Letter from the President

As the warm weather comes to an end and winter stares us in the face, it’s hard to believe that my tenure as your President is nearly half over. I am pleased to report that the year has started strong. We managed to post record attendance at the Summer Institute and the Tri-State Institute was an overwhelming success. We have also implemented a new and improved website, and have already surpassed last year’s sponsorship numbers. Each of these initiatives was a tremendous amount of work, but all were very rewarding in the end. For everyone who has been involved in making these initiatives a success, I want to extend my gratitude.

We all have goals in our professional lives. Budget goals, sales goals, charge hour goals (for you consultants out there), and professional development goals are at the top of our minds each and every day. HFMA is no different. Each year, National establishes goals for each of the chapters. These goals focus on the amount and quality of education provided, membership satisfaction, the number of members attracted and retained, the number of Certified Healthcare Finance Professionals within each chapter and financial viability. You may not realize it but you, as Chapter members, help us achieve these goals. The Chapter gets credit when you attend an event, pass the CHFP exam, join HFMA or recruit others to join HFMA. With these goals in mind, I would like to provide you with a year-to-date report card. The table below depicts where the Chapter stands in relation to our goals as of October 31st.

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<th>Goal</th>
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<td>Membership Satisfaction</td>
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As you can see, after only two events, you have helped us achieve nearly 41% of our education goal by simply attending events. With several events to go and your continued support, I am confident we will meet, if not substantially exceed this goal.

You will also notice we are significantly short of our membership goal. We generally expect a fair amount of attrition at the beginning of the fiscal year for folks who have allowed their memberships to lapse. It’s usually not because they don’t intend to renew, but because the renewal application takes a while to rise to the top of their stack. More often than not, they do eventually come back. In order to meet the membership goal, we rely on retaining our current members, as well as gaining a few new ones. If you have not already done so, please take a moment and complete your renewal application. Also, within this newsletter, you will find information about a new member-get-a-member program that we will be holding this winter. Be sure to take advantage of the opportunity for great prizes while helping us reach our membership goal.
Although we are currently meeting our certification goal, we don’t have much room for error. All it would take is for one or two certified members to transfer out of our Chapter and we would be left short. If you have been considering certification, the time is now. You will find information in this newsletter related to the certification program, including the resources the Chapter makes available to you and the ways in which the Chapter can help defray the cost if your employer does not reimburse you for the exam.

Finally, by the time you read this message, you should have received the Annual Chapter Satisfaction Survey distributed by National. If you have not already done so, please take a moment and tell us what you think about the Chapter. After all, this is your Chapter. Please remember that you are evaluating the Chapter and not National HFMA activities. As I mentioned before, we take these surveys very seriously during our planning process. Our goal is for more than 55% of respondents to fall into the “Very Satisfied” or “Extremely Satisfied” categories. Filling out the surveys is yet another way you can help us achieve our goals.

I very much appreciate all the support we get from our members and our sponsors. Continue to “Believe to Achieve,” and together we will all be successful. Thank you for a great start to the fiscal year. I can only hope the second half of my tenure goes as well as the first half.

Chris Woosley – President
Kentucky Chapter – HFMA
2011-2012

Preparing Your Organization’s Training Program for ICD-10

Authors: Katie Carolan, VP of Operations, Health Record Services, Baltimore and David Reitzel, CMC, CPHIE, Grant Thornton, LLP, Chicago

How to assess your organization’s ICD-10 readiness, train staff, and predict the costs of converting to this new system.

At a Glance
- Training for ICD-10 is going to be expensive, though predictions of how expensive vary widely.
- Healthcare finance executives should create a flexible, multiyear capital and operating budget to prepare for ICD-10 conversion and the training and support that will be required.
- Healthcare organizations also should assess staff knowledge in the critical ICD-10 areas and begin training now to be ready for go-live by early 2013.

As organizations eye the looming transition to ICD-10, the question arises regarding who needs to be trained on this new coding system. The simple answer: Everyone who cares for a patient, touches a medical record, or processes a bill.

For healthcare finance executives, early understanding of who in their organization needs training—and when—is critical for both budgeting and staffing. A good plan that starts now and continues beyond the Oct. 1, 2013, go-live date means a smoother transition that both lessens staff productivity losses and minimizes revenue slow-downs.

