Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

4rth Quarter 2013

2014 is heralded to be the banner year for change impacts on healthcare operations. With do much commanding the attention of our members, I thought it would be interesting to query some of our members and experts in the field about what they have on their "2014 Watch List". Sometimes we only have questions, not the answers to the items we need to keep an eye on. In addition to keeping a careful watch on ICD10 and the ACA, there are a number of additional topics to "watch". I did the rounds at San Diego and collected some very interesting quotes:

Charles Brown, University of Washington

Integration is the top issue for many providers. Partnerships and big system consolidation will drive the quest: How do we get efficiencies and cost reduction out of the system? What can we expect out of the "economies of scale?"

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Carla M. DewBerry, K&L Gates

New HIPAA rules will give patients direct access rights to lab results. These changes go hand in hand with CLIA changes which will allow laboratories to disclose lab tests results directly to patients. See Carla's CLIA Update for more details on page 7.

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Linda Corley, Xtend Healthcare

NCD (National Coverage Decisions) and LCD (Local Coverage Decisions) are directly linked to the diagnosis code. At every level, coverage determination/ABN generation, claims edits, claims processing and denials are all driven by the diagnosis. How will CMS modify the NCD/LCD this year for ICD10? When that data becomes available what is the plan for your claims edit and CDM/Revenue Cycle vendors to perform rapid updates, test and deliver? How long will we have to wait to update our systems with the new NCD/LCD after ICD10? Will claims have to be held, or will there be later recoupments? A very important issue to watch.

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Scott Owens, Data Systems Group

"Although there is an industry perception that the payers are ready to begin testing submission of ICD-10 claims data, the reality is that with only 8 months to go there has been very little published or announced from the payers in terms of their readiness. While many providers may be ready to test either on their own or with their vendor, there has been minimal acceptance of test scenarios by the payers and/or their associated clearinghouses. Providers at the very least should insure that their

continued on page 5...

Contributing Writers

Peggi Ann Amstutz
Charlie Brown
Carla DewBerry
Day Egusquiza
Jim Heilsberg
Cathy LeMay
Judy Veazie

THANK YOU!!!

Editor's Corner

by Judy I. Veazie | CRME, CCT

After several years of masterfully editing the Northwest Outlook newsletter for Washington-Alaska HFMA Fredrik Andreasson transitioned out of his role as Editor. With the year fast approaching, I was asked to keep the news flowing to our members during the transition.

Some of you know that I have been writing The Healthcare Biller column for Aspen Press for over ten years. But I doubt that you know my first healthcare editing gig was for HFMA. Actually, editing the Northwest Outlook is sole reason I am in healthcare management today. Although I was new to healthcare, I applied for a job as PM Business Office Manager and the CFO interviewed me by spreading out all the HFMA publications on his desk. He was taking the Board member role that oversaw the publications and needed someone to do the editing, formatting, pictures and interviews that drive the newsletter and I had a journalism background. This CFO, Carl Craig hired me and that year under the leadership of our youthful new chapter President John Tiscornia, we went on to win the National Prize for best publication.

As with any subject, writing about a topic or industry is a great way to learn about the industry I sat through endless presentations on budgeting, regulation, filing cost reports, etc. What a great preparation for the language of our business!

The hot topics on our "watch list" during those early days was the impact of new regulation, pressures on the cost of healthcare and pricing, newly insured into the marketplace and struggles to acquire and upgrade to new technology.

Some things never change on that list, but we keep adding additional items. Our change in the format of our publication by using the Front Page for the hot topics is our way to kick off this year under that theme "What is on your Watch List?"

When I conducted an informal query with Region 11 Symposium attendees from our chapter, they hit on some big issues for all of us to track. One of the quotes Carl Craig used in our first edition was "The Chinese have a "blessing":**

"May you live in Interesting times"

2014 will indeed be an interesting time!

**Chinese New Year—Blessing or Curse???

The background..... "May you live in interesting times"

A traditional Chinese idiom which seems to be similar is translated as: "It's better to be a dog in a peaceful time than be a man in a chaotic period."

It is speculated that the phrase is the first of three curses of increasing severity, all of which are seemingly positive statements. The other two statements are, among several alternatives with similar meanings.

- **"May you come to the attention of those in authority."**
- **"May you come to the attention of powerful people."**
- **"May you come to the attention of important people."**
- **"May you find what you are looking for."**
- **"May your wishes be granted."**

Excerpts from Wikipedia

President's Message

From
Carla DewBerry
Chapter President

I hope your 2014 is starting well and that you had some time to recharge over the holidays. Now that the holidays are over, it is likely that a continuous stream of questions, problems, opportunities ideas, and to do's are continuing to float across your desk. Keeping current can be overwhelming, but I wanted to highlight some of the resources that HFMA makes available to you in an effort to streamline your access to summary and detailed information, so that you can both stay informed and access the information that is most important to you.

Even the Fonz is a 12th Man!

Photo by: Richard Anzalone

Josh Lewis, Chapter Treasurer; Henry Winkler, aka The Fonz; and Jason Faaborg, Culbert Healthcare Solutions at the Region 11 Symposium in San Diego.

Chapter meetings are place where you can gather information on a variety of topics. You can download handouts from these meetings at the Washington-Alaska website (http://www.waakhfma.org/) to create your own resource library. You can see and exchange information with your peers at the chapter social events (both social events associated with meetings and stand-alone social events). You can educate yourself, our staff and your colleagues at road-shows (the Chapter hosts local training sessions at our member locations - let us know if there is a topic of interest).

The Chapter is partnering with other chapters (Oregon, Hawaii, Nevada and the various California chapters) to have a regional symposium. We just returned from the Region 11 Symposium in San Diego. The agenda included a wide array of topics, vendors had an opportunity to show their innovations and capabilities, and speakers contrasted developments across the various states.

