# The Virginia AAHAM Insider

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

**Summer 2013** **Volume 27 Issue 1**

## The President's Message

Hello Fellow Virginia Chapter of AAHAM Members:

As we prepare for the next few years in healthcare, The Virginia Chapter of AAHAM is here to help you meet the challenges that are coming our way! Educational conferences/workshops, newsletter articles, legislative updates, third party payer committee support and networking opportunities are just a few of the ways that we can assist facilities or individual providers in ensuring that they continue to have successful financial performance.

Not only are changes occurring at the National level but at the State of Virginia level as well. Effective July 1, 2013, new regulations were passed by the state that mandates Third Party Payers are primary over possible Auto Accident Medical plans. In addition, Hospitals must obtain an additional Assignment of Benefit or ensure that the wording requirements by the State is added to your current form (s) signed at admission.

Of course we want to continue our efforts at the National level regarding the Modernization of the Telephone Consumer Protection Act. Our efforts are being recognized in a positive manner but we must keep the issue at the forefront. It is important that our membership continues to communicate with our Virginia State Senators and Representatives. If The Virginia Chapter of AAHAM can assist in any way please just give me a call.

Martha Jefferson Hospital will be hosting a Back to Back Workshop July 28, 2013, so be on the look out for the registration notice the second week in July. In addition, make sure you save the following conference dates: The Virginia Chapter of AAHAM's Fauquier Meeting on October 11, 2012, National ANI on October 16-18, 2013 in New Orleans and the Virginia Chapter of AAHAM's Annual Conference on December 11-13, 2013 in Williamsburg. In times where changes are occurring in healthcare almost daily, it is vital that we keep up-to-date on the new regulations and to network with other providers to ensure our success.

We look forward to seeing everyone at our upcoming events!!!!

Have a safe and fun summer!

Respectfully,

*Linda*

Linda B. McLaughlin, CPAM

President, The Virginia Chapter of AAHAM

**INSIDE THIS ISSUE:**



The Virginia AAHAM Insider

3rd Place Winner for Excellence in Journalism

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## Quality of Care Linked to Billing, Collections

By: *Evan J. Albright* | May 7, 2013

The back office is as important as the clinical departments when it comes to overall quality of care, a new survey has found.

Patients who had positive experiences related to billing gave higher marks for quality of care than patients who had issues with the billing process, according to the survey by TransUnion Healthcare. Negative billing experiences also affect a provider's bottom line, as the survey found that patients who experienced problems were less likely to take advantage of proactive healthcare options such as regular checkups and cancer screenings.

In all the survey found:

- Nearly 70 percent of survey respondents who gave the highest ratings to their quality of care over the past two years also gave high ratings to their billing and payment experiences, compared to only 24 percent of those who gave low ratings to their quality of care.
- More than 75 percent of those who gave high quality of care ratings also said they had a clear understanding of costs at least some of the time, compared to only 52 percent of those who gave low quality of care ratings.
- Two-thirds said that receiving clear information on expected out-of-pocket costs before receiving treatment would have a positive impact on their decision to use a provider, and 65 percent said that clear, easy-to understand bills would do the same.

More than 60 percent of respondents reported that cost information at the point-of-service would positively impact their decision to seek non-critical care.

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# Workers Compensation—

## by Heather Eavers, CPAT/CCAT

Billing for Workers Compensation claims can be tricky. These claims are often tied up in the AR for quite some time while providers try to navigate denials and stalls. So it is no surprise that Worker's compensation is a topic in the 2013 Virginia General Assembly Session. Recent independent studies have shown that WC costs in Virginia are the fourth lowest in the nation. However, the actual medical costs are above average. Some of the concerns from a provider's perspective are payment delays and reimbursements.

There are two types of WC coverage, federal and state. Federal applies to miners, maritime workers, and government workers. State applies to employees of state and private businesses. In addition, self insured employers are covered by ERISA, a federal jurisdiction. When doing claims follow-up it is important to know which set of guidelines your claim falls under.

At this time Virginia has no fee schedule for workers compensation claims. In addition, Virginia does not have a statute or regulation requiring the payment of WC claims in a specified period of time. However, ERISA does mandate that there is a 90 day payment timeline but does not offer penalties for violations. One of the benefits of not being a fee schedule state is that providers can ask for and accept 100% of charges.

On the other side, a con of being a non fee schedule state often means that insurance carriers will impose their own rules regarding appropriate payment rates. Usual, Customary, and Reasonable reductions are a quite common claim payment reduction that WC carriers use. When receiving a reduction for UCR it is important to shift the burden of proof back to the insurer. It is reasonable for the insurer to consider a provider's full billed charges as reasonable and customary. Respond back with a statement to the insurer that the charges billed accurately reflect the hospital's usual fees and are based on commonly recognized standards within the medical community. You may demand for a detailed itemized list of all denied charges and an explanation of the facts used to declare charges excessive (what area are they basing this on? What year's data are they basing it on?)

WC carriers also use silent PPO's. It is important to check the EOB to insure the provider really has a contract with the PPO mentioned. If not, follow through to have the claim reprocessed.

At the 2013 session of the General Assembly, key issues around WC are to be the rising medical costs and fair business practices. VHHA will be recommending the following changes:

- Encouraging market-based, private negotiations between payers and providers to determine appropriate payment rates and terms
- Adding prompt payment provisions
- Limiting provider liability for attorney fees
- Implementing a statute of limitations on claims submissions.

Workers Compensation continues to offer room for improvement on all fronts. If Virginia adopts a fee schedule this perhaps would mean a price reduction for providers, but less of an administrative burden.

Resources: David Nichols (RMC); VHHA web site; AAHAM webinar presented by Claims Assist in 2011, AHC.

