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DÉJÀ VU ALL OVER AGAIN

CMS Changes Rules for Diagnostic Testing Arrangements (Again)

By David G. Schoolcraft, J.D.
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Miller Nash LLP

It is becoming an annual event. Once again the new year brings rule changes from CMS modifying how physician groups may provide and bill for in-office diagnostic tests.

In its latest round of changes, CMS revised the "anti-markup rule," which, in certain circumstances, limits reimbursement available to a physician group for in-office diagnostic tests. Although the final rule provides greater flexibility than the version CMS published for comment back in the summer of 2008, the new anti-markup rule requires careful review of diagnostic testing arrangements to ensure compliance. The toughest issue for many physician groups will be to deal with the fact that the rule goes into effect on **January 1, 2009**.

The stakes are high. As with all other billing rules related to the federal Medicare program, compliance is not optional. Particularly for large urban medical clinics with referring physicians in multiple offices and centralized locations for diagnostic tests, existing arrangements need to be checked against the new rules and modified as necessary to ensure compliance going forward.

Background and Proposed Rule

In the past, CMS applied an anti-markup rule to limit payments to physicians for the technical component ("TC") of a diagnostic test purchased from an outside supplier. This meant that a physician who purchased the TC from an outside source could bill Medicare only for the lowest of the outside supplier's net charge, the physician's actual charge, or the Medicare fee schedule amount. In response to concerns over the potential for abusive overutilization of diagnostic testing services, CMS revised the anti-markup rule in the 2008 Physician Fee Schedule final rule issued on November 1, 2007. Under the revised rule, a physician or other supplier could not mark up either the TC or the professional component ("PC") of a diagnostic test that was purchased from an outside supplier or performed at a location other than the office of the billing physician or other supplier. The rule had previously applied to

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Letter from the Publisher and Editor

Dear Reader,

Although health care is currently one of America's strongest industrial sectors, it has and will continue to be affected by meltdowns in the real estate, retail, government and financial sectors.

- When unemployment increases people lose health insurance
- Investment portfolio losses reduce margins and capital
- Government deficits threaten reimbursement levels

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David Peel, Publisher and Editor

Washington Healthcare News 2009 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2009	Urban Medical Clinics	December 1, 2008	December 22, 2008
February 2009	Human Resources	January 2, 2009	January 19, 2009
March 2009	Rural Hospitals	February 2, 2009	February 23, 2009
April 2009	Insurance Carriers	March 2, 2009	March 23, 2009
May 2009	Information Technology	April 1, 2009	April 20, 2009
June 2009	Rural Medical Clinics	May 1, 2009	May 25, 2009
July 2009	Facilities	June 1, 2009	June 22, 2009
August 2009	Human Resources	July 3, 2009	July 20, 2009
September 2009	Finance	August 3, 2009	August 24, 2009
October 2009	Community Health Centers	September 1, 2009	September 22, 2009
November 2009	Senior Living	October 1, 2009	October 19, 2009
December 2009	Urban Hospitals	November 2, 2009	November 23, 2009

Tameeka L. Aviles, CRPS
Director, Strategic Sales, TIAA-CREF
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only the TC of a diagnostic test. After receiving industry questions about the scope of the revised rule and its effect on existing arrangements, CMS delayed the effective date until January 1, 2009, and said it would consider making changes.

In the 2009 Physician Fee Schedule proposed rule released on July 7, 2008 ("Proposed Rule"), CMS announced its proposed modifications to the anti-markup rule. Specifically, CMS proposed that the anti-markup rule would apply in all cases in which the TC or PC of a diagnostic test was either: (1) purchased from an outside supplier; or (2) performed or supervised by a physician who did not "share a practice" with the billing physician. CMS proposed that a physician would share a practice only if he or she worked exclusively for the billing physician as an employee or independent contractor.

The Final Anti-Markup Rule

In the final anti-markup rule (the "Final Rule") issued on October 30, 2008, and effective January 1, 2009, CMS adopts a more flexible approach than under the Proposed Rule. CMS is no longer concerned with whether a diagnostic test was purchased from an outside supplier. Instead, the changes finalized by CMS focus entirely on whether the physician who performs or supervises a diagnostic test "shares a practice" with the physician who bills for that test. Under the Final Rule, the physician who performs or supervises a test shares a practice with the billing physician if either of the following two alternative tests are met:

1. The physician supervising the TC or performing the PC performs "substantially all" (at least 75 percent) of his or her professional services for the billing physician or other supplier; or
2. The TC is conducted and supervised or the PC is performed in the office of the billing physician or other supplier.