HFMA National offers an excellent annual institute, and National offers other sessions in various locations throughout the country. (There is discussion of a National offering in Seattle next spring - stay tuned.) In addition, National uses a variety of techniques to keep us informed. For example, National is running a Case Study Contest where service providers identify a problem they addressed and how it was solved. These short one page case studies are a quick read and they address situations that may be relevant to you. (You can read the case studies and Cast your ballot until March 31, 2014 by using the following link: https://www.hfma.org/Content.aspx?id=1501)

HFMA Click to Connect >>>>>>>

Our goal is for HFMA to be your link to relevant information, people and ideas. ■

2014-2015 Election Results and Chapter Leadership Team

by Cathy LeMay

In January, Chapter members were asked to select Officers and Directors from a slate of highly qualified individuals to serve on the WA-AK HFMA Leadership Team for the upcoming year. Officers and Directors will be sworn in at our May meeting and will assume responsibility for their roles on June 1, 2014. **Please join me in congratulating the following individuals.**

HFMA Board & Directors

June 1, 2014 – May 31, 2015

President – Charlie Brown
President Elect – Peggi Ann Amstutz
Secretary – Rik Lewis
Treasurer – Josh Lewis
VP/Program Chair – Janet Walthew
Immediate Past President – Carla DewBerry

Chapter Directors

Gary Bartlett
Anthony Dorsch
Bruce Houlihan
Jennifer House
Patty Jorgensen
Jennifer Mitchell
Patti Peterson
Gail Sarchet
Mike Smith
Dean Taplett

I would like to personally thank everyone who agreed to run for positions on the 2014-2015 WA-AK HFMA Leadership Team. I continue to be impressed and inspired by the level of commitment our Chapter volunteers demonstrate. I am grateful for the opportunity to work, learn and play with all of you!

OIG Annual Work Plan - Late Release

Editor's Note: After a delay of more than three months (normally the OIG Annual Work Plan is published in October), watchful healthcare professionals and compliance experts finally got their first take on the anticipated data. I checked with a number of compliance support contractors and consultants and most of them have just started their review of the detail at press time. Peggi Ann Amstutz from Moss Adams promptly responded with her top watch list items. See her top list in this publication.

Mark Your Calendar

Spring Conference Spokane, Washington

May 7-9, 2014

Join us for the Swearing In
of our new
Officers & Board Members
at the
NORTHERN QUEST CASINO

SEE YOU THERE!

...continued from page 1

claims vendor is currently able to correctly process, indentify, edit appropriately for ICD-9 and ICD-10, and they should know what their vendor's plan is for testing on their behalf with the payers when they are ready. Although the conversion to 5010 was in preparation for the upcoming ICD-10 requirements, if history is a lesson then the providers should be prepared for many payers to either come on board at the last minute or know they will be changing the requirements as they learn more and receive more files."

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Andrew Busz, Washington Hospital Association

Medicaid rebasing: reducing and updating their new kind of grouper and payment methodology (IP & OP). Special Focus on: The transition to the APR (All Payer Group) which is a step closer to compliance with integration of the ICD10 format.

The State Task Finance task force is representing the hospital interests in working with the state, keeping a watch on their intent to balance the changes as closely to "budget neutral" as possible.

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Molly Brown, Peace Health

One impact from 2013 that we need to keep an eye on is the review of accuracy of billing for PT and OT with the "visit cap" tracking in place.

Even more we must actively monitor the impacts and compliance to the "Two midnight rule". CMS assures they are conducting "educational audits" (see Day Egusquiza blog excerpt about this expanding impact on our operations and billing)

The key area to watch is Clinical Documentation, which is the key to all these 2014 compliance and reimbursement rules for 2014.

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David Cartier, Cardon Outreach

As soon as the ACA law was passed, the question among employers and benefits people was: Is there still going to be a reason for COBRA? Offered a choice between heavily subsidized coverage in the health act's insurance exchanges or paying full price under COBRA, most people are going to choose the exchange.
The headlines read "HHS Clarifies that ACA Qualified Health Plans are Not Subject to Federal Anti-Kickback Statute; Expresses Concern about Providers Paying Premiums for Enrollees" When questioned about the role of hospitals payment of insurance premiums under ACA, the initial response was favorable, but then in November HHS's "anti-kickback" stand seemed to take U-turn regarding the ACA subsidized plans.

The agency expressed "significant concerns with this practice," stated that it "discourages this practice" and warned that it "intends to monitor this practice and to take appropriate action, if necessary." The final answer on the question about COBRA, payments of premiums, etc. is still pending.

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Other topics often mentioned:

ACA and the health exchange impacts on providers and patients. One impact area will be customer service and self-pay collections:

- Point of Service Collections: Large deductibles will be hitting every payer class and we will be getting a new influx of patients who are dealing with $5K (or more) debt with new sticker shock. This will cause push back to providers on price and revenue integrity. Customer service will have to be prepared for this.
- Transparency: Due to the increasing focus on healthcare costs to companies and individuals there will be increased demand for transparency from the healthcare sector AND the payers. Payers will increasingly come under the microscope (especially for profit). Watch out for the push overall against for profits. News headlines with healthcare executive salaries are just the beginning of a new level of examination.

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Rosemary Holliday, Holliday & Associates

New 2014 Visit Code Updates by CMS require a close watch on the updates by your CDM team. Should the hospital retain new and established visits? Should the hospital retain the 5 levels? Are all payers changing their requirements? Are the criteria clear and understandable for those selecting charges or codes? What is the impact on CAH hospitals? ■

OIG 2014 Work Plan Watchlist

by Peggi Ann Amstutz | Moss Adams LLP

The OIG just published their 2014 workplan on 1/31/2014. Here are a few items you may want to explore within your organization before the OIG takes a peak and makes a recommendation….

Critical access hospitals—Payment policy for swing-bed services

Policies and Practices. We will compare reimbursement for swing-bed services at critical access hospitals (CAHs) to the same level of care obtained at traditional skilled nursing facilities (SNF) to determine whether Medicare could achieve cost savings through a more cost effective payment methodology. Context—Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services. The Balanced Budget Act of 1997 (BBA) created the CAH Program to ensure access to health care services in rural areas. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed CAHs to receive Medicare reimbursement equal to 101 percent of reasonable cost and have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval. (Social Security Act, § 1814(l).) Neither the BBA nor the MMA established any length-of-stay limits for swing-bed utilization. Unlike CAHs, traditional SNFs are reimbursed under a PPS through case-mix, adjusted per-diem prospective payment rates for all SNFs. The payment rates represent payment in full for all costs associated with furnishing covered SNF services to Medicare beneficiaries.

Outpatient evaluation and management services billed at the new-patient rate

Billing and Payments. We will review Medicare outpatient payments made to hospitals for evaluation and management (E/M) services for clinic visits billed at the new-patient rate to determine whether they were appropriate and recommend recovery of overpayments.

Context—Preliminary work identified overpayments that occurred because hospitals used new-patient codes when billing for services to established patients. The rate at which Medicare pays for evaluation and management services requires hospitals to identify patients as either new or established, depending on previous encounters with the hospital. According to Federal regulations, the meaning of "new" and "established' pertains to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past 3 years.

