The Virginia AAHAM Insider

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

Winter 2013 Volume 29 Issue 1

The President's Message

Hello Fellow Virginia Chapter of AAHAM Members:

The Virginia Chapter of AAHAM is proudly putting to bed another amazing year of leading and learning. Our 31st for those who are keeping track. Hopefully, you didn't miss any of it, especially our Annual Meeting and Conference at the Williamsburg Lodge. It was a highly successful event and it capped off a year of education saturated with the implementation of new government regulations and new revenue cycle strategies.

The Chapter Board and Committee Members have worked tirelessly to bring subject matter experts to the podium to discuss ICD-10, 501(R), Medicare and Medicaid rules and reimbursement changes, and, of course, the Affordable Care Act. Our work is not done. Not even close, In fact, as busy as 2013 was, 2014 looks to be even busier. The new Board and Committee Members have a lot to plan in 2014 to meet our commitment of providing meaningful and high quality education to our members.

We're kicking it off in March with our Spring Conference in Charlottesville. After that, we're planning a joint payer summit with HFMA in April in Richmond. October always brings us back to Warrenton for a full day of information and then back to Williamsburg for our Annual Meeting. In between, we'll be offering plenty of learning opportunities, including our highly rated and widely sought after Back-to-Basics classes. In short, we're gearing up for another very busy year and we look forward to sharing it all with our members. Please keep an eye on what's coming by visiting our website at www.vaaaham.com. And, as always, if you want to get involved in chapter leadership, please consider joining a committee.

Respectfully,

Jack Pustilnik

2nd Vice President

INSIDE THIS ISSUE:

The Virginia AAHAM Insider

2nd Place Winner for Excellence in Journalism

2012-2013 National Journal Award!

The Future of Managed Care Contracting—How do You Measure a Winner—Part 2

As we stated in Part One of this article, the Managed Care environment is changing. In fact, we think, the entire healthcare service environment is shifting and we, as providers, need to recognize this evolving environment from both a clinical and financial standpoint. Part one talked about the history of healthcare services and the development of various reimbursement methodologies. This history of clinical services is actually an expansion of data collection and data elements that better defined the patient's condition and the treatment(s) that better diagnosed the patient's condition and monitored the patient's outcome. This history of data collection and better definitions of services rendered is best reflected by the expansion of Current Procedural Terminology (CPT) codes; Health Care Procedural Coding System (HCPCS); and the International Classification of Diseases (ICD-9) over the last twenty (20) years. Our documentation standards have improved significantly and with it so has the ability of various actuarial and financial minds to create several (new) reimbursement methodologies. We talked about many of these methodologies in Part One so we will not repeat ourselves here except to make the specific, focused point that "data" fundamentally changed reimbursement methodologies and will continue to do so.

From our professional history with Best Practice Associates and Altarum Institute, we want to make sure that you maintain (or develop) a winning position in the managed care world of contracting so we need to make some critical points here before moving on to the new managed care methodologies.

1. With the coming of ICD-10 CM/PCS in October 2014, there will be a new diagnostic coding system (moving from approximately 30,000 codes to over 180,000 codes) that will clearly be more specific in diagnostic assignment, comorbid conditions and complications occurring during or after a procedure.
2. With the implementation of Diagnostic Related Groups (DRGs) in 1983 and the initial weights assigned to each DRG, it took three years of improved (more specific) documentation for better ICD-9 coding assignment resulting in different weights for reimbursement purposes.
3. Under ICD-10 CM/PCS, documentation must again improve to accurately assign the code. This will lead to the reality of a different case mix for each hospital; and the reality of another three years of better coding assignment resulting in different weights for reimbursement purposes.
4. The current crosswalk from ICD-9 to ICD-10 indicates a varying percentage of ***ONE*** to ***MANY*** code assignment changes. However, the crosswalk from "the many" ICD-10 codes relates back to one ICD-9 code.
5. Managed care companies who want to accept your ICD-10 codes and translate them back to ICD-9 codes for payment are, therefore, potentially underpaying you for that DRG if your more specific ICD-10 codes could indicate a change in the DRG.
6. The fact of the matter is that EVERYONE – government, managed care companies, hospitals, physician practices, research centers, post-acute care services, etc. – are all starting out at the same place…no historical data.

Therefore, it is our belief that since everyone is starting out with no baseline ICD-10 data; we are all on the same playing field when it comes to managed care contracting. No one can project what YOUR data will be going into the ICD-10 environment so we should be able to take some initiative in negotiating new managed care contracts. Incidentally, 'evergreen' contracts should be terminated now and new contracts, no longer than 3 years (due to the maturing of DRG weights), should be entered into with annual data reviews.

