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National Webinars

- November 16, 2017: 2017 IRHA Fall Forum
- January 25-26, 2018: 2018 HFMA IN Winter Institute
- April 12-13, 2018: 2018 HFMA IN Spring Institute

Please check website for updated information on upcoming Institutes (including hotel reservations) and other events: www.hfma-indiana.org

Use the new HFMA Weblink for easy access to HFMA National leadership activities and membership tools!
Dear Fellow Indiana Pressler Memorial Members,

Welcome to the 2017-2018 Chapter Year for Indiana Pressler Memorial! I am honored and humbled to have the opportunity to serve as President in the year ahead. I never would have imagined serving in this role when I joined HFMA in 1999. Probably like many of you, I joined because I had a supervisor who was a member and encouraged me to sign up. I remember attending a few meetings and feeling a little nervous because I didn’t know many people and I was early in my healthcare career so some of the things I heard people talking about didn’t make a whole lot of sense to me. But I joined a committee and then another. I became a Committee Chair, joined the Board of Directors and was finally talked into joining the Executive team. The years have flown by and I’m incredibly grateful for the friendships I’ve made and the experiences we’ve shared. We have an awesome Chapter and I look forward to sharing the amazing new year ahead with all of you!

In April, we wrapped up the 2016-2017 year with our Spring Institute and President’s Reception. We were treated to a day and a half of exceptional education, a vendor show, networking opportunities, and welcomed our new board members Nick Eichelma, Karen Meyer, and Lisa Earl, Chapter Treasurer Michelle Trowell, and Assistant Treasurer Billy McNeely. We also took time to recognize and thank our immediate past President, Jack Bishop for his service. Under Jack’s leadership our Chapter received 95 out of 100 points on the Chapter Balanced Scorecard, just missing 100 points by being short a handful of members in our membership goal. We continued the celebration of Jack at ANI, where he accepted the Bronze Award for Excellence in Certification and a Mulit-Chapter Yerger Award for the Region 7 Summer Institute. Congratulations Jack, and many thanks for your leadership and service!!

To build upon those successes in the 2017-2018 year, our Chapter Officers and key committee chairs traveled to Phoenix, AZ in April for the National HFMA Leadership Training Conference. We were able to share ideas and success stories with other chapters from across the country and brought back fresh, new ideas to provide the best education to our membership across the State, keep our membership connected and engaged, and grow our presence amongst early careerists, women in healthcare, physicians, and payors. In May, our Chapter leaders and volunteers met at Ft. Harrison for our mini-LTC, where we developed those ideas and success stories into the game plan for the
Institutes and Events over the next year. Don’t worry if you weren’t able to attend – we are looking at ways to engage new volunteers throughout the year.

Our next event is the Tri-State event to be held at the Hyatt Regency in Cincinnati on September 20-22nd. This is our bi-annual event with the Kentucky, Southwest Ohio, and Central Ohio Chapters. We have an excellent slate of speakers lined up and will host a networking event at the Handlebar in the Great American Ballpark to watch a Cincinnati Reds game. This was a highlight to the event two years ago and this year we have reserved the entire space, including the box seats outside of the restaurant. Registration is available through the website www.hfma-indiana.org. I hope to see you there!

In closing, thank you to all our Chapter leaders and volunteers. It is your time and dedication that makes our Chapter top-notch!

Sincerely,

Amy Herron
To all of our Sponsors: Thank you for your continued support, which enables us to provide programs, events, and address the needs of our Chapter members. Your sponsorship is truly appreciated.

The photo on the front page of our Newsletter was taken at the Porter County Fair, one of the many Fairs that occur throughout the State during the summer. My family has been going to the County Fair for a long time – much longer than I care to think about. I remember our kids experiencing things for the first time – including 4H, crafts, animals, magicians and carnival rides. The children are adults now, but still enjoy the fun and family atmosphere of the County Fair. The County Fair is just one of the many traditions and wonderful things to do in Indiana during the summer, and I hope you are able to find some time this summer to relax and enjoy time with your family and friends.

This edition of the Hoosier Times Newsletter contains a wide variety of information including HFMA National and local updates, Chapter member and Indiana Hospital Association spotlights, and timely articles on healthcare industry topics. We hope you will find the Newsletter useful, and we would love to hear from you on how to improve the Newsletter and better meet your needs. Please do not hesitate to reach out to us with your suggestions. Our Committee would like to extend a special thank you to those who have contributed write-ups, articles and photos to this Newsletter, including Darren Cook, Jesse Ford, Jim Miller, Jeff Moffatt, Travis Skinner, Jon Townsend, and Brad Willkie.

Last but not least, I would like to express my appreciation to our Chapter Communications Committee members – Bill, Eric, Jerry, Rick and Sally - for their time and great work in putting together this edition of the Hoosier Times.