Payments for patients diagnosed with kwashiorkor

Billing and Payments. We will review Medicare payments made to hospitals for claims that include a diagnosis of Kwashiorkor to determine whether the diagnosis is adequately supported by documentation in the medical record. Context—To be processed correctly and promptly, a bill must be completed accurately. (CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 1, §80.3.2.2.) A diagnosis of Kwashiorkor on a claim substantially increases the hospitals' reimbursement from Medicare. Kwashiorkor is a form of severe protein malnutrition that generally affects children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. It is typically not found in the United States. Prior OIG reviews have identified inappropriate payments to hospitals for claims with a Kwashiorkor diagnosis.

Oversight of hospital privileging

Quality of Care and Safety. We will determine how hospitals assess medical staff candidates prior to granting initial privileges, including verification of credentials and review of the National Practitioner Databank. Context—

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Hospitals that participate in Medicare must have an organized medical staff that periodically appraises its members (42 CFR § 482.22). A hospital's governing body must ensure that the members of the medical staff, including physicians and other licensed independent practitioners, are accountable for the quality of care provided to patients. Robust hospital privileging programs contribute to patient safety.

Rural health clinics—Compliance with location requirements

Policies and Practices. We will determine the extent to which Rural Health Clinics (RHCs) do not meet basic location requirements and the extent to which Medicare reimbursements to such clinics are occurring. Context—The Balanced Budget Act of 1997 (BBA) authorized CMS to remove from the RHC program clinics that do not meet location requirements. In 2005, OIG recommended that CMS promulgate regulations to implement the BBA. However, CMS has yet to promulgate the final regulations. As a result, RHCs that no longer meet eligibility requirements continue to receive enhanced Medicare reimbursement.

Physical therapists—High utilization of outpatient physical therapy services

Billing and Payments. We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Context—Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or medically necessary or were not properly documented. Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Documentation requirements for therapy services are in CMS's, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 220.3. ■

New CLIA Rule-Open Access to Lab Results

by Carla DewBerry | K&L Gates LLP

The new CLIA rule (42 CFR §493.1291) reads as follows:

> Upon request by a patient (or the patient's personal representative), the laboratory **may** provide patients, their personal representatives, and those persons specified under 45 CFR 164.524(c)(3)(ii), as applicable, with access to completed test reports that, using the laboratory's authentication process, can be identified as belonging to that patient. So CLIA will provide the laboratory with the right to choose to provide lab tests results directly to patients.

But the HIPAA rules are also being revised to **require** HIPAA covered labs and other HIPAA covered entities to allow patients to have direct access to lab results. This was accomplished by revising the HIPAA rules to delete the exception which provided that CLIA lab results were not subject to HIPAA. As changed the regulation (45 CFR §164.524) includes lab tests in the general HIPAA rule which provides that:

> Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set...

The new rules will be effective 60 days after publication of the final rule in the Federal Register. Publication is scheduled for 2/6/2014. Further, HIPAA covered entities must comply with the applicable requirements of the new final HIPAA rule within 240 days after the date of publication in the Federal Register. ■

Social Networking Events Update

by Charles R. Brown | UW Medicine

Our members spoke up during the membership survey a couple years ago and indicated they would like to see the chapter coordinate more socializing opportunities. The chapter leaders responded and developed two annual events to bring our members together in a social setting.

HFMA night at the Mariners has been a huge success and 2014 will mark the third year for this event. We had almost 50 attendees to this event last year. Members were provided discounted tickets, then everyone caught up with their colleagues over free food and drinks in the Hit-it-Here café. The networking turned into celebration as we watched the Mariners pull out a win just for the event.

As the Mariners get ready to head off to spring training, your coordinating committee is actively researching optimal dates for this year's event so make sure to read next quarter's newsletter and check your email to catch this year's game date!

The first annual WA/AK HFMA golf tournament was held in Suncadia during our 2013 fall meeting. This was another hugely successful event and included lots of contests, prizes, and free green fees for providers. Almost 40 attendees hacked up the course and had a great time laughing and socializing while chasing a little white ball around in the sunshine. The course play was designed as a scramble so golfers of all skill levels were able to participate and not feel intimidated. This year's winners included: Bruce

Charlie Brown awards the 1st annual golf trophy to Rick Stegman and Bruce Backer.

Backer, Jay Cooley, Mike Smith, and Rick Stegman. They were the first foursome to get their names engraved on the rotating trophy.

Another objective of the golf tournament was to raise money for scholarships to fund membership fees. Thanks to all the generosity of our sponsors, we were able to raise over $5,000, which we will use to increase HFMA membership by funding the first-year membership fees of 10 new members! If you would like to nominate someone you would like to see join our chapter please contact Charlie Brown (charlieb@uw.edu).

The second annual golfing event will be held during our September Fall conference in Bremerton. Read the newsletter and check your email for more information on how to register and/or sponsor this event. ■

LEADERSHIP MATTERS

How Do I Change My HFMA Information?

All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

The easiest way to make changes is via the internet. Simply follow these steps to change any of your personal information.

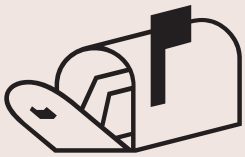
Please note: you must make your own information changes. The Chapter cannnot make these for you.

1. **Log on to http://www.hfma.org**
2. **Go to the membership section**
3. **Log in using the username and password prompts**
4. **Follow instructions to access your Profile**
5. **Edit information.**

$100

You could win $100 by writing an article for N.W. Outlook! Share your knowledge & experiences with other HFMA Members. You can help make a difference!

Please send information & articles for upcoming newsletters to:



Judy Veazie

E-mail: judyveazie@yahoo.com

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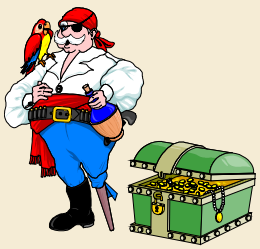


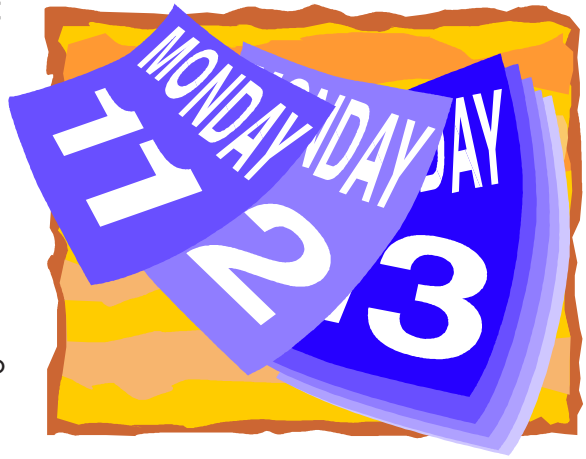
Share your wealth of knowledge by submitting an article or experience for the Northwest Outlook newsletter ....that way, we are all enriched!