*Heather Eavers, CPAT/CCAT, CHAA* is the Reimbursement Analyst at Augusta Health.

heavers@augustahealth.com

***Save the Date and watch for upcoming notice:***

# *Back to Basics Workshop*

***Presented by Linda McLaughlin, CPAM***

***July 27, 2013***

***Patient Access***
***Billing***
***Credit & Collections***
***Revenue Cycle Management***

***Martha Jefferson Hospital***

500 Martha Jefferson Dr Charlottesville, VA 22911

**Earn CEU's ● Prepare for upcoming exams ● Refresh your skills**

**If Cash is King, Then Process Must be Queen—by Rob Borchert**

Throughout our industry, we have all heard "CASH IS KING" and the typical interpretation of this phrase is *the collection of money…from government payors, commercial payors, and private payors*. I am sure that this interpretation is meaningful and has been used as a driving force in many projects. Most of us have been involved with a "collection project" at one point in our career. These collection projects come about because our Accounts Receivable is TOO HIGH AND/OR TOO OLD OR BOTH. In fact, if we have been in the business long enough, we have probably been through a NUMBER OF collection projects and have the scares to prove it.

What I find interesting is the fact that the total focus on these collection projects is the ability to bring more cash in the door within a specified period of time and that no one is even considering the reason (s) why you got there in the first place. No one is analyzing or documenting the reason(s) as to why one would get paid NOW (after a long period of time) and not when the claim was first submitted. That reminds me of another saying…'why is it that we have enough time to do the clean-up tasks the second time around when we didn't have enough time to do it right the first time.' We all have heard various reasons why the Accounts Receivable got into such a condition:

- New system conversion
- Current system does not work right
- Late charges confused the first claim and now we have to work with the payor to correct
- They did not pay according to contract
- Insurance was not verified
- Wrong insurance first time around
- Always a problem with Registration
- Not enough staff in the Business Office

Maybe some of these reasons are true but what it all comes down to is "PROCESS". Yes, it is true. Everything occurs because of PROCESS and once you realize that, you realize that Process must be the "Queen" sitting next to the King. Now if we were to give a general description to each of these royal terms, one would have that say that:

- A King is someone who is never challenged. One who has many servants and people working for him and all of them performing their tasks without question (at least publically). A King is someone who is valued and respected and, hopefully, makes the right decisions for his subjects. Just like in chess, the King is valuable but can only move one space at a time
- A Queen is someone who is respected and very much aware of the King's attitudes and behaviors. A Queen is usually very much aware of the attitudes and behaviors of the King's subjects as well and many times will talk with the King to guide him to make the right decision. The Queen, although not a final decision maker, is the key influencer to the King. The Queen can actually be stronger in personality and will than the King but no one talks about it. And just like in chess, the Queen is invaluable because of her flexibility in being able to make various types of moves depending on need.

Can anyone begin to see my connections between Cash being the King and Process being the Queen? I hope so because aside from the description of the Queen above, she must be treated with care by her subjects and, in the case, the subjects can be somewhat flexible in how they treat her with care. So, she not only influences the King but she also is the key component in making the King great!

*Continued on next page…*

**If Cash is King, Then Process Must be Queen—by Rob Borchert-***continued from previous page*

So, if you agree that in order for the King to be great (and the cash flowing in), the Queen must be looked at also since I think that the reason why Accounts Receivable gets into a 'bad' condition is because of poor or bad processes. Therefore, the Queen is the critical piece to a good AR. So the best way for us to look at our Queen is to ask questions about 'her movements' within each of the functional areas of the Revenue Cycle. Now, I know that I will not touch on all of the questions but you should feel free to modify my questions as well as add to them for your own analysis.

Access Management:

- Who does Access Management report to?
- Does scheduling, pre-registration, registration (including ER), insurance verification and financial counseling all report to the same person?
- Does scheduling schedule all areas of patient access
- What about ancillary areas? What about OR – both ambulatory and inpatient?
- Do you have centralized scheduling?
- Do all of the scheduling areas collect the same data?
- Do the scheduling areas collect diagnostic information for medically necessary purposes - whether it is for ancillary testing, inpatient admission, same day surgery, etc.?
- Who obtains the pre-authorizations or pre-certifications?
- Does your IT system support all of these facets of Access Management?
- Who verifies the patient's coverage under the presented insurance plan?
- Is insurance verification done through HIPAA transaction sets?
- Are the patients informed of their responsibility and asked to bring in the deductible or co-pay?
- Once scheduled, are the patients contacted prior to their arrival as part of pre-registration?
- Can scheduling and/or registration inform the patient of their financial responsibility?
- Do you scan insurance cards?
- How much paper is involved with the Access Management process?

Medical Management:

- Is Nursing part of the Medical Management team?
- What is the status of the 'discharged-not-final-billed' report in dollars and area?
- Do you have benchmarks for the coders?
- If you have outpatient coders and inpatient coders, are they cross-trained? Can they be?
- Do you have the electronic medical record? Is it multi-functional with the physicians?
- Do you have drop-down boxes in the EHR have reflects diagnoses?

*Continued on next page...*

**If Cash is King, Then Process Must be Queen—by Rob Borchert-***continued from previous page*

- Does your EHR have any language tools to reflect significant components for coding?
- Do you have separate chart abstractors for deficiency identification?
- Is there a backlog in transcription?
- What is your current process of communication with physicians regarding delinquencies?
- How old is your oldest outstanding claim due to incompleteness?
- What do your by-laws or medical staff privileges state about incomplete charts?
- Who deals with physicians who are tardy with their charts?
- Is there any 'spine' in dealing with 'problem' physicians?
- What are your top 10 (or 50) diagnoses for the last 6 months or year?
- How many of these top diagnoses are designated as "unspecified"?
- Do you do concurrent review?