This plan should include:
- A general awareness campaign about the changes that ICD-10 will require for the entire organization
- An assessment of staff knowledge in the critical ICD-10 areas
- Implementation of individual, role-based training
- Creation of post go-live support, reassessments, and continuing education

First Step: Awareness for All

Provider organizations should have begun the awareness process regarding ICD-10 in 2010, if lessons learned from Canada’s implementation of ICD-10 are an indication. That country’s implementation showed it takes a lot longer than expected and results in a substantial drop in productivity by coders—a 50 percent drop to start, with a continuing 10 to 25 percent drop moving forward (Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS: Challenges, Costs, and Estimated Benefits, a report prepared for Blue Cross and Blue Shield by the Robert E. Nolan Company, October 2003, and Johnson, Kerry, Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital, American Health Information Management Association, 2004).

Who Should Be Trained on ICD-10?

The following types of professionals should be included in the first phase of an organization’s education and training program:
- Senior executives
- Medical staff
- Financial management professionals (accounting, billing)
- IT staff
- Clinical department managers
- Health information management and coding staff
- Quality management professionals
- Utilization management/case management staff
- Any performance improvement group professionals
- Tumor registry staff
- Research staff
- Audit/compliance staff
- Business associates

What level of education will be required for various staff? In general, patient access and revenue cycle staff will require a baseline knowledge, and IT staff, physicians, and clinical coders will require an in-depth understanding.

Continues on page 3
The American Health Information Management Association (AHIMA) states that ensuring organizational awareness, establishing a training plan, and preparing a multiyear budget are all key steps for Phase I of ICD-10 implementation (first quarter 2009 through second quarter 2011).

Because nearly every hospital department needs to be aware of the magnitude of effort required in the transition to ICD-10 and must budget accordingly, awareness training should begin immediately. A hospital’s marketing team, working in conjunction with the organization’s health information management (HIM) department, should coordinate the strategic content of this message to staff. In addition to using traditional communications techniques such as posters, newsletters, lunch meetings, or departmental meetings, hospitals also should consider harnessing the power of social media to get the message out.

Assess Readiness and Training Needs

With general awareness education underway, healthcare finance officers should turn their attention to budgeting for ICD-10 training. In creating a budget, a baseline assessment of staff knowledge in critical areas, such as those jobs listed in the sidebar on Page 2, should be performed to see where gaps in knowledge and skills exist.

Coding staff should be assessed on their knowledge in four areas:

- Medical terminology
- Anatomy and physiology
- Pathophysiology
- Pharmacology

Because ICD-10 requires a more in-depth knowledge of these four areas, all coders—representing inpatient, outpatient, radiology, and emergency services—should be included in the initial assessment.

After an assessment is performed, an education program catered to each individual’s needs should be developed and put into the budget. Initial baseline training should begin this year, with more intense ICD-10 training taking place in early 2013. AHIMA recommends 50 hours of coder training for both ICD-10 clinical modification (CM) and procedure coding system (PCS) for 2013 (Majerowicz, Anita, “Developing an ICD-10-CM/PCS Coder Training Strategy,” Journal of AHIMA, April 2011).

Quick Returns, Immediate Rewards

After coding assessments of staff are completed, there are three areas where healthcare finance executives help their organizations achieve a quick ROI in ICD-10 preparedness.

Clinical documentation improvement. Many organizations have clinical documentation improvement programs in place today to accommodate electronic health records (EHR) implementation and meaningful use criteria. Because ICD-10 dictates that documentation become more specific, any education efforts undertaken now will inevitably yield positive returns in ICD-9 coding outcomes, bearing fruit early.

Begin by applying the Pareto principle: Assess clinical documentation for the 20 percent of diagnoses and procedures that represent 80 percent of the organization’s revenue. Be creative, and look at your data differently—instead of merely reviewing your top DRGs, look at fewer cases by DRG and shift to the top three admitting surgeons. Highest paying procedures such as interventional radiology also are good targets.

Fix ICD-9 codes presenting problems now, because those problems are likely to expand with ICD-10. Sampling techniques are useful for this phase. Results of this assessment will quickly identify which medical specialties need training and which do not.

