



Dispatch

virginia-washington dc chapter

Spring 2010

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Appropriate Use of Data for Financial Projections – A Study to Maximize Managed Care Contract Performance

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Officer's Message

Greetings HFMA Members,

As we enjoy moving from the harsh cold of winter into the warm and inviting season of spring, I am reminded of the importance and renewal properties of change. A change of seasons can deeply impact our moods and behavior just as the changing healthcare and financial climate impacts our lives in a profound way.



President, Elizabeth Gerding

Over the past two years healthcare finance leaders have been faced with daunting challenges including a time of recession, a financial meltdown and looming healthcare reform. Each of these situations had the power to challenge our toughest leaders, and all three at once has been described by Richard L. Clarke, President, HFMA National, as "the perfect storm." Yet, despite the many challenges, not only have our leaders risen to the occasion, but they have in most cases, maintained financial performance at expected levels. That, indeed, is a major accomplishment.

Obviously, our challenges are not over and it is certain that there is much change ahead. As we move toward the future it is a good time to take stock of resources at our disposal that can help us to be prepared, educated and informed. HFMA is one of those valuable resources that give our members access to current information and education on issues that are impacting our industry. At the local chapter level we are responding to our members' feedback and making changes in the way we offer education. By adding more one-day sessions in regional locations, and webinars that do not require lengthy time commitments and the expense of travel, we are making education more accessible and affordable to our members. Most recently, during the months of March and April, VA-DC HFMA provided four separate sessions in Virginia and DC, three webinars and one networking event! And, the planning is in full gear for more offerings over the summer months so make sure you watch for email and direct mail announcements. As always, our website www.vahfma.org, is a great place to visit for a current calendar events and I encourage you to join in and take advantage of what our chapter has to offer.

Another benefit of your membership is access to the many resources available on the National HFMA website, www.hfma.org, the HFM Magazine, a variety of Forums and E-Bulletins and many additional educational opportunities.

May 31 marks the end of the HFMA fiscal year and with it the end of my year as your President. It has been my honor to serve in this capacity for the chapter and I would like to take this opportunity to thank all of the dedicated, talented and energetic volunteers who have served with me on the board and committees, our sponsors who insure our ability to fund important goals and initiatives, and, most of all, our members who are at the core of everything that we do.

As the age-old adage goes, "the only constant is change," and Donna Littlepage, your incoming President for the 2010-11 year is poised and ready to continue to bring positive changes and enhancements to VA-DC HFMA. Best wishes for a great year!

Elizabeth Gerding
President, VA-DC HFMA

MAKING IT
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Appropriate Use of Data for Financial Projections – A Study to Maximize Managed Care Contract Performance

By Thomas E. Persichetti

Healthcare delivery is a data-intensive business. Each patient who enters the medical system establishes a clinical and financial record. Detailed summaries of these records can help a provider identify emerging utilization trends and how these trends may impact their profitability. The purpose of this discussion is to highlight how providers can effectively use their patient volume data to predict future volumes. Examples are given in the context of managed care contracting, but the concepts discussed can apply to any financial projection.

While various types of payment methodologies exist, this discussion will concentrate on the fee-for-service (FFS) model. Under an FFS arrangement, revenues are generated by patient volumes and the intensity of the services provided. Each provider offers a unique set of services and will typically have a service profile that remains reasonably consistent, however, limited data sets and external forces can have a meaningful impact on the service profile. The goal is to gain a better understanding of data credibility and the importance of making adjustments to enhance the data's predictive power.

Data Collection

Most healthcare providers have the ability to track patient volumes. When performing financial analysis for the purpose of modeling future revenues under managed care contracts, it is important to evaluate the data's appropriateness, accuracy, completeness, and credibility.

Appropriate data consists of data that allows the provider to perform the desired analysis. For example, analysis of commercial managed care data should include only commercial managed care data and exclude all managed Medicaid or Medicare data. Data accuracy should be checked to determine whether the data set includes all various elements needed to perform the analysis, like determining whether the date range is correct or scanning the data for any duplicate records. Data completeness means ensuring that the data set includes all the data intended to be studied. For example, if performing a study of 2009 data in January of 2010, the data set, depending on system limitations, may exclude claims that have not yet been adjudicated, thereby understating the patient volumes for 2009. Data credibility refers to the relative predictive power of the underlying data set. Generally speaking, the higher the volume of data, the greater the predictive power. A more detailed explanation of data credibility appears later.