Patient Financial Services:

- What is reflected in the DNFB regarding open charges?
- What is your percent and dollar value of late charges?
- What is the ranking of the ancillary areas regarding the timing, number and dollar value of late charges?
- Do you have a policy on late charges? Is it different for inpatients vs. outpatients?
- What is the volume of front-end edits that occur daily?
- Can you prioritize them and reflect them back to the point of origination?
- What is your average percentage of clean claims on a daily basis?
- Do you use HIPAA transaction sets?
- Are you using the 277 set for immediate feedback to payors on claim edits?
- Is your business processing office segregated by financial class?
- What happens when someone goes on vacation or leave?
- Do you know your days in AR by insurance company?
- Do you know the behavior of an insurance company by the way it pays small claims versus large claims? Are you aware of any patterns? Is your staff aware of any patterns?
- Do you have a denial management team?

*Continued on next page…*

**If Cash is King, Then Process Must be Queen—by Rob Borchert-***continued from previous page*

- Are you aware of the types of internal denials that can be resolved within your own facility?
- Are you aware of the types of external denials that are contractually related?
- Are you aware of how many claims you are writing off by reason?
- Are you aware of the number of denials that are challenged turn into wins?
- Are you aware of how many times a claim is handled before it goes out the door?
- Are you aware of how many times a claim is handled after the first denial?
- Are you aware of how many denials occur due to diagnosis?
- Do you know your top 10 denial reasons by payor?
- Are you monitoring payments against contracts?
- What is your contractual percentage by payor? Have you compared payors?

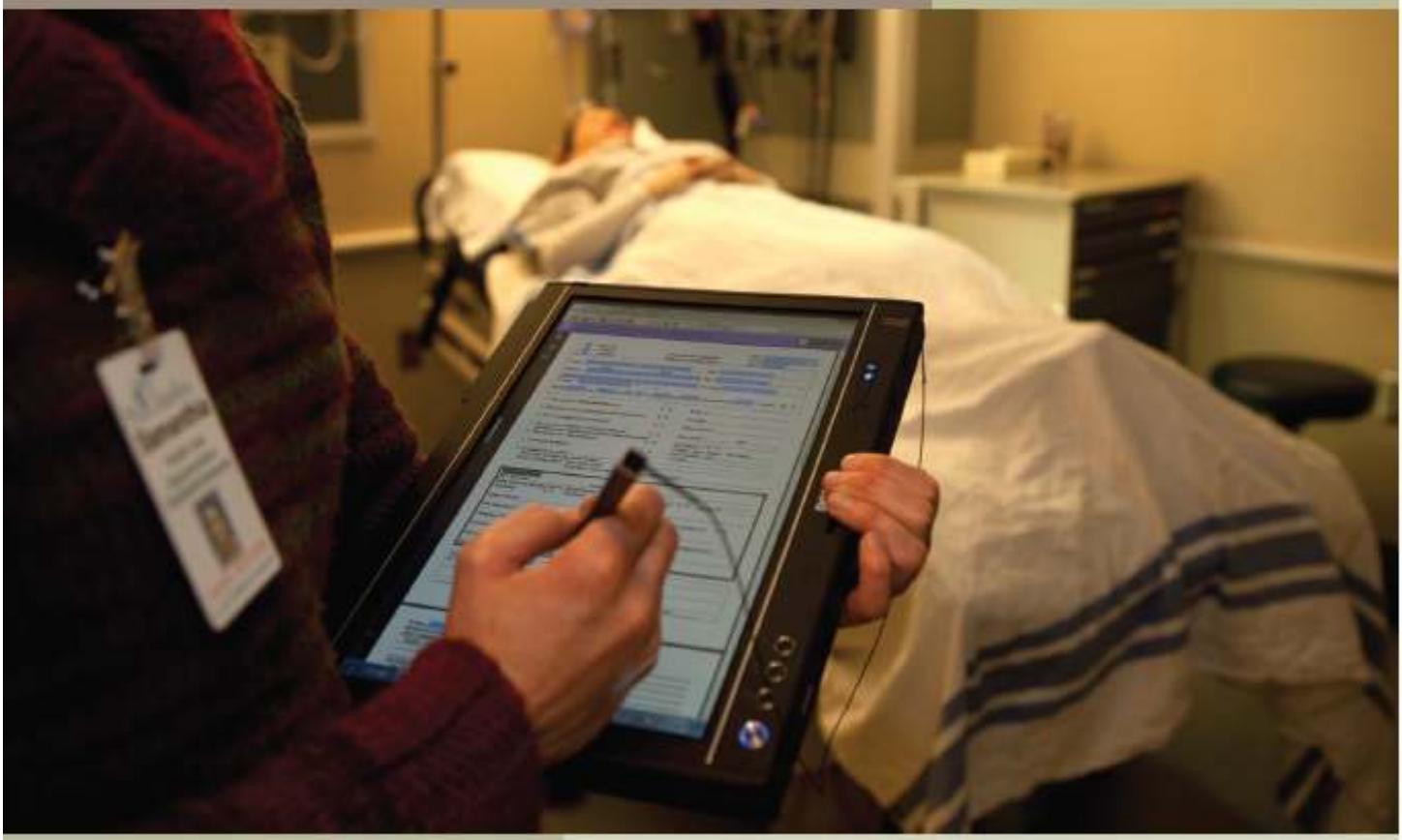
Wow! Can you see why the Queen is so special? I think we find it easy to fall into the busyness of our day and by the time we stop to breathe, we are ready to go home. This is why a Revenue Cycle Management Committee (RCM) is so vital to every organization. Since we are talking royalty, think of the Revenue Cycle Management Committee as the Knights of the Round Table. Every Knight brings a unique experience to the table and shares their thoughts and processes with everyone to enhance the group.