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The Future of Managed Care Contracting—How do You Measure a Winner—Part 2

Now that we have stated some basic information in considering the managed care contracting process, we would like to present some considerations regarding managed care contracting moving forward into the ICD-10 environment. Please remember two key points: 1. We are all starting out at the same place; and 2. You can make the decision on who will be the 'winner'. With this in mind, we present several ideas regarding the following reimbursement methodologies:

Medical Decision-making Model (Value-based Benefit Design)
Capitation Model
Quality Measures and Payment Model
Bundling Model
Patient-Centered Medical Home Model
Physician-Team Model

In considering any "model", any good business puts together a strategy in which to conduct their discussions with each contractor. To do this appropriately, one should utilize the following considerations:

1. Gather competitive pricing from all sources possible (local, regional and national for comparison)
2. Use market research to understand trade-offs consumers are willing to make between price, convenience (i.e., location) and quality of service
3. Assess the value to you of a loss leader
4. Calculate customer value profile to include transaction and future projections
5. Scrutinize cost reports for accuracy
6. Inventory your "soft selection" factors
7. "Sell" the organization's pricing strategies to physicians and staff
8. Identify and follow enterprise metrics, and
9. Set your market position

Medical Decision-Making Model (Value-Based Benefit Design): In thinking through this model, there is much consideration regarding the high volume or low volume utilization of specific services. After you have performed the tasks associated with building a pricing strategy, you then need to focus on two major factors. One – does the utilization of specific services in our facility, network, practice, etc. , reflect any semblance to a "Center of Excellence" profile; and, Two - are there other related 'entry' services (of lower value) that you are willing to give away in order to capture the Center of Excellence market. With the specificity of ICD-10, one can better define the profile of this type of patient and thus focus a marketing strategy. In any discussions with third party payors, the quality treatment of their members should be of utmost concern and in this Value-Based Benefit Design model, there would be very clear, documented protocols for specific Center of Excellence services that would demand a different (higher) reimbursement factor. These protocols could definitely involve 'quality measures' that must be met by the facility, practice, etc. within the Center of Excellence services. This measurement would therefore demand a higher reimbursement factor than services not having these measurement criteria. We know that there are quality measures out in the healthcare environment today and some of these could be used in the protocol. Other measures can be developed to be more specific to a Center of Excellence protocol such as decreased cost of medications; earlier (and appropriate) discharge than the average length of stay; therapy improvements one day earlier than standard; etc. With these specific quality measures, one could ask for a 10% increase in the standard reimbursement factor and/or ask for the same or higher percent increase by incorporating one or two lower value entry services into the protocol. This Center of Excellence approach can be offered to the payor as an excellent marketing strategy to assist in expanding their market share.

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The Future of Managed Care Contracting—How do You Measure a Winner—Part 2

Capitation: Most of us probably remember the days of capitation and, by now, we may have learned some lessons from that undertaking. In the near future, under ICD-10 CM, a new approach to this model may be considered. With this more specific diagnostic information, one could better define the type of patient that could be profitable in a Capitation reimbursement model. For example, there may be better avenues for patients with multi-conditions to be seen by specialists under a capitated plan and not just primary care physicians. In one's multi-database, can a series of patients with similar multi-conditions be treated in a quality manner with better outcomes and less admissions? We speak of multi-condition patients such as:

- Diabetics with ophthalmology problems
- Arthritic patients with obesity problems
- Orthopedic patients with migraines
- And others that you can think about…

These patients could see an Ophthalmologist for their vision problems and also receive monitoring for their diabetes. Similar care can be provided for the other two examples. All of these cases could be monitored with quality outcomes through a capitation plan with a physician Group Practice. A Capitated Model for multi-specialty groups could work efficiently and also provide high quality services to the managed care members. Certainly this approach should be taken into account when studying all reimbursement models.

Quality Measures and Payment Models: This model is similar to the first model presented – and is essentially a Medical Decision-Making Model - except for the fact that the first model focuses on the development of a Center of Excellence while this model is based on all of the services offered by the hospital. This model works with a managed care company to incorporate quality measures in as many rate structures and protocols as possible. Quality measures have been developed and accepted in our industry over the past few years. Some organizations have already incorporated quality measures into managed care contracts already. This approach allows for the hospital and the managed care network to work together and apply these published measures to a reimbursement structure so that these hospitals receive the bonus when the measurement is met or surpassed. The attractive aspect about this model is that it is already in existence in many contracts and with the focus on quality it operates similar to a shared-risk contract. The risk to the hospital is that of maintaining and surpassing the contracted quality measures for reimbursement purposes and the risk on the managed care company is for a higher layout of payments, above their projected budget.

Bundled Payment Models: Although there has been a lot of discussion around bundled payments, this model has been around for years in the form of Diagnostic Related Groups (DRGs), Ambulatory Patient Groups (APGs), and Ambulatory Patient Classifications (APCs). Yes, DRGs are actually bundled payments for inpatient care and APGs and APCs are bundled payments for certain outpatient services. With these serving as a base line built on years of data to support your position, a hospital with a history of post-acute care services could approach a managed care company and talk about bundled reimbursement rate for a specific clinical condition episode for both the hospital stay and a post-acute period of time (e.g., 90 days). Historical data is the key for success in this model. The more we know about a patients' post-acute experience, the better negotiating you can do with the managed care company. Knowing the cost of quality care for an episodic experience (e.g. post-surgical rehab) and offering a bundled package (with a fair profit) is the key to this model. In the same light, one could bundle just the post-acute experience for a specific patient condition and still remain profitable. Rather than a per diem approach, this bundled approach puts the risk on the facility and not on the managed care company – something the payer might be willing to entertain. Therefore it is imperative that careful modeling be conducted prior to presenting this type of scenario to leadership.

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The Future of Managed Care Contracting—How do You Measure a Winner—Part 2

Other forms of bundled payments could involve physician's reimbursement. This model is difficult (but possible) to accomplish in dealing with the physician community. This model works best with stacks of historical data, especially by specialty. Physicians strive for evidence-based decision making, making this approach appealing if you can reach concurrence on the normative amount of time and a realistic physician expectation of reimbursement. Once in agreement, a bundled plan could be presented to a managed care company. As noted with the other bundled reimbursement methodologies, the risk is truly on the hospital and provider and not on the managed care company. If an agreed upon bundled plan for a specific surgical or medical protocol could have a mutual risk clause such that if the bundled episodic plan is shown to only produce negative numbers after nine months, the cancellation of such a plan would be immediate with no penalty and a new unbundled plan would go into effect, there would be more of an opportunity to utilize this model.

