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Strategic Guidance for Healthcare Executives

Optimizing Healthcare Revenue and Achieving Compliance in a Complex & Evolving Regulatory Environment

June 7, 2018

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Introduction

Running a healthcare operation was complex even before recent activity shook the industry into a near-constant state of flux. Whether considering the shifting relationship between payers and providers, increased cyber-security threats, outcomes-based models, or any of the seemingly countless concerns, the need for organizations to stay one step ahead of change has never been so great.

At AAFCPAs, we take that goal to heart. Our work in the healthcare space requires us to be vigilant about risks faced by Community Health Centers, behavioral health providers, in-home and senior care facilities, and private medical practices. We frequently delve into subject matter that helps our clients direct their operations, remain compliant, and manage profitability.

Our guidance is founded on four decades of experience providing healthcare clients with incisive financial knowledge and strategic management advice. As the industry evolves, we embrace the opportunity to continue to collaborate with our clients to help drive financial and operational improvements to make you thrive!

Please contact me with any questions, information, or expertise advise.

Matthew Hutt, CPA
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"AAFCPAs are proven leaders in Healthcare! I like and enjoy that my AAF Partners regularly speak at industry events. They are very involved and knowledgeable with Community Health Centers and have the respect of all in the industry. As a client, this makes me feel good and also speaks volumes for the quality and value of the firm."

John Chambers, Chief Financial Officer
DotHouse Health Inc.

AAFCPAs Advises Healthcare Providers to Position Themselves for Change

We may not be able to fully predict how future changes to the Affordable Care Act (ACA) will affect the healthcare system, but AAFCPAs advises healthcare clients to position themselves for change. AAFCPAs' Matt Hutt reflects on recent healthcare reform news, and shares insight into what providers may expect.

Healthcare providers must position themselves for change, and focus on short and long-term Strategic Planning. Providers should now: assess the profitability of programs & services, watch expenses, contain costs, and control risks.

Providers should consider discontinuing/ outsourcing services that are not a loss leader, and that cost the organization, for example: Lab and Social Service Programs. Providers may consider adding more profitable programs/ services, such as Pharmacy.

Healthcare providers should re-evaluate their necessary levels of financial reserves. This should be incorporated into their cash management and investing strategies.

Providers must be careful now of investments and growth plans while there is so much uncertainly with healthcare reimbursements. Some of the really big providers are now struggling with their fiscal health, arguably because they grew too big too fast by expanding their footprint and service offerings.

Providers should evaluate the benefits of forming strategic alliances (healthcare collaboratives) with complementary providers, such as: a Community Health Center providing outpatient/primary care services aligning with a Hospital to provide inpatient services, or aligning with a Human & Social Services agency for Behavioral Health services. Alliances may offer meaningful benefits, including: shared revenue & costs, enhanced geographic footprint, and perhaps most significant: access to a more diversified patient group. When it comes to the reimbursement landscape, the more diversified your patient group, the more

safeguarded providers are from risks. AAFCPAs has advised clients in forming mergers and strategic alliances, helping them to optimize and leverage each other's strengths.

Providers may be able to improve quality and

> "When it comes to the reimbursement landscape, the more diversified your patient group, the more safeguarded providers are from risks."

outcomes, and provide services as part of an integrated delivery system by participating in an Accountable Care Organization (ACO) model. We have advised behavioral health agencies on the implementation of community partnership programs and the financial impact that these can have on the agencies' operations.

Now more than ever, the healthcare industry has myriad rules and regulations, and today's providers are navigating significant changes in the way they conduct business and care for their patients. Providers must quickly adapt to the changing regulatory environment, and capitalize on emerging opportunities to reduce costs, streamline efficiency, and achieve more coordinated and integrated forms of healthcare delivery.

Identifying Strategic Partnership Options for Provider Organizations Navigating Reimbursement Complexities

Behavioral health is one of many healthcare sectors caught in the midst of uncertainty, as healthcare reform again stands on the cusp of massive changes. With the reimbursement model shifting from fee-for-service to fee-for-value, provider organizations are tasked with understanding those changes, while determining what an episode of care entails.