Revenue cycle staff education. Translate the knowledge gained from documentation reviews into actionable teaching modules that a physician champion can present to the rest of the medical staff. Short, specialty-focused physician education sessions presented by physician champions are best practice. Organizations also should consider changes in the documentation capture process, particularly in EHR environments where additional prompts and drop down boxes can be implemented to aid physicians in creating ICD-10 ready, clinical documentation.

Payer and physician contract negotiations. Finance officers have the opportunity to gain some ICD-10 traction in contract negotiations via two avenues: in negotiating with payers and in negotiating with physician practices.

Many contracts with payers are based on code definitions. As these are entered into, or renewed, it makes sense to model the reimbursement impact of ICD-10 versus ICD-9. Working and planning together, coupled with a cooperative testing plan, will help both parties. Physician practice revenue projections should also be modeled, as they will change with ICD-10. Any negotiation for purchase should include ICD-10 upgrade language.

Continues on page 4
Coders should plan on investing in additional training or retraining in 2013, particularly as revenue cycle issues arise.

are contracting now for supplemental coding and billing support in 2013. Top vendors and experienced personnel are being booked early, so many providers

in documentation will steer many DRGs to “unspecified” waste buckets that	
						predictably reduce reimbursement and fundamentally erode the economic and quality benefits of converting to the ICD-10 code set. Further, unspecified coding raises red flags for potential audits and revenue take backs.

Predicting the Cost

When it comes to cost, the only “known” is that the conversion to ICD-10 is going to be expensive. Industry wide estimates show huge variances.

According to the RAND Science and Technology Policy Institute’s 2004 estimate, it will cost between $425 million and $1.15 billion in one-time costs to implement ICD-10—plus between $5 million and $40 million a year in lost productivity. Blue Cross and Blue Shield’s study for the ICD-10 transition showed one-time costs at $5.5 to $13.5 billion, with recurring costs estimated at $150 to $380 million annually.

During its 2011 ICD-10 coding summit in Baltimore, AHIMA experts projected that an inpatient coder will need 50 hours of training in 2013 at a cost of $3,219, while an outpatient coder will need 16 hours of training at a cost of $644 per coder in 2013. Additional costs will be incurred in 2011 and 2012 for education. The 2008 Nachimson Advisors LLC report The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories, released in October 2008, predicts physician practices costs for the ICD-10 transition at about $83,290 for a small practice (three physicians), $285,195 for a medium practice of 10 physicians, and $2.7 million for a large practice (100 physicians).

IT also needs to be brought on board to make sure vendors and systems are ready for the transition. Software, hardware and service upgrades will probably be required, with additional training on the new applications needed, adding to the costs. Small systems in many institutions currently not on IT’s radar also need to be included in this phase.

Healthcare finance executives should use these benchmarks to build estimates for financial impact, planned for in a flexible, multiyear capital and operating budget.

Finance and revenue cycle staff also need to be involved in this phase. It is important not to forget to include training cost for revenue cycle staff if the organization is upgrading systems. Also, the revenue cycle is highly ICD dependent; therefore, workflow processes, forms, and reports all should be evaluated for ICD-10 readiness. In addition, preparations and planning for longer billing cycles and higher numbers of denials should be made.

October 2013 and Beyond

The go-live phase of 2013 requires organizational agility, especially in revenue cycle, HIM, and IT. Finance officers should budget for significant drops in coder productivity, which will have an impact on revenue and will require additional labor resources (whether from internal staff, outside agencies, or contract workers). Top vendors and experienced personnel are being booked early, so many providers are contracting now for supplemental coding and billing support in 2013.

Organizations also should plan on investing in additional training or retraining in 2013, particularly as revenue cycle issues arise.
Kentucky Implements Managed Medicaid

Author: Jeanene Whittaker, Bottom Line Systems, Inc.

On September 8, 2011, the Kentucky Cabinet for Health and Family Services (CHFS) received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a state-wide network of managed Medicaid. The change is expected to save the State in excess of $1.3 billion over the next 3 years. Passport Health Plans will continue to be the exclusive Medicaid MCO for Louisville and the 15 counties surrounding the metropolitan area. CHFS has contracted with CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky to serve the remaining regions throughout the State.