If the diagnostic testing arrangement satisfies either one of those two alternatives, then the physician who supervises or performs the test is deemed to "share a practice" with the billing physician and the anti-markup rule will not apply. With this approach, CMS requires that a sufficient nexus exist between the physician performing or supervising the test and the physician who orders the test so as to limit the risk of overutilization.

The first alternative (the "substantially all" test) is more flexible than the Proposed Rule in that the physician who supervises or performs the diagnostic test is not required to work exclusively with the billing physician. This means that the supervising/performing physician may be a part-time employee or independent contractor of the billing physician, as long as the 75 percent requirement is met. Put differently, the billing physician or other supplier may avoid the anti-markup restriction even if the physician who supervises or performs the test provides up to 25 percent of his or her professional services for other groups or entities.

The second alternative (the "site-of-service" test) focuses on where the diagnostic test is performed in relation to the physician who ordered the test. The anti-markup rule will not apply if the TC is conducted and supervised or the PC is performed in the same building

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where the ordering physician regularly furnishes patient care. This is especially relevant for large urban medical clinics or multispecialty groups that have several office locations. As long as the diagnostic test is supervised or performed at an office location where the ordering physician performs substantially the full range of patient-care services that the ordering physician provides generally, the anti-markup rule will not apply.

If the anti-markup rule applies, the billing physician may bill Medicare only the lesser of the Medicare fee schedule amount for the test or the performing supplier's "net charge" to the billing physician for the test. Under the definition of "net charge" in the regulations, the billing physician is precluded from recouping overhead costs such as the cost of equipment and space. Only the fee charged by the supplier of the test may be billed to the government. In practical terms, if the anti-markup rule applies, it is likely that the billing physician may actually lose money on each test. Given this risk, physician groups and their counsel should closely examine existing arrangements to determine whether restructuring may be necessary.

Application to Common Diagnostic Testing Arrangements

The following examples show the ways in which common arrangements in physician groups that offer diagnostic testing services will be affected by the Final Rule.

Example 1: Radiologist is employed part-time by Clinic A and provides services as an independent contractor to Clinic B and Clinic C. Clinic B has imaging equipment located at its only office location. Does the anti-markup rule apply if Radiologist supervises the TC and performs the PC for all three clinics and the clinics bill Medicare for the tests?

Radiologist's status as an employee or independent contractor is irrelevant for purposes of the new anti-markup rule. If Radiologist as a part-time employee performs at least 75 percent of his or her professional services for Clinic A (the "substantially all" test), Clinic A is not subject to the anti-markup rule when it bills for the TC and PC. Clinic B will avoid the markup limitation under the "site-of-service" test. The TC is conducted and supervised and Radiologist performs the professional read at Clinic B's office location, where the ordering physicians regularly furnish patient care. Assuming that Clinic C does not have imaging equipment located on site, the anti-markup rule will apply to the TC and PC of the diagnostic tests supervised and performed by Radiologist.

Example 2: Clinic D is a large multispecialty group and has several office locations throughout the Seattle area. Physicians X and Y are members of the group and perform services in Buildings X and Y, respectively. Clinic D contracts with Pathologist to provide diagnostic testing services in Building X one day a week.

The anti-markup rule will not apply to tests ordered by Physician X, but will apply to tests ordered by Physician Y. Assuming that Pathologist contracts with other groups in the area, the services she performs for Clinic D will probably not meet the 75 percent requirement. Physician X meets the "site-of-service" test because he performs substantially the full range of patient-care services in Building X that he provides generally. Although Physician Y is a member of the same group, the anti-markup rule applies because the TC and PC are not conducted in the same building where Physician Y provides services.

As the foregoing examples illustrate, analysis under the new anti-markup rule requires a detailed review of the underlying facts and relationships between the billing physician and supplier. Problems may be avoided through careful planning and adjustment of existing arrangements to ensure compliance with the rule.