Data Selection

Management should consider what data to use prior to performing any financial analysis. When modeling utilization data to evaluate managed care contracts it is important to consider what type of analyses might be performed in this modeling. A comprehensive multi-year data set that includes the major managed care

payers is preferable. The data set should include the relevant information that will allow an analysis of the contractual terms. For example, if a facility is reimbursed on a per case basis by one payer, a per diem basis by a second payer, and a percentage of charges by a third payer, the data should capture the relevant information so that modeling can be performed on an individual payer basis and in the aggregate.

Additional considerations should be given to the time needed to collect the data as well as any limitations in the data. For analyzing commercial claims, it is important to use full year sets of data in order to minimize any variations in utilization caused by seasonality. This becomes more necessary with the increasing popularity of high deductible health plans. If there are any known limitations to the data, considerations should be made to obtain alternative data. The time and cost of obtaining alternative data should be weighed against the overall benefit. Any known data limitations must be disclosed regardless of whether alternative data is used.

Data Credibility

Data credibility refers to the sample size of the data used in the analysis. Having an adequate sample size is a significant issue in determining the usefulness of data analysis for the purpose of modeling expected revenues. If data is modeled from an inadequate sample size there is an increased likelihood that random fluctuations in patient utilization patterns could materially affect the expected profitability of future contract revenue. This is particularly important if specific considerations were made to negotiate higher reimbursements for certain services in exchange for lower increases in other areas.

Data credibility refers to the relative predictive power of the underlying data set. Generally speaking, the higher the volume of data, the greater the predictive power.

For example, consider a hospital that uses past volume information of a Managed Care Organization (MCO) to estimate the future inpatient revenue. Generally speaking, inpatient admissions occur as a result of random events. This randomness allows for fluctuations in the distribution of the number of maternity admissions compared to medical or surgical admissions. The specific distribution of admission types and the associated length of stay for any single MCO over the course of a single year may provide a weak estimate of the next year's distribution of services. The expected reliability of this estimate is a function of the variability of the admissions. This data by itself may not be reliable for modeling future revenue.

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Credibility theory can be used as a guide to understand the randomness of data that is used for predicting future events. Actuaries at MCOs use credibility theory when combining the risks of individual or small group business with larger risk classes to determine required premium rates.

For example, an MCO may be writing a premium for a group of 200 insured lives. The group's experience may indicate that the required premium is \$500/month. However, the MCO's manual rate based on the demographics of the group's population may be \$450/month. The MCO rating manual may indicate that the credibility of a 200 life group is 60%. The required premium for this group would assign 60% weight to the group's actual experience and 40% to the MCO's manual rate. The calculation of the group's required premium would be $60\% * \$500 + 40\% * \$450 = \$480/\text{month}$.

The same concept can be applied to provider utilization data to determine how to effectively model future utilization in a provider's MCO portfolio. The two main factors in understanding whether a provider's data is credible to use in forecasting future random events are volume and variability. Consider a primary care physician practice. A primary care practice does a very high volume of relatively few procedures. Looking at the distribution of office visit codes between the top MCOs that the primary care practice participates with, there will likely be little variability amongst the distribution of the top five office visit codes. Contrast the primary care practice example with the amount of claims that exceed a hospital's inpatient stop loss level. If we assume that the stop loss limit is the same for all MCOs, one MCO may have no claims exceed the stop loss level while another may have 3% of gross revenues exceed the stop loss level. The following year, the opposite may occur. Performing the analysis of stop loss provisions using the aggregate set of data from all MCOs will limit this variability. While there will still be random fluctuations for each contract, this approach increases the likelihood that actual results will be closer to expected over the entire portfolio of contracts.

So how can a provider know what data is credible to use and what, if any, guidelines can be used to determine credibility?

The best way to evaluate the credibility of the data is to look at the consistency of the distribution of claims between time periods and between MCOs. For example, if gross revenue in the ER department is 20% of total outpatient gross revenue for three straight years, then this would signal with strong credibility that ER gross revenue in future periods will be around 20%. But if one particular MCO has 30% gross revenue in one year and 15% in the second year additional consideration should be made to determine what estimate to use in projecting future revenues.

An additional method would be to use expected utilization statistics to determine what data is credible. This requires a more rigorous statistical analysis and is beyond the scope of this discussion.

Data Adjustments

Under the best circumstances, analysts will have data that is accurate, appropriate, and comprehensive. Unfortunately, this data only quantifies past experience and current conditions are often different from those in the past. Therefore, it is essential to consider relevant factors when projecting past experience into the future. It is important to focus on external influences that have occurred in the data reporting period that may have biased the data as well as any external influences in the projection period that may influence future revenues in a material way.