Timelines:
The initial implementation date of October 1, 2011 was extended to November 1, 2011 in response to hospitals’ request for more time to complete the contracting process. Letters of Intent may not be used for purposes of contracting after October 5, 2011. Providers who wish to contract with any of the MCOs after that date, must use a binding agreement. More information can be obtained by contacting the companies directly. Eligible enrollees were notified of their payer participation choices and were encouraged to select an MCO by September 22, 2011. If no selection was made by the deadline, CHFS made the assignment. Members have until December 31, 2011 to change their plan selections for the 2012 coverage year.

Trainers Stay Vigilant After Go-Live

The transition to ICD-10 is an enormous undertaking—one that will require careful management not just before and during implementation, but also afterward, until staff productivity stabilizes and issues related to implementation are resolved. That is why training partnerships and collaborations will be essential. Providers should utilize online and college-based educational services and information available through AHIMA. Senior managers and physicians should be included in the search for solutions to issues that result from the transition to ICD-10. Some organizations also may choose to leverage an outside ICD-10 specialty partner for project management.

It’s important that healthcare finance professionals not become complacent following the go-live phase. Follow through should continue for as long as it takes to establish a stable process and get cash flow back on track. There will be significant post-implementation problems, such as claims denials and rejections or coding backlogs. A process should be created for quickly identifying these problems, and feedback loops should be completed to fix them as soon as possible. General awareness and communications programs should be used to keep everyone in the loop throughout the transition.

ICD-10 Training: Expenses to Consider

Five areas of cost related to ICD-10 training should be evaluated as an organization begins to plan for organization wide training programs that will address multiple levels and layers of stakeholders:

1. Equipment:
   - Computers and printers
   - Networking
   - Security

2. Software:
   - Software licensing, installation, and support
   - Computer-based Training Material (i.e. customized to your organizations)

3. Personnel
   - Project management or coordination
   - Data analysis support
   - Technical assistance and training

4. Services
   - Training by third parties
   - Hosting services
   - Programming by third parties
     - Customizations
     - System interface development
   - Data conversions
   - Security assessment and setup
   - Online connectivity
   - Facilitation
   - Disaster and recovery

5. Space and operations
   - Equipment rental
   - Facilities rental

Continues on page 6
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<tr>
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<tr>
<td>Farmington, MO 63640-4401</td>
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<td><strong>WellCare of Kentucky</strong></td>
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<tr>
<td>Louisville, KY 40253</td>
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<td><strong>Provider Services/Provider Relations</strong></td>
</tr>
<tr>
<td>855-454-0061</td>
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<tr>
<td>Allison Christie-Lee, Director Provider Relations 502-719-8530</td>
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<tr>
<td>866-643-3153</td>
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<td>866-643-3153</td>
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<tr>
<td>CoventryCares of Kentucky P.O. Box 7812</td>
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<td>London, KY 40742</td>
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<tr>
<td>Kentucky Spirit Health Plan Claim Processing Department P.O. Box 4001 Farmington, MO 63640-4401</td>
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<td>WellCare Health Plans, Inc. Claims Department P.O. Box 31372 Tampa, FL 33631-3372</td>
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<td>Claim Disputes P.O. Box 3000 Farmington, MO 63640-3800</td>
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<td>Claim Payment Appeals – denials for incidental procedures, untimely filing, non-covered codes and unlisted procedure codes: Wellcare Health Plans, Inc. Claims Department P.O. Box 31370 Tampa, FL 33631-3370 Fax: 877-277-1808</td>
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<td>Appeals for payment policy related issues (EOB Codes beginning with IH, MK or PD) Wellcare Health Plans, Inc. Payment Policy Appeals P.O. Box 31426 Tampa, FL 33631-3426 Fax: 877-277-1808</td>
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<td>Provider Claim Dispute Form can be downloaded from the website. Provider portal allows electronic submission of claim disputes.</td>
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<td>Instructions for specific appeal or adjustment requests located on the provider portal, but actual on-line adjustments not available.</td>
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<tr>
<td>CoventryCares of Kentucky Attn:</td>
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<tr>
<td>Appeals Department 9900 Corporate Campus Drive, Ste 1000 Louisville, KY 40223</td>
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<tr>
<td>Provider Claim Dispute Form located on the website. Re-submit to: Kentucky Spirit Health Plan P.O. Box 3000 Farmington, MO 63640</td>
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<td>Wellcare Health Plans, Inc. Attn:</td>
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<td>Appeals Dept P.O. Box 436000 Louisville, KY 40253 Fax: (866) 201-0657</td>
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Considering HFMA Certification? It’s easier than ever...here’s the scoop!