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General Policy
The statements and opinions expressed in articles or features are those of the author(s) and do not necessarily reflect the view of the Indiana Pressler Memorial Chapter, the Healthcare Financial Management Association, or the Editor. The Editorial Board reserves the right to edit material and to accept or reject contributions whether solicited or not. All correspondence is assumed to be released for publication unless otherwise indicated. All rights reserved.

Questions regarding articles or features should be addressed directly to the author(s). All article submissions must be typed and sent via email or provided on a disc.

Editor’s Note by David Parry
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Yolanda Jaime is the Manager of Central Business Office and one of the leadership gems at The Methodist Hospitals, Inc. She is dedicated to work, and her family (especially the grandchildren). Join me in finding out a bit more about our Member in the Spotlight.

Hoosier Times (HT): What is your career/current position?
Yolanda Jaime (YJ): I am the Manager of the Central Business Office (CBO). I started at Methodist in the registration/patient access area and stayed there for about 5 years before transferring into the Business Office in a collector position. I worked my way up to the Supervisor Billing/Collection position in 1982, and became the Manager of the CBO in 1997.

HT: How long have you been with your current employer?
YJ: I have been with Methodist Hospitals since 1973, approaching 45 years.

HT: Is there anyone who really helped you in your career?
YJ: I can’t really say I had specific mentors, but several individuals helped me throughout my career. For me, learning to know who to go to with different types of questions or issues helped. Also, you have to be an aggressive investigator in learning how payors work, or how systems work in order to resolve the numerous issues or denials which you face daily in the revenue cycle.

HT: What are some of your current job challenges?
YJ: In today’s age, the biggest challenges are the insurance companies that are constantly changing requirements which cause denials on the hospital claims. The denied claims problem has become more prevalent with changes related to prior authorization and medical necessity issues coupled with the physician offices that may not be aware of all the changing insurance requirements. In addition, insurance companies have shorter timeframes for the appeal of denials and combined with lower staffing ratios, this combination makes staying on top of denials a true challenge.

HT: Tell us about your family.
YJ: I celebrated 43 years of marriage on July 27th. My husband and I have one son, one daughter, and 5 wonderful grandchildren. My weekends are pretty much going to some type of activity with my grandkids, with soccer being a big one.

HT: Any pets?
YJ: I have one dog, Molly, who is 5 years old and spoiled rotten.

HT: Where did you go to school?
YJ: I graduated from Westside High School in Gary, Indiana and have taken courses at Indiana University Northwest.
**HT**: What are your hobbies or what you like to do for fun?
**YJ**: I love to read, and of course, spend time with my grandchildren.

**HT**: What are your favorite vacation spots?
**YJ**: I am Puerto Rican, so Puerto Rico is one of my favorites spots to vacation. Also, I have family in San Antonio, Texas, and I love to vacation there as well.

**HT**: How did you get involved with HFMA?
**YJ**: I became involved with HFMA through work and have used the great information provided in the various newsletters/bulletins over the years.

**HT**: Do you serve on any HFMA committees or external organizations?
**YJ**: No, I am not currently involved with any committees at this time.

**HT**: What is the last good book you read?
**YJ**: My favorite author is Diane Palmer and her stories are always filled with action, and of course, a little romance.

**HT**: Favorite movie?
**YJ**: I do not have a favorite movie as there are too many of them out there, but I do not like to watch spooky movies.

**HT**: Favorite TV show?
**YJ**: I like to watch shows like America’s Got Talent, and I love watching Fool Penn and Teller because I am always asking myself “how do they do that?”

**HT**: What is something that would surprise people about you?
**YJ**: At work, I am usually quiet, somewhat serious, but still have a pleasant personality. However, out of work, my family is my life and we are always having a great time. I have a habit of breaking out in a song regarding whatever conversation we are having. This trait drives my husband crazy and I tell him “I can’t help it, it just comes out. My daughter calls it a ‘Yolanda Moment’, and I have seen my talent of breaking out in song being inherited by my grandkids.”

**HT**: If you could go back in time, what advice would you give your younger self?
**YJ**: I probably would not have gotten married so young and would have gone off to college. I was raised in a very strict Puerto Rican family environment, so I was very naïve of the real world, and I was not allowed to go to college.

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Thank you to Rick Rhew, member of the Communications Committee, for this update.
With the recent retirement of Doug Leonard, Brian Tabor now serves as president of the Indiana Hospital Association, which represents the interests of approximately 170 Indiana hospitals. The association is the chief advocate for hospitals and their patients, representing their interests with the State of Indiana, the federal government, the business community, regulatory agencies, accrediting bodies, and other stakeholders.

Prior to joining IHA in 2008 as vice president of Government Relations and then moving to Executive VP-Government Relations, Mr. Tabor worked in various policy roles for the Indiana General Assembly and in government relations for the Indiana Association of REALTORS®. He currently serves on several governing boards, including Covering Kids & Families of Indiana, the Indiana Health Information Exchange, the Sycamore School, and the Indiana Fiscal Policy Institute. He is also the 2016-17 president of the Governmental Affairs Society of Indiana. Mr. Tabor graduated from Purdue University with a B.A. in political science and an M.S. in agricultural economics. He grew up in Connecticut.