Political, economic, social, technological, and public health factors can all influence the future utilization patterns of commercial managed care members. Estimates of how these external factors influence future revenues is more art than science. Historical experience in like conditions may indicate the nature of these changes. For example, one may consider relevant changes in behavior in previous economic downturns to estimate the effect this may have when using 2007 data to predict 2010 utilization patterns.



Thomas E. Persichetti

While there may be numerous external influences to consider, it is best to make a list of the events that would have the most significant impact on the projection. This list is really a "what if" list. It enables the user to perform scenario tests to determine the impact of these variables. The following is an example of a list that a hospital may use to project revenues for the next 12 months:

How will the new imaging center, or expansion of services offered at competing facilities affect our patient volume?

What change in volume should we expect when a major local employer has switched their employee benefit administration to a new MCO?

Are there any services that increased as a result of the H1N1 virus that may not carry forward into future periods?

Is the increase in patient bad debt a result of the popularity of high-deductible health plans? If so, what is the trend in the growth in popularity of these plans and the impact on future revenues?

With the signing of the new health reform law, will pressure from lost revenue in Medicare Advantage plans force MCOs to take a stronger stance during our next round of negotiations?

The purpose of this exercise is to show that projected revenues are predicated on the assumption that the past is a relevant predictor of the future. While there is a strong correlation between past and future utilization patterns, estimates can and should be fine-tuned by adjusting for any known external factors.

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Even worse, if a provider accepts capitation under the wrong set of assumptions, the provider could turn an otherwise profitable relationship into a loss.

The exercise of forecasting contingent events is not an exact science. This process blends the information we do know, such as past utilization patterns, and projects it forward with considerations of information that we don't know or cannot yet quantify. It is more important to understand what we don't know rather than what we do know, as the risk lies in the unknown. Even in consideration of these unknowns, with such a wealth of data at their fingertips any provider should be able to use this data to maximize future revenues. A thorough data selection process, use of credible data, and making reasonable adjustments to reflect differences in the projection period from the baseline period can enhance the accuracy of any projection while accounting for potential risks.

Conclusion

Healthcare providers have a wealth of information at their disposal. The effective use of this information can help gain an upper edge in contracting with managed care organizations to increase revenue and provide relief from increasing budgetary pressures. While this discussion focused on an FFS payment structure, the concepts outlined can be applied to any form of payment across the risk spectrum from FFS to full capitation. In fact, as a provider is willing to take on a more risk-based payment structure, the more necessary it is to use appropriate data in making decisions. Under FFS payment, ineffective modeling can result in net revenues that do not maximize the potential reimbursement.

Meeting Photos...



Meeting Photos...Norfolk & Phoenix



Your 2010 Board



Conga!



WONDERFUL CONFERENCE, WONDERFUL PEOPLE



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Virginia HFMA Member Profile

Interview By: Raymond Bradley



Melanie Lewis, CPA

Mrs. Lewis is responsible for overseeing the internal audit and compliance functions for the 21 clinical departments of the University of Virginia Medical School. She acts as the Compliance Officer and HIPAA Privacy Officer for the Foundation. In addition, she is the Team Leader for Managed Care Contracting and handles the Foundation's liability insurance programs.

UVA Health Services Foundation is an academic medical group practice committed to the uncompromised delivery of quality patient care. HSF was founded in 1979 as a private, non-profit organization to further the interests and goals of the University of Virginia Health System. HSF provides expanded physician benefits and supports the financial and administrative functions of 21 clinical departments in a variety of ways.

The "University of Virginia" portion of the name indicates the strong relationship with the University's Medical Center and School of Medicine, however, the Foundation operates independently. HSF processes billing for UVA physician services, which are submitted and paid separately from Hospital or lab charges. HSF is a 501 (c) (3) charitable organization.

VAHFMA: Melanie, you are responsible for internal audit, compliance and privacy officer duties, with some team leader roles for managed care contracting, and some insurance programs thrown in for good measure. Tell us about your start in healthcare finance and the course of your career.

ML: Well, it did evolve over time. I started with the Medicare fiscal intermediary in Connecticut, but we moved to Charlottesville in 1988. I started as the sole internal auditor. Gradually as that function grew so did my responsibilities. I think my opportunities and growth were provided and shaped as much by the events as by my willingness to take on new challenges.

VAHFMA: Give us some examples of those events.

ML: One of the first major events was the Pennsylvania University teaching physician case. It was settled in 1996 and at that time major academic teaching hospitals were worried that the Department of Justice (DOJ) was going to go after every facility. After an internal audit of our medical documentation, we self disclosed in 1996 to the DOJ and wrote into the settlement compliance program requirement. So I inherited the compliance function.

VAHFMA: So then when HIPAA regulations hit the scene?