Looking ahead to 2010 and beyond, CMS continues to indicate that more changes affecting diagnostic testing arrangements are in the works. For now, the in-office ancillary services exception to the Stark law remains intact, but with increasing pressure on CMS to control spending, it will be important to keep an eye on CMS this year to see whether it decides to revisit the issue. In the meantime, physician groups must again review in-office diagnostic testing arrangements in light of the new anti markup rule.

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Managing Investments Through the Volatile Financial Crisis

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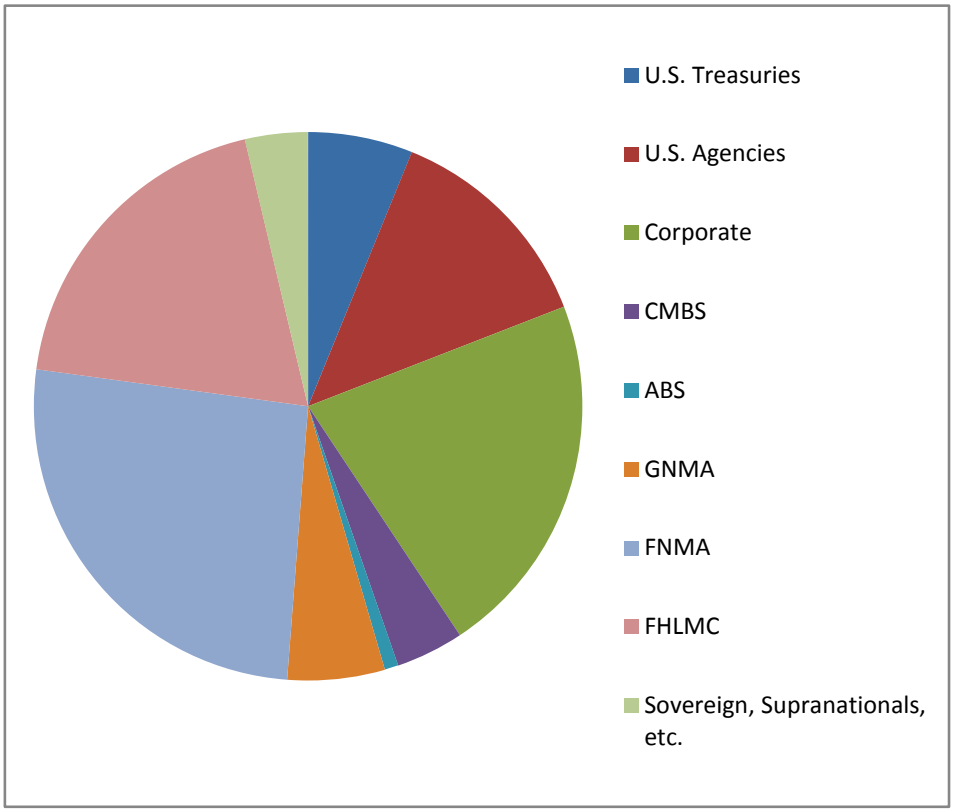
During these volatile times in the financial markets, investors are wondering where, other than Treasuries, fixed income portfolio allocations should be made. This question is especially important after the downfall of storied investment institutions like Merrill Lynch, Lehman Brothers and Washington Mutual. One answer involves shifting investment goals from incremental outperformance to preservation of principal. Diversification provides meaningful risk reduction and would support this new goal. Basic diversification involves investing across the various fixed income sectors, as well as within each sector. For example, investment selections could be made among several issuers in the corporate sector, different types of municipalities in different states, and various types of collateral within the structured product sector. These sectors are discussed further below.

The Corporate Sector: An investor's corporate bond focus should be on an issuer's market leadership and financial stability as well as the issue's structure. An issuer's access to capital to retire maturing debt and fund new business is necessary for short-term viability. Long term viability may be inferred through a strong balance sheet, limited leverage, and stable earnings generation capacity. Corporates require continuous monitoring because, as has been seen so often this fall, a company's financial situation can change quickly, with disastrous consequences.