Mr. Tabor comments to our membership: “I look forward to working with HFMA and its members in my new role. I have enjoyed collaborating with your organization on issues like Medicaid reimbursement and supplemental payment programs and there are certainly challenges ahead and great uncertainty right now when it comes to these topics. However, by advocating with state and federal policymakers together, we can ensure a stable system of health care financing for Indiana. Our board has identified important strategic areas for us, such as maintaining HIP 2.0 and expanding insurance options, improving price and quality transparency for consumers, and improving the health status of Hoosiers as we move toward population health. We have had some success already in these areas, but there is much more work to do and I am excited to continue our partnership with HFMA”.

Thank you to Bill Carmichael, Vice Chairperson of the Communications Committee, for this update.
On May 11-12, Chapter Board and Committee members convened at Fort Harrison State Park Inn for this year’s Mini-LTC. The golf and horseback riding that had been scheduled for Thursday afternoon were canceled due to the weather, so we gathered at Dave and Busters to have some fun before the meetings...

Later that evening, members talked over dinner and enjoyed a trivia contest....
Chapter Committees, along with their goals and membership for the 2017-18 year are listed below...

Awards and Recognition Committee
- Goal: Seek out opportunities for membership recognition and awards from Chapter/HFMA services
- Members: Jack Bishop (Chairperson)

Communication Committee
- Goal: Work with all committees to provide communication and education for members through the Chapter’s Newsletter and Website
- Members: Bill Carmichael (Vice Chairperson), Eric Day, Sally Hardgrove, David Parry (Chairperson), Rick Rhew, Jerry Smith

Education Committee
- Goal: Design all educational programs for the Chapter. This includes immediate needs served by half-day, one-day and two-day sessions. The committee incorporates education from the following major functions: Receivables, Finance, IS, Physician Practice Management, Compliance, Reimbursement, and Managed Care
- Members: Aaron Adami, Lindy Beldyga, Trae Christian, Dan Coons, Hilary Dolbee, Lisa Earl, Nick Eichelma, Heidi Hamby, Megan Iemma, John Kraft, Nick Kuzera, Amber LaRue, James Loveless, Nick McLaughlin (Chairperson), Karen Meyer, James Miller, David Nie, Jon Townsend, Doneta Wire

On Friday morning of the Mini-LTC, members met to discuss plans and set goals for the upcoming 2017-18 year...
LINK Committee
- The goal of the LINK committee has been to provide a coordinated mechanism for HFMA Chapters to give feedback to National HFMA on proposed regulations/legislation that could affect our industry, by getting feedback from a cross section of our provider membership. Feeding that information back to National in this coordinated fashion enables National HFMA to present a collective voice to those legislators responsible for creating and passing those laws or regulations. The continuance and focus of these Chapter Committees is currently being evaluated by National HFMA.
- Members: Brad Willkie (Chairperson); additional members to be determined

Membership Committee
- Goal: Provide better coordination and awareness of member needs, through:
  - Achieving Balance Scorecard requirements
  - Contacting members who have not been attending recent events or need to renew their membership
  - Attracting other groups and increasing the number of student members
  - Maintaining the membership directory
  - New member orientation activities and events
- Members: Lisa Earl, J. Hopkins (Chairperson), Nick Eichelman, Doneta Wire

Networking Committee
- Goal: Focus on the social and networking needs of the members, creating a variety of opportunities for members to enhance the professional and social aspects of their membership
- Members: Al Baldwin, Grant Brackin, Sara Falconer (Co-Chairperson), Angie Flora, Megan Iemma, Clayton Kelly, Damon SantaMaria, Thelma Retz, Jeremy Richey, Patricia Rocap, Michelle Trowell, Joshua White (Co-Chairperson)

Professional Development Committee
- Goal: Facilitate Chapter members’ professional growth by providing certification information and working with National HFMA to promote professional development through on-line tools
- Members: Lisa Earl, Shannon Ebenkamp (Chairperson), James Loveless, Farrah Mahoney, Stacey McCreery

Sponsorship Committee
- Goal: This committee is responsible for obtaining sponsors as well as administering the various financial opportunities for our sponsors. The committee will work with the sponsors to ensure that the sponsors’ and Chapter’s needs are being met.
- Members: Stephanie Bernhardt, Rich Bishop, Bryan Gordon, Darren Cook (Co-Chairperson), Becky Funk, Kathi Geiger (Co-Chairperson), Alicia Henson, Aaron Johnson, Frank Morelli, Shawn Williams, Brad Willkie

SUBC – Adhoc Committee
- Goal: Review, comment and act on initiatives impacting healthcare institutional billing at the national and state levels; meets quarterly
- Members: Healthcare providers, payers, software vendors, consultants; Jim Miller (Chairperson)
The political upheaval in Washington hasn’t escaped widespread scrutiny and criticism, but one of the foremost rural healthcare leaders believes how providers forge ahead, despite the circus-like atmosphere on Capitol Hill, will determine the course of healthcare delivery in rural America. “All of (Washington) D.C. is crazy right now,” said Alan Morgan, CEO of the National Rural Health Association (NRHA), while addressing the Indiana Rural Health Association (IRHA) at its 20th Annual Conference in June. “No one knows what’s happening in D.C. “One year ago, we were expanding healthcare coverage under ACA (the Affordable Care Act of 2010). Now, under the new administration, expanding coverage is not as important as getting government off your back and repealing Obamacare.”