Behavioral health is one of the areas that remains ambiguous. Pricing for behavioral healthcare continually stumps payers, as ongoing care is typically needed. Medicaid has traditionally helped patients with behavioral health issues seek the treatment they need, but with the cuts the government is currently suggesting, behavioral health could be fundamentally affected.

As such, payers must evaluate how they will structure their value-based reimbursements in this area. One solution relies on the emerging model of population health — health outcomes that apply to a large patient population.

Population health has been a hot topic in the healthcare industry and is considered a key component in ensuring that higher quality care at lower costs can be delivered to population

"Behavioral health is one of the areas that remains ambiguous. Pricing for behavioral healthcare continually stumps payers, as ongoing care is typically needed."

groups. Using this as part of the solution, however, is largely dependent on provider organizations' ability to effectively extract proper data and analytics.

Behavioral health must be integrated into a population's health profile to ensure patients receive a holistic and coordinated plan for care delivery. Financially, health management is complex because first-and-foremost there are

limited funds, and payers are figuring out how to approach these health issues that don't have an easily defined episode of care. Healthcare organizations are evaluating the most efficient and effective way to allocate the money they do receive, and preparing for risks that appear when the patient cannot "get better" and a penalty is inevitable.

In Massachusetts, we are seeing community health centers and behavioral health agencies experience common patient overlaps, which is causing a natural integration between the two organizations.

At first, these providers assumed the government would view the integration as positive, resulting in higher billings. Unfortunately, it has been difficult to take a holistic view of how behavioral health affects the entirety of the patient's journey. As ACO (accountable care organization) models gain popularity, billing and risks need to be accounted for.

At AAFCPAs, we work with provider organizations' CFOs and executive management to support readiness for value-based reimbursement models, including: establishing

"We advise our clients to evaluate the complete care coordination process as it applies to the entire continuum of care."

the financial flows and solutions for long-term services that serve the patient base. As provider organizations focus on behavioral health and the perspective payment systems, it will be critical that care is coordinated and that all ongoing medical issues are anticipated. We advise our clients to evaluate the complete care coordination process as it applies to the entire continuum of care.

A major concern we hear is around the Centers for Medicare and Medicaid Services (CMS)

Our clients are currently seeking our guidance and expertise on the following questions:

- How do provider organizations best identify and coordinate with financially strong partners that provide high quality care?
- How do providers anticipate the financial impact that is going to accompany confusing reimbursement models?
- How can they best navigate the integration between behavioral health agencies and PCPs?
- How can they mitigate payer penalty risks, and support a potential loss incurred?

approval of the 1115 waiver (the waiver supports the restructuring of the MassHealth program to provide integrated, outcomes-based care to 1.9 million Massachusetts residents), and if that pool of money is going to help provider organizations get their program off the ground. As this waiver could potentially be repealed, we advise organizations to:

- Understand the implications of MassHealth Reform
- Develop innovative care delivery solutions that are less costly and more efficient
- Evaluate their financial structure and identify organizations with which they can partner
- Establish a cash reserve to account for reimbursements they may not receive under the fee-for-value model or to cover unforeseen penalties
- Develop a proposition plan to present to ACOs based on realistic data, and prepare to answer questions received based on analysis & facts

As the financial performance of provider organizations continues to be directly correlated to the quality of care, it is important to maintain the proper partnerships and solid infrastructures needed, especially when care for behavioral health requires provider, payer and patient to work together to achieve optimum outcomes.

Best Practices for Complying with HIPAA & Safeguarding Patient PHI Accessible to your Business Associates

Providers' responsibilities for protecting "electronic health records remain likely to be a top target for hackers," Experian found. To further heighten & complicate these risks, providers' responsibilities for protecting personal health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) extend to certain vendors, referred to as "business associates (BAs)" in the HIPAA regulations. Healthcare, behavioral health and other organizations that maintain and process PHI need to have sound controls, policies and procedures to protect patients' PHI, and these controls, policies and procedures must also extend to all BAs who have access to PHI.

Who is a HIPAA Business Associate?