Patient-Centered Medical Home Model: This is a somewhat new model based on the exchange of medical information among various facilities and physician practices. As a definition, "the patient-centered medical home is a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety." [American College of Physicians]. Also, according to the American College of Physicians, the most effective way to realign payment incentives to support the PCMH model involves incorporating three different components:

1. A "bundled" monthly care coordination payment for medical professional work occurring outside of face-to-face patient visits;
2. A visit-based fee-for-service component; and
3. A performance-based component to reward the provision of efficient, high-quality services.

Although the idea of patient-centered medical home is new to the market, it has the potential to function as a cost-reduction and cost-effective approach to quality. If this concept is realized we project additional reimbursement methodologies will be developed around this model as it becomes more prevalent in the market.

Physician-Team Model (from the American Medical Association): This is a brand new model that was presented at the most recent AMA conference. It is a consideration of a bundled payment for a team of physicians (Hospitalist, Surgeon, and Anesthesiologist) in a specific patient care setting. Although this approach is in the "think-tank" stage right now, it could be a workable reimbursement model with certain clinical condition episodes. If one has the ability to gather data from the various specialties mentioned here or others in a surgical setting, one should begin the analysis of the current distinct reimbursement constructs and conduct some model testing to discuss the results as a viable option for a more profitable approach to quality service.

So…where does a winner go from here? If this is your area of responsibility or an area that intrigues you, the way to start is to conduct a profitability analysis by your top three to five payors. Next perform an ICD-10 financial analysis for both inpatient and outpatient. With these comparatives, choose one payor and begin modelling for a new contract (service by service, if needed). Adjust profit levels with each modelling approach. With all of this data and analysis, draft a White Paper, explaining your process, data sets, methodology and application, as well as the risk approaches to acceptability and profitability. Utilize the most appropriate models as described in this article. If it all makes sense, make a presentation to your leadership and fully discuss the value-added design that comes from thinking-out-of-the-box. We refer to the term "winning" as it relates to achieving success in an effort or venture. As such, this is truly a time for winners to step up to the plate and work in a positive and constructive manner with managed care companies in building the new reimbursement future of healthcare.

After internal discussion and recent client experiences, WATCH FOR PART THREE. In part three, we will present data-driven experiences that may help you both now and in the future.

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Cashing in on Revenue Cycle Improvements

There is nothing more important to potential creditors than a borrower's liquidity position. With all of the uncertainty in the health care industry—and the economy today for that matter—there is no substitute for the margin of safety and flexibility that cash provides.

Most health care providers recognize the importance of liquidity and treat the cash on their balance sheet as sacred. But defending the balance sheet is only part of the battle. Surprisingly, many managers fail to take the necessary steps to increase their liquidity position.

Of course, there are myriad factors that can undermine a hospital's efforts to generate cash flow from operations: payor reimbursement, economic conditions, competitive landscape, cost and supply of labor, demographics of the market, etc. While it is true that hospital management has little to no control over these factors, there are other areas where it could have an equal—if not greater—impact to the credit profile.

In particular, managing the payment cycle can help cash flow, but it also serves as a signal to potential creditors. Having a consistent focus on improving these measures demonstrates to creditors that management is competent and attentive to issues that it can affect. Conversely, large fluctuations in bad debt expense and/or days in accounts receivable or a large percentage of "old" receivables causes a financial analyst to question the competency of management and the integrity of the historical income statements.

Challenges to Increasing Liquidity

The Affordable Care Act introduces additional uncertainty into an already murky revenue picture for health care providers throughout the country. Who is covered by insurance and how much will the insured be required to self-fund will likely remain uncertain for some time. Although state budgets have improved somewhat, uncertainty remains in state Medicaid reimbursement programs. The integration of technology, such as electronic health records, holds great long-term promise, but short-run costs, shifting requirements and implementation challenges make planning difficult. Most creditors will expect a competent management team to have a plan, which is robust enough to provide flexibility with each of the above factors; however, banks and other creditors also recognize that these issues are challenges and any plan to address them will be fraught with uncertainty.

Given the uncertainty of supply/demand, pricing and expenses, it is imperative that providers improve cash flow through factors that are within their control. Indeed, it is more important than ever that management develop a "fortress balance sheet," to borrow a term often used in the banking industry.

One clear indication of the importance of liquidity is the view of the rating agencies. The measures: cash to debt and days cash on hand have the clearest correlation to hospital ratings of all the metrics shown in the Standard and Poor's industry medians. Obviously, increasing revenue and cutting expenses are two ways of increasing cash, but options for affecting the profit and loss statement are usually limited. One can do nothing about the supply/demand balance and there is little to be done about reimbursement rates. Cutting expenses is always good, but by far the largest expense—personnel costs—is the hardest and most painful to cut. Other sources of revenue—investment income, contributions, government allocations, etc.—are usually dependent on external factors, which defy management intervention. *Continued on next page*

Cashing in on Revenue Cycle Improvements—continued from previous page

Uncovering Cash Trapped in Working Capital

Given the lack of options for intervention on the revenue side and the challenges for affecting change on the expense side, one might feel as though balance sheet improvement is not possible. This view fails to recognize that there might be significant cash tied up in working capital and this is an area where management can exert influence. In fact, decreasing just five days in the payment cycle can have huge impact on company's balance sheet.