Morgan stated the NRHA opposed most of the provisions in the American Health Care Act (AHCA) of 2017, which the U.S. House narrowly passed (217-213) on May 4. The AHCA, according to Morgan, did not adequately address the health disparities, payment difficulties and workforce issues that rural facilities continually face. He described the AHCA as “anti-rural” and that any similar legislation considered by the U.S. Senate must target substantially more money to battle the opiate crisis – “the growing scourge on our nation” – as well as provide additional funding for physician extenders to improve patient access in rural areas.

Despite the uncertainty over the future of the Affordable Care Act and Congressional attempts to “repeal and replace” it, Morgan reassured IRHA conferees that healthcare remains one of the pillars of rural America and that positive trends are occurring.

“Healthcare, small businesses and rural schools are the key to rural America,” said Morgan in his keynote address to IRHA. “Healthcare is at the top of economic drivers in rural economies. We have to keep healthcare front and center.”

Morgan noted that rural advocates continue to work closely with White House and CMS panels to magnify the importance of rural healthcare, especially in how it spurs economic development throughout rural communities. This work, he commented, has been especially challenging, given the long-standing perception that agriculture is the principal focus among federal officials.

Regulatory relief would be welcomed in rural areas, Morgan commented, but that rural healthcare leaders need to identify where regulatory burdens and hurdles exist and how to “get over them.” He pointed out that elimination of the direct physician supervision requirement for outpatient therapeutic services remains a primary goal for NRHA.

Morgan cited a recent U.S. Census Bureau statistic as an encouraging sign: the population migration to U.S. cities from rural counties has recently flattened out at 46 million – to remain at about 14.1 percent overall. This leveling off of population shift follows a decades-long trend from the early 20th Century when agriculture was the paramount economic engine in rural America.
That trend, together with frequent quality indicators that hospitals and physicians perform consistently better than their urban counterparts, provides “wonderful opportunities for students” and for the future of healthcare delivery in rural areas. And, Morgan remarked, that Congressional reintroduction of the “Save Rural Hospitals Act” earlier this year reemphasizes a bipartisan recognition of the importance of rural hospitals in areas and populations that are often medically underserved.

Despite the optimistic signs, Morgan cautioned that the ongoing threat of rural hospital closures, declining life expectancy and increased health disparities among rural Americans, and the exploding opioid crisis have placed immense stress on the rural healthcare delivery system. Morgan noted that at the current rate 25 percent of the nation’s approximate 1,800 rural community hospitals will close within the next decade.

“We have to keep rural hospital doors open,” stressed Morgan. “In rural America we have the most in need but have the fewest options (for care).”

Morgan’s comments came at the outset of IRHA’s annual conference, which annually is the largest healthcare conference in Indiana. Over 550 healthcare professionals and students, as well as over 100 exhibiting companies, attended the two-day event at the French Lick Resort. The 2018 IRHA Annual Conference will be held June 26-27, 2018 in French Lick.

About the Author
Jim Miller is a member of the Education Committee and Chairperson of the Indiana State Uniform Billing Committee for HFMA’s Indiana Pressler Memorial Chapter. Jim is Revenue Cycle Consultant for the Indiana Rural Health Association and may be reached at: jmiller@indianarha.org (P) 812.478.3919

A few other photos from the IRHA Conference...

HFMA Chapter and IRHA member Jim Miller (Green shirt) facilitates a session on the future of healthcare for medical and allied health students attending the conference

HFMA Chapter members Kathi Geiger and Richard Altman at Networking reception

Panel Discussion: Indiana Opioid Crisis and the Impact of Collective Efforts
HFMA’s ANI was held from June 25-28 at the Orange County Convention Center in Orlando, Florida. This year’s event had more than 4,000 attendees (62 from our Indiana Pressler Chapter), and included 80 educational sessions, 350 exhibitors, and many networking opportunities...

Sunday’s keynote session, “The Changing Landscape of America”, was presented by MSNBC’s Morning Joe hosts Joe Scarborough and Mika Brzezinski.

Carol Friesen (HFMA 2017-18 Chair, and Vice President of Health System Services at Bryan Health) along with Margie Amato (CAO at Bryan Heart) spoke at one of ANI’s final Wednesday sessions about “Creating Meaningful Communications Between Clinicians and Finance”.