Inpatient 2 Midnight Rule Updates

Excerpt from Day Egusquiza Blog

Lots happening so let's get started with the CMS change of the criteria for inpatient vs. observation known as the Two Midnight Rule. Here are the updates:

1) UB national committee/NUBC has redefined a code in its billing data set to allow hospitals to denote inpatient claims meeting CMS's 2 midnight BENCHMARK through a combination of outpatient and inpatient services. Effective 12-1-13, hospital can use occurrence code 72 on inpatient claims to denote the date span of contiguous outpatient hospital services that preceded the inpatient admission. Per George Argus/AHA and Kathy Reep/FHA.



First/last visit dates Occurrence code 72
The from/through dates of outpatient services. For use on outpatient bills where the entire billing record is not represented by the actual from/through service dates of form locator 06 (statement covers period)...AND (new) on inpatient bills to denote contiguous outpatient hospital services that preceded the inpatient admission.

Expect CMS announcement soon. HINT: Develop an internal method to get the date on the Inpatient UB...NOW! This will provide valuable information to the MAC for their 'probe and educate' audits which will be beginning immediately.

2) Examples of 'rare and unusual' 1 day inpatient stays: inpatient only and released last week: initiation of a vent during the inpatient stay that may result in a 1 midnight stay. CMS /MACs indicated they were still researching the best way to handle transfers. (RAC SUMMIT: IF the patient comes from a hospital, the receiving hospital has to START OVER with the 2 midnight presumption or 2 midnight benchmark. They CANNOT use the midnight from the transferring in hospital) See CMS's 11/27/13 "Reviewing Hospital Claims for Patient Status: Admissions on or after 10-1-13.

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3) Location does not equal 'inpatient.' In the same 11-27 update - excellent info on location does not equal inpatient. (EX: If the patient is in ICU - still not an automatic inpatient. If the patient needs tele - not an automatic inpatient as observation can be done in any location of the hospital)

4) Probe and Educate audits to begin immediately! Yes, many MACs have been publishing their notices that the Probe and educate audits will begin now. Some have done a great job of outlining the exact info they will expect when they do their PRE PAYMENT requests for records. Sample 10-25, 0-1 LOS. All hospitals, exceptional CAH, can anticipate a probe. Here is an excellent, detailed outline of what will be requested, including how the ADR will be received with a 30 day turn around for decision. MONEY WILL BE RECOUPED... DOS: Oct 1-March 31, 2014 Noridian

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NOTE: CAHs - please be aware that all aspects of the new rule DO apply to you.. I am a bit concerned that you are not being audited. Bad habits could exist by the time so stay diligent and learn from the findings as they are posted.

5) Certification form can head off many problems. Yes, it is not required but how can we train the consistent message:
Why did the patient need to be in an estimated 2 midnight stay?
After the first outpatient midnight, does the

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patient need another midnight to resolve the patient's condition? if so, 'attest' to the 2nd midnight. (So 1 outpatient and 1 inpatient -= inpatient but subject to audit.)
In the ER- immediately query, can the ER/ Hospitalist/Attending (whoever is directing care) attest to 2 midnights?

PS: When someone/UR says - patient doesn't meet 'criteria.' Be sure to say: You mean, the doctor can't attest/certify to 2 midnights - right? As not meeting Interqual or Milliman is NOT the definition of an inpatient. Never has been, never will be. It is a reference guide, only.
PPS: Other payers? The Admit to Inpatient and REASON FOR ADMIT - very doable for ALL payers. But each payer has their own pre-certification process which may allow more or less days PLUS they may only approve OBS stay. Nuts...but let's get started and watch how it evolves.

6) Pre payment and post payment audits - post Oct 2013. Same reference as #2 - "CMS will conduct prepayment patient status probe reviews for dates of admission on or after OCt 1, 2013 and before March 31, 2014. CMS will not conduct post payment patient status reviews for claims with dates of admission Oct 1-March 31, 2014." The complete outline of audit sampling and findings is included. Minor, moderator or high error rates will move to next steps. All 0-1 days of stay will be eligible for audit. NO AMNESTY. Remember - the RAC can audit other inpatient issues, just not patient status.

7) U of WI group did an assessment of the 2 midnight change. OBS to Inpatient ..CMS reduced hospital payments by .02 as they forecast more inpatients. WI group found opposite as they also found a drop in general medical patients, the hospital lost $1,378 per case placed in observation vs. a positive margin of $2,163 for inpatients. Pretty powerful stuff. (Thanks, RAC Relief)

8) RAC SUMMIT: Great, super wonderful RAC

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CORPORATE SPONSORS

The Chapter would like to thank the following companies for 2013 - 2014 sponsorships:

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Summit last week in DC. One of the updates is that the new RAC contracts and re-alignment of the country is on hold... definitely into 2014. Stay tuned. Other: 70% of all appeals are currently 'stuck.' Could be closer to 5 years to resolve/per Cleveland ALJ office's volume that was presented. HINT: Spend more on preventing the denial thru AGGRESSIVE documentation education, new forms/ certification, UR involved at the point of entry into the system, all providers and nursing join the Integrated CDI program... Can't wait 5 years to get the funds back.. AHA's RAC TRAC showed similar appeal %/44% and yet less in the overturn rate/closer to 70%...

Others: Systematic delays that result in 2 midnights DO NOT equal an inpatient. Think weekends... be very clear of the condition of the patient for other factors so the weekend delay for Cardio services is not the reason for the 2nd midnight... (Cardio is the hot button...for sure)

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HEY, FREE WEBINAR WITH COMPLIANCE 360

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Day E. and her team are doing the second part on the two midnight rule: 'ATTACKING THE 2 MN RULE" - an operational focus.

When: Tues, Feb 11th
Time: Noon Eastern
time` for 1 hr

Go to their website to register: https: / / www3.gotomeeting.com / register / 627878134
Topics we won't shy away from:
New Extension of Probe and Educate period / NOT DELAYED , 72 occurrence span code / 2 MN benchmark communication tool and Yes, a sample certification form and how to make it work.

****** Press Release: Feb 8, 2014 ******

CMS Postpones Sections of 2 Midnight Rule to October, "Education Audits" to Continue

Expanded Probe and Educate - THE 2 MN IS NOT DELAYED

CMS expanded the probe and educate audits thru Sept 30, 2014. What that means - we do know that the MACs will continue PRE PAYMENTprobes to identify compliance with the elements of the 2 MN. THey are to do education to prevent repeat errors, but will increase audits if problems are identified. NO RAC audits can be done on any 2 MN rule - now thru Sept 30, 2014. No POST PAYMENT audits of the 2 MN during this period. So we are all required to follow the regulations, effective 10-13, but the probe and educate period has been expanded. Audits = denials and no payment as they are PRE PAYMENT. 10-25 records based on the size. (Selecting hospitals for review) CAHS- going last as on hold right now...silly 96 hr rule. (PS I don't think it is a good thing to have the CAHs not audited. Bad habits will continue and not identified early and fixed. UG) The RACS issued a complaint about being excluded.