A good Revenue Cycle Management Committee meets once a week for no more than 90 minutes and focuses on processes that lead to a smooth relationship between King and Queen. I could go into so many positive aspects of the RCM Committee that it would be another article. However, let me just say that I have been involved with and/or established a RCM Committee in most of my clients and by openly discussing many of the questions above, have been able to truly enhance processes and increase CASH. In a good RCM Committee, there should be members from ALL revenue generating departments including nursing, OR, ancillary areas, Compliance, and invited guests as lags and gaps are uncovered. Not everyone need attend every meeting. This is why the Chair prioritizes the agenda and invites departmental staff when they are to discuss their processes and management techniques. Minutes from each meeting are also kept as a reference to tasks and accomplishments. Again, charts and graphs should be maintained and the facility, as a whole, should also be aware of the discussions happening during the RCM Committee.

People, process, and technology working together form a wonderful relationship that enhances productivity, reduces redundancy, and improves cash flow. In the upcoming months and next couple of years, these things will become critical to the success of every institution. With the implementation of EHR, meaningful use, ICD-10 coding environment, and new reimbursement methodologies, understanding process will be the key to making it all work. Understanding process also helps to relieve the stress that occurs when 'things don't go right'. We should all remember that there is no right or wrong process, there is just the BEST PROCESS.

**Rob Borchert, Best Practice Associates**
**rob@bpa-consulting.com or (315) 345 5208**

# You see
uncompensated care shortfalls.



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# AAHAM Legislative Day 2013

**By Elizabeth Staas, AAHAM Legislative Chair**

**AAHAM Members from all across the country gathered in solidarity April 3 & 4, 2013 to gain further knowledge of critical issues affecting the healthcare industry and meet with legislators to present requests for action. The Virginia Chapter was represented by Linda McLaughlin (VCU Health System), Brenda Chambers (HCA Healthcare), Linda Patry (Mary Washington Healthcare), Jack Pustilnik (Advanced Patient Advocacy), Elizabeth Staas (Recondo Technology) and Anuradha Das (Conifer Health).**

**Over 100 AAHAM Members joined forces this year for National AAHAM Legislative Day to meet with their state legislatures. This year's Legislative Day topic focuses again on the Telephone Consumer Protection Act (TCPA). In order to foster responsible and prompt communications between healthcare providers, their agents, and consumers, and to preserve the integrity of the US Credit system, it is imperative that Congress take immediate action to modernize the TCPA for the 21st Century. To better understand the position and area of concentration: Optimal care cannot be provided without access to patients using modern technology such as an automated dialer to a cell phone line. It is crucial to be able to use cell phones of patients to provide such services as appointment reminder calls, messages to call for test results, and collection of accounts.**

1. **Cell phone only households reported for 2012 was at 35.8%.**
   - **A. 60% of 25-29 year olds live in cell-only households.**
   - **B. 51% of 30-34 year olds live in cell-only households.**
   - **C. Adults living in poverty (51.4%) were far more likely than adults who were not poor (28.9%) to be living in wireless –only households.**
   - **D. This trend will continue to grow.**
2. **In 1997 there were 56 billion minutes of cell phone usage. In 2012 that figure has grown to 2.32 trillion minutes.**
3. **Land-line only households have dropped to 11.2% in in the first half of 2011.**
4. **Nearly one of every six American homes (16%) received all or almost all calls on wireless telephones despite also having a landline telephone.**
5. **Healthcare providers often use auto-dialers and need to communicate with patients regarding appointment reminders, lab test results, scheduling of routine exams, follow up visits, etc.**
6. **We are NOT proposing changes to telemarketing rules. We are not talking about randomly selected numbers, but rather numbers that are provided to us by the consumer/patient.**
7. **In 2011, there was 41.8 billion dollars in uncompensated health care as reported by the American Hospital Association.**
   - **A. Healthcare providers and their agents need to be able to contact consumers on any phone number provided by the consumer.**
   - **B. Healthcare providers and their agents need to rely on efficient methods such as auto dialers and pre-recorded messages.**

***C.*** **The prohibition of the use of modern technology results in greater uncollectible balances for healthcare organizations thus increasing the cost of healthcare.**

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## AAHAM Legislative Day 2013—*continued from previous page*

**By Elizabeth Staas, AAHAM Legislative Chair**

**In preparation for the meetings 'on the hill' in Washington, DC leaders in the industry spoke with the AAHAM Representatives. Discussions were led by Chris Merida, Director, Federal Legislative Affairs, American Express and Jason D. Goldman, Senior Telecommunications Policy Counsel and Managing Director, Environment, Technology & Regulatory Affairs Division, U.S. Chamber of Commerce. Additionally, Matthew Barry, Bloomberg Government and Healthcare Expert Loren Duggan, Bloomberg Government, Chief Legislative Analyst spoke to the group followed by Erik Rasmussen, Director of Legislative Affairs, American Hospital Association.**

**Your Chapter representatives met with the offices of Mark Warner, Tim Kaine, Eric Cantor and Frank Wolf. The positions AAHAM is taking were presented in very positive conversations and were well received. This is the time for other AAHAM Members to join and speak directly to their legislators to alert them that the current TCPA is causing a hindrance in the healthcare industry and needs to be modernized. The collaborative discussions will continue to encourage change and the betterment of how the healthcare industry communicates with the patients that we serve.**

**If you are interested in lobbying at your local or regional level and are in need of some pointers and how to get started, please contact your AAHAM Legislative Chair, Elizabeth Staas, 804-337-3694 or Elizabeth.Staas@RecondoTechnology.com.**

# Member Spotlight—David Nicholas, CPAM
## By Heather Eavers, CPAT/CCAT

David is our current VA AAHAM treasurer and is about 18 months into his 24 month term. He has several job functions as treasurer. They include paying bills, bank deposits, conference registrations, providing financial reports to the Board, coordinating annual filing of tax returns, and giving input on policy and procedures.

