Upcoming Events

January 28–29, 2016  Winter Institute
Renaissance Indianapolis North, Carmel, IN

National Webinars (link)

March 2016  IRHA Collaboration

April/May 2016  Spring Institute

Please check the website for updated information and events: www.hfma-indiana.org
Dear Fellow Members of Indiana Pressler Chapter:

It is hard to believe that Fall is here and the leaves have changed colors! Just as the seasons change, the healthcare industry continues to evolve and change as well. One of the biggest changes we faced recently was the implementation of ICD-10 which went into effect October 1, 2015. Many facilities have been preparing for this change for a couple years now and it would appear that things have gone fairly smoothly, but we’ll wait and see.

Jack Bishop and I attended The Fall Presidents Meeting that was held Sept 20th-22nd in Chicago. This meeting was a great opportunity to hear an update from the HFMA President/CEO and the HFMA National Chair. In addition, we learned from other chapters in our region on some of the successful practices they have implemented. At a national level, HFMA is working on addressing some of these challenges.

- Diversifying the membership
- Payer outreach
- Physician outreach
- Early Careerist outreach
- Transforming the volunteer experience
- Reducing Administrative burden on chapters volunteers
- Innovating at the National Level
- Collaboration with physician and nursing leadership groups

By the time you read this newsletter, the chapter’s membership satisfaction survey will have been distributed by the HFMA National office. The survey is an excellent opportunity for you to share your thoughts and ideas regarding both local and national HFMA - both strengths and opportunities. I hope that many of you took this opportunity to provide feedback. The survey results will be reviewed by our leadership team to determine changes needed. We are anxiously waiting for the results.

Up to this point our Chapter had held a Summer Institute, a Mini Leadership Training Conference and in September we held a Multi-Chapter event in Cincinnati. I would like to personally thank all of our Officers, Directors and Volunteers for their hard work and dedication in putting these events together and for attending them. This Chapter would not be the success it is without each and every one of you and your commitment to excellence.

In closing, as we move through Fall and into the Holiday season, I would like to personally wish all of you well. I would also like to end by thanking our sponsors. Without your continued support, we would not be able to put on these great events. Your continued support allows our chapter be successful. Our educational institutes are so critical to the success of the chapter. They give our membership the opportunity to receive quality education and the opportunity to network with peers throughout the state. So once again, Thank You!

Yours in HFMA,

Randall J Russell
**Certification Corner**

*by Shannon Ebenkamp*

REPRINT: Please contact Shannon if you have questions about the CHFP program. Because the program has dramatically changed this year. We thought it would be important to reprint the summary that Shannon put together for the Summer Issue.

The CHFP Certification Program has undergone some significant changes that went into effect June 2015. Below are notes from National explaining the changes and why the changes were made to the program.

**Changes to HFMA’s CHFP Certification Program**

HFMA’s strategic vision characterizes the current healthcare business environment as the transformation of care to achieve value. Providers, physicians, and payers are all confronted with new business challenges. The nature of the business environment and its impact on industry stakeholders supply both the demand for and elements of a new approach to the CHFP.

**New CHFP program features**

- A learning program designed to build comprehensive industry understanding and sharpen business skills;
- CHFP designation earned by successful completion of both modules;
- Online study materials created specifically to assist in mastering the business content.

**Why is the certification program changing?**

The healthcare reform environment has caused the industry’s key stakeholders—providers, payers and physicians—to fundamentally rethink existing business models. Care transformation is business transformation. The necessary success factor for finance professionals today: Change-oriented business acumen. The existing certification program focuses narrowly on applied finance and financial reporting and does not address the business environment.

Questions? Please contact Shannon L. Ebenkamp the certification chair for our chapter. Contact information is shebenka@mhhcc.org or 812-996-2935.

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**Committee Information**

**EDUCATION COMMITTEE REPORT**  
*By Amy Herron*

The Winter and Spring Institutes are well under way. Watch your inbox for information regarding the Winter Institute. The brochure should be ready soon. Bob, Lindy and their team has put together a great educational line up.

Additional education sessions are available through the HFMA National Website. Please see the link on the first page to the webinars.

The Education Committee is busy working with IRHA to collaborate on events in March and June. We are also planning outreach sessions for Evansville and Ft. Wayne.