EXCELLENT examples of the 1 and 1 /2 MN benchmark in the Medlearn. Observation: our audit team is also struggling with the one outpatient and two additional inpatient=inpatient. (REGARDLESS of the clinical guidelines)... Use the MedLearn as it has ER, outpatient, surgery, and Observation examples.

For questions please contact:
Day Egusquiza, President
AR Systems, Inc • PO Box 2521 • Twin Falls, Id 83303
daylee1@mindspring.com

WA-AK HFMA Conference & Trade Fair

*2014 is here… "**Go for the Goal**" continues to be the theme as Healthcare Reform, ICD-10, Insurance Exchanges, and many other significant issues continue to influence our path in 2014.* ***Our Keynote speaker, J.D. Kleinke will present:***

Countdown to Meltdown? Preparing Your Organization for Obamacare, Market Reform & the Brave New Healthcare World

Often referencing his often quoted Wall Street Journal article: The Myth of Runaway Health Spending (February 2012), J.D. Kleinke is a favorite source of journalists and bloggers trying to make sense of healthcare reform. HFMA members and conference attendees will get the most current view of Mr. Kleinke when serves as our February 2014 keynote speaker.

Please register today to be counted!

WHEN
Tuesday, February 25, 2014 1:00 PM - Thursday, February 27, 2014 12:00 PM Pacific Time

WHERE
Hilton Seattle Airport & Conference Center
17620 International Blvd,
Seattle, Washington 98188
800.445.8667
Discounted Rooms Available until 2/14/14
Reserve Online HERE

"In the old days, people never questioned cost because they were basically given a blank check," says Kleinke. "Industry figured it out and said, 'This is madness.' "

> ***Whether you see health spending as a crisis, depends, in part, on your focus. To Kleinke, shifting the burden is good and necessary.***

"The moderation has been driven by cumulative improvements in medical care and by insurers, and by marketplace disciplines on the demand for medical care. Consumers are finally getting more involved in managing and paying for their own care."

> ***"Because people feel the economic pain directly, they've actually changed behavior, and spending did start to come down."***

"Moreover, while the insurance expansion aspect of the law has gotten most of the attention, much of the ACA consists of various efforts to "bend the curve" of spiraling healthcare costs that threaten to bankrupt federal health programs, including the popular Medicare."

J.D. Kleinke

Alaska Healthcare Watch

Alaska Healthcare Commission

This column is intended to update and inform the Chapter Members about Alaska healthcare financial news

Written by Cathy LeMay of Healthcare Resource Group (HRG) (sitting in for David Morgan)

Alaska Tabacco Program Efforts Honor 50th Anniversary of Surgeon General's Report on Smoking

It was 1964. The Beatles landed in New York, Mary Poppins was a hit movie, Ford introduced the Mustang, and the U.S. Surgeon General released the first Surgeon General's Report on Smoking and Health.

The fight to end tobacco use has come a long way in the past 50 years. According the Centers for Disease Control and Prevention, the United States has cut smoking rates by more than half (from 42 percent in 1965 to 18 percent today) and per capita consumption of cigarettes by more than 70 percent. However, the battle is far from over. According to the CDC, tobacco use is still the No. 1 cause of preventable death in the United States.

Over the past 14 years, Alaska has made great strides by committing to a comprehensive tobacco prevention and control program, which, thanks to our governors and Legislature, is funded close to the level recommended by the Centers for Disease Control and Prevention. "Alaska is setting an example for the nation with its strong and sustained commitment to fighting tobacco use," said Matthew L. Meyers, president of the national Campaign for Tobacco-Free Kids. "Alaska's efforts are paying off by preventing kids from smoking, saving lives, and saving money by reducing tobacco-related health care costs."

Results of Alaska's effort include:

- Alaska's high school youth smoking rate has declined 40 percent between 2007 and 2013 and 70 percent since 1995.
- In 2012, only 21 percent of Alaska adults smoked, down from 28 percent in 1996.
- The Alaska Federation of Natives and 84 tribes in Alaska have passed smoke-free and tobacco-free resolutions.
- About half of Alaska's population is covered by smokefree workplace laws.
- Alaska school districts are partners in this battle, with 20 districts having adopted comprehensive tobacco-free campus policies.
- Ten of the 14 members of the Alaska Association of Housing Authorities are protecting their residents with smoke-free housing policies.
- Local tobacco taxes have been raised in several communities to deter youth initiation, one of the most effective steps in protecting Alaska youth from becoming smokers.
- Alaska's vendor sales to youth are at an all-time low, at 4.2 percent (preliminary rate), down from a high of 34 percent in 1996.

"Alaska has made tremendous progress in reducing smoking use," said Dr. Ward Hurlburt,

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Alaska's chief medical officer. "But it is unacceptable that tobacco still kills and sickens so many people, and places such a huge financial burden on our society. On this 50th anniversary of the first Surgeon General's report, it's time for our nation and our state to take strong action to end the tobacco epidemic. We know how to do it, and we cannot afford to wait another 50 years."
A complete copy of the Surgeon General's report is available at:
http://www.surgeongeneral.gov/library/reports/

50-years-of-progress/index.html

Transmitting Public Health Reportable Data via Health Info Exchange

Health Information Exchange (HIE) has become increasingly important for moving clinical information among disparate health care information systems, while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care.

The Alaska HIE went into production in June 2013. Two facilities are live with the querybased/ interfaced HIE; eight facilities are in the process or have already joined the querybased/interfaced HIE; 10 clinics are using the view-only HIE access; 30 clinics are requesting access to the view-only HIE access as soon as possible; and several other facilities are in the process of reviewing contracts and discussing options with their internal stakeholders.

The Alaska HIE will be the most convenient way to transmit reportable public health data, such as immunization data, syndromic surveillance data, cancer case data, and reportable laboratory results to the department. The Alaska HIE will be the only transport mechanism by which DHSS will accept public health reportable data. Beginning Dec. 1, 2013, no new interfaces have been implemented between providers and DHSS. Messages that were being sent through previously developed interfaces will continue for a short period of time to allow for proper reporting transitions.

The Alaska HIE service can be used to meet the public health Meaningful Use requirements and options for Stage 2. For more information on participation with the HIE and Alaska eHealth Network, please visit www.ak-ehealth.org.