A business associate is any organization or person working in association with, or providing services to a covered entity (HIPAA-covered entities include health plans, clearinghouses, and health care providers in certain situations). Some of the most common BAs with access to PHI include: lawyers, accountants, outsourced billing providers, consultants, data/cloud storage vendors,

> "Providers' responsibilities for PHI under HIPAA extend to certain vendors…"

contracted healthcare/ancillary service providers, translators/interpreters, IT vendors, and claims/coding consultants.

When it comes to PHI and HIPAA, preventative controls, policies and procedures must also extend to BAs

AAFCPAs advises covered entities to implement a robust HIPAA/PHI training and education program for all members of the workforce. We also advise providers to develop and institutionalize a Risk Management Program, including an ongoing risk assessment process. The risk management program & assessment for HIPAA covered entities should

incorporate BAs and the extension of risk they pose for a healthcare organization.

One of the key themes within HIPAA is to limit the collection and transmission of PHI to the minimum necessary. Providers should implement policies and controls that anonymizes key PHI to limit what is available to BAs. This can be done through removing personal identifiers from reports provided to BAs, or by building parameters into electronic medical record (EMR) or other systems to limit identifiers or make them anonymous.

Protect PHI and Mitigate Risks with Business Associate Agreements (BAAs)

In many cases, PHI breaches occur in the transmission of data between healthcare organizations and their BAs. These transmissions typically occur at the beginning of an engagement with a BA, and at the conclusion of an engagement or project. AAFCPAs recommends that clients have a clear understanding of your BAs' controls, processes and procedures and the risks they pose for the covered entity. Providers must have compensating controls to ensure vendors and BAs are properly securing and transmitting PHI.

Business associate agreements (BAAs) can be a critical tool for understanding & documenting these controls, processes and procedures, and ultimately in protecting PHI. BAAs are a contract between a HIPAA-covered entity and a HIPAA business associate, and they stipulate and document how the BA will use, disclose and reproduce PHI, safeguard PHI, and notify the covered entities in the event a breach of PHI occurs.

AAFCPAs reminds clients that the BAA document in and of itself does not eliminate

AAFCPAs has highlighted for your consideration some best practice recommendations for mitigating the risk assumed by organizations through their BAs.

Transmissions of all PHI should be done with security in mind and by ensuring healthcare providers and BAs have email encryption and secure data transmission protocols in place.

It is critical that provider organizations obtain signed BAAs before any PHI is transmitted to a BA.

Healthcare organizations should ensure that BAAs are updated annually, or periodically depending on changes with BAs, or stipulations within BAAs. BAAs may be in effect for a specific term, or cover the organization and the BA in perpetuity, depending on the nature of the services provided.

Consider customizing BAAs depending on the consultant / service provider relationship. Customization may specifically define terms, such as: the duration of the project / engagement being performed, the level of access to PHI given to the BA, and approved uses of the PHI.

Often BAs utilize subcontractors to perform services. BAs must incorporate subcontractors into BAAs when applicable, and the covered entity should understand the BA's controls over transmission of PHI to subcontractors.

Make the BAA a part of your routine vendor or service provider on-boarding process, and new vendor approval process, including potentially performing background checks as new BA relationships arise.

Healthcare providers should perform a periodic inventory of vendors to determine whether they have access to, or possession of PHI and conclude whether a BAA has been obtained or needs updating.

A significant risk with PHI is that BAs may retain PHI in unsecure databases or servers well after the conclusion of an engagement or project, and after the BAA effective period has lapsed. Healthcare organizations should stipulate best practices within their BAAs to ensure BAs are properly securing PHI. Some of these best practices include secure storage of PHI, and destruction of PHI at the conclusion of any project or engagement by a BA. Consider getting confirmation from BAs when PHI is destroyed (and stipulating that requirement in the BAA).

Healthcare entities should assign a responsible party to own and manage the BAA process. Common BAA champions for healthcare organizations include the chief compliance officer, CFO, a member of the business office, or an IT team member. This person should be responsible for keeping an inventory of BAAs, including their effective dates, and understanding high-level controls that BAs have in place over PHI.

your risk. These agreements serve as a guide in understanding risks and control activities, but formal risk assessments provide management with assurance that key business processes have control activities in place, and that they are achieving the organization's objectives to protect PHI.