**SPONSORSHIP COMMITTEE**  
*By Nick Kuzera & Jim Christie*

With the Tristate HFMA event behind us, the sponsorship committee has been hard at work finalizing our corporate partner renewals (56 currently). Additionally, we are planning Consultants on Call for the Winter Institute with substantially discounted rates for our provider attendees. There will be several event sponsorship opportunities available.

Please contact Jim Christie (jchristie@PerformanceServices.com) or Nick Kuzera (nkuzera@connance.com) with any questions you have.

**RECRUITING VOLUNTEERS**

We appreciate all of the volunteers that help make this chapter great. If you know of anyone who is interested in getting more involved please let us know.
DO YOU REMEMBER...

by Jim Miller

Race Fans, ‘Court’ Jester?

(Below - From left) Holly Bishop, Brad Willkie and Connie Bishop lead a large contingent of HFMA members on a tour of Gasoline Alley garages following a finance institute at the Indianapolis Motor Speedway in May 2003. HFMA members enjoyed a practice session at IMS and a visit from long-time Indy 500 historian Donald Davidson after the morning-long institute.

(Right) A slightly myopic, gnarly-toothed “patriot” (alias a prominent Indiana hospital CFO and long-time HFMA stalwart) pleaded his defense for healthcare fraud during a mock trial at the Annual Institute in Indianapolis in 2005. The mock trial, expertly yet comically litigated by local healthcare attorneys, focused on the second round of fraud and abuse guidance released earlier that year by the OIG.

Do you have fun pictures like these or memories you would like to share? Please send them to Inhoosiertimes@gmail.com. We would love to feature them in the newsletter.
What do you think of when you think of the fall season? I think of Brown County with the beautiful colors of the trees changing. I think of the farmers harvesting the fields. I think about the weather, if it is going to be cold in the morning but warm in the afternoon. I hope that my college or pro football teams win on the weekends. To me, fall reminds me of change.

As healthcare professionals we know about change. Some of us have been focusing on the world of ICD-10 and reimbursement changes. Wasn’t that change enough? (Probably not, after all we chose to work in healthcare.)

Others have experience change through acquisitions and mergers. Or maybe a change in jobs. This can cause feelings of anxiety, uncertainty, and excitement all at the same time.

Through all of these changes, it is encouraging to know that the HFMA community is there for you. If it is a resource for governmental requirements and guidelines or just support for work or even personal needs, this group is here to lift you up and help you through the change you are experiencing.

We want to hear from you on the changes and challenges you are experiencing. Email us at inhoosiertimes@gmail.com.
ICD-10: Off to a Good Start - For Now

by Jim Miller

The long-awaited implementation of ICD-10-CM has not run into any major snags following its October 1 start-up.

So it appears – at least from initial reports.

The much-dreaded slowdown in reimbursement may still be in the offing as payers, providers and vendors alike deal with the increased demands on coding and medical documentation associated with ICD-10, yet early reports indicate a smoother transition to ICD-10 that originally feared.

“Our claims are going out,” said Tonya Satterfield, Revenue Cycle Applications Manager for St. Vincent Health. “We’ve not heard of many problems, which may be a tribute to the quality of training for our coders.

“It may be far too soon. We’ll see with the ultimate outcomes.”

Satterfield’s remarks seem to reflect other anecdotal comments and published reports from a number of publications and list serves. In its October 11 edition, Healthcare Finance News reported discussions with dozens of providers who cited only two significant problems resulting from the implementation: a failed internal coding system at a Midwest hospital and a hospital in the Northeast that experienced a glitch in its billing software that allowed ICD-9 codes to automatically pass front-end edits.

Like Y2K, when the healthcare industry feared massive system failures, doom was predicted with the advent of ICD-10. But industry-wide preparations, aided by two one-year delays by CMS, may have made the difference.

Indiana CFOs Karen Meyer (Rush Memorial) and John Kraft (Pulaski Memorial) acknowledged success in releasing claims after the October 1 start date. Both are waiting for the initial payments from Medicare and commercial insurers, although Rush Memorial has recorded Medicaid payments.

But perhaps the biggest unknown at this juncture is how commercial insurers will handle physician payment, especially on the heels of CMS’ decision this summer to allow a one-year grace period for ICD-10 coding on physician claims. An online article in Healthcare Payer News, dated October 15, appears to back up that uncertainty.