Medicaid Facing Surge in Costs: Governor Forms Advisory Group with Deadline

Governor Sean Parnell has called for a comprehensive strategy that fits Alaska's needs, a plan with attainable goals and a timeline. There needs to be collaboration with the Legislature, health care providers, payers, consumer groups and a defined public process. The state will take into account the recommend-ations of the Medicaid Task Force, including moving tocost-based rates, increased care coordination, payment reforms, expanded use of the patient-centered medical home model, and others.

The newly formed Medicaid Reform Advisory Group will comprise one member of the state House of Representatives, one member of the state Senate, and three additional appointees, including the chairman, named by the governor. The commissioner of Health and Social Services will be a nonvoting member and provide support staff. The panel's final report must be submitted to the Legislature for approval no later than Nov. 15, 2014, and be ready for inclusion into the governor's fiscal year 2016 budget proposal.

The advisory panel is charged with meeting three key reform mandates: stability and predictability in budgeting, increasing the ease and efficiency of navigating the system by providers, and providing whole care for the patient by uniting physical and behavioral health treatment.

The time is right for this process. Medicaid is

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becoming a larger and larger portion of the state's operating budget, making it critical for the state to look at what areas are working and improve upon those successes. Areas that are inefficient and nonproductive will be examined to enhance the delivery of service to reach the maximum quality of health outcomes at sustainable budgetary levels.

Updates on the Medicaid Reform Advisory Group can be found on the department's website at www.dhss.alaska.gov. The advisory group welcomes public input which can be submitted via email at: Medicaid. Reform@alaska.gov.

Health Care Commission Works with State Agencies to Improve in Health Care

When the Alaska Health Care Commission was established in 2010 under Alaska Statute 18.09.010, the state laws governing the responsibilities of the Department of Health and Social Services (DHSS) were revised to add a duty to create a statewide health plan based on the recommendations of the commission. DHSS and the commission recently launched a collaborative effort with other state agencies that have a role in purchasing or regulating health care to develop an action plan for implementation of the commission's recommended policies.
The commission's recommendations revolve around eight core strategies for improving value — increasing affordability through higher quality — in health care:

1. Ensure the best available evidence is used for making decisions.
2. Increase price and quality transparency.
3. Pay for value.
4. Engage employers to improve health plans and employee wellness.
5. Enhance quality and efficiency of care on the front end.
6. Increase dignity and quality of care for seriously/terminally ill patients.
7. Focus on prevention.
8. Build the foundation of a sustainable health care system.

Visit the Commission's website to see its recently released 2013 Annual Report and to track activities related to development of the statewide plan for improving value in health care: http://dhss.alaska.gov/ahcc/.

Alaska Ranks First in Neonatal & Infant Survival

A long-term statewide effort to address access to health care for pregnant women and infants has produced the lowest neonatal (birth to 28 days of life) and infant (first 365 days of life) mortality rates in the nation. Alaska's neonatal mortality rate hit an all-time low of 1.92 deaths per 1,000 live births, according to an annual summary of vital statistics for 2010–2011 published by the American Academy of Pediatrics.

This is the second year in a row that Alaska has led the nation in the lowest neonatal mortality rate. The state's infant mortality rate was also the lowest of all states at 3.75 deaths per 1,000 live births, a dramatic drop from the 8.3 deaths per 1,000 live births in the early 1980s. The dramatic reversal has been due to support by the health care community for regionalization of perinatal and neonatal care, says Stephanie Birch, section chief of Women's, Children's and Family Health.

50th Anniversary of "Great Quake" Spurs 6 - Day Exercise

The Great Alaskan Earthquake lasted nearly three minutes and — at a magnitude of 9.2 on the Richter scale — was the most powerful recorded earthquake in North American history. What if it were to happen again today? That's the premise of Alaska Shield 2014, a sixday emergency preparedness exercise scheduled for March 27, 2014 (the 50th anniversary of the

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quake).

The multi-agency exercise will be held in 13 Alaska communities and on all University of Alaska campuses. The exercise is being coordinated by the Department of Military and Veterans Affairs, but the Division of Public Health Section of Emergency Programs will lead medical efforts and serve as a supporting element for hospitals, shelters and mass casualty responses. "This will be the largest, most comprehensive training we've ever conducted," says Andy Jones, emergency program manager for the division.

Jones stresses that public preparedness relies heavily on personal preparedness. "Every Alaska family should have emergency supplies and an emergency response plan in place. For another catastrophic earthquake to hit Alaska, it's not a matter of if, but when."

The medical response section of the exercise is looking for licensed healthcare providers and non-medical people to volunteer to make this exercise as realistic as possible. For more information, go to www.haleborealis.com. To learn more about building a emergency supply kit, go to http://www.ready.alaska.gov/prepare/.

Alaska Health Care Commission Update

The Alaska Health Care Commission was established by the Legislature in 2010 to advise the state on policies for improving health and health care for all Alaskans. Members are appointed by the Governor, and represent stakeholder groups specified in statute. Since its inception the Commission has 1) created a strategic framework for health system improvement including a time-specific vision with measurable objectives; 2) conducted numerous studies, increasing knowledge and understanding of current problems in the health care system; 3) designed a comprehensive body of specific, relevant and measurable market-based policy recommendations for improving health care cost and quality; and 4) created a template for a statewide health plan based on the recommendations of the Commission, and are currently facilitating development of that plan.

The Commission will sunset on June 30, 2014 unless legislation to extend the sunset date is enacted. The Division of Legislative Audit conducted a Sunset Audit of the Commission this year, finding that the Commission is fulfilling its intended purpose and operating in the public's interest, and recommending the termination date be extended three years to June 30, 2017 to provide adequate time to coordinate with the Department of Health & Social Services on the development of a statewide health plan.

The Commission's vision is that by 2025 Alaskans will be the healthiest people in the nation and have access to the highest quality, most affordable health care. We will know we have attained this vision when, compared to the other 49 states, Alaskans have: 1) the highest life expectancy; 2) the highest percentage population with access to primary care; and, 3) the lowest per capita health care spending level. Alaska is currently ranked 29th, 27th, and 49th respectively for certain indicators associated with each of these three measures.

Studies of the current condition of the health care system conducted over the past three years include a description of the delivery system structure and financing; actuarial analyses of physician, hospital, durable medical equipment, and drug prices and cost drivers; health care accounting and finance; overview and impact of the Affordable Care Act; and impact of Alaska's medical malpractice reforms.

Alaska Health Care System Transformation Strategies and 2013 Policy Recommendations
The Commission has identified the following core strategies as essential for improving value in Alaska's health care system.