Several Indiana Chapter attendees got together Sunday afternoon before the opening session.

A section of the Exhibit Hall on Monday and Tuesday.

Afternoon snacks in the Exhibit Hall.
The Evansville HFMA Regional Mini-Institute was held on July 26, 2017 and was a success with 16 attendees, three presenters, and two legislators in attendance. We had a great venue at the Evansville Country Club, and the presentations were interesting and topical.

Tom Skoog spoke about the challenges of cyber security facing the Healthcare Industry. He touched on why healthcare is a target, who the bad actors are, and what needs to be done to prevent cybercrime from affecting our industry.

Left to right: Carrie Brogan and Kim Capin from Cash-Pro, Inc. at the Mini-Institute’s Check-in Desk.

Left-to-right: State Representative Holli Sullivan (District 78) and State Senator Vaneta Becker (District 50) discussed health care issues facing Hoosiers such as early childhood care, nursing home care, expanding medical instruction, and the opioid crisis.
Stacey McCreery gave an excellent presentation on the often overlooked need for succession planning in healthcare organizations, not only as a strategic plan, but as part of business continuity. She stressed that it doesn’t have to require a great deal of time to reap tangible rewards.

Jeff Moffatt of Blue and Co. discussed the benefits and drawbacks of wRVU production-based compensation models and the challenges of maintaining these plans. Jeff also spoke about identifying strategic opportunities in production-based compensation plan redesign and hospital-physician alignment initiatives related to participation in value-based reimbursement programs (see his article in this Newsletter).

Attendees and speakers also enjoyed good conversation over lunch....
DO YOU REMEMBER WHEN . . .

Let’s look back to a few moments from yesteryear that we can remember and take pride in.

The chapter has an extensive collection of old photos, and chances are we have a picture of some fond memory or event that you might have. We’d love to hear from you . . .

Yours in HFMA,

JIM MILLER

Veteran HFMA leaders John Diehl (left) and Paul Usher (center) greet Gail Walker at a networking reception in the early 2000s. Diehl and Usher were longtime hospital CFOs and Indiana Pressler Memorial Chapter presidents in 1982-83 and 1997-98 respectively, while Gail Walker supported the chapter for many years as a sponsor and volunteer.

Chapter volunteers (left to right) Marija Milivojac, Terry Cole, LaMont Freeze and Margaret Bauman proudly display their HFMA Follmer Bronze awards during the President’s Reception at the chapter’s annual institute in April 1998. The Follmer Bronze Award is the first national Founders Merit honor presented to members for volunteer service to HFMA.

The late Stan Pfeister (left) receives sponsorship recognition from HFMA National Chairman Rich Henley at the 2000 Annual Institute in Indianapolis. Pfeister, who passed away in October 2014, was a longtime chapter sponsor, volunteer and friendly face at HFMA events.
Save the Dates… for these upcoming Programs and Events

2017 Tri-State Fall Institute & Vendor Show
HFMA Chapters from Indiana, Southwest Ohio, Kentucky, & Central Ohio

Event Date: September 20-22, 2017
Networking reception Wednesday evening (September 20)
Baseball game Thursday evening (September 21)
Location: Hyatt Regency - 151 W 5th St, Cincinnati, OH 45202
Registration and Hotel Link: Tri State Conference

2017 IRHA Fall Forum

Event Date: November 16, 2017
Location: Bel Air Events Center, 3014 South Webster, Kokomo, IN 46902
Event Information: 2017 IRHA Fall Forum

2018 HFMA Indiana Winter Institute

Event Date: January 25-26, 2018
Location: Indianapolis Marriott North
3645 River Crossing Pkwy, Indianapolis, IN 46240
Registration and Hotel Link: 2018 HFMA Indiana Winter Institute

2018 HFMA Indiana Spring Institute

Event Date: April 12-13, 2018
Location: Indianapolis Marriott North
3645 River Crossing Pkwy, Indianapolis, IN 46240
Registration and Hotel Link: 2018 HFMA Indiana Spring Institute
Healthcare Board Members and Corporate Officers have a fiduciary responsibility to ensure that their organization is properly managed, financially sound, committed to achieving the corporate mission, and is in compliance with laws and regulations. Among their many requisites is a thorough understanding of the organization’s environment and risks. One of these risks – data breaches – is a significant threat that cannot be ignored. Cybersecurity must be a corporate priority. Board and Executive Team Members need to work together to establish appropriate Board oversight, and Management must ensure appropriate operational systems exist and are consistently maintained for an effective cybersecurity program.

In June 2017, the Ponemon Institute reported the cost of a data breach in the U.S. (across all industries) increased nearly 10% in the past year and now averages $7.35 million. The report further spotlights that globally, healthcare sector breaches are among the most costly at an average cost of $380 per compromised record, compared to an all-industry per record cost of $141. In 2016, the U.S. healthcare sector experienced 377 data breaches – its highest number ever. Elevated levels of healthcare cyberattacks are expected to continue as an increasing number of diverse systems (including biomedical devices) become connected to the main corporate network, and intrusion methods become more sophisticated.