The Municipal Sector: A municipal allocation can be diversified in several different ways: 1) geographically, thus mitigating exposure to regional economic slowdowns or catastrophes such as hurricanes, earthquakes, etc; 2) by source of payment -- e.g. tax-backed general obligation debt versus project specific revenue debt, which is backed by tolls or user fees -- thereby limiting the effects of reductions in tax revenues or property values; and 3) by sector, avoiding exposure to high default risk sectors such as industrial



This pie chart shows how the Lehman Aggregate Index is diversified. Municipal bonds could be considered for further diversification.

development, land secured debt, elderly care and tobacco settlement bonds. Underlying credits should be reviewed if there is an insurance wrap on the bond.

The Mortgage Sector: The agency-backed mortgage security market, which includes three Government Sponsored Entities (GSE), Fannie Mae, Freddie Mac and Ginnie Mae, continues to perform well in an environment where investors are focused on safety and principal preservation. These issues are almost as secure as Treasuries, because the United States government continues to imply their guarantee in an effort to stabilize the country's housing market. The government's backing of GSEs give them the added benefit of liquidity in these times of volatility, allowing them to be sold efficiently in the secondary market.

Diversification in the current economic climate requires not just sector allocation, but also conservative investment choices with attention to issuer balance sheets, leverage and earnings generation. Watch this space in future issues for more detailed core fixed income diversification articles.

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Recovery Audit Contractor (RAC) Coming Soon to Washington: Are You Ready to Handle Medical Record Request Audits?

By Mary Re Knack
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and

By Arissa M. Peterson
Healthcare Attorney and Associate
Williams Kastner

The Department of Health and Human Services (HHS) must implement a permanent, national Recovery Audit Contractors (RAC) program by January 1, 2010. The program is expected to be underway in Washington by August 2009, with HealthDataInsights, Inc. (HDI) assigned as the contractor.

The purpose of the RAC program according to the Center for Medicare and Medicaid Services (CMS) is to reduce improper Medicare payments through the efficient detection and collection of overpayments, including Non-Medicare Secondary Payer overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments. CMS has concluded the RAC demonstration program that began in 2005 was a cost-effective success. RACs discovered over $1 billion in improper payments, 85% recovered from hospitals, during the demonstration program at a minimal cost to the government. While RACs also identify underpayments, the demonstration program revealed that 96% of claims were overpayments. Thus, the clear focus of the program is to identify and correct Medicare fraud and abuse.

There are two kinds of RAC audits – automated and medical record reviews. Automated reviews utilize RAC's proprietary software to discover obvious billing errors. The majority of audits performed are medical record audits where the RAC requests medical records to audit.

Once the program is underway, providers will need to respond to record requests in an effective and timely matter. Eight percent of the total denials during the demonstration program involved failure to respond timely to RAC requests for records. Therefore, providers are well-advised to begin preparing now to respond to record requests and to implement effective response and compliance programs.

Under the permanent program, a provider must provide medical records within 45 days of the request, although the provider may request an extension. In late October, CMS announced medical record request limits based upon the type of provider. These medical record request limits are available for download at http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp. Providers may want to become familiar with these limits now before receiving the first RAC request letter. For example, for an inpatient hospital, RAC may request ten percent of average monthly Medicare claims (max of 200) per 45 days. This is still a considerable number of medical record requests that can be made within a short period of time.

To prepare, it is recommended that providers form a RAC response team that will implement an efficient process to handle record requests tailored to the provider's individual needs. As processes to handle RAC requests for records, the response team may want to consider: (1) logging the RAC's request in an automated system, noting the deadline and evaluating whether an extension may be nec-

essary; (2) copying the patient's complete medical record; (3) submitting copies of medical records to RAC by the deadline; (4) maintaining duplicate paper and electronic copies of every medical record request sent to RAC; (5) tracking receipt of documentation by RAC; (6) tracking the deadline for the RAC determination (60 days from receipt of the medical record); (7) tracking the outcome of the RAC review; and (8) tracking the deadline to appeal the RAC decision (120 days from receipt of the decision).

Providers may also want to review their medical records management system to determine where older medical records are stored, since going forward the look-back period is three years, with a maximum look-back of October 1, 2007. For medical records stored off-site, providers may want to evaluate now how those records will be accessed and how long it will take to access them. Providers may also want to determine if they will have an internal or external group review the records and perform a "mirror" audit on the records, or whether they will wait to get the RAC results. Retrospective and proactive audits should be conducted periodically, especially on any RAC overpayment determinations.