The article reported that four major health insurers – Aetna, Humana, Anthem and Cigna – vary in their application of the CMS-imposed grace period.

According to spokesperson Matt Clyburn, Aetna is requiring its providers to use ICD-10 coding for all transactions with an October 1, 2015 date of service and forward. Anthem spokesperson Gene Rodriguez stated the CMS announcement applies to Medicare Part B FFS (fee-for-service) claims only, and that all claims including Medicare Part B, must have a valid ICD-10 code for a date of service on or after October 1, 2015. Cigna will consider a code as invalid if it has not been coded to the full number of character required, said spokesperson Mark Slitt, while Humana will continue to follow CMS guidance on the transition, noted spokesperson Kate Marx, without providing further details.

The uncertainty about physician billing may have been mitigated at Rush Memorial as Meyer noted its physician practices “are doing well, “ and that its physicians are documenting appropriately, especially in primary care and surgical services.

However, Satterfield remained cautious about optimism in this area.

“We’re concerned about how the commercials (insurance companies) will use the additional data,” she said. “We’re concerned about the additional specificity (afforded by ICD-10 coding) and its long-term effect.”
Medicare Advantage Shadow Billing: Don’t Leave Money Behind for your Sub-Units
by Mario Feher, IMA Consulting

Hospitals actively involved in an accredited teaching program are entitled to supplemental payments for the reimbursement of medical education costs associated with treating Medicare Advantage (MA) patients. To receive the medical education payments for these patients, an information only, or “shadow” bill must be submitted.

Frequently, a portion of these payments is overlooked at teaching hospitals that have active psychiatry and/or rehabilitation sub-providers because these sub-units are not eligible for Indirect Medical Education (IME) payments. However, psych and rehab sub-units are eligible for Graduate Medical Education (GME) payments and should be shadow billed not only to remain compliant, but also to ensure the hospital receives all monies to which it is rightfully entitled.

BACKGROUND
“Shadow billing”, synonymous with “no pay” or “information only” claims, is an unofficial term that refers to the process wherein hospitals submit claims to their Medicare Administrative Contractor (MAC) for inpatient services provided to Medicare beneficiaries who are enrolled in a MA plan. These claims are submitted, per instructions from CMS through a series of Transmittals, for the purpose of requesting supplemental Indirect Medical Education (IME), Graduate Medical Education (GME), and Nursing Allied Health Education (NAHE) payments, and for the proper reporting of Medicare beneficiary days to be counted in the Medicare fraction of the Disproportionate Share Hospital (DSH) calculation. Shadow Billing for MA patients by hospitals began with the passage of Balanced Budget Act of 1997 (BBA ‘97), wherein sections 4622 and 4624 of BBA ‘97, provided hospitals with additional payments for IME and GME costs for their patients enrolled in a Medicare managed care program. Initially the MA plans were responsible for reporting all of the claim “encounter” data to CMS. Ultimately, reporting these claims became the responsibility of the provider. Prior to the passage of BBA ‘97, IME and GME payments to teaching hospitals were available only for traditional Medicare fee-for-service (FFS) patients.

IME payments are made to account for the indirect costs of teaching interns and residents and are based on the ratio of the number of interns and residents per hospital bed. Hospitals typically receive their IME payment via a remittance advice as claims for Medicare beneficiaries are submitted and approved for payment. GME payments are intended to cover the direct cost associated with an approved teaching program and are paid based on the ratio of residents, the costs associated with training the residents and the hospital’s Medicare patient load (percent of Medicare patients). Hospitals receive their GME payment via the cost report settlement.

Subsequent to the passage of BBA ‘97, CMS released a series of Program Memorandum (PM)/Transmittals, beginning with PM A-98-2 issued July 1998, that detailed how providers were to request these supplemental payments. In February 2003, CMS issued PM A-03-007, which modified PM A-98-2, and provided additional payments to Non-IPPS teaching hospitals and hospital-based units additional payment for GME and NAHE costs. Hospitals and units excluded from IPPS and specifically identified in this transmittal are Rehabilitation hospitals and sub-units, Psychiatric hospitals and sub-units, Long-term Care hospitals, Children’s hospitals, and Cancer hospitals. Because these supplemental payments for IME/GME/NAHE are processed by Medicare Part A and not the MA plan, providers must submit a separate claim (i.e., a “shadow bill”) to Medicare Part A through their respective MAC in approved Uniform Billing (UB) format. Clearly, the instructions in each of these PMs provide for significant reimbursement opportunities for teaching facilities.