Effect of Reducing AR by Five Days

	Before	After
Cash	$ 91,529	$ 95,542
AR	$ 40,137	$ 36,123
Other Current Assets	$ 10,000	$ 10,000
Total Current Assets	$141,666	$141,666
Total Current Liabilities	$ 95,000	$ 95,000
Debt	$ 110,276	$110,276
Patient Revenue	$293,000	$293,000
Total Operating Revenue	$305,000	$305,000
Operating Expenses	$298,900	$298,900
Depreciation	$ 33,550	$ 33,550
Current Ratio	149.0%	149.0%
Days Cash on Hand	125.9	131.4
Days AR	50	45
Cash/Debt	83.0%	86.6%

The example may appear trivial, but five days of accounts receivable (AR) represents more than $4 million in this case. Many health care providers can achieve changes of this magnitude in 6 months to one year, with proper attention and a focus on gradual improvements. Representatives of Community Hospital Corporation, a company that provides consulting and management services to rural and community hospitals, noted that even more extreme examples exist. In one case, a hospital was showing more than 30 days of "unbilled" accounts, resulting in serious cash flow shortfalls. The example in the table also points out the increased margin of safety from turning over accounts receivable. If an emergency occurred, this organization would not have excess cash to cover its obligations; likely, it would have to sell assets, factor receivables or execute some other compromise. This demonstrates the danger of looking at working capital as a measure of short-term liquidity strength. Reducing its days in accounts receivable by 10% effectively creates an emergency fund of more than $4 million. Furthermore, an increase in accounts receivable balances often signals to an analyst a number of problems: revenue may have been overstated, bad debt may have been understated, management is unable or unwilling to effectively deal with its payers, processes and procedures are not adequate to process claims and a host of other deficiencies that relate to management effectiveness.

The process of filing and collecting claims is lengthy even in the best of circumstances, but oftentimes hospitals focus solely on the tail end of the process (i.e., collections). Clearly, collecting for services rendered is vital, but there are a number of steps prior to collections, which provide an opportunity to eliminate waste. This is an area where hospitals can learn from process improvement techniques used in other industries.

Process Improvement

Using Toyota Production System's or other lean manufacturing methodology, providers can focus on eliminating waste and making the process more efficient. As with any process, there is an opportunity to eliminate waste at every stage and there are many different kinds of waste: transportation, inventory, motion, waiting, overprocessing, overproduction, defects, resources and talent. All of which can contribute to time in the process.

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Cashing in on Revenue Cycle Improvements—continued from previous page

One key point that the most effective providers emphasize is precertification on the front end. Obtaining authorization before a patient even arrives is a key to eliminating waste later in the process. The idea is that taking extra time and devoting resources before the patient arrives eliminates the need to hassle patients or negotiate with insurers later in the process and more importantly, upfront authorization greatly reduces bad debt due to misunderstanding over coverage or inability to pay. Precertifcation also provides an opportunity to improve patient satisfaction. By clearly articulating the patient's financial responsibility before a procedure, indeed before the patient arrives, the hospital avoids promoting sticker shock and limits difficult conversations when a patient does not have the capacity to pay. Failure to precertify procedures tends to create waste of overproduction and overprocessing.

Another key aspect of efficiency within the revenue cycle is the education and training of persons responsible for tasks throughout the billing cycle. With the rapid changes in the health care industry, it is difficult to stay up to date on requirements. In addition, constantly evolving technology and system infrastructure can create a stressful environment for those responsible for managing the system. Keeping the workforce confident that they are performing the job accurately is important and training is vital in this regard. Perhaps equally important is ensuring that the staff is accountable for and empowered in performing the tasks from scheduling through billing and collections. Generally, billing errors are the result of poor training or a failure of institutional focus on the importance of quality. Errors of this type are known as "defects" in lean manufacturing terminology and this is perhaps the most expensive form of waste as defects often lead to performing the same task two or more times.

Ideally, work teams can be cross-trained to ensure a full understanding of the process and the organizational structure is arranged to minimize hand-offs between departments. Movement of activities between departments tends to create waste by "inventory" build-up, "waiting" times, and increases the risk of "defects."

Many providers despair of the inability to make significant reductions in bad debt or days in accounts receivable, but as with any task, advancement is a gradual evolution of marginal improvements. Considering the demands on time of management and staff, it may seem difficult to justify devoting resources to process improvement, but the benefit of increased liquidity and demonstration of management effectiveness can greatly enhance a provider's credit profile.◈

Ritchie Dickey is a vice president with Lancaster Pollard and is based out of the firm's office in Atlanta. He may be reached at rdickey@lancasterpollard.com.