Author: Don Frank, Bottom Line Systems, Inc.

HFMA certification is a terrific way to confirm and highlight your credentials as a knowledgeable member of the healthcare community. With new changes to the program in 2011, the process has been streamlined and makes it easier to complete the certification process.

Why should you become certified? The Certified Healthcare Financial Professional (CHFP) designation benefits you, your employer, and our chapter in numerous ways:

• You confirm your qualifications and expertise as a healthcare professional;
• Your continued participation in educational events highlights your commitment to our profession and ensures that you stay in touch and informed regarding industry developments;
• Your CHFP status shows others the value of HFMA membership and certification;
• Surveys have shown that certified members tend to earn higher salaries and are more likely to be hired for upper-level positions in healthcare finance.

In order to obtain your CHFP designation, the requirements are as follows:

• Current and active HFMA membership;
• Successful completion of one comprehensive certification exam.

It’s that simple! No more waiting periods or multiple exams in order to obtain your certification. Once you have achieved your CHFP designation, you can maintain your certified status by remaining an active HFMA member and completing 90 contact hours in eligible education programs every three years. Of the 90 contact hours, 45 hours must be in healthcare finance-related topics, with a minimum of 20 hours to be completed in each of the three years.

Now is the time to pursue your certification! In order to encourage and support your efforts to become certified, our chapter will reimburse you for the cost of your study materials and exam fee if you pass the exam and your employer does not cover these costs.

If you are interested in certification and would like additional information, please contact Cindy Sharp, Certification Chairperson for the Kentucky HFMA Chapter, by phone at 812-949-5690 or by email at csharp@fmhhs.com. You can also visit the HFMA CHFP website at www.hfma.org/chfp for more information on requirements, study materials, and the exam.
Why Are ACOs So Important to CMS?

An HFM Web Extra

Many observers believe that the Centers for Medicare & Medicaid Services’ (CMS) ultimate goal in healthcare reform is to pay for covered services at capitated rates that are just high enough to assure adequate levels of quality and access for patients, but also low enough that providers are delivering affordable services at high levels of efficiency.

Mindful that capitated payment under managed competition failed in the 1990s, CMS knows that the major causes of that failure included:

- Few evidence-based quality standards pertaining to the process and outcomes of care
- Virtually no capabilities on the part of hospitals and most physicians to manage risk
- Inadequate IT capabilities to support hospital and physician managers’ need for real-time information to manage clinical quality, resource consumption, and financial outcomes
- Rationing of care, often through fairly arbitrary denials, by the insurers who accepted capitated payment as they vendorized providers to maximize their profits.
- Conflicting financial incentives between physicians and hospitals that tended to create overutilization of oversupplied acute care service capacity
- The tendency of hospitals to cost shift their losses from HMO-covered patients to Medicare until the Balanced Budget Act of 1997 transformed relationships, spiked increases in private insurance premiums, and ended that era

To avoid such pitfalls this time around, CMS is planning to roll out several initiatives which if successfully implemented would allow the agency to set capitated rates that would pass most of the risk on to providers and insurers in ways that:

- Are consistent with explicit quality standards
- Maximize the population’s health status and minimize demand for acute care interventions by utilizing primary care providers to manage chronic conditions more effectively through medical homes
- Reduce the unit costs of hospital and specialty physician services per episode of care through the use of bundled payments for these services
- Integrate the delivery and financing of healthcare through ACOs that would develop the tools and relationships necessary for successfully coordinating and managing risk, quality, access, and financial results

In a real sense, the successful development of ACOs would permit CMS to contract directly with providers in much the same way the agency now contracts with insurers under the Medicare Advantage program.