Laws and regulations require healthcare organizations to implement appropriate security measures, and substantiate them through documentation and audits. In 2016, the HHS Office for Civil Rights (OCR) issued an updated audit protocol with expanded administrative, physical and technical safeguard requirements, and launched its Phase 2 HIPAA Audit Program (Audit Program). While the primary purpose of these continued audits is to learn what tools, technical assistance and guidance are needed by organizations, the OCR also acknowledges that they may take further actions if significant deficiencies are revealed – which could subject an organization to major fines and potential reputational risk.

Organizations should act now to use these updated audit rules as an opportunity to understand and remediate their security shortcomings, even if they are not among the healthcare entities being audited under the Audit Program. Persistently high levels of cyberattacks coupled with the need for HIPAA compliance point to an increasing number of OCR breach investigations and compliance audits.

The need for cybersecurity to be a corporate priority continues to increase; Board Members and Corporate Officers who do not provide reasonable fiduciary oversight for cybersecurity are exposing the organization – and perhaps even themselves – to significant risks and potential liabilities.

Management must apply the same level of direction, expertise, and structure regarding cybersecurity as they have historically given to other critical areas such as the corporate mission and finances. A cybersecurity update should be a standing Board agenda item. In addition, Board Members should assess their knowledge and expertise on cybersecurity; if appropriate, Boards should obtain additional education or supplemental consulting, or add a Member with security expertise.

Management’s ownership and ability to administer the cybersecurity program along with the required tools, processes and policies should be both enabled and confirmed by the Board. Does Management have the knowledge and resources to run an effective cybersecurity program? Is cybersecurity perceived and run as a corporate-wide and multi-disciplinary risk management program? Cybersecurity is not just a technology issue: it must involve leadership from all corporate disciplines (e.g., finance, legal, clinical, human resources, information technology) and encompass activities throughout the organization.
Cybersecurity requires significant considerable work and there is no simple, one-time solution. While technology solutions play an important role, the biggest impact will come from educating employees to always practice good security hygiene. The following ten, relatively straightforward security steps can provide significant protection:

1. Maintain security policies and procedures, with mandatory ongoing user education and awareness training.
2. Apply secure, baseline builds using only approved devices and software, and stay current on patches/releases.
3. Use a multi-layered network with firewalls and segments/subnets to limit unauthorized or malicious content.
4. Perform frequent system back-ups that are stored offline and offsite, and test system restorations and recovery plans.
5. Regularly conduct risk assessments to validate security and regulatory goals are being met.
6. Monitor network and system logs, perform penetration tests, and address unusual or unauthorized activities.
7. Restrict user access to work needs and use limited, segmented privileged accounts.
8. Use encrypted, two-factor authentication and secure connections for remote and mobile devices.
9. Develop and communicate a removable media policy (e.g., flash drives) that requires encryption and scans before uploads.
10. Create an Incident Response Plan, do mock tests, and encourage employees to report both minor and major incidents.

A Board-driven and Management-led cybersecurity program will enable your organization to take the right steps to protect itself from data breaches or harmful events. Cybersecurity is about identifying, understanding and effectively managing risks, but even the best cybersecurity programs cannot eliminate all risks. Board and Management discussions should include identification of which risks to avoid, accept, mitigate, or transfer through insurance, as well as legal implications and specific plans associated with each approach.

References:

About the Authors

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David Parry is a member of HFMA’s Indiana Pressler Memorial Chapter, and Chairperson of the Chapter’s Communication Committee. David is Senior Manager in the Healthcare Group at Mazars USA, and may be reached at: David.Parry@mazarsusa.com (C) 219.242.0445
With revenue cycle complexity continuing to grow, there seems to be an endless need to keep staff up to speed and be able to put best practices into play. Unfortunately, the vast array of payers, each with their own anomalies in claims responses, use of claims adjustment segment and remark codes and, often, differing terminology on their websites and in correspondence, make it nearly impossible to keep up with defining optimal processes, let alone effectively train staff on them. It’s just as challenging to ensure that staff retain what they learn. The following principles and techniques can help you successfully address these challenges. Also, while this article focuses on revenue cycle companies, these measures can be applied to other types of firms.

Recognizing that a revenue cycle services company’s most precious asset is its people, successful companies strive to have the best trained staff in the industry. Specific steps a company can take include:

- Review the quality of staff work to identify additional training needs
- Establish incentives and rewards for quality results
- Create an extensive and up-to-date library of resource and training materials
- Provide frequent and schedule educational refresher and update sessions
- Perform ongoing quality reviews followed by feedback and advice
- Continue to research and analyze opportunities to improve processes and investments in staff

Another important factor to consider is that as a company dedicates more resources and attention to training, employees may not be satisfied with it. Perhaps the biggest challenge in training and retention is adapting the approaches to engage the four generations in today’s workforce; traditionalists, baby boomers, Gen Xers and Millennials.