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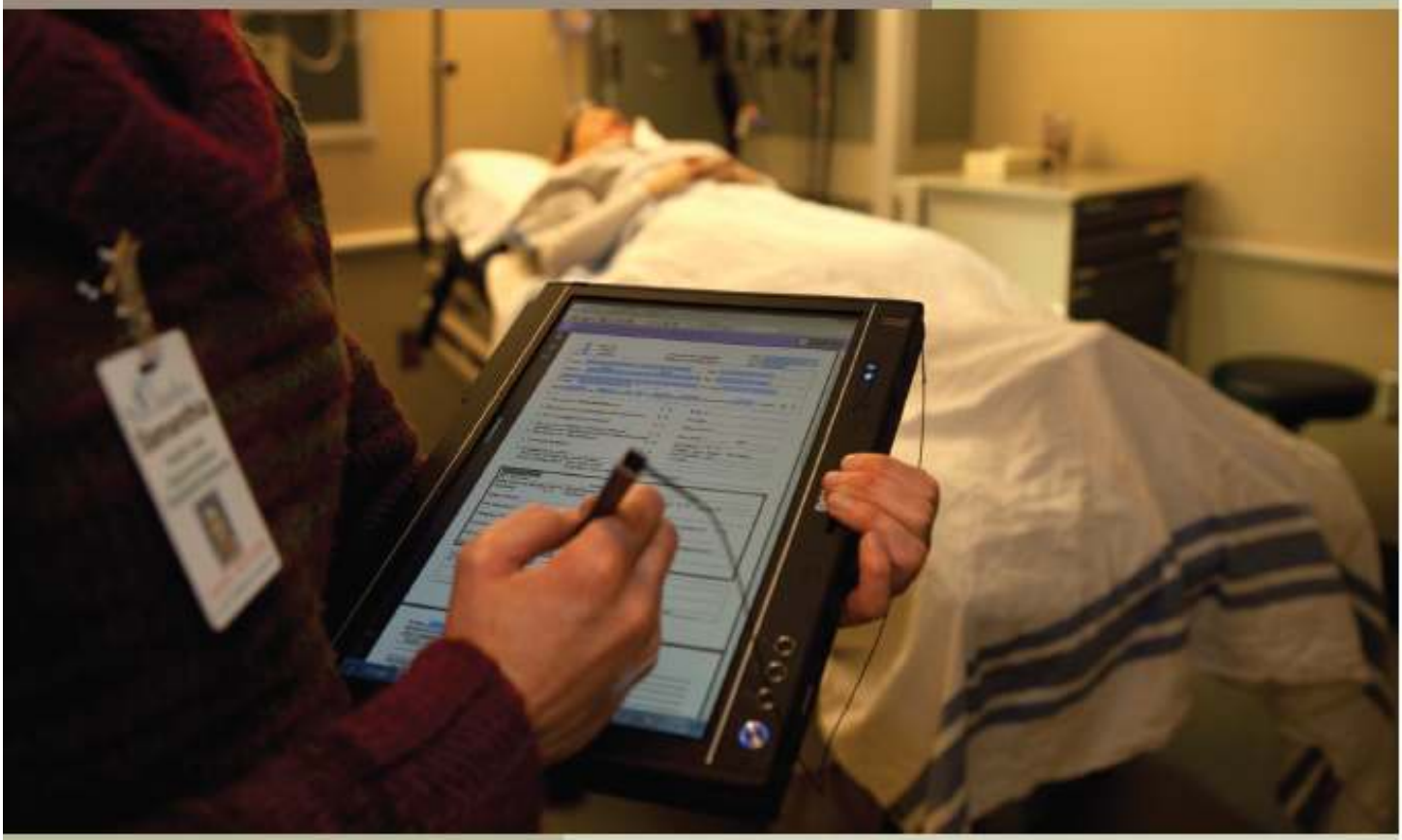

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Highlights … Annual Meeting and Conference—Williamsburg, VA

A Visit from George Washington

"Spinning back to the path taken regarding the formation of the Nation"

George Washington with the VA AAHAM board. Lt to Rt: Chris Fisher, Denise Martin, Brenda Champbers, Katie Creef, Amy Beech, Leanna Marshall, George Washington, David Nicholas, Michael Worley, Charles Lewis, Jack Pustilnik.

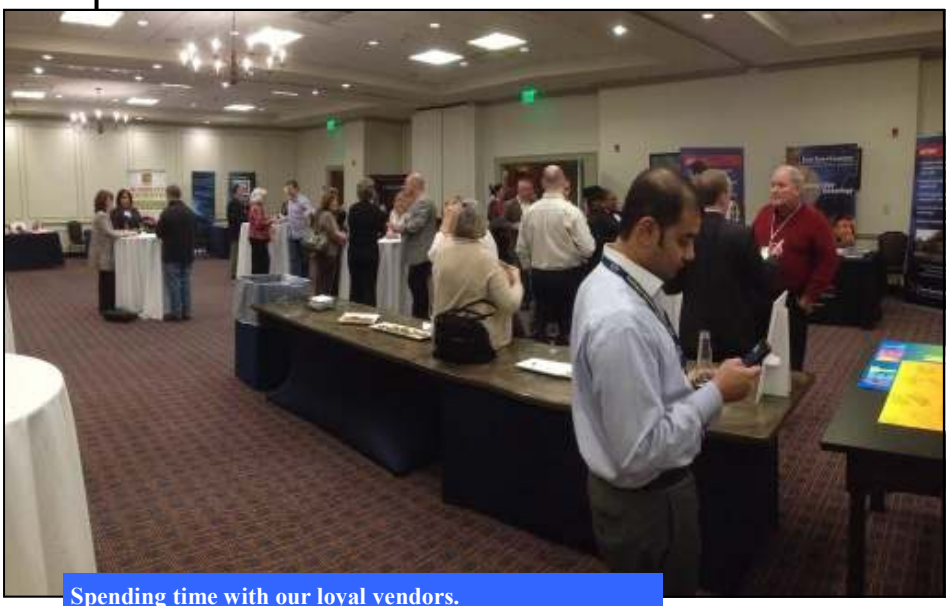
On the way to dinner… Fife & Drum Core and Torchbearer escort.