ML: Right then I was given the privacy responsibilities also.

VAHFMA: Well all of those connect, but how about the Managed Care contracting role?

ML: That was a different opportunity altogether. We found that we were not particularly good at communicating between the different stakeholders in the managed care contracting process and that the function was in a silo. Senior management wanted some more depth and breadth in the managed care contracting process. So I was asked to essentially break down the silos and address the physician concerns regarding contracting. We created a cross-functional team to develop strategy and then implement the strategy. Today, if any one person working in managed care contracting left the organization, the function would not miss a beat.

VAHFMA: That is a considerable shift from your primary responsibilities?

ML: Yes, but I looked at it as a team leader approach. No one from managed care reports to me and they shouldn't, but we do need to communicate and work together in order to be effective in the contracting process.

VAHFMA: So you obviously established yourself within the organization as a solution person who has the flexibility to take on new projects. What has this broader role caused you to change in your responsibilities?

ML: We have moved the compliance function from a detailed audit function to a strong concentration on education. We are using a risk based approach for both compliance audit and internal audit, including billing edits, claim scrubbers etc. Also my role allows me to handle and oversee a variety of projects including: external audits, system implementations, liability insurance, and more.

VAHFMA: So how do you get all of that done?

ML: I could not do what I do without good people.

VAHFMA: What do you look for when hiring?

ML: I have to be careful when I pick people. My personal preference is to pick staff that you can paint a vision and let 'em run. I have to balance that preference between people who are independent and also make excellent team members. We have many customers—from administration to physicians—so I look for the go-getter who can also be a team player.

VAHFMA: It sounds like you are looking for well rounded individuals, not just one particular plug and play skill set.

ML: Exactly.

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Virginia HFMA Member Profile

Interview By: Raymond Bradley

VAHFMA: So how do you advise people to develop these well rounded traits?

ML: Oh there are so many ways. Take a class outside your normal interests or field. When an opportunity comes up, step up and volunteer for it, even if it is not in your normal area. Find where your skills mesh with a project or opportunity and then use it to learn and expand. Do not give yourself boundaries. The skills needed are not necessarily the formal training you have received. For CFOs and CEOs recognize that these are great opportunities to keep people engaged and excited about their jobs.

VAHFMA: What are the hard parts of your job?

ML: Well it is no secret that working with physicians is not easy, particularly, if you have to deliver bad news. An associate of mine who is a psychiatrist said, "Most physicians are insecure and do not want to be told they are wrong."

VAHFMA: So how do you handle the problem doc?

ML: I have two buckets: "Bad actors"-those who are just plain mean and obnoxious and the "Do not want to buy in" type. The first bucket works best if you just hand them off to authority. Luckily, we have very few of this variety. For the second type, you lay out the rules with a clear internal escalation and appeal process. You have to recognize and understand that physicians, like many people tend to "shoot the messenger" when they don't like the resolution to an issue. So we use a committee, primarily of peers, to help.

VAHFMA: What are the fun parts of what you do?

ML: I really enjoyed getting into the managed care contracting. When the Team was created, we asked the question, "What do we need to get in order to continue our mission?" We got away from the "I want" and asked the "I need" questions. It took 4 to 5 months, but we really got into what do we need to sustain the organization's mission. We did intensive internal and outside verification of what we should get; we got to be the bearer of good news for a change, and developed some good cooperation with the hospital. It was also fun to get the physicians engaged in the contracting process, to get them to talk to one another.

VAHFMA: What was most effective in your negotiations?

ML: Bring a doctor into the room.

VAHFMA: Biggest hurdle?

ML: Everyone wants to be the big guy like Anthem.

VAHFMA: You have been a long time member of HFMA, but are in the physician realm, any advice for the chapter?

ML: Yes. I went to a session long ago and found it to be totally hospital based and cliquy. It turned me off. About 6 -7 years ago I went to a session in northern VA and it was excellent and provided great learning for physician groups—*Keep a balance.*

VAHFMA: What is your advice for the new person starting out in healthcare finance?

ML: Be open to new experiences; try new things, even within your organization.

VAHFMA: What are your personal interests and hobbies?

ML: Horses, we show American Saddlebreds, and music of all types, but lean toward country, blues, and rock and roll. I am taking guitar lessons and I love it, but I am terrible. It is a great way to take the pressure off my right brain and use my left brain, and it helps me relax.

VAHFMA: What restaurant would you recommend in the Charlottesville area?

ML: Well, we have many wonderful ones, but my husband is a chef so we are a bit picky, we like an Asian fusion tapas restaurant called, "Bang! "

VAHFMA: Melanie thank you for taking the time to chat with us today.