NEW MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Traci J Lopez</td>
<td>Business Office Supervisor</td>
<td>King’s Daughters Medical Center</td>
</tr>
<tr>
<td>Lisa A Caldwell</td>
<td>Director Utilization Management</td>
<td>King’s Daughters Medical Center</td>
</tr>
<tr>
<td>Ed Delp</td>
<td>Finance Director</td>
<td>James B Haggin Memorial Hospital</td>
</tr>
<tr>
<td>Lewis L. Perkins</td>
<td>VP Patient Care Services</td>
<td>Norton Cancer Institute</td>
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<tr>
<td>Jill R Grabeel</td>
<td>Asst Controller/Financial Coordinator</td>
<td>Lake Cumberland Regional Hospital</td>
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<tr>
<td>Christine Bowman</td>
<td>American Hospital Directory, Inc.</td>
<td></td>
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<tr>
<td>Aydan Spanyer</td>
<td>Asst. Director, Reimbursement</td>
<td>University of Kentucky</td>
</tr>
<tr>
<td>Connie Farmer</td>
<td>Billing Office Manager</td>
<td>Manchester-Memorial Hospital</td>
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Sponsoring New HFMA Members PAYS OFF in PRIZES!
Author: Don Frank, Bottom Line Systems, Inc.

The list of benefits to HFMA membership is long. The educational programs, webinars, online resources, and networking opportunities helps keep all of us in touch with what’s happening in healthcare on a local and national level.

There is another way that your HFMA membership can pay off for you, as well as a friend or colleague too! HFMA’s Member-Get-A-Member Program rewards you for sponsoring someone who joins HFMA between now and April 30, 2012. The new member gets all of the benefits of HFMA membership, while you get to choose a reward for yourself! Here is how it works:

- If you recruit one or two members, you get the choice of an HFMA apparel item or a $25 VISA prepaid card;
- If you recruit three or four members, you get a $100 VISA prepaid card AND an entry into a drawing to receive a $1,000 cash prize;
- If you recruit five or more members, you get a $150 VISA prepaid card AND an entry into a drawing to receive a $2,500 cash prize;
- For every recruit, you also get an entry into a drawing for an iPad2, and an entry into the drawing for the Member Get-A-Member Make a Difference Grand Prize, which pays $3,000 in cash to you and makes a $2,000 donation in your name to a charity of your choice.

But wait...there’s more! From November 1, 2011 through December 31, 2011, the Kentucky HFMA Chapter will be sponsoring a State Member-Get-A-Member program. By sponsoring a new HFMA member who joins during this timeframe, your name will be entered into a drawing for a $250 prepaid gift card. This program is for Kentucky members only, so one of our own members is guaranteed to be the winning name drawn. The drawing will be held at our Winter Institute in January 2012.

Please note that in order to be eligible for either of these programs, the new member must list you as their sponsor when they sign up to join HFMA. Additional details on the national Member-Get-A-Member program can be found at www.hfma.org/mgam. If there are any questions regarding the Kentucky Member-Get-A-Member program, please contact me directly at dfrank@onlinebls.com.
The 2011 HFMA Tri-State Fall Institute was held at Belterra Casino in Florence, IN on September 14 – 16. It was held jointly by the Indiana Pressler Memorial, Kentucky, Central Ohio and Southwestern Ohio chapters of the HFMA. The keynote address on Thursday was given by J.D. Kleinke, CEO at Mount Tabor in Portland, OR. He discussed the effects of government reform and how your organization can navigate a health care system in the greatest changes of its history.

There were 3 Break-out sessions provided on Thursday morning. Jane Berkebile, Vice President of Revenue Cycle at OhioHealth, discussed aligning people, process and technology to reduce bad debt, increase cash collections, manage charity care and improve customer service. Christopher Kalkhof discussed building an integrated service line care continuum, strategic pricing, and managed care contracting strategy. Chris Keough of King & Spalding Law provided Medicare DSH adjustment update.

There were also 3 Thursday afternoon break-out sessions. Joseph Cleves, Partner at Dressman, Benzinger & LaVelle, discussed integrated project delivery. Ruth Levin from Revenue Care Consulting Group discussed the gainsharing program to achieve greater efficiency, cost savings and quality improvements. Jamie Cleverley discussed using data and metrics to identify cost reduction opportunities.

Thursday afternoon’s general session included Eric Zimmerman from McDermott Will & Emery in Washington DC which provided the Washington update.

Friday’s keynote address was given by Ralph Lawson, CFO at Baptist Health South Florida, to discuss US healthcare economics. Lastly, Matthew Weekley from Plante & Moran discussed “Taking Washington Out of Healthcare Reform.”

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**2011 Tri-State Fall Institute**

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The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE
The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION
The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.

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