The ramifications of a PHI breach, including damage to a provider's reputation as well as criminal and civil fines, are too significant to not have key preventative measures in place to mitigate the risks of breach or violation.

AAFCPAs advises clients in developing and institutionalizing risk management programs, including establishing ongoing risk assessment processes. In addition, our Business and IT Advisory practice helps clients better secure

"...The BAA document in and of itself does not eliminate your risk."

patient data by providing HIPAA Security Rule assessments, subservice provider controls assessments, IT security assessments, and data de-identification /Safe Harbor Rule.

Denials Management: Best Practices in Improving Revenue Cycle Processes & Monitoring Third-Party Denials

The complexities surrounding third-party revenue cycle management, patient eligibility, and systems capabilities to support process design changes continue to increase, as do third-party claim denials across virtually all payers. Denials can affect the bottom line of healthcare organizations, leading to lost revenue and productivity; however, in many cases, denials are preventable. In order to prevent denials, it is critical that healthcare organizations develop & implement an effective denials management process,

"Denials can affect the bottom-line of healthcare organizations, leading to lost revenue and productivity; however, in many cases, denials are preventable."

including: strong controls & processes at all stages of the revenue cycle; active monitoring to understand the nature & cause of ongoing denials; and an ongoing commitment of continuous improvement to prevent denials, and improve collections. AAFCPAs provides the following best practices, and key denials management principles and techniques to guide our clients who are healthcare providers in developing and institutionalizing a denials management process.

Preventative Measures Over Denials in the Revenue Cycle

An effective denials management process follows the entire revenue cycle from beginning to end.

AAFCPAs believes that it is crucial for organizations to dedicate sufficient resources at the beginning of the revenue cycle, including: front-desk staff training, financial counselors and effective insurance verification. These resources and processes should be complemented with a strong cash-collection process over co-pays and nominal charges. AAFCPAs encourages clients to

actively monitor the ratio of point-of-service cash collections to total cash collections. Organizations that maximize patient-portion collections at registration minimize collection costs post-encounter, and improve this critical key performance indicator.

After an encounter has taken place, and the billing and collection responsibilities have transferred to coders and billers, providers should apply a claims check or "scrubbing" process that allows for billers to identify potential denials before they are submitted to insurers. Effective claims scrubbing processes are far less costly than re-billing and chasing an already denied claim.

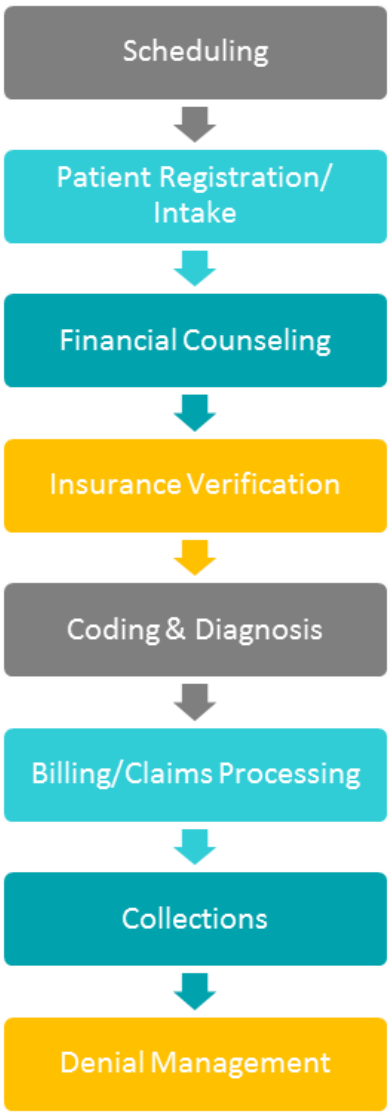
At the back-end of the revenue cycle there are a myriad of controls and processes that should be in place to monitor, track and follow-up on third-party payer denials. Effective denial management is only as strong as the resources dedicated to the process. Practice management systems capabilities may need to be reviewed to ensure your organization is effectively tracking the necessary denial data. Further, the

"Effective denial management is only as strong as the resources dedicated to the process."

system must be capable of producing meaningful reporting to support improvements.