**Millennials want just-in-time learning**

In the article “Designing Learning for Millennials,” the author, Akanksha Sharma, writes: “While most companies are still clinging to the traditional formal and sporadic talent development practices, they do not resonate with how Millennials prefer to learn today. Millennials choose to learn in new and different ways. For them, formal learning doesn’t contribute much to substantial retention and they expect more informal, just-in-time learning sources to acquire and assimilate knowledge. For them, context is more important than content.”

Other authors echo this message, adding that baby boomers may favor more traditional and static training methods like PowerPoint presentations and handbooks, while younger workers may gravitate towards more interactive, technology-based forms of learning. Others contend that new methods of training, preferred by Millennials, work well for all generations.
Understanding the need for interactive training tools does not solve the challenge of keeping training up to date in a highly dynamic healthcare environment. To address that challenge, change your corporate culture to include these guiding principles:

- Employees need to be personally accountable for their education and career development
- Employees must be provided with the right tools to learn what they need to know
- We must continuously maintain those tools

**Participatory education**

The culture must be one in which staff can independently resolve the challenges they face. A key component is to increase employee involvement in developing their tools. Instead of top-down process improvement, engage interested staff and give them permission to spend time on research and problem-solving instead of focusing only on worklists. Collaborative teams create tools to guide decision-making, but use language and categories that they define and understand.

Reinforce structures that ensure staff can communicate what they want, when they want, and the way they want, such as through individual and group meetings, suggestion boxes, and semi-annual staff satisfaction surveys.

By monitoring the work environment and adapting to generational differences, your company can more effectively navigate the complex training environment, and advance the skills and satisfaction of its most valuable asset: Their people.

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**About the Author**

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Long considered an objective basis for benchmarking provider productivity in fee-for-service (FFS) environments, the use of Work Relative Value Units (wRVUs) may begin to lose some relevance as value-based reimbursement becomes more of a reality. Federal regulations such as the Medicare Access and CHIP Reauthorization Act (MACRA) as well as the economics of healthcare spending in the U.S. will inevitably result in a transition from traditional production and compensation models based upon quantitative measures such as wRVUs and wRVU-related benchmark data to value-based payment programs that rely on more qualitative criteria. In fact, in Patient Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs), bundled payment programs, and other value over volume payment initiatives, wRVUs can in some regards be considered counterproductive to these quality driven programs. This will likely result in a shift from commonly used production based compensation plans to value-based models that account for the ever increasing importance of quality of care, patient outcomes, resource utilization, and patient/provider satisfaction.

Work Relative Value Units (wRVUs) are a component of the Centers for Medicare and Medicaid Services’ (CMS) Resource Based Relative Value System (RBRVS), which is primarily used to determine reimbursement for the professional component of Designated Health Services (DHS) provided to governmental health plan (e.g. Medicare) beneficiaries. wRVUs are a measure designed specifically to reflect the work, effort and intensity required of the provider (e.g. physicians, mid-levels, certain therapists, etc.) in providing a specific service. These wRVUs are weighted by CMS based upon the type of service being provided, and therefore the annual total of these wRVUs for a specific provider or group of providers are often used to benchmark overall productivity.

A benefit of this method of comparison is that the wRVU is a universal measure of the volume and complexity of services provided. That is to say that when we would like to compare the relative productivity of providers where reimbursement rates and payor mixes vary, wRVUs provide a common basis for measurement that is not dependent on financial circumstances that are typically out of the direct control of the provider. Because of this, hospitals and health systems commonly use wRVUs as a basis for determining provider compensation. Production-based compensation models are often based upon a certain dollar value per wRVU “produced” by a provider, creating an incentive for the providers be as “productive” as possible without the burden of billing and collecting for the services provided.

A disadvantage of production-based compensation models is that since they typically do not directly account for reimbursement rates, payor mix, and other factors impacting net revenue, there can be a disconnect between the actual financial performance of a practice/provider and the compensation paid based upon wRVUs. It is not uncommon for hospital-based practices to realize annual net losses after all operating expenses including provider compensation. Add to this the fact that payors, most notably Medicare, have continued to advocate for reimbursement models that place more importance in value over volume, and our traditional production-based compensation models come
into question. While a production-based model may be for the most part effective when reimbursement is based upon the volume of services provided, they typically do not consider the “value” of those services, where value is defined as follows:

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]

When considering “value” in a FFS environment, we are most likely referring to the reimbursement for services provided. Medicare specifically calculates reimbursement “value” for services rendered by providers (i.e. Physician Fee Schedule (PFS) reimbursement) through the following (albeit simplified) formula:

\[
\text{FFS Value} = (\ peRVU + mpRVU + wRVU) \times \text{Conversion Factor}
\]

The peRVU and mpRVU are defined as the Practice Expense Relative Value Unit and Malpractice Expense Relative Value Unit respectively. These values are combined with the corresponding wRVU value for each service included in the PFS and multiplied by the current conversion factor, which for 2017 is $35.7751, to determine the Medicare reimbursement for the service (there are typically other geographic adjustments made as well, however these have been omitted for purposes of this discussion).

