir in ½ tsp chocolate chips in each cup.**
- **Beat cream cheese & remaining sugar mixture until blended. Stir in Cool Whip & spread over Jell-O cups.**
- **Pour lime Jell-O over cream cheese mixture. Insert wooden popsicle stick in the center of each cup. Freeze 3hrs or until firm. Remove pops from cups before serving.**

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.

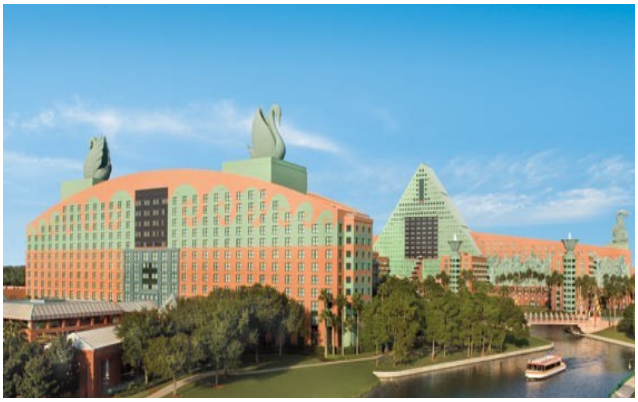
Calendar of Events:

2015 Annual National Institute

Walt Disney World Swan and Dolphin - http://www.swandolphin.com/

Orlando, Florida

October 14-16, 2015



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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Platinum Sponsorship - $1,500

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Free Registration at <u>BOTH</u> the May & December educational conference for four (4) sponsor employees**
- **Plus much more...**

Gold Sponsorship - $1,200

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Plus much more...**

Silver Sponsorship - $1,000

- **Exhibit space available at <u>EITHER</u> the May <u>OR</u> December Conference**
- **Half-page ad in ALL newsletters**
- **Half-page ad distributed at <u>BOTH</u> meetings**

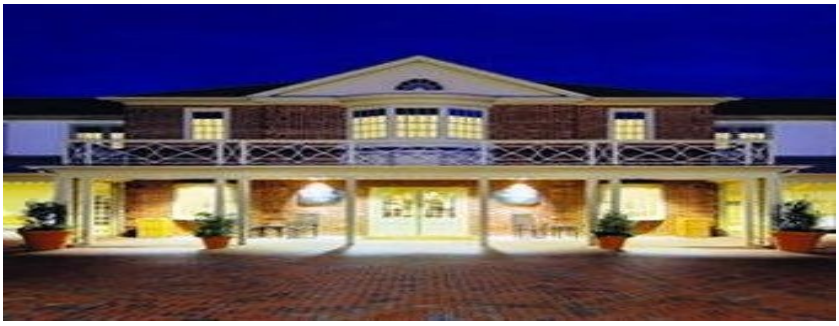
The Virginia Chapter of the American Association of Healthcare Management (VA AAHAM) exists to provide or facilitate professional education, promote professional excellence, provide opportunities for sharing management strategies and tactics through professional networking. You and your organization 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 also benefits from the financial support that many organizations provide. I hope that you will consider supporting Virginia AAHAM this year.

—***Saurabh Sharma, Vendor Sponsorship / Corporate Partners Chair***

Mark your calendars!

Upcoming VA AAHAM events:

- **October 9, 2015: Fall Regional Meeting Faquier Hospital Warrenton, VA.**
- **December 2-4, 2015: Annual Meeting and Conference, Williamsburg, VA.**



Go to our web site for more information and registration:

www.vaaaham.com

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

To: All Virginia Chapter of AAHAM Members:

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 2014. 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

squick@augustahealth.com

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.