I. Ensure the best available evidence is used for making decisions
Support clinicians and patients to make clinical decisions based on high grade medical evidence regarding effectiveness and efficiency of testing and treatment options. Apply evidence-based principles in the design

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of health insurance plans and benefits.

II. Increase price and quality transparency
Provide Alaskans with information on how much their health care costs and how outcomes compare so they can become informed consumers and make informed choices. Provide clinicians, payers and policy makers with information needed to make informed health care decisions.

III. Pay for value
Design new payment structures that incentivize quality, efficiency and effectiveness. Support multi-payer payment reform initiatives to improve purchasing power for the consumer and minimize the burden on health care providers.

IV. Engage employers to improve health plans and employee wellness
Support employers to adopt employee health and health insurance plan improvement as a business strategy. Start with price and quality transparency, and leadership by the State Department of Administration.

V. Enhance quality and efficiency of care on the front-end
Strengthen the role of primary care providers, and give patients and their clinicians better tools for making health care decisions. Improve coordination of care for patients with multiple providers, and care management for patients with chronic health conditions. Improve Alaska's trauma system.

VI. Increase dignity and quality of care for seriously/terminally ill patients
Support Alaskans to plan in advance to ensure health care and other end of life decisions are honored. Provide secure electronic access to advance directives. Encourage provider training and education in end-of-life care. Establish a process that engages seriously and terminally ill patients in shared treatment decision-making with their clinicians. Use Telehealth and redesign reimbursement methods to improve access to palliative care.

VII. Focus on prevention
Create the conditions that support and engage Alaskans to exercise personal responsibility for living healthy lifestyles. High priorities include reducing obesity rates, increasing immunization rates, and improving behavioral health status.

VIII. Build the foundation of a sustainable health care system
Ensure there is an appropriate supply and distribution of health care workers. Create the information infrastructure required for maintaining and sharing electronic health information and for conducting health care analytics to support improved clinical decisions, personal health choices, and public health.

New policy recommendations include:

- Ensure the best available evidence is used for making decisions: Finding that waste in the health care system due to misused medical resources is significant and application of high grade evidence to clinical decision-making can increase effectiveness of medical treatment, improve quality of care, and reduce wasteful spending, the Commission recommends that Commissioners of State agencies responsible for purchase of medical services:
  - o Incorporate high grade evidence-based medicine when making determinations relative to provider payment methods and health plan benefit design, and in so doing coordinate to create a consistent approach, support a transparent process and develop policies that do not restrict access, and ensure prior authorization processes are efficient and user friendly;
  - o Provide learning and skill development opportunities in critical appraisal for staff involved in policy decision-making, and include health care providers and consumers;
  - o Provide patient decision-support tools to assist plan members and public program clients make effective health care choices in consultation with their clinicians;
  - o Promote provider-patient relationships through payment and benefit design that support providers to monitor patient compliance, and patients to comply with best practices for management of chronic conditions.

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- Engage employers to improve health plans and employee wellness: Finding that employers play an important role in the health of their employees and improving health care cost and quality; market forces in Alaska's health care system are impacted by certain state policies; Alaska's workers' compensation premiums are the highest in the nation due to high medical benefit costs; and, abuse of prescription opioid narcotics is a critical concern for employers; the Commission recommends that the:
  - o Legislature and the Department of Health & Social Services (DHSS) investigate and support mechanisms for providing health care price and quality transparency;
  - o Legislature and DHSS establish an All-Payer Claims Database;
  - o Division of Insurance consider modifying payment regulations to eliminate unintended adverse pricing consequences;
  - o Department of Administration and the State university system play a leadership role in implementing essential elements of successful employee health management programs;
  - o Legislature reform the Alaska Workers' Compensation Act to modernize the medical fee schedule and improve quality of care and outcomes for injured workers through evidence-based treatment guidelines, and restrictions on reimbursement for opioid narcotics and repackaged pharmaceuticals;
  - o Licensure boards of prescribing clinicians establish guidelines governing the practice of prescription medication dispensing;
  - o The State adopt aggressive prescription opioid control policies and programs, including upgrade to real-time and ongoing operational support for the drug monitoring program database, continuing education requirements for prescribing clinicians and guidelines for appropriate dosage by licensure boards, and monitoring by agencies responsible for the purchase of medical services.

- Increase price and quality transparency; Strengthen the health information infrastructure: Finding there is insufficient information to support health care consumers to seek value in care decisions, and to support and evaluate payment reform and delivery system improvement; that Alaska's Hospital Discharge Database is an important source of data but is incomplete due to insufficient participation; and that All-Payer Claims Databases are increasingly in use in other states to support transparency and health care system improvement; the Commission recommends that the:
  - o DHSS require participation in the Hospital Discharge Database; and,
  - o Legislature and DHSS establish an All-Payer Claims Database.

Next Steps

Over the past three years the Commission has identified a series of specific, relevant and measurable market-based policy recommendations for improving value in Alaska's health care system. Agency initiatives are planned or underway that would implement a number of these recommendations, and coordination has begun between these agencies and the Commission to document implementation action plans in a Statewide Health Plan. Extension of the Commission's sunset date as recommended by Legislative Audit would provide for continued coordination, accountability, evaluation, and refinement of the Statewide Health Plan. Plans for 2014 also include continued identification of policies regarding the employer's role in health care and also transparency, as well as opportunities for improving fraud and abuse prevention. ■

Winter in Alaska!

hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Assistant Dir/, Fin. Reporting Analysis	UW Medicine	Seattle, WA	click for more information
Controller	Grande Ronde Hospital, Inc.	La Grande, OR	click for more information
Director, Budget & Financial Planning	Legacy Health	Portland, OR	click for more information
Director of Finance	PeaceHealth	Vancouver, WA	click for more information
Director of Financial Reporting	Community Health Plan of Washington	Seattle, WA	click for more information
Finance Contracts Administrator	PAML	Spokane, WA	click for more information
Finance Program Manager	PeaceHealth	Longview, WA	click for more information
Financial Analyst, Decision Support	UW Medicine	Seattle, WA	click for more information
Government Program Financial Analyst	UW Medicine	Seattle, WA	click for more information
Internal Consultant	Premera	Seattle, WA	click for more information
Lead Consultant	Premera	Seattle, WA	click for more information
Lead Internal Consultant	Premera	Seattle, WA	click for more information
Mgr., Reporting & Integration (Acct)	PeaceHealth	Vancouver, WA	click for more information
Prog Fin Analyst, Cost Management	UW Medicine	Seattle, WA	click for more information
Senior Financial Analyst	Mason General Hospital	Shelton, WA	click for more information
Supervisor Insurance Accts Receivable	Providence Health System	Liberty Lake, WA	click for more information

NATIONAL OPPORTUNITIES

Whether you're climbing the ladder or you've reached the top, you must stay continuously focused on your career. HFMA gives you a distinct advantage every step of the way. Professional certification programs, career self-assessments, employment opportunity updates, resume referral services, mentoring opportunities, and national and local leadership opportunities let you have a hand in shaping the future of the industry and the profession.