The RAC must complete the review of the medical record and issue a determination within 60 days from receipt. Providers may then appeal a RAC determination by following the Medicare appeal rules, which require appeals to be filed within 120 days. Providers should consider identifying a point-person to handle the appeals process and evaluate now whether to involve outside legal counsel in the appeals process. CMS noted that one of the "successes" of the three-year demonstration program was that providers do not appeal every overpayment determination; therefore, providers should consider whether they want to institute a vigorous appeal program. The benefits of appealing RAC determinations were discussed in the December 2008 issue, "OIG Holds Hospital Boards Accountable on Fraud Audits," by Donna Herbert, Vol. 3, Issue 12, at 1-2.

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Best Practices in Payer Contracting

By Jamon Rivera
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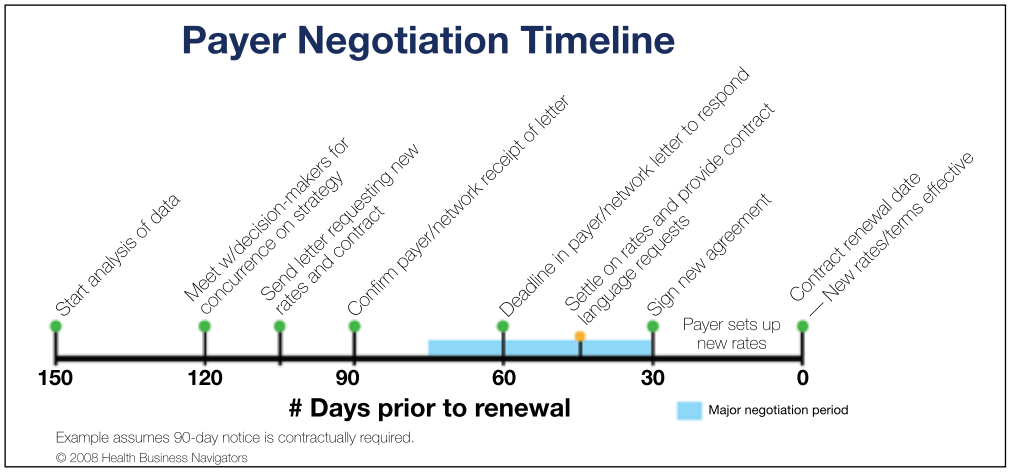
Health Business Navigators

With skyrocketing costs and declining payer reimbursements, practices are struggling with ways to increase or even hold the bottom-line. In a recent Medical Group Management Association (MGMA) survey, "maintaining physician compensation levels in an environment of declining reimbursement"[1] ranked #1 when members were asked to rate the challenges they are facing. The Center for Studying Health System Change confirms these concerns in its study that found "flat or declining fees from both public and private payers appear to be a major factor underlying declining real incomes for physicians."[2] Practices can improve their revenues through an aggressive payer contracting strategy. How?

Preparation

Negotiating new contracts with payers can seem daunting. Many practices sign every contract without determining the impact to the bottom line or administrative responsibilities. By following a few simple steps, practices can confidently sit down at the negotiation table with payers.

Inventory all current agreements. Create a spreadsheet identifying key information from each contract including payer/network name, anniversary, term and termination, reimbursement, notice period to renegotiate, automatic renewal, contact information for the payer/network representative, etc. Meanwhile, create a Timeline (see above illustration) for each contract to be negotiated to delineate the numerous steps necessary for successful, timely negotiations.



Leverage

Size does matter. Larger groups often have greater leverage in negotiating higher rates and contract provisions. But even a one-doctor practice should attempt to negotiate with payers. It is important to identify a negotiation strategy that is unique to practice and market. Factors might include: number of members, clinical/service outcomes, influence of employers, specialty shortages, multi-specialty group clout, payer-requested referral patterns, or a particularly poor past contract. Remember that the real trump card in any negotiation strategy is the ability to "walk."