Dinner by candlelight—Kings Arms Tavern in Colonial Williamsburg.

Highlights … Annual Meeting and Conference—Williamsburg, VA

The 2014-2015 Board being sworn in. Thanks Laurie Shoaf, National AAHAM Chairman of the Board for doing the honors! Lt to Rt: Laurie Shoaf, David Nicholas, President; Denise Martin, 2nd VP; Dushantha Chelliah, Treasurer; Amy Beech, Secretary, Chris Fisher 1st VP.

Jack Pustilnik and the Towne Crier.



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Highlights … Annual Meeting and Conference—Williamsburg, VA

Dinner at Seasons

Dinner at King's Arms Tavern in Colonial Williamsburg

Katie presenting the Awards:

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Leanna Marshall, CPAM

PFS Consultant

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Charlottesville, VA 22902

CPAM Study Sessions will be conducted by Leanna Marshall on the third Saturday of the month from 9:00am until approximately 3:00pm.

Newly Certified…

First Name	Last Name	Certification	Facility
Paula	Cormany	CPAT	Inova Health Care Services, Inc
Debra	Curry	CPAT	Fauquier Health
Sybil	Daigrepont	CPAT	Inova Health Systems
Amy	Francisco	CPAT	MWHC
Anne	Gibson	CPAT	Centra Health
Marilyn	Gould	CPAT	Medicorp Health System
Jacelyn	Hailstalk	CPAT	Mary Washington Hospital
Jayme	Johnston	CPAT	Centra Health
Gail	Metts	CPAT	Mary Washington Heathcare
Lydia	Nieves	CPAT	Mary Washington Hospital
Augusta	Smallwood	CPAT	Inova Alexandria Hospital
Patricia	Smith	CPAT	Mary Washington Hospital
Mallory	Webb	CPAT	Centra Health
Chris	Fisher	CCAT	Augusta Health
Jessica	Grant	CCAT	Augusta Health
Ashleigh	Harman	CCAT	Augusta Health
Renee	Morris-Taylor	CCAT	Hunter Holmes McGuire VA Med Ctr
Laurie	Pow	CCAT	Inova Health Systems
Eugenia	Reed	CCAT	Augusta Health
Crystal	Robertson	CCAT	Augusta Health
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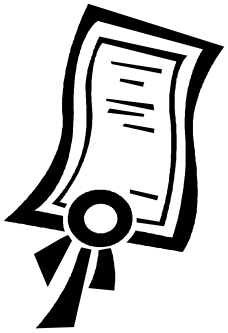

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

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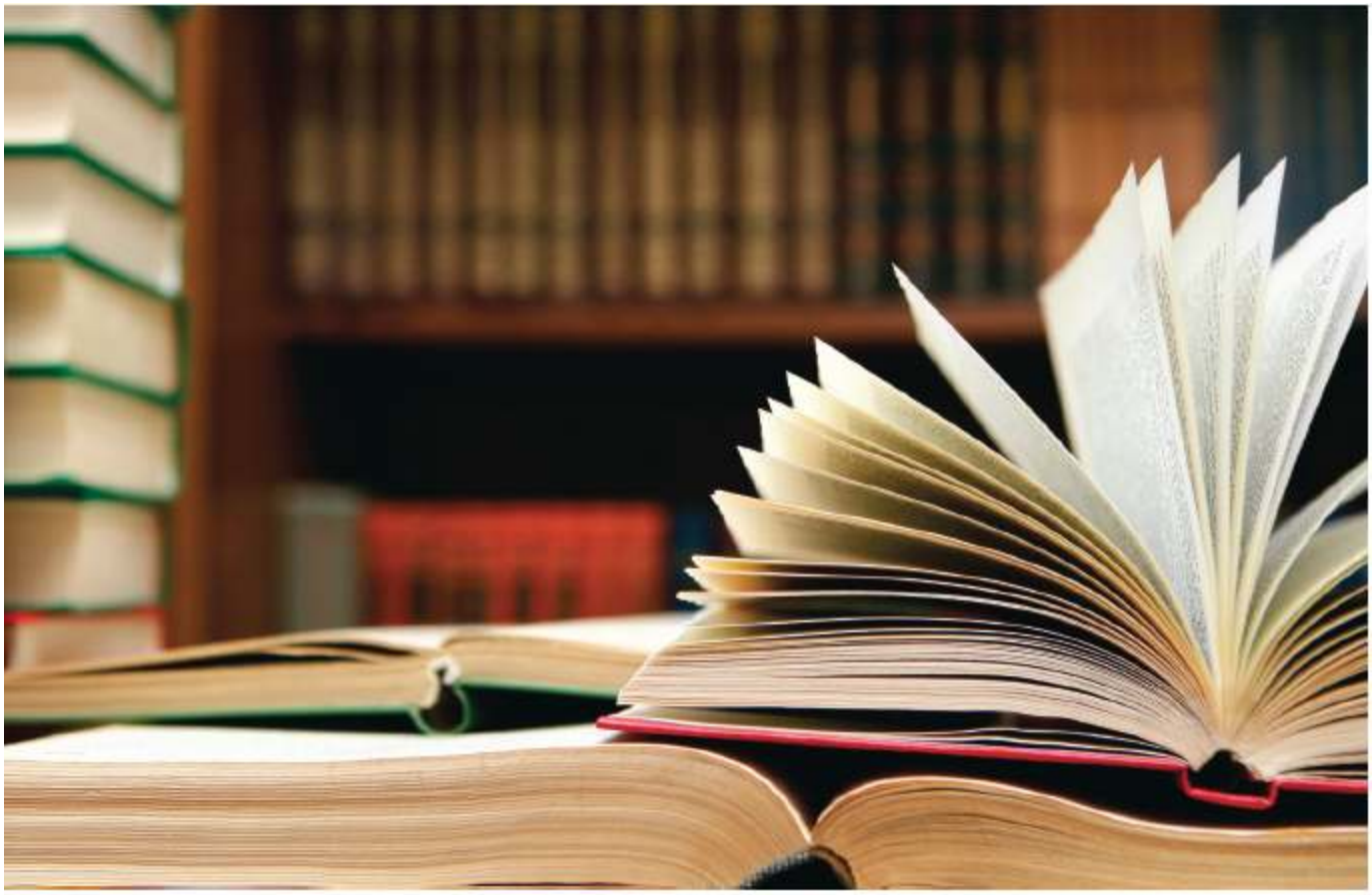