David has been a member of AAHAM for 11 years. He loves being a member because he is able to network with his peers. He also likes that AAHAM provides him an opportunity to stay in touch with friends and colleagues.

Outside of AAHAM, David is the Director of Operations at RMC. He has been at RMC for 11 ½ years. RMC offers solutions to help providers to lower their AR through denial management, recovery projects, credit balance auditing, and more. Some of his job duties at RMC include marketing, new project implementation, project management, purchasing new equipment, and billing and follow-up functions for client AR on certain projects. He enjoys his job because of the variety of work that is involved.

When he is not working David likes to go to the gym and bowl in a bowling league. He has been on a bowling league for 8 years. He has even served as Treasurer for that league. In addition he is a big Star Trek fan and enjoys getting together with friends on Wednesday nights!

David is a very valuable board member for the VA AAHAM.

**David Nicholas, CPAM**
David.Nicholas@rmccollects.com

RMC
Receivables Management Consultants, Inc.

**Receivables Management Consultants, Inc.**
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- Personal challenge and satisfaction
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An AAHAM certification demonstrates your:

**Commitment**—to your field and your ongoing professional development.

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CPAM & CCAM 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 CPAM/CCAM 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, CPAM**

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

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 |
|---|---|---|---|
| Karen | Griffin | CCAM dual | Augusta Health |
| Robyn | Brydge | CPAT | Augusta Health |
| Susan | Dillow | CCAT | Augusta Health |
| Katina | Eavey | CCAT | Augusta Health |
| Louise | Fletcher | CCAT | Augusta Health |
| Jessica | Grant | CPAT | Augusta Health |
| Susan | Layman | CPAT | Augusta Health |
| Shannon | Love | CCAT | Augusta Health |
| Claudia | Marrs | CCAT | Augusta Health |
| Jessica | Marshall | CPAT | Augusta Health |
| Trista | McGuire | CCAT | Augusta Health |
| Stephanie | Metcalfe | CPAT | Augusta Health |
| Crystal | Robertson | CPAT | Augusta Health |
| Karen | Robertson | CPAT | Augusta Health |
| Lisa | Showalter | CCAT | Augusta Health |
| Amanda | Stone | CCAT | Augusta Health |
| Dianne | Strader | CPAT | Augusta Health |
| Linda | Wade | CPAT | Augusta Health |
| Mary | Walker | CCAT | Augusta Health |
| Jena | McFaddin | CCAT | Augusta Health |
| Deborah | Hall | CPAT | Centra |
| Ashley | Gilliland | CCAT | Centra Health |
| Belinda | Schultz | CPAT | Fauquier Health |
| Patricia | Duckworth | CPAT | Fauquier Hospital |
| Eunice | Meredith | CPAT | INOVA Fairfax |
| Delgardo | Franklin | CCAT | Inova Health System |
| Ronda | Macedo | CPAT | INOVA HEALTH SYSTEM |
| Angela | Perin | CPAT | Mary Washington |
| Holly | Dobson | CPAT | Mary Washington Healthcare |
| Charles | Huggins | CPAT | Mary Washington Healthcare |
| Marlene | Melchior | CPAT | Mary Washington Healthcare |
| Nezenine | Munoz | CPAT | Mary Washington Healthcare |
| Victoria | Pratt | CPAT | Mary Washington Healthcare |
| Lisa | Schadtler | CPAT | Mary Washington Healthcare |
| Jenny | Maynard | CPAT | N/A |
| Suzanne | Ryder | CPAT | N/A |
| Deborah | Kingston | CCAT | Primary Health Group JohnstonWillis |
| Lauren | Strong | CPAM | Rappahannock General Hospital |
| Mary | Bishop | CPAT | University of VA |
| Tiffani | Hatcher | CPAT | University of VA Medical Center |
| Amber | McDaniel | CPAT | University of Virginia |
| Heather | Norvelle | CPAT | UVA Medical Center |

# Certification Review

## Patient Access

Collecting as much as possible as soon as possible is the cornerstone of a successful revenue cycle. Name five (5) points where a patient could make a payment.

1.
2.
3.
4.
5.

## Billing

List four (4) types of amount a participating facility can bill to a Medicare patient.

1.
2.
3.
4.

## Credit & Collections

Name and define the two (2) types of bankruptcy filings for individuals.

1.
2.

## Revenue Cycle Management

Define the following accounting terms:

1. Liabilities -
2. Current liabilities -
3. Assets -
4. Current assets -
5. Equity -
6. Revenue -
7. Expense -
8. Income -


**Go to www.aaham.org and click on Member ListServe/Certification ListServe for the answers.**

# 2012 Membership Application

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*Take Advantage of these important benefits…*

*Problem solving and solution sharing with your associates;
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*Reduced Fees for Chapter Education Events
*Access & prep. assistance for certification tests that demonstrate your professional skills;
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| | |
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| Certification: | Employer Name: |
| Job Title: | Mailing Address: |
| Day Phone #: | City: |
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**MEMBERSHIP RECOMMENDED BY:**_____

For additional information, contact Miguel Wilkens @ 410-227-3051 or via email @ mwilkens@medical-account.com .

Please mail the completed form with your dues Payment of $30.00 to the following address**:**

**Treasurer, Virginia AAHAM**
David Nicholas
6800 Versar Center, Suite 400
Springfield, Virginia 22151
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Take advantage of our new online membership application and payment options. Visit our website at http://www.vaaaham.com/Membership_Application.html.