Once the nature and extent of denials is reportable, management may begin to analyze and correct claims for resubmission. AAFCPAs encourages clients to focus on the "low hanging fruit" initially to improve collections. Immediate attention should be given to claims that are preventable in nature. Once a proper denial reporting process is in place, systematic issues resulting in repeat denials should become apparent relatively quickly. Common preventable claims include: letting payer billing deadlines lapse, provider credentialing issues, patient eligibility issues, coding errors, and prior referral / authorization documentation, among others.

Denials Management Must Be Addressed at All Stages of the Revenue Cycle:



In order for denial management to be effective, organizations must commit to dedicate specific billing personnel and other resources to regularly monitor, report and re-bill denied claims. This team should have a mindset and clear expectation of continuous process improvement to remedy preventable denials at the onset of the encounter.

Implementing Key Performance Indicators (KPIs) over Denials

After organizations have implemented preventative measures over denials to the revenue cycle, the next step is implementation of regular reporting and management. Depending on service type, programs, and nature of the organization, healthcare entities should identify the key performance indicators over denials that are most critical to identifying trends and ensuring billing and collections are operating as effectively as possible. Some common KPIs for denial management include: collection ratios, denial write-off ratio, denial re-submission collection rate, and clean claims submission rate. Implementing KPIs over denials to monthly financial reporting will help set goals and expectations to further define success over the third-party billing processes.

Understanding Denial Causes

The need for a robust denial management process should be clear. As healthcare organizations continue to merge, take on alternative payment contracts, expand and diversify services, it is ever more important to delineate the causes and sources of denials. Based on certain payer-specific requirements, or community program requirements, some denials are inevitable. Denials should be tracked and reported for program accomplishment and statistical purposes, and classified as preventable versus non-preventable. Some of the most common issues that come to light after denials have been effectively reported and summarized are often isolated in nature. For example, healthcare organizations may find that one single provider site is an outlier causing more denials, and that these are due to front desk control breakdowns specific to that site. Given the rate of provider turnover in the healthcare industry in recent years, it is not uncommon to learn that a significant amount of denials are related to delays or errors in credentialing new providers. Additionally, a thorough analysis of denials will identify issues with specific payers and will give billing and collection personnel the opportunity to troubleshoot claims up front with that provider.

"Healthcare entities should identify the key performance indicators over denials that are most critical to identifying trends and ensuring billing and collections are operating as effectively as possible."

AAFCPAs' Healthcare Consulting & Reimbursement Solutions

This denials management guidance is a fine demonstration of the insights gained by

AAFCPAs having spent over four decades providing incisive financial knowledge and strategic management advice to help our clients obtain optimal reimbursements, maintain regulatory compliance, increase cash flow and sustain performance. Our Healthcare Practice, and integrated Business Performance, Internal Controls & IT Advisory Practice provides best practice recommendations and operational process reviews surrounding third-party billing and collection, accounts receivable management, reserve analysis, fee schedule analysis, business process improvement, and recommendations for implementing denial management processes. Additionally, AAFCPAs advises clients in the creation and customization of reports and key performance indicators, so clients are positioned to understand trends and mitigate potential issues relating to their denial management process. We utilize advanced, data extraction software to summarize denial data directly from practice management systems, and convert that data into useful graphs, charts and tables to help management quickly analyze and understand the reasons for denials.

Best Practices for Maintaining Your Charge Description Master to Maximize Revenue

AAFCPAs reminds healthcare clients of the critical impact an accurate and up-to-date Charge Description Master (CDM) can have on the organization's revenue cycle success. The CDM is the *central mechanism of the revenue cycle*, and the accuracy of the data elements serves as a link between service delivery, billing, and optimal reimbursement. Missing

"CDM is the *central mechanism of the revenue cycle*, and the accuracy of the data elements serves as a link between service delivery, billing, and optimal reimbursement."

charges, over charges, and coding errors can adversely impact your revenue and create significant compliance issues, including penalties for charge overages.