7 Ways to Minimize Your RAC Financial Risk

By Brian Shannon

The Recovery Audit Contractor (RAC) demonstration project found over \$1,000,000,000 of improper payments from just a handful of states. The permanent program will likely generate several times that amount. Even though your organization may not be receiving many complex review letters yet, you should be preparing to minimize your financial exposure as much as possible. Here are seven ways to accomplish just that:

1. Mail Yourself a Mock RAC Letter

Many providers are concerned about how the RAC letters will be handled in their facilities. Some popular questions are: Who will the RAC letter be routed to within our hospital? How long will it take for that letter to get to the right person after we receive it from the RAC? Will there be any consistency to how our internal team treats this process?

One quick and inexpensive way to address these questions is to mail yourself a letter as if it was from your RAC. Go ahead and make it look official, address it to the person who is responsible for RAC letters and document exactly what day you put it in the mail. Then, wait to see what happens. Even if you are already receiving letters from the RAC and they appear to be handled correctly, I would suggest that you mail a sample letter every month to ensure that your process is still running smoothly. (If it is not, wouldn't you want to learn that from a practice letter before you miss a deadline with your RAC because the right person did not receive their mail in time?)

2. Review All Four RAC Websites

All issues need to be formally approved and posted on the RAC websites before they can pursue those with providers. Given that, review your regional RAC website on a weekly basis to see if there are any updates. However, do not stop there. Take a few minutes every couple weeks and review the other three RAC sites as well. If a different region has had success with a series of DRG's, it only is a matter of time before your RAC will add that to their approved list as well. Be pro-active and see what is going on from a national basis and get your team prepared. You can learn more about the four national RAC's at: www.aha.org/rac.

3. Increase Your Billing & Coding Resources

While medical necessity was the category that produced the most improper payments during the demonstration project, the permanent program has only approved DRG related issues as of the first quarter of 2010. Many hospitals have built up their RAC team largely focused on clinical resources, but they do not seem to have added certified billers and coders to meet the increased demand that is soon to be coming. If your facility gets inundated with RAC letters, your existing team members will likely not be able to handle all of that additional work. I would encourage you to add another FTE if possible or partner with a company who could provide this as a service to you. Doing nothing will probably result in adding to your financial exposure from the RAC's.

4. Plan for an Audit Revolution

Given the overwhelming financial success of the RAC demonstration project, all other payers must be salivating over the opportunity to perform similar audits on you in the future. While this is painful to think about, your audit concerns need to focus on more than just the RAC's. Plan for Medicaid, Blue Cross, United, Aetna, etc. to quickly piggy-back off of the wild success that the RAC's have had.

Accordingly, your internal committee should probably not be called your "RAC Team" but rather your "Audit Response Team." Think more globally about how auditing will change in the near future. It would be helpful to have a plan in place to handle audits that come from any payer, not just RAC.

5. Focus on Getting it Right from the Start

While responding to the RAC's is a necessary endeavor, your real goal should be much broader than that. In an ideal world, you would like the auditors to never find any reason to come calling. In order for that to happen, you must be focused on revenue integrity and data correctness right from the start. How do you do that?

Get more committed to your denials management process! Regardless of how good you think it is now, there is always room for improvement. You probably need to have parallel task forces to accomplish this. One would be for your newly named "Revenue Integrity Team" and the other would be your "Audit Response Team." The combination of both of those efforts will produce short and long term results which will pay dividends to your organization.

6. Be Prepared for the Long Haul or Partner with Someone Who Is

Even though a defined appeals process has been established for the RAC's, that timeframe has turned out to be much longer than anyone expected. For example, there are many providers from the demonstration project that are still waiting to have resolution on their appeals. Given that the permanent program will grow to 50 states, what will the appeal timeline look like for you? Common sense would suggest that many appeals in the future will take years to finalize. Given that, do you have the time, resources and patience to work through this process over the course of several years? If you are not sure, I would encourage you to partner with a company who can help you do just that. And, make sure they charge you a flat fee for the appeals; otherwise you may end up winning the RAC appeal but giving all of your proceeds to your vendor.