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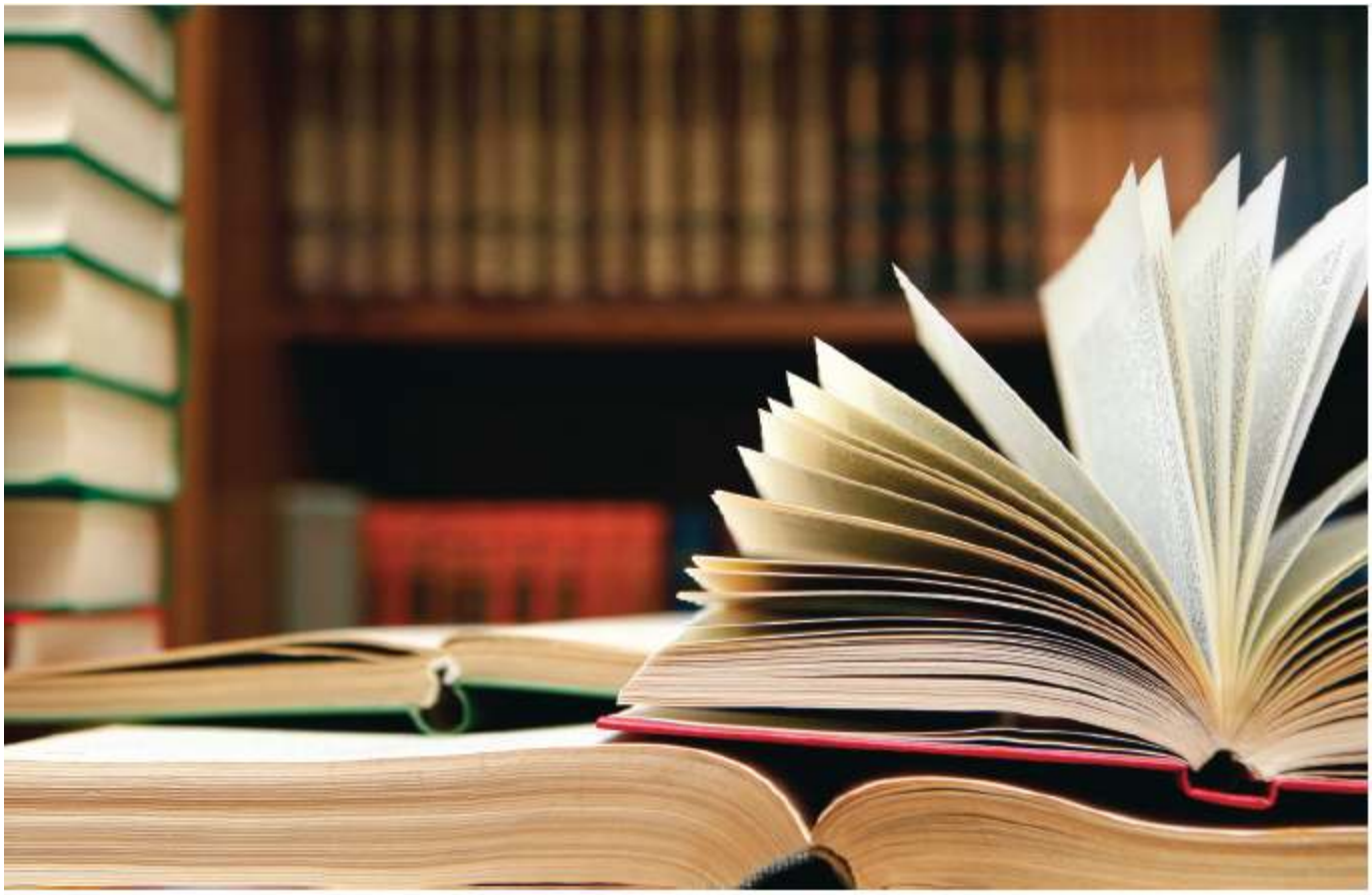

# *Smart Moves: How Hospitals Manage Risk When Borrowing*

## *By: Kass Matt & Nick Gesue*

**Smart Moves: How Hospitals Manage Risk When Borrowing**

In an uncertain world, managing financial risk is essential for any business.

This is especially true today for health care organizations. Hospital leaders have to deal with managing a multitude of risks, such as clinical outcomes, reimbursement cuts, regulatory requirements, competing hospitals and more.

While the importance of managing clinical risks is well understood, the 2008 financial collapse and recession demonstrated to many health care executives the significance of how the structure of capital debt can contribute to a hospital's overall risk as well. (For example, the credit crunch made it extremely difficult and expensive to obtain or renew letters of credit, leaving hospitals with fewer options to enhance variable rate debt.) To address this, hospital leadership must identify and mitigate risks associated with their hospital's debt, investments and balance sheet. While these are interconnected with total financial risk, and should be considered as part of an organization's total debt management policy, let us focus on how a hospital can manage its risk exposure by choosing the appropriate debt structure to finance capital projects or refinance existing debt.

**Mitigating Debt Risks**

When considering the options, a hospital's top priority is to balance both the upfront and ongoing capital costs with the nonfinancial terms and covenants of a debt structure. This balance is key to managing its current exposure to risks associated with short and/or long term debt. The debt structure used to achieve this balance will depend on a variety of factors for a hospital, including credit worthiness, geographic location, current capital structure, financial capacity to take on risk and the capital market's "appetite" for health care transactions.

A hospital's financing team must assess all of the above as well as take into consideration the project (renovation, replacement, acquisition) and objectives when evaluating structured debt products. The best option will be the one that fits the hospital's needs while achieving the lowest possible cost of capital within acceptable risk parameters.

Let's take a look at how three hospitals, using different debt structures, obtained the capital they needed and managed their debt risks.