The Virginia Chapter of AAHAM Executive Board 2011-2013

Chairman of the Board

(Chapter of Excellence Committee)

Kathleen Hughes, CPAM

Director of Patient Accounting

Augusta Health

PO Box 1000, Fishersville, VA 22939

Office—(540)332-5159 Fax—(540)332-4616

Email—k1hughes@augustahealth.com

President

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

Linda McLaughlin, CPAM

Director, Finance and Governmental Services

VCU Health System

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Email— lmclaughlin@mcvh-vcu.edu

First Vice President

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

Amy Beech, CPAM

Patient Accounts Supervisor

Augusta Health

PO Box 1000, Fishersville, VA 2293

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Email—abeech@augustahealth.com

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(Committee Chairperson: Education Committee; Government Relations Committee)

Jack Pustilnik, CPAM

Director of Employee & Professional Development

Advanced Patient Advocacy

1025 Boulders Parkway; Suite 400, Richmond, VA 23225

Phone—(804)327-6899 Email—jpustlnik@apallc.com

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Chris Fisher, CPAM

Patient Access Coordinator

Augusta Health

PO Box 1000, Fishersville, VA 2293

Office—(540)332-5030 Email—cfisher@augustahealth.com

The Virginia Chapter of AAHAM Executive Board 2011-2013

Treasurer

(Committee Chairperson: Vendor Awards Committee)

David Nicholas, CPAM

Director of Operations RMC, Inc.

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

Email: David.Nicholas@RMCcollects.com

Appointed Board Member

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

Brenda Chambers, CPAM, 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

Email—Brenda.Chambers@hcahealthcare.com

Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall. CPAM

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Email—ayden1@embarqmail.com

Honorary Board Member

Michael Worley, CPAM

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

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COMMITTEES

- Third Party Payer
- Government Relations
- Publications
- Chapter Awareness
- Website Development
- Membership
- Education
- Scholarship
- Finance
- Chapter of Excellence

If you are interested in serving on a committee contact one of the Board Members.

RMC
Receivables Management Consultants, Inc.

Receivables Management Consultants, Inc.
6800 Versar Center; Suite 400
Springfield, VA 22151
Phone: (703) 321-9400
Fax: (703) 321-8765
www.RMCcollects.com

"I couldn't be happier -- RMC has collected over $2 million in outstanding A/R for us, reducing A/R days by 49% and decreasing outstanding A/R by 52%. At one time we had considered bringing billing and follow-up back in-house, but they're doing such an outstanding job we decided to continue outsourcing."
– Administrator, Inpatient Psychiatric Facility

OUR SERVICES ARE CUSTOMIZED TO MEET THE NEEDS OF OUR CLIENTS

> Business Office Outsourcing – Total or Partial
From billing through collections, follow-up, appeals, and recovery, RMC has the commitment and experience to be your trusted business partner.

We're ready to provide a total outsourcing solution, or assist you with any segments that are difficult or costly to manage internally:

- Acute Care Hospital
- Specialty Department (Psychiatric, Rehab, Hospice)
- Ambulatory Surgical Centers
- Home Health

> Insurance Billing – Follow-Up – Recovery

- Medicare Deductible & Coinsurance
- Medicaid
- Managed Care
- Workers' Compensation
- Blue Cross
- Commercial Insurance

> Revenue Recovery Projects for Underpayments

> Denials Management

> Clean-Up Projects for Very Aged or Backlogged Receivables

> Credit Balance Audit and Resolution

> Interim Management

> Training

"We're very pleased with the level of collections coming in, and with how RMC works to build the team. They've given us much better coordination; it's like they're part of our staff. In addition to billing and follow-up they helped implement our new computer software system, setting up billing protocols and helping us make processes more efficient."
– Administrator, Ambulatory Surgery Center

Woodrow Samuel Annual Scholarship Application

Purpose:

The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987. The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter, and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization.

A maximum of $1,000 scholarship award will be given.

Eligibility:

Eligible nominees must:

- Be a Virginia AAHAM member or a child of a Virginia AAHAM member as of January 1 of the current year.
- Eligible nominees can apply for the scholarship award on an annual basis.
- Members must be employed full time in a healthcare related field and dependents must be enrolled in an accredited college or school.
- Chapter dues of the member must be paid prior to the acceptance of requested scholarship applications.
- Classes taken must be taken during the current school year.