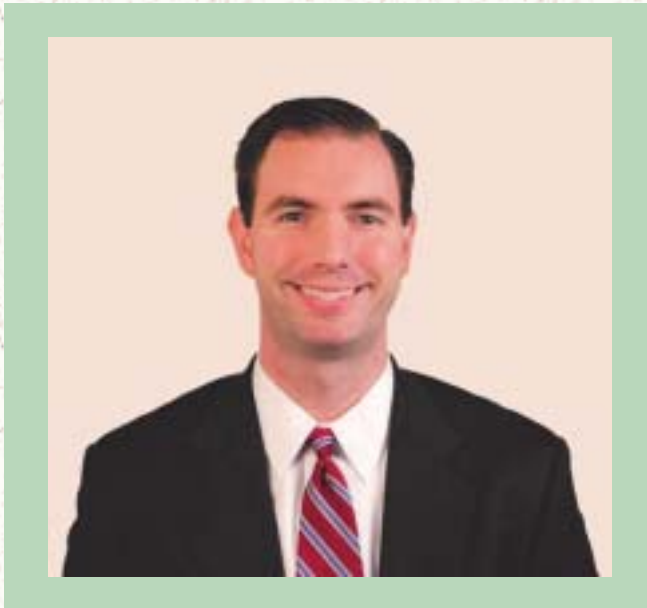
7. Build Your External Team and Plan for Implementation

Many providers THINK they have everything in place to manage all of the audits coming their way. However, so did most of the hospitals during the demonstration project. The unfortunate reality is that many of you need help. If you cannot pull together funds to add FTE's, then partner up with external resources who can help. You should have a RAC attorney who you can call when you need their services. Additionally, do you have a company that can provide both DRG and medical necessity claims review and support in the event your existing team cannot manage the increased volume?

Hopefully you will not need to utilize all of these services, but since you cannot really tell what your workload is going to be it is wise to set some partnerships up now.

If you agree that you may need some external help, please remember that most partners need some time to implement. You need to sign an agreement and then given the nature of the RAC reviews, you may also need to set up electronic access to your system. This can take two or three months. Don't wait for the RAC's to create a problem for you, proactively plan for success in this area.

Hopefully these ideas will help minimize your current and future financial risk related to the pending audits. While it can sometimes be difficult to plan for the unknown, there is simply too much at risk not to be prepared. Do yourself a favor and implement the steps above. It would be great to have all of them in place and not need them than the other way around!



Brian Shannon is a writer, trainer and member of the National Speaker's Association. Additionally, Mr. Shannon is President of the EJB Group, an international company specializing in healthcare sales, leadership and productivity.

He has worked with hundreds of healthcare providers over the years sharing ideas and information on opportunities related to the entire revenue cycle. Mr. Shannon is also currently partnered with a variety of best of breed companies who provide services to hospitals. Brian resides in Charlotte, NC with his wife and two children.

If you would like to learn more about him, please visit his website at www.brianshannon.net.

It's been a long, long time comin', but I know a change is gonna come....

By Chuck Salvo

After nearly one year of contentious debate (which still remains), President Barack Obama signed into law the *Patient Protection and Affordable Care Act* on March 23, 2010. The sweeping legislation will impact nearly every entity that delivers services in the healthcare sector, from patients and insurers to physicians, hospitals and pharmaceutical manufacturers. The most significant and far reaching provisions are those aimed at ensuring access to a portion of the nearly 47 million Americans who currently do not have health insurance.

And while 14 state Attorneys General have filed suits claiming that certain provisions are unconstitutional, the tenets of this package are unlikely to be overturned and our members need to start preparing for enormous change. For providers, those changes are most glaring when you consider:

- The compound annual growth rate of Medicare spending is to be reduced to 1.4% between 2010 and 2019 (it was 8.1% between 2008 and 2009).
- Federal and state DSH payments to decrease by a combined \$43 billion over 10 years.
- New physician owned hospitals are prohibited as of December 31, 2010 and in-office ancillary payments to physicians will sharply decline in 2011.
- Part B payments for certain surgeons, and primary care providers, will increase substantially. Approximately 29.5 million newly insured healthcare consumers will enter the market.

Although the bill tops out at more than 2,400 pages, the VADC Chapter can provide you and your organization with valuable guidance on specifics of the bill, tools to help you assess the bill's impact and connect you with industry experts who can help guide your organization as the reform package is gradually implemented. Whether you are a reform proponent or an opponent, as Sam Cooke so soulfully put it, a change is gonna come.



Chuck Salvo
Publications Chair
(charles.salvo@lewin.com)

News and Notables

Congratulations to Chuck Salvo and wife for being proud parents of a newborn baby boy!



"You did it; it's a big f---ing deal."

Vice President Joseph Biden, March 23, 2010

VP Joe Biden was overheard on a live microphone expressing his excitement as President Barack Obama signed into law a sweeping package of reforms aimed at improving access and reducing healthcare costs.