CHALLENGES
In the current environment, hospitals must continuously fight to recoup monies to which they are rightfully entitled. All the while, these efforts need to be balanced with a myriad of compliance issues and regulatory guidance that is complex and sometimes unclear. As discussed earlier, in order for hospital providers to submit shadow bills for their MA patients, they must submit a separate claim to their MAC (and not the MA plan). Accordingly, this methodology places the onus on the hospital to ensure that the necessary information is provided on the claim, including specific information that must come from the beneficiary upon registration.

Often all of the information needed to submit a shadow claim is not obtained during the registration process causing large buckets of claims to never be submitted. Further, providers must ensure that the claim includes the applicable condition codes and other necessary information so that the claim can be properly processed. While many providers have addressed this issue by way of conducting retrospective reviews and incorporating internal processes to identify these claims prospectively, providers often fail to identify all of the eligible claims that they should be billing. Even in organizations that are doing retrospective reviews, simply
missing 1% - 2% of these claims can result in significant lost revenues.

Shadow billing is further compounded by a common misconception that shadow bills are analogous to IME bills. While the IME payment is a component of a shadow bill, so too is the GME payment. All too frequently, the GME component is “out of sight, out of mind” as the time required for the GME payment to be received is much longer than the average of two weeks for the IME payment. In this regard, for shadow bills that only receive a GME payment, such as patients discharged from a psych and rehab sub-provider, the shadow claim simply goes unbilled. In instances such as these, payments are left on the table and MA days go unreported.

INSIGHTS
The requirements for the provider to submit information only claims for the aforementioned sub-providers were originally part of CR 5647, T 1311, 6/20/2007, which required all IPPS, IRF PPS, LTCH PPS to submit advantage only claims. CMS then issued CR 6821 on 5/5/2010 as one final chance for the providers and reiterated the requirements. Hospitals were required to attest that it had done so. The clearest guidance comes from CR 2476, T A03007. This Program Memorandum outlines intermediary and standard system changes needed to process requests from hospitals and units excluded from the IPPS for DGME and N&AH education supplemental payments for managed care enrollees. As such, hospitals need to ensure that their billing processes are in line with CMS guidelines to mitigate any possible negative consequences associated with not being compliant. In the same respect and given the current economic climate, hospitals can’t afford to leave money to which they are entitled behind. Specific to claims associated with psych and rehab sub-providers, hospitals and health systems need to evaluate their internal policies to make certain that the billing professionals within the organization understand the impact of the GME component and the implications if claims from these sub-units are not billed. Further, hospital billing systems should be validated to determine whether information only claims for psych and rehab sub-units are configured to be billed automatically. Having a system in place to submit the shadow bill simultaneously with the commercial bill helps to minimize the possibility that a shadow claim will be “missed”.

Knowing how to bill these types of claims is equally important as the billing function itself. If the appropriate TOB and condition codes are not in place for an information only claim, there is a good chance that the submission will be rejected. Rejected claims can be problematic as these claims will require additional time to research and rebill, if they are even identified. If a process is not in place to identify rejected shadow bills, the possibility exists for these claims to continue to represent a lost opportunity.

Per the regulatory guidance discussed previously and Chapter 3 Section 20.8 of the Medicare Claims Processing Manual, claims should be submitted using a 111 bill type for teaching hospitals with psychiatric and rehabilitation units. Additionally, claims must be submitted to the MAC with condition codes 04 and 69. The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill to the PS&R report type 118 for MA enrollees in non-IPPS hospitals and non-IPPS units to capture MA inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

SUMMARY
Pressure to enhance and recoup all forms of revenue throughout the organization will continue to increase, as will efforts by CMS to guarantee all required information is captured. Teaching hospitals with psych and rehab sub-providers can situate themselves on the right-side of these curves by making certain their billing policies, systems, and procedures adequately and effectively bill information only claims for Medicare Advantage beneficiaries.