**Kennedy Health System—Voorhees, N.J.**

***Public Offering of Tax-Exempt, Fixed-Rate Revenue Bonds***

Kennedy Health System operates three campuses in New Jersey: Cherry Hill, Stratford and Washington Township. In recent years, Kennedy had funded its strategic capital projects through operating cash instead of debt. Although this approach allowed the health system to minimize debt, it compromised its overall financial profile by reducing its liquidity position. As a result, Moody's lowered the health system's A2 rating to A3 in November of 2011.

In the meantime, Kennedy Health System had plans to make significant capital improvements at all three campuses and decided to refinance its existing debt and finance future capital projects to leverage its balance sheet. Kennedy's leadership chose to proceed with a public offering of tax-exempt, fixed-rate bonds to fund about $20 million in new projects and refinance about $46 million in existing indebtedness. The health system was able to take advantage of the strong, resurging health-care market for rated credits to issue tax-exempt, fixed-rate bonds in order to refund Series 1997 A and Series 2001 bonds and finance its new capital projects. As a result, the health system was able to generate more than 15% in debt

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service savings, which equates to $8.8 million in net present-value savings. In addition to the low cost of capital, the bonds were sold without a mortgage or debt-service-reserve fund required, thus ensuring maximum flexibility for the organization going forward.

By choosing tax-exempt, fixed-rate bonds, Kennedy eliminated interest rate and remarketing risks. Additionally, the structure avoided renewal risk or bank risk. Amenable covenants and the lack of a mortgage or debt service reserve fund requirement also increased organizational flexibility for future strategic considerations.

**Cameron Memorial Community Hospital—Angola, Ind.**
***USDA Community Facilities Program Direct and Guaranteed Loans, Bond Anticipation Notes, Bank Construction Loan and Equity***

The leadership team of Cameron Memorial Community Hospital, a 25-bed critical access hospital in Angola, Ind., decided to modernize its aging facility in order to provide the efficient delivery of medical care necessary to remain competitive. After thoroughly reviewing an array of financing options, Cameron was able to obtain a commitment from the USDA Community Facilities Program for a $37 million direct loan at a fixed-interest rate as well as a commitment for $10 million of guaranteed loan funds.

While the USDA commitments squared away the permanent financing, the hospital still needed to secure the construction financing. The relatively large project cost and associated construction risk proved problematic for several banks, despite the promise of the USDA takeout. Therefore, Cameron's leadership committed to an innovative funding solution: the sale of $37 million of tax-exempt bond anticipation notes (BANs) for a three-year term. The BANs were secured by the anticipated proceeds of the permanent USDA direct loan and received a "MIG 2" rating by Moody's Investor Services (the second highest short-term debt rating available), resulting in a cost of capital near 2%. The rest of the $53 million project financing came from $6 million in hospital equity and a $10 million construction loan from the community bank that was serving as the USDA Community Facilities guaranteed lender. The bank's construction loan will be paid off by the USDA Community Facilities guaranteed loan after construction is completed. The guaranteed loan will have a market-based interest rate and a 25-year term and amortization. In total, Cameron obtained funding at a low cost of capital, with a blended interest rate below 3% for the construction period and below 4% for the 40-year life of the post-construction, permanent debt.

In reviewing the hospital's overall capital structure risk, let's examine the debt offering's component parts. For the $37-million USDA direct loan, there was no interest rate risk since it was fixed rate, no refinance or renewal risk as the term equals the amortization and no bank risk. For the guaranteed $10-million loan, $9 million was guaranteed and $1 million was not guaranteed, so there are different risks to take into consideration. For the $9-million piece, the hospital has the option to fix the interest rate at any time—essentially nullifying interest rate risk. The $1-million piece is variable rate, so there is interest rate risk involved. There was no refinance risk as the term equals the amortization and no bank risk because the loan is provided directly by the bank (no bank credit enhancement). All in all, while Cameron's debt structure is relatively complex, the only capital structure risk to the hospital is minimal interest rate risk (on only $1 million of a $47 million offering), which hospital leadership deemed acceptable.

**Fulton County Health Center—Wauseon, Ohio**
***Privately Placed, Tax-Exempt, Variable-Rate Bonds***

Fulton County Health Center (FCHC) is not your typical critical access hospital. Founded in 1973 in Northwest Ohio, FCHC has grown to include the main 25-bed hospital, which includes several specialty units, such as a cancer center, cardiac catheterization lab and sleep center, several medical clinics and a 71-bed senior living facility.

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FCHC, in good financial standing, faced an expiring bank letter of credit (LOC) that enhanced a 2005 bond issue. The hospital had an outstanding swap with a significant negative mark to market value, which was not tied to the LOC-backed bonds.

After reviewing all available options, FCHC selected a multimodal, privately placed sale of $28.75 million in bonds with a regional bank. This option addressed the upcoming LOC expiration and allowed the swap to stay in place to maintain an effective interest rate hedge.

Additionally, the variable-rate, tax-exempt direct purchase structure removed the bank credit risk and the renewal risk with a five-year term instead of the typical one- to three-year LOC extension period. While the variable rate bonds and the separate swap exposes the hospital to some interest rate risk, it was deemed acceptable in light of the short term and the current low interest rate environment. However, FHCA has the flexibility to refinance the bonds should interest rates rise.

**Maintaining Good Financial Health**

As you can see, managing risks associated with a hospital's capital structure is essential to the organization's overall financial health. A hospital's choice of debt structure, which should balance the cost of capital with the available terms and covenants, is an important risk management tool. In the process of choosing the best structure, it's important for hospital leaders to know their balance sheet's strengths and weaknesses, understand how rating agencies and investors measure various risk components and determine their organization's tolerance for risk.

> **"...managing risks associated with a hospital's capital structure is essential to the organization's overall financial health."**

The capital strategies highlighted above show the importance of being able to access debt with optimum efficiency with the lowest possible risk exposure. Therefore, it is imperative to assemble a knowledgeable and experienced financial team, consisting of internal and external experts, to navigate the ever-changing capital markets and to determine the best possible debt structure to ensure this priority.