To access HFMA National's Job Bank please click here!

For more information on these listings or to include a listing, please contact Kimie Delos Reyes at (360) 567-3594 or email at: kimie@hawesfinancial.com

See also National HFMA's website (www.hfma.org) for additional job listings.

[Last Update: Feb 2014]

New Members

The Washington/Alaska Chapter is pleased to announce the following new members:

Martin Benum
Experian

Patricia Cannon
Northwest Hospital

Rena Cardenas
MultiCare

Carol Doherty
Group Health Coop

Cathy Gross
Wrangell Medical Center

Caroline Heckathorn
Concur

Brian Hosey
Puget Sound Blood Center

Galen Kelly
Southcentral Foundation

James Morgan
Geneva Woods Pharmacy, Inc.

Patricia Rasco
Virginia Mason Medical Center

Katherine Ray
ECG Management Consultants, Inc.

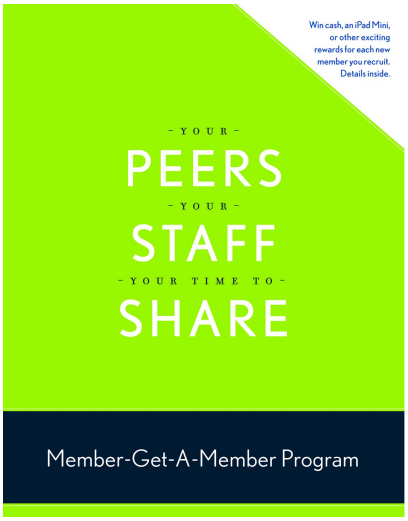
Nikki Scott
Seattle Procure Management

Carolyn Sinquefield

Beth Tubbs
Overlake Hospital Med Center

Lenore Williams
Ge Healthcare Partners

Get Connected!



MEMBER-GET-A-MEMBER PROGRAM

HFMA members are leading the change in the healthcare finance industry. Help build the momentum. Invite your peers, your staff, and others in your organization to join the nation's leading membership organization for healthcare financial management executives and leaders - HFMA.

Recruit new HFMA members and you could win:

- HFMA apparel item, duffel bag, or smartphone accessory
- $25, $100 or $150 Visa Prepaid Cards
- Cash prizes of $1,000 or $2,500
- Apple iPad Mini
- Grand Prize of $5,000*

CLICK TO FIND OUT HOW

Risk Factor...

by Jim Heilsberg | Whitman Hospital & Medical Center

At recent Region 11 conference I was intrigued by two statements:

- Biggest risk factor for cancer is age
- Biggest risk factor for death is age

I am known for weird articles and this may be one of the weirdest but if you like what I have said before, read on. If not, then stop now...you have been warned.

One of the speakers at region 11 talked about cancer. There were many points the speaker talked about.

They included

1. Number of deaths from cancers in last 100 years.
2. Types of cancers that have had the most growth versus those that have declined.
3. Cancers that have decreased due to treatment, lifestyle etc.
4. What is the source of the improvement?

It was encouraging to see research on what the source of cancer is and what treatments are developing to help provide temporary or permanent solutions to cancer....so that the biggest risk factor of death takes us all in the end...which is age.

Many people believe that if you take care of yourself you will last longer…and they are right...most of the time. Youth regularly believes that we are invulnerable, only to realize with age that many of the things done in our youth, comes back to haunt us.

This is most poignantly seen in professional football athletes. The professional football player is a physical abnormally. The lineman for example is rare to find in our world. Not many people are 6'7" tall or taller and fewer want to put massive muscle on their body so they weigh in at plus 300 lbs. and can run very fast for short distances. The running backs are equally unique. Effective running backs range in size from under 6' to 6'3" tall. They all have phenomenal muscle mass and look more like bowling balls then a normal person. These wrecking balls hurdle themselves at the 300lb plus lineman with hope that they get past them or in some cases through them. The end result is continual hammering of body parts against body parts.

Many professional careers last 2-5 years and a few last 10 years. The athletes are paid significant sums of money. In the end, athletes can live very painful lives as they reap the benefits of a youth filled with constant hammering on their bodies. Many end up with early deaths and pain filled lives.

While the athlete is seen as getting what they deserve, many of us seem to think we don't get what we deserve or in many more cases recently, we believe if we take good enough care of ourselves, we can avoid cancer or other negative health impacts. We are right...we are also wrong because we are constantly bombarded with hazards in our life. We can't avoid these impacts on our bodies. In the end, the biggest risk factor for each of us is....life. The biggest risk factor for death is life. The biggest risk factor for death is old age.

So…with all this great information about cancer research and potential for a cure, what are we to make of it? For me I believe the answer is as Spock said so many times on Star Trek…Live long and prosper. Live a life filled with joy, healthy food, great pie, great faith, great friends and much love. Let the biggest risk factors in your life be mitigated by the opportunities taken not lost as you work to live a full life. We never know when life will be cut short from things outside of our control. Let old age be the biggest risk factor for you but don't bet your life on cures that can extend your life so you can then try to make up for lost time or lost opportunities. Have a great day today and share love with those you see and care about.

When my dad died I did not get one more time to say I love you and it has been a great life living with you. I did not get chance to say one more time how much I was going to miss his laugh and jokes. Make today count. I regret more what I don't do then what I do that helps others laugh, feel loved and that they matter. Looking forward to next time I see you along the way. ■

Upcoming Chapter Meetings & Educational Events

DATE	EVENT	LOCATION
Feb. 25 - 27, 2014	Annual Conference & Trade Fair Conference: Monday Trade Fair: Tuesday & Wednesday Go for the Goal	Seattle Hilton & Conference Center SeaTac, WA 
Mar. 17, 2014	WA-AK HFMA Free Webinar 340B Drug Pricing Program Hot Topics & Takeaways	Webinar (noon - PST) Noon - PST
Apr. 27 - 29, 2014	Leadership Training Conference LTC	National Harbor Maryland
May 7 - 9, 2014	Spring Conference Swearing in of New Officers & Board	Northern Quest Casino Spokane, WA
Sep. 17 - 19, 2014	Fall Conference	Kitsap Conference Center Bremerton, WA

www.waakhfma.org

NW Outlook

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