Mario Feher, Director
IMA Consulting
Waves of Compliance
by Ken Blickenstaff, BlickenStaff, LLC

Here at BlickenStaff LLC, we watch the healthcare horizon for changes that are “making waves” in the area of compliance. Below I highlight a number of headlines featured so far this year that I hope you will find useful. Please refer to the original source for the full story.

Change in CMS Contractor Instructions for Illegible Handwritten Signatures

In CMS Transmittal 604 (Change Request 9225), CMS contractors, “…shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry, if the signature is illegible.” However, Medicare requires a handwritten or electronic signature (stamped signatures are not acceptable). The new requirement to consider other evidence in the event of an illegible signature applies to Medicare Administrative Contractors, Zone Program Integrity Contractors, the Comprehensive Error Rate Contractor, and the Supplemental Medical Review Contractor. The effective date (as well as the implementation date) was August 25, 2015.

UCLA Health’s September Notification of Data Breach

We live in an increasingly-mobile world, where “work time” often extends beyond business hours and off company property. In September of 2015, UCLA Health notified some of its patients about a faculty member’s laptop having been stolen on July 3, 2015. The event, “…may have involved personal information of patients who received services in the Department of Radiation Oncology during the last three years.” The letter to patients instructs them to contact ID Experts, the vendor engaged by UCLA Health to assist with the event. This stolen laptop event is a reminder to us all to ensure our electronic devices are properly protected with encryption. While password-protection is a deterrent to would-be data thieves, a determined criminal may still be able to access files if the password is not part of an encrypted system. A lost or stolen properly-encrypted laptop would likely not be considered a breach, as the thief would require a decryption key to read any protected health information.

H.R. 876 – “Notice of Observation Treatment and Implication for Care Eligibility Act”

On August 6th, 2015, H.R. 876 – “Notice of Observation Treatment and Implication for Care Eligibility Act,” or the “NOTICE Act,” became public law. Beginning in August of 2016, the NOTICE Act requires a patient receiving observation services as an outpatient for more than 24 hours, at a hospital or critical access hospital, to be notified not later than 36 hours after the patient begins receiving such services (or, if sooner, upon release) of the patient’s status as an outpatient. In addition, the hospital must notify the patient of the reasons and implications of the status (such as cost-sharing requirements and/or for subsequent eligibility for coverage for services furnished by a skilled nursing facility). Further guidance from CMS is expected to be forthcoming.


Released on October 6, 2015, an OIG Policy Reminder addresses “information blocking” and its implications for safe harbor protection under the Federal anti-kickback statute (42 U.S.C. 1320a-7b(b)). An example given in the Policy Reminder is of a hospital furnishing software or information technology to an existing or potential referral source, such as a physician practice. Specifically, that safe harbor condition requires that “[t]he donor (or any person on the donor’s behalf) does not take any action to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or [EHR] systems (including, but not limited to, health information technology applications, products, or services).” 42 CFR § 1001.952(y)(3). Actions to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or [EHR] systems include, but are not limited to, inhibiting a competitor from interfacing with the

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donated system, and/or EHR technology vendors agreeing with donors to charge high interface fees to non-recipient providers, suppliers, or competitors.

The Tri-State Conference committee planned two events for the conference in Cincinnati. Attendees had their choice between a Reds vs Mets Baseball Game or Brewery Pub Tour. To the right are some pictures from the Reds event.

Tri-State Conference Networking Event: Cincinnati Reds Game
Working to Leave: 
Finding My Cuban Roots
by Estelle Welte, Medical Data Systems (MDS)

In early October, a group of healthcare leaders, including former U.S. Senate Majority Leader Bill Frist, traveled to Cuba with the intention of obtaining a better understanding of the country’s healthcare delivery system. Led by Kraft Consulting out of Nashville, Tennessee, I was honored to be among the 24 traveling within this healthcare delegation.

Opinion on travel to Cuba varies, and can be quite contentious depending on who you may engage on this topic. You have some Cuban-Americans who believe any travel or “tourism” provides support and money to a communist regime that oppresses its citizens. Having been born to a Cuban mother, who fled that country in 1960, I have had first-hand experience with the varied opinions of family members/Cuban-Americans. The opportunity to travel to Cuba was personal on many levels, but also somewhat humanitarian, as I considered the implications of my visit, and what to do with the information and knowledge I obtained. Sometimes trips and experiences such as this are intended to make you think. They may be meant to make you see the great gifts in your own life. I experienced a range of emotions on my travels to Cuba, and still struggle to articulate them in this piece. I will try to give you a basic sense of our itinerary, but more than that a sense of the life that exists for today’s Cuban citizens.