"This is a way to keep your hand in it a little bit,"

Jerry Dooley (SWVA Today, 3/05/10)

Jerry Dooley replaced Eric Deaton, who ended his nearly three-year tenure at Wythe County Community Hospital to become CEO of the 300-bed Danville Regional Medical Center. Dooley will fill the role as Interim CEO and last served as CEO of Terre Haute Regional Hospital in Indiana.

Novant Health posted a \$197 million profit in 2009. The Winston-Salem-based health-care system added three hospitals in 2009, including Prince William Hospital and health system in Manassas, VA.

"There is management in place that will continue to run the hospital with outside consultants. This is not going to be the city running the hospital."

David Catania, Washington DC City Councilman (Washington Post, 4/15/10)

After failing to make its \$2 million-plus annual payment in lieu of taxes and to maintain performance measures, the DC government seized control of United Medical Center from operator Specialty Hospitals of America. The move comes less than three years after the company took over the former Greater Southeast Community Hospital.

"If a person decides not to buy health insurance, that person by definition is not engaging in commerce. If you are not engaging in commerce, how can the federal government regulate you?"

Virginia Attorney General Kenneth Cuccinelli (Reuters, 3/22/10)

A.G. Cuccinelli filed a suit in Federal court claiming the reform package fee imposition on persons without healthcare insurance violates a recently enacted state law protecting the right of Virginia residents to refuse unwanted health insurance. Since the bills passing, 13 other state attorneys general filed suits claiming the Health Reform package exceeds Congress's powers to regulate commerce, violates 10th Amendment protections of state sovereignty, and imposes an unconstitutional direct tax.

Meet This Town: Charlottesville

Home to over 40,000 residents and located less than 70 miles from our state's capital, Charlottesville, VA is well-known for history, entertainment and a diverse industry. In 2004, the City was ranked as the Best Place to Live in America, and has consistently been listed as one of the Best Places to Live and Best Places to Retire by Money and Fortune Magazine (Charlottesville.org). Charlottesville is home to famous writers John Grisham and Rita Mae Brown. Past authors that claimed it as home included Edgar Allan Poe and William Faulkner. The City has a history of being a readers' and writers' paradise and also appeals to entertainment and education seekers.

Perhaps the most recognizable heritage in Charlottesville is Monticello, the home of Thomas Jefferson. It was built in 1770 and is still visited by many tourists today (Monticello.org). On the mountaintop, you will find many venues of entertainment. There are guided tours of the home, garden tours, wine tasting, a museum, and the graveyard of Thomas Jefferson himself. A full day can be spent enjoying the history of our great country.

Thomas Jefferson was not the only president to call Charlottesville home. Our fifth president, James Monroe, claimed this city as well. His home place is known as Ash Lawn-Highland and is open for tours, museum events, and gift shop visits(ashlawnhighland.org).

Aside from being full of history, Charlottesville is also full of fun. The Charlottesville Pavilion is located right Downtown Charlottesville and includes events such as 'Fridays After Five' that involves musical entertainment, food, drinks, and outdoor seating. For 2010, these events start on April 23rd and go through June 25th. Some of the upcoming Pavilion headliners are Sheryl Crow and B.B. King. You can't beat great entertainment and nice, warm weather!



If you're in the mood for fine wine, don't forget to visit the Arcady Vineyards. With the purchase of one ticket, a guest can visit either four wineries or two wineries and two breweries. The tour guide can pick you up from your hotel and escort you along the Monticello Winery/Brewery Tasting Trail. Half way through the tour, the guide will serve you an appetizing platter of cheese and locally-made chocolate and fruit. Visit www.arcadyvineyard.com for more information.

Other vineyards in the Charlottesville area are Jefferson Vineyards, Barboursville Vineyards, Horton Vineyards, Sugarleaf Vineyards, and First Colony Winery.

Looking for the creative environment? The Glass Palette may be a good stop during your Charlottesville trip. It's an interactive glass art studio where you can make gifts or

keepsakes to remember your trip. The tools, materials, and instructions are provided for you. You can choose from an array of activities such as making beads, stained glass, sandblasting, or fused glass jewelry with precious metal clay. A few other artsy creations can include picture frames, bowls, plates, vases and coffee mugs. More information about the Glass Palette can be found at <http://www.theglasspalette.net/pages/walk-ins.html>.

Another hidden attraction in Charlottesville is the Carter Mountain Orchard. It will reopen for the season on April 16th and will be open through November. On your trip to the orchard, you can pick your own fruit to purchase, enjoy the views of the beautiful mountain, visit the vineyard, and join in craft festivals (depending on the time of year). There is also a Mountain Grill that includes Aunt Sarah's Bakery with home-made apple cider donuts, fresh-baked apple pies, apple caramel cookies, and delicious lunch foods. Apple butter, jams, jellies and gift items can be found in the Country Store at Carter Mountain Orchard.