AAFCPAs advises clients to perform routine maintenance of the CDM at least annually, and ideally quarterly. Additionally, the CDM should be examined outside of routine maintenance with the addition of new services, payer contract changes, or other internal corporate changes. Keeping an accurate CDM will help maximize revenue and avoid payer denials.

Healthcare Organizations Should Address These Items While Reviewing Their CDM:

- Reimbursement codes should be available in both the Electronic Health Records (EHR) and Practice Management (PM) systems to ensure all services provided and documented are billed.
- New, current year codes should be added prior to their effective date.
- Outdated codes should be marked expired with their corresponding effective date.
- The charge fee schedule should be

analyzed throughout the year and compared to your payer contracts; monitor for any charge fees that may be set lower than the reimbursement rate.

- National Drug Code (NDC) numbers should be current and accurate.

Other data elements to review include:

- Global days set correctly
- Departments or modalities attached to codes
- The accuracy of code descriptions
- Default place of service for codes
- Modifiers attached
- Revenue codes added

Note: The items listed are not all inclusive, and could differ based on your PM system's capabilities, specialty, or other billing rules.

Review the Charge Fee Schedule

Most organizations start setting their fee schedule by a percent of Medicare, e.g. 150% or 200% of the current year Medicare allowable. This is a good foundation to start, but AAFCPAs encourages clients to go a step further to ensure revenue is maximized per code, and fees are competitive in your market and specialty. Once you have a baseline fee schedule, it should then be matched up with all other contracted fee schedules to be sure you have no rate lower than the highest payer allowable.

Maintain Updated Contracts

AAFCPAs advises clients to maintain a copy of all contracts, including their fee schedules. Providers should have a contracted fee, whether it is the payer's standard rate or a carved out negotiated rate, for every procedure code, even if your organization does not bill for all codes. Knowing your rates for all codes will allow you to better understand what you may be reimbursed in advance of performing a service, and to understand whether starting a new procedure will be cost effective. This information may also help control internal costs, and ensure you are being reimbursed appropriately.

"Once you have a baseline fee schedule, it should then be matched up with all other contracted fee schedules to be sure you have no rate lower than the highest payer allowable."

If you do not have a copy of all fee schedules, we advise you to reach out to your contracted payers and request a copy. Payers are contractually bound to provide you with a copy of ALL your rates. For government payers, most fee schedules may be downloaded online. For Medicare, this should be done on a quarterly basis; for other payers, an annual basis.

Fee schedules should be input into your billing system so you may track the accuracy of your reimbursements. If your system does not have the capability to store these fee schedules in a way that would allow you to monitor the accuracy of payer allowables during payment

posting, a manual/external contractual analysis should be performed at least monthly. You may do this by:

- Running payment reports from your billing system
- Reviewing payer allowables on the Explanation of Benefits (EOB)
- Comparing allowables on the EOB to your contract fee schedules

Analyze Reimbursement Rates Regularly

It is imperative to keep abreast of private and government payers' reimbursement rates on at least a quarterly basis. Payers can, and do change the allowables often for certain procedures or drug codes. Reviewing these on a consistent basis will help ensure you are keeping fees set above the current reimbursement rates.

Unfortunately, many healthcare organizations do not know they are leaving money on the table. Without a steady review of the CDM, losses may go unnoticed for years and the financial impact could be costly. AAFCPAs advises clients to implement processes and procedures to maintain an accurate and compliant CDM. Performing a quarterly or annual audit on the CDM is a wise investment to ensure your organization is up-to-date on current year changes and to make certain your fee schedule is properly set. This will help providers to locate lost revenue from missed charges and coding errors, reduce the risk of billing overcharges, and identify and fix compliance issues pre-bill, preventing costly rework and late charges.

Additionally, AAFCPAs advises healthcare clients to monitor, test, and constantly enhance their internal controls and processes, as well as consider external factors that could impact their reimbursement.