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## *Hospital Spotlight— Augusta Health Fishersville, VA*

Augusta Health is an innovative medical facility dedicated to serving its community, bettering the lives of its patients, and continually offering up to date and high quality care. This is exemplified through the many awards and recognitions granted to this hospital annually. A not-for-profit organization with over 200 staffed beds and 35 service lines, Augusta Health is well-equipped and ready to address many of the health needs of its community comprised of Augusta County, Staunton City, and Waynesboro City of Virginia. Through their actions, Augusta Health holds true to their mission to promote the health and well-being of their community through access to excellent care.

The recently completed Heart and Vascular Center is one example of how Augusta Health maintains a contemporary stance in a competitive field. This state-of-the-art facility provides all clinical and diagnostic services within Augusta Health's cardiovascular and pulmonary service line in one location. It is a convenient location for their patient population, who would other wise need to make hour long trips to receive the immediate critical care.

Augusta Health has enjoyed several great achievements and rewards recognizing the extraordinary care they work continuously to provide. In 2013, Healthgrades recognized Augusta Health as one of the America's 100 Best Hospitals, which places Augusta Health in the top 2% among the hospitals in the nation. Augusta Health also received the Patient Safety Excellence Award and the Distinguished Hospital Award for Clinical Excellence from Healthgrades. In addition to these accomplishments, Augusta Health has received the coveted Thomson Reuters/Truven100 Top Hospital award in both 2011 and 2012. The 100 Top Hospital award winners demonstrate top performance on both how patients are cared for through clinical measures and how the hospital performs as an efficient business. A select few of the Top 100 hospitals are awarded the Everest Award, an award that honors hospitals that have achieved both the highest current performance and the fastest long-term improvement over five years. Augusta Health, devoted in its commitment to professionalism and excellence, proudly accepted the Everest Award in 2011 and 2012.

Focused on patient and community centeredness, Augusta Health has recently pushed even further in their mission by completing a Community Health Needs Assessment. The results are expected to give insight to the healthcare challenges of the community and aid in the development of strategies to address these needs. Augusta Health's objectives of improving the health of their community and progressively advancing their services and capabilities will continue through professionalism and committed teamwork. Exceeding national standards has become more than a goal for Augusta Health, it is an expectation.

## *Crazy Man Harry...*

*Another Motivational Moment with Kelly Swanson*

Crazy Man Harry sits on the corner of Route 29 and Old Wiley School Road. You don't have to live there to know him - just drive by and you'll see him sitting there in his rusty old lawn chair with the one broken strap dragging the ground. He'll be wearing those same old boxers and stained t-shirt, waving around that brown paper bag with that wild look in his eyes and the frizzy gray hair. And like most days, he will be screaming at people as they pass - obscenities mostly. And when you get just close enough to see the yellow in his eyes and the spittle in the corners of his mouth, he'll scream at you too. *Get out! Get the hell out!*

Complain if you will, but it won't do any good. People have been complaining about him for years - for as long as he's been sitting out there - ever since he got back. You see, years ago, Harry and a group of his buddies hopped on a bus and took off for Vietnam. And Crazy Man Harry was the only one to come back alive. And since then he just hasn't been the same. Something in him just snapped and he's been forced to relive this moment over and over in his head -the moment where he tried to save his friends. Where all he could do was scream *Get out! Get the hell out!*

Crazy Man Harry lives on the corner of Route 29 and Ole Wiley School Road. You don't have to live there to know him. But drive by, and chances are good he'll yell at you too. But if you don't mind, we'd appreciate it if you'd turn the other cheek, and remember that people are rarely if ever what they seem. And sometimes those "difficult" people are normal people, just like us, who got stuck in a difficult circumstance.

www.kellyswanson.net

# National News— www.aaham.org

**Important Dates for 2013:3**


- **2013 ANI—October 16-18, 2013 at the Sheraton New Orleans in New Orleans, LA**

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

2013 Certification Schedule

August 1, 2013—Registration deadline for Fall CPAM/CCAM exams

August 12-23, 2013 CPAT/CCAT/CCT exam period

September 2, 2013—Registration deadline for November CPAT/CCAT/CCT exams

October 28—November 2, 2013 Fall CPAM/CCAM exams

November 11-22, 2013—CPAT/CCAT/CCT exam period

December 2, 2013—Registration deadline for February 2014 CPAT/CCAT/CCT exams

## 2013 CPAM/CCAM Professional Certification Training Webinars

Patient Access—July 19, 2013
Billing—August 2,02013
Credit & Collections—August 16, 2013
Revenue Cycle Management—August 30, 2013

**Visit our web site for more information and to register.**

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

The Department of Financial Counseling, Division of Patient Access-Outpatient, seeks a Full-time Fin'l Svcs Audit Sup Coord to join their team to maintain the day-to-day operations of the Cobius Audit Monitoring System to include data input and scanning of documents, access approval/change control and basic user training. Coordinates the collection of financial, medical data and documents in response to audit requests. Serves as primary contact with EHR in addition to preparing audit responses at the direction of the departmental management.

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*—Denise Martin, Vendor Sponsorship / Corporate Partners Chair*

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- **October 11, 2013** **Fall Regional Conference, Warrenton , VA**
- **October 16-18, 2013** **Annual National Institute, New Orleans, LA**
- **December 11-13, 2013** **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:**

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.

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

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# What is AAHAM?

AAHAM is a premier professional organization for healthcare administrative management. Our goal is to provide quality member services and leadership in the areas of education, communication, representation, professional standards and certification. Virginia AAHAM was founded in 1982 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a based constituency of healthcare professionals.