As you can see, there is a plethora of activities to be enjoyed in Charlottesville, VA. We are lucky to have such a wonderful, historic landmark right in the center of our state. Anytime you're in the area, it is definitely worth the trip to *Meet This Town!*

In a surrounding area of Charlottesville there is a company called Blue Ridge Balloon and you could go for an evening of hot air balloon riding if you have the time to drive about 30 minutes from the city.



THE HEART OF A LEADER

By: Sheryl Roush

“Leadership is not so much about technique and methods as it is about opening the heart. Leadership is about inspiration—of oneself and of others. Great leadership is about human experiences, not processes. Leadership is not a formula or a program, it is a human activity that comes from the heart and considers the hearts of others. It is an attitude, not a routine.” - Lance Secretan, Ph.D., Industry Week

Yesterday's style of leadership of control, manipulation and intimidation are old-school and ineffective. Today, people are being deemed as the most valuable asset in any organization, causing leaders celebrate the skills of individuals on their team, and learn to harness intrinsic motivators to make their people shine. Human Resource departments are shifting the paradigms to “talent management” to retain quality staff and those valued “human assets.”

Organizations are only as successful as the men and women who make them work. HR Expert Susan Heath writes, “Employee involvement is creating an environment in which people have an impact on decisions and actions that affect their jobs... it is a management and leadership philosophy about how people are most enabled to contribute to continuous improvement and the ongoing success of their organization.” The level of trust in command has been built on being able to speak one's mind, offer input into the decision, then acting in full support of that leader's final decision.

Team members ask two consistent questions: “Where are we going?” and “How am I doing?” They are asking for the Mission, Vision, Direction, and Feedback on their personal performance. They seek leadership to offer them that. Once established THEN they can step up as leaders in their own life, and become truly “empowered” to do their tasks well.

Of the things that people want in organizations is being assigned interesting and challenging work is at the top of the list. People do want to be delegated tasks, but not “dumped on.” It is HOW the work is assigned. They want to improve their skills and be empowered to think for themselves. People want to be heard, even if their ideas cannot be implemented.

Harvard University psychological theorist David C. McClelland, indicated that the three things that make a great place are: 1) you trust whom you work with; 2) you have pride in your work; and 3) you enjoy the people with whom you work. My own research within organizations reveals that pride is never an issue – people have it. It's the other two items that challenge teams. If trust—in any relationship—is destroyed—it is the hardest to rebuild. Author Marsha Sinerar, writes “Trust is not a matter of technique, but of character; we are trusted because of our way of being, not because of our polished exteriors or our expertly crafted com-

munications.” During times of change in an organization trust can be built by frequent, concise, and accurate communication, reinforced by timely follow-through on promises made.

Our lives need to have meaning and have significance today, more than ever. Warren Bennis, bestselling author of *Leaders* and *On Becoming a Leader*, concludes that at least 15% of an organization's success is due to leadership. Professor Bennis further believes “Good leaders make people feel that they're at the very heart of things, not at the periphery. Everyone feels that he or she makes a difference to the success of the organization. When that happens people feel centered and that gives their work meaning.”

Marcus Buckingham's research through the Gallup Organization, published in *Now, Discover Your Strengths* and *Go Put Your Strengths to Work*, is streamlined information based on the premise “Great leaders discover what is universal and capitalize on it. Great managers, by contrast, perform their magic by discovering, developing and celebrating what is unique about each person who works for them.” Buckingham suggests “we need to know how to identify people who have it (leadership), or at least the potential for it. We need to know how to create an environment that nurtures it and celebrates it.”

Leadership, management and mentorship are siblings in the same family. Our world will always need all three. What does it take to truly be a great leader today? As the song lyrics from Van Buren Benny suggest, “You 'gotta have heart!”

From *Heart of a Woman in Business: Stories, Strategies and Skills for Business Success*, by Sheryl Roush (Book).

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Sheryl Roush, President of Sparkle Presentations, Inc., is an internationally top-rated trainer, conference keynote speaker, and retreat facilitator. She has presented to HFMA. She has authored 13 books including the Heart Book Series and presented over 3,000 programs in nine countries, that rekindle the spirit, raise the bar, and create excitement. Sheryl is a Past District Governor of Toastmasters International and earned their elite Accredited Speaker designation for outstanding platform speaking skills. She has been a Professional Member of the National Speakers Association since 1990 and earned both the Member of the Year and the Golden Microphone awards. Sheryl is also a Past President of ICF/San Diego Professional Coaches Alliance.

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