This perspective on Medicare reimbursement being representative of “value” presents somewhat of a paradox when we specifically consider value-based payments under MACRA and the Quality Payment Program (QPP). These initiatives are intended to move the Medicare program from a strictly volume based reimbursement model to one that provides incentives for high value (and penalties for poor value). There are several components that will be factored into the various programs under MACRA and the QPP, however it is expected that quality and cost will given the greatest weighting in the ultimate determination of value-based performance. Quality will be measured by a variety of clinical best practices and outcomes-based criteria, whereas cost will be measured by the Medicare reimbursement paid under an episode of care, on a per Medicare beneficiary basis, or some other comprehensive measure of Medicare’s cost (i.e. reimbursement paid).

Even under this value-based model, however, Medicare will initially continue to reimburse under the current FFS model, with adjustments for value-based performance assessed after a period of time required to compile and evaluate provider data (there is expected to be a two-year period before performance results will be reported and bonuses are paid/penalties are assessed). As a result, volume-based production will continue to have a financial incentive with some accounting for value after the fact. This is where the paradox lies in this methodology, since when we overlay the two value formulae discussed previously we have the following:

\[
\text{Value-Based Payments} = \frac{\text{Quality}}{[ (\ peRVU + mpRVU + wRVU) \times \text{Conversion Factor} ]}
\]
Since providers will initially be reimbursed under the existing FFS model under MACRA (and potentially other value-based payment models), the incentive remains to drive volume which in turn increases the denominator and lowers value equation above. Because of this, the initial incentive to drive volume can turn out to be counterproductive if there is not a corresponding indication of quality in the numerator of the equation to offset the FFS cost. As a result, traditional wRVU-based compensation models will not be able to match financial incentives to desired outcomes (i.e. high value) without factoring quality as a measure of relative productivity.

It is important to note that a value-based production and compensation model will be directly dependent on the value-based reimbursement programs available. Although Medicare has defined its own pathway to placing more importance in value over volume, value-based compensation will be most effective if there is greater participation across all payors. However, with Medicare establishing a precedent for weening providers from FFS reimbursement and considering the economics of most provider groups, the move to value-based production and compensation is likely more feasible than it has ever been.

About the Author

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The Office of Inspector General (OIG) has been reviewing the Medicaid electronic medical records (EMR) incentive payments for both eligible professionals (EP) and eligible hospitals (EH) for the past year and a half. It’s been reviewing a small sample of the largest payments issued to EHs—and an even smaller sample of payments issued to EPs—per state.

OIG found a lot of overpayments for EHs and EPs—roughly $66.7 million in overpayments for the Medicaid portion for EHs (even before reviewing $14.6 billion in Medicare payments) and an extrapolated $729 million in overpayments to EPs.

Worried about large potential overpayments of taxpayer dollars, Congress has started pressuring the Centers for Medicare & Medicaid Services and OIG to begin auditing and collecting. Once the push to collect was publicized, there was severe pushback from the major EP players.

Per recent reports, OIG made a midyear update to its 2017 work plan to conduct another round of EMR audits.

This update specifically targets Medicare payments made to EHs. OIG is targeting payments made during program years 2011 to 2016, which totaled roughly $14.6 billion.

Act now before OIG comes calling to audit your facility. If OIG audited a facility today for payments received in 2011, most facilities would have problems providing the data for many reasons.

Here are some of the biggest problems we have seen when assisting hospitals trying to provide data for any EMR audit (Meaningful Use, Medicare or Medicaid):

- Management has changed
- Information technology leaders that were in charge of EMR are gone
- Facility changed EMR systems (maybe more than once) and left the previous system on unfriendly terms
- The data has been purged from their system
- Facility didn’t keep detailed records for all EMR payment variables

If any of these issues sound familiar, immediately address them so there’s time to gather the data. There’s no reason to struggle through an EMR audit. Having your data gathered and reviewed well before OIG calls can provide peace of mind.

The auditor will seldom have any positive adjustments suggested for the auditee during a governmental audit. However, numerous positive adjustments can be made that most likely would negate some negative adjustments or increase the payment for that particular payment year.

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Hoosier Times - Summer 2017

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MAYBE QUESTIONING THE NORM SHOULD BE THE NEW NORM.

Every time a bar gets raised, a record gets broken, or a new star shines, it’s because somebody was curious. Wondering how high they could reach. How much they could do. As a proud sponsor of Indiana HFMA, we applaud that. Questioning everything makes anything possible.
Sometimes the best solutions are revealed when you change your perspective — and finding the right perspective is easier when you have a knowledgeable advisor. Our hospital and health system experts can help your organization gain a new perspective to rise above its challenges. Helping providers succeed in today’s ever-changing healthcare industry is a higher return on experience.

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