Travel to Cuba is diligently regulated by the U.S. and Cuban governments, and a specific agenda is outlined and strictly adhered to. Our healthcare delegation visited Cuba’s Latin American School of Medicine (ELAM), The Frank Pais Orthopedic Hospital, a local community polyclinic (primary healthcare), the Cabildo Quisicuaba Community Project, which administers HIV and AIDS health projects in Cuba, and the Museo Nacional de Belias Artes (Cuban National Museum of Art). We were provided with presentations on various healthcare, cultural, and economic topics. We were afforded extensive question and answer opportunities at all of the previously mentioned locations, and also met with a Social Psychology Professor from the University of Havana, a representative from the Ministry of Health (MINSAP), a Cuban economist, and a Foreign Service Officer from the US Interests Section in Havana.

Travel in and around Havana was performed by bus, which provided insightful views of the various parts of the city. We toured within local communities, ate at various Paladors, and viewed the well-traveled sections of Havana (intended for tourists). Focusing on healthcare and this country’s higher than average life expectancy, as published by the World Health Organization, we concentrated our efforts and questions on understanding the specifics of their healthcare delivery. Healthcare is “free” in Cuba but highly regulated.

You must utilize your local polyclinic for your healthcare needs. The Cuban government, as a whole, emphasizes preventative care. They have procedures in place to check on citizens and their health, including elderly that may be immobile, and doctors will visit in the home. Each physician within the polyclinic is held accountable for the health of the citizens in the community surrounding/assigned to those clinics. Statistics are carefully monitored and managed. Incidents of infant mortality and cancer diagnosis are carefully tracked. The day to day lifestyle in Cuba is a major health contributor. A diet rich in fruits and vegetables, limited resources for transportation which result in a great deal of walking/exercise, and no access to fast food outlets (no McDonalds and Burger King in Cuba), add to the life expectancy of Cuban citizens. Due to the general acceptance of smoking in their culture, incidents of lung cancer still remain high. We questioned physicians and healthcare workers on treatment for various diseases and although resources and medications are limited, Cuba has placed a national emphasis on healthcare research, pharmaceutical development, and purport significant resources to provide extensive healthcare education and support internationally.

On the rare instance in which we were given time to ourselves, to explore on our own, I personally had the opportunity to branch off with our
Cuban Tour Guide, Graham, who was assigned to our delegation. My goal was to locate where my Grandfather had his businesses on the street behind the capital, and where my mother grew up also located in the community behind the capital. As we maneuvered through the streets of Havana, my eyes were truly opened to the living conditions of its citizens. Although conditions weren’t “hidden” from us during our bus trips, I experienced a range of emotions walking the same streets where 54 years ago my mother and her family lived. Although the neighborhood I experienced was quite different from what she lived in, I was moved beyond measure to have stood on those streets.

Just prior to my neighborhood excursion, we toured an old cigar factory named Partagas. No longer a working factory, the building itself was set for restoration. Under a layer of aged dust, the architecture from years past was beautiful. The wood floors, door, and detailed wood crown molding were worthy of salvage. After some broken Spanish conversation with the security guard, he allowed us to see many areas of the building where no doubt Cubans spent countless hours rolling the now famous symbol of their country. I took many pictures trying to “take it all in”. I photographed the capital from the windows, thinking this was the view those workers had each day. Upon return from my trip, while sharing my travels and pictures with my mother, she was shocked that I was in the Partagas factory specifically. It turns out my Great Grandmother worked there, every day, for most of her life. To say that it was a gift to have been in the building and that I was able to share photos with my mom does not do the feelings and emotion justice.