AAFCPAs has spent over four decades providing incisive financial knowledge and strategic management advice to help our healthcare clients obtain optimal reimbursements, maintain regulatory compliance, increase cash flow, and sustain performance. AAFCPAs is available to provide strategic advice on your CDM in order to optimize reimbursement and maintain regulatory compliance.

The Impact of Revenue Recognition on Healthcare

Revenue Recognition: ASU 2014-09, Revenue from Contracts with Customers (Topic 606), is effective for public business entities, and certain not-for-profit entities that have publicly traded conduit (or direct) debt, with annual reporting periods beginning after December 15, 2017. All other entities are required to adopt this by annual reporting periods beginning after December 15, 2018. Entities may now early adopt.

This new standard may result in significant changes to the timing and amount of revenue recognized by an entity. AAFCPAs advises that healthcare provider clients prepare now to determine how the new Revenue Recognition Standard affects your financial picture, your stakeholders, and the way you do business.

How May the Standard Impact Healthcare Providers?

- The new standard may lead to delayed revenue recognition, especially in incentive or performance based contracts where certain performance obligations have to be met in order to record revenue. This may, at times, misalign the patient revenues and patient expenses.
- Third party payor contracts will have to be analyzed and bundled in order to be accounted for properly. Each "bundle" may need to be treated differently.
- Variable consideration will need to be addressed for all scoped in revenue types in order to determine accurate transaction prices. These prices may no longer match cash value received. It may be difficult to distinguish between bad debt and variable consideration.

What Revenue Streams May Be Affected By The New Revenue Recognition Standard?

- Fee for service, incentive based and capitated payments will be affected.
- Certain revenue streams will be scoped

out, such as government grants and contracts, and charity care which may or may not include self-pay revenue.

The new standard will require significant management judgment in addition to changing the way many healthcare organizations recognize revenue in their financial statements.

Healthcare organizations must understand and consider the impact of recognized or deferred revenue on any debt covenants, as well as any potential concern that financial statement users may have regarding profitability changes. It is important to be proactive so you are able to communicate with lenders, grantors, and the Board, and mitigate any concerns that may arise regarding your change in financial position.

Related Insights

AAFCPAs is enthusiastic about sharing expertise that can help organizations improve. Other healthcare insights include:

- New Care Management Services Billing Guidelines for Behavioral Health Providers
- New Care Management Services Billing Guidelines for Health Centers
- Congress Passes Another Two-Year Suspension of the Medical Device Excise Tax
- AAFCPAs to Lead Medicare and Medicaid Cost Report Trainings in MA and RI Providing Coveted Guidance

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Talk Healthcare

Our experts are always happy to connect. If you have questions about how healthcare is evolving, contact Matt Hutt to learn more.

AAFCPAs fully understands the complexities of the healthcare industry, and offers proven and valuable solutions to help you meet your business goals.

Healthcare Consulting & Reimbursement

- Provider Partnerships, Consolidations & Coordination of Care Advisory Solutions
- Guidance on the Transition to Value-Based Reimbursements & Data Driven Patient Care
- 340B Pharmacy Program Audits
- Optimizing Reimbursements: Operational Assessments, Denials Prevention & Management
- Guidance for FQHCs on Optimizing Reimbursements Under Medicare PPS Tracking & Monitoring Risk Based Contracts
- Cybersecurity, HIPAA Compliance, and Safeguarding Patient Personal Health Information
- Interim CFO Solutions

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About AAFCPAs

AAFCPAs is an attractive alternative to the Big 4 and National CPA firms. We provide best-value assurance, tax, accounting, and business & IT advisory solutions to nonprofit organizations, commercial companies, and wealthy individuals/estates. Since 1973, AAF's sincere approach to business and service excellence has attracted discerning clients along with the best and brightest CPA and consulting professionals. AAF donates 10% of its net profits annually to nonprofit organizations.

AAFCPAs is an independent member of PrimeGlobal, Inc., the fourth largest CPA firm association in the world. These resources provide our clients with seamless national and global reach. Our pay-as-you-use model is considered advantageous by our diverse clients who appreciate exceptional value.