Nomination Procedure:

- Nominees must:
- Complete the application form
- Include at least one letter of reference.
- Include or attach any documentation you would like to have considered.
- Include an essay on why winning the scholarship is important.

Submission:

The form will be completed and returned to the address listed at the end of the application. This application will be postmarked no later than January 30th of the year the application is submitted to the Virginia State AAHAM Scholarship Chairman.

All application materials and supporting documentation will be reviewed by the Virginia State Scholarship Committee. After all applications are reviewed, the applicant will be notified if they have been selected as a Scholarship recipient by the Chair of the Scholarship Committee.

Review Process:

All applications will be reviewed and scored by the Scholarship Committee. Points are awarded based on the following criteria:

- Active in school related organizations (e.g. Honor Society, FFA, Ecology Club, Science Club, Beta Club, Student Council, etc.)
- Elected leadership position in school or community related clubs or organizations
- Demonstrates community involvement (e.g., membership in Scouts, 4-H, civic group/club, volunteer work)
- References
- Essay (Explains why _____is important to the applicant and/or his/her family.)
- Awards received for school or community involvement

Section A—Application

Type or print all answers clearly. Fill in all information completely. Use a blank sheet of paper to continue answers, and number them to correspond with the question number (for example, D—Goals).

Last Name _____ First Name _____ MI _____
Address _____
City _____ State _____ Zip Code _____
Daytime Telephone _____ Evening Telephone _____
Date of Birth _____ E-mail address _____
Present Place of Employment or Accredited School _____
Address of Employer or School _____
_____
Dollar Amount of Scholarship Being Requested _____

Section B—Education

Current School/College You Plan to Attend _____

Section C—Essay and Reference Letter

For Virginia members, please write an essay in 250 words or less on how the healthcare field has benefited you and the reason you would like to further your education. For dependent's of Virginia State AAHAM members, please write an essay in 250 words or less on the reason you would like to further your education and the reason you have chosen your career field major. Feel free to list any education experiences which have

this scholarship is important to you. Submit your answer on a separate sheet that includes your full name in the upper right hand corner.
A reference letter must accompany the application. It must state the reason why they feel the candidate deserves to win the scholarship.

Section D—Signatures

I certify that the information on this application is correct and represents the candidate to the best of my knowledge.

_____ _____

Applicant's Signature Date Application Submitted

Section E—Submission and Deadlines

Applications must include all signatures and titles. It must also include your written essay and reference letter. Submission deadline is January 31, 2013. The application is to be submitted to:

Amy Beech, CRCE-I
Augusta Health Business Office
PO Box 1000
Fishersville, VA 22939
(540)332-5030
abeech@augustahealth.com

Please do not write below this line.

_____

Date Application was received _____

Scholarship Committee Chair Signature _____

Scholarship Approved or Awarded? _____ YES _____ NO

National News— www.aaham.org

The renaming of our renowned certifications was announced at the Annual National Institute (ANI) in New Orleans, LA. The new AAHAM designations now accurately reflect the scope of knowledge and skills required to secure these prestigious certifications. The names are designed to more accurately reflect current job and industry titles and reinforce the association's growth and continued focus on healthcare revenue cycle professionals. Also unveiled was news regarding a new mid-level certification, the CRCP, Certified Revenue Cycle Professional. This new exam is designed for mid-level managers and tests the participant's knowledge of the revenue cycle. 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.

2013 Certification Schedule

March 3, 2014—Deadline for May 2014 Exam Period (May 12-23, 2014)

June 2, 2014—Deadline for August 2014 Exam Period (August 11-22, 2014)

September 2, 2014—Deadline for November Exam Period (November 10-21, 2014)

December 1, 2014– Deadline for February 2015 Exam Period

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/

Sponsorship

Platinum Sponsors

Credit Control Corporation
Chamberlain Edmonds/Emdeon
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Healthcare Financial Management
NHI Billing

Gold Partners

DECO

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Penn Credit

Bronze Partners

ROI Companies

A special THANK YOU to our Annual Corporate Partners for their support!

Sponsorship

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**
- **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 also benefits from the financial support that many organizations provide. I hope that you will consider supporting Virginia AAHAM this year.

—Denise Martin, Vendor Sponsorship / Corporate Partners Chair

dmmart515@aim.com

Mark you calendars!

Upcoming VA AAHAM events:

- **March 7,2014 Spring Regional Meeting, Charlottesville, 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:

The Virginia Chapter of AAHAM Education Committee, in an effort to provide our members with "Back to Basics" training is looking for interested parties to conduct a 30-45 minute webinar series. The web series would focus on professional development for operational level staff or first time managers. Presenters can share their professional experiences in networking, positioning yourself to grow in your organization, establishing yourself as a leader and a go-to person, etc. Please contact Gio Naranjo at gnaranjo@claimlogic.com or 405-548-1492 if you can assist in this education opportunity.

Linda McLaughlin, CPAM

President, The Virginia Chapter of AAHAM

Jack Pustilnik

Second Vice President, The Virginia Chapter of AAHAM

Watch our web site for details:

www.vaaaham.com

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**

Chris Fisher, CPAM
cfisher@augustahealth.com

Tammy Shipe, CCAT
tshipe@augustahealth.com

Heather Eavers, CPAT, CCAT
heavers@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.