As I walked the streets of the community surrounding the Capital, we encountered citizens of Cuba that showed little emotion/expression. This made me unsure of whether they welcomed American tourists or would rather we not be there. Very young children seemed happiest, probably unaware of the limited future ahead and the daily struggle to provide food and basics. With buildings in decay and streets dirty from years of neglect, the continued embargo and limited resources weigh heavy in the air. Families live with multiple generations under one roof. Housing is limited. Newly married couples will likely live with ones parents and in that home may be grandparents and still more growing children. Resources for food are limited. What we take for granted, i.e. milk, spices, and meat, they know all too well that quantities are limited and access to them must be cherished. The Cuban government is proud that “no one starves” (ration cards), and healthcare is free, but walking on the streets where my mother once walked as a young girl, I wondered how things will ever improve for the citizens of today’s Cuba, and I felt helpless to impact any real change for their future. Although the walk was moving, emotional, and a lot to take in, I felt safe the entire time. Crime is non-existent and punishment for crime severe. Never once did I feel unsafe, even in the most challenged communities of Havana.

Upon my departure from Cuba and on our ride to the Jose Marti’ airport, I felt a tug to stay. However, at the same time I had a small feeling that I had accomplished what I intended and wasn’t sure I needed to ever return. I have significant family roots in Cuba. I acknowledge and honor that. Although I have family members that have yet to acknowledge my trip or ask about my experiences there, I know they have their reasons and I have mine. I won’t pretend to know all the specifics of the politics between our two countries and I acknowledge that any government can manipulate what it wants its citizens, tourists or the world to see. At the end of the day, all of that noise was not my focus. I chose to focus on the individual citizen, what care they receive, and how they live. I had the chance to talk to a young artist who is in his early twenties, about the same age of my son. In his effort to explain his art and my effort to understand his vision, I found the essence of my trip. He had used pencil and charcoal chalk to draw a man on a bicycle cart, selling his wares on the streets of Havana. What was different about this bike cart was that he had added helicopter blades extended from the top and a landing pad “X” just under the wheels. In broken English he explained that the man depicted in the picture, like many Cuban citizens, “works, so that one day he might leave”.

What that means to each Cuban citizen may be different. It may mean “leave” their circumstances, it may mean “leave” poverty, and/or it may mean “leave” the country. In this young man’s eyes, I saw my son, but I also saw a generation uncertain of where their future would lead them. Hopeful they will move beyond the circumstances that exist for them today.

I will be forever changed by my trip to Cuba and I am grateful to have had this opportunity.

Estelle Welte is the Senior Vice President at Medical Data Systems, Inc. (MDS), and current Secretary (Officer) for the South Carolina Chapter of HFMA. She may be reached at (772) 559 – 8782 or via email: ewelte@meddatsys.com
Revenue Cycle: Baby Boomers vs Millennials
by Yvonne Perez and Terry Blessing, MediRevv

There is no question that a patient’s interaction with your organization begins and ends with revenue cycle. Taking that into consideration, health care organizations are continually looking for ways to engage their patients while attempting to advance internal initiatives, such as population health, new payment models, improving the patient experience, etc. and still collect the dollars for services rendered.

Let’s start at the beginning, BOOMERS! Yes the “Baby Boomers”, we all know the stories “walking up hill both ways to and from school, in the biggest blizzard ever or the heat of the Sahara and getting straight A’s while pursuing a double major in four years and working at the same time.” Well maybe we should all be paying a little more attention to them, because the Boomers are here and this aging population is currently affecting healthcare services in a big way. According to Pew Research Center approximately 10,000 Baby Boomers turn 65 daily for the next fourteen years – that is 10,000 new people who are eligible for Medicare, per day! The Boomers were born between 1946 and 1964, totaling 75 million, which is approximately 30% of the U.S. population. Another important fact about the Boomers is that almost 20% of this population are minorities. According to an American Hospital Association report, the 65 and over age group will triple between 1980 and 2030. The Boomer demographics are challenging healthcare: clinically, financially and socio-politically.

Because of many circumstances that were present during the boomers life, wars, economic downturns, and the way they were raised due to their parents’ hardships, they require a little softer approach to interaction. Simply put, revenue cycle services must provide the ‘soft-qualitative’ customer service techniques that resonate with Boomers, such as:

**Accessible customer service.**
There is a growing need for multilingual, multicultural, and multigenerational approaches as well as sensitivity to any physical differences such as hearing loss. Boomers desire:
- Immediate access or at least minimal wait time to customer service
- Comprehensive information regarding the patient statement and payment options
- An accurate, easily-understood patient statement

**Self-service solutions, such as**
elegant, simple-to-use technology available for PC and smartphones. Boomers are tech savvy. They use search engines, apps and patient portals extensively, so long as the technology is valuable to them. The patient portal that allows for easily readable and understandable invoicing, deductibles, insurance payments and patient responsibility is a tremendous advantage to Boomers, as is, of course, the option to pay online.

**Revenue cycle news** via email or text messaging. Revenue cycle news can be simply the notification that the commercial payer has paid ‘x’ amount leaving a balance due (list amount) to be paid by a specific date.

As revenue cycle experts lets help the Boomers help us. Allowing the Boomers to maintain their independence and control by meeting their expectations of immediate customer service, comprehensive patient statement, and simple-to-use technology opportunities will enhance their patient experience while resolving our account balance. Now that we have taken a look at the Boomers, let’s flip the coin and head to the other end of the spectrum. Millennials!! If, if it can’t be conveyed in 140 characters or less we don’t stand a chance. The demand for instant response and lack of desire for person-to-person interaction drives this segment of our patient population. Millennials are living in the first truly global environment, one that is linked by social media, which enables sharing information and opinions, and is by navigated by (among other tactics) self-promotion. There is no limit, actually, to the potentiality of their influence.

So, how do we connect them to our collection strategies? Flip the model on its head! Let’s start looking at connection strategies rather than collections strategies.

Once the patient is on-site, informed consent becomes key. As we all know, Millennials want engagement Twitter-style – in 140 characters or less. The reality is that the message may go beyond 140 characters, but it still needs to be short and meaningful. Make sure that demographic information – including cell phone number, and email address – is collected upon initial contact with the appropriate approval from the patient to allow for connection opportunities. This is the generation who lives by “there’s an app for that”, so quite literally, identifying an app that includes an immediate recognition of informed consent could allow for meaningful connection in via text messaging, not to mention obtaining an immediate response from the Millennial. In the workplace, Millennials by nature will not allow their own creations to be rebranded. They expect to receive credit and want to be heard. Self-empowered, they do not hesitate to voice their opinions, even to their superiors. The good news is they are expected to be more innovative, communicative, educated and group-oriented. They have the highest expectations for...
customer experience, generally with an unusually short attention span.

On July 18, 2014, Robbie Couch of the Huffington Post noted, “Throughout the first four years of the Millennial Impact Project, the following trends emerged and evolved:

- Millennials engage with causes to help other people, not institutions.
- Millennials support issues rather than organizations.
- Millennials prefer to perform smaller actions before fully committing to a cause.
- Millennials are influenced by the decisions and behaviors of their peers.
- Millennials treat all their assets (time, money, network, etc.) as having equal value
- Millennials need to experience an organization’s work without having to be on site.”

Here are a few MediRevv recommendations for communication with Millennials as customers:

- Develop targeted specific scripting
- Utilize social media
- Incorporate patient portal with easy quick access
- Create an atmosphere of a group environment allowing sharing of experiences
- Respond quickly and meaningfully

In addition, emails can be key when guiding a millennial patient through an enrollment and determination process. The immediate acknowledgement of informed consent allows for further follow-up or preemptive contact with patients regarding potential assistance linkage. This could also lead to pre-visit questioning regarding non-HIPAA intrusive information and result in paperwork completion prior to a patient’s arrival. Managing patient paperwork and time will create heightened patient satisfaction and cooperation throughout the patient experience.

A patient’s interaction with your organization begins and ends with revenue cycle. Make it the most enjoyable experience possible for both the Boomers and the Millennials! Or in 140 characters or less it is ….. PTs interaction begins & ends w revcycle, make it a great experience for #Boomers and #Millennials.

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Meet your new Indiana Chapter Administrator — Kristen Montgomery!

After interviewing several candidates the officers and board of directors are happy to announce that Kristen started with the Chapter on November 2. Kristen brings a background of experience in marketing, finance, purchasing, and administrative support. We are especially excited about her social media experience and look forward to enhancing these opportunities for the Chapter.

Kristen and her family live in central Indiana and is looking forward to joining the Chapter and meeting members and volunteers.

NEW Chapter contact information:
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Email: info@hfma-indiana.org

Please join us in welcoming Kristen to the Indiana chapter and plan to meet her at the Winter Institute in January 2016.

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Please note that some photos are actual re-prints from archived paper prints and not always the best quality.

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