Rate Analysis

With preparatory steps done, start the analysis. Pull a 12-month utilization report from the practice management system that snapshots ALL (not just the top 10 or 20) procedure codes with modifiers and place of service. Include the number of units, charges, payments, current contract reimbursement rates, and cost to perform. Use this data to predict by payer what would happen if you swap your old rates for new ones at the same 12-month utilization.

Medicare's Resource Based Relative Value Scale (RBRVS) and Relative Value Unit (RVU) have become the benchmarks for many payer contracts. Having a well-

defined, industry-accepted, publically available baseline has great advantages. But consider the following:

- Know the practice's best Medicare year and compare it to the year of Medicare the payer proposes.
- Medicare rates are very low and so the rates should be factored at a percentage considerably greater than 100%.
- A default calculation is necessary for anesthesia, J Codes, and procedures for which Medicare does not assign a value.
- In Medicare's quest to remain budget neutral, modifiers, like Budget Neutrality Adjuster and Geographic Price Cost Indices (GPCI), have adjusted rates downward in recent years.
- Congress gave practices relief from the proposed 10.6% cut in Medicare rates in July 2008, but there are projected decreases in Medicare rates over the next decade. Therefore, multi-year or auto-renewing contracts with rates based on "prevailing Medicare year" are not advised.

Reimbursement analysis requires careful attention to modifiers, place of service and other factors. Determine the likely loss or gain, by procedure and in aggregate, while calculating the cost to perform each procedure. For example, if new offer rates based on 145% of a certain year of Medicare RBRVS (or given conversion factor, if based on RVU) are acceptable in aggregate, but some procedures would be performed at a loss or too little margin, ask for "carve-out" rates for those few outliers to bring them into line with financial goals.

Finalizing the Deal

Once desirable rates have been agreed upon, read the substantial 15-30 page agreement before putting pen to the signature line. Know the laws of your state that affect provisions related to "insured" plans, recognizing that the "self-insured" plans accessing the agreement will not likely be subject to those laws. Spell out acceptable timely payment and filing requirements; define "assignment;" require all policies and procedures to be on the payer Web site; define Medical Necessity without plan variation; require prior written consent for ANY amendments, and more. Expect to hear "we don't negotiate." Don't accept this response. Ask for the rep's manager, know the practice deal-breakers going in and stay the course, despite these obstacles.

[1]MGMA 2008 "Medical practice today: What members have to say." June 2008.

[2]June 2006, Ha T. Tu, Paul Ginsberg. Center for Studying Health System Change

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Jamon Rivera is Health Business Navigators' (HBN) Northwest Regional Director of Business Development. HBN, based in Bowling Green, KY, provides practices nationwide with tools and services related to payer contracting and credentialing. Mr. Rivera has spent the last six years on the practice management side of the industry with extensive payer negotiation experience. HBN was founded in 1999 by its CEO, Penny Noyes, who spent 18 years on the payer side of the industry. To learn more about HBN visit their web site at www.healthbusinessnavigators.com.

JCW, Inc.: Evolving with Technology, Building for the Future

For more than two decades, JCW, Inc. has been delivering comprehensive commercial general contracting services on time, with quality and on budget. That's something President Marc Jenquin says doesn't happen by accident. "We communicate with our clients," he explains. "It's the foundation of our success." And success is something that JCW continues to enjoy throughout the Pacific Northwest as they specialize in the construction and remodel of medical and dental facilities.

Recent projects, such as Fircrest Assisted Care Alzheimer Facility in McMinnville, Oregon and Gresham Urgent Care in Gresham, Oregon, exemplify the characteristics that JCW brings to each facility they build or remodel. Handling all phases of construction – even completing pre-construction stages such as feasibility studies and value engineering – JCW ensures that each client is presented with a plan that works for them. Jenquin stresses that projects go smoothly from start to finish because his team of professionals work closely with clients, coordinating with architects, engineers, developers, interior designers, and financial institutions. "My team leads from concept through completion," he says. "Our experienced, well-educated staff maintains a focus on efficiently constructing premium buildings with quality in every detail."

> *"We've worked with JCW on several new building projects. They've demonstrated a solid track record of producing quality projects on time and on budget."*
>
> David Welsh
> President
> CIDA Architects

One such project, the Mt. Scott II Professional Center in Portland, Oregon was designed from the "inside out" according to Jenquin and frequent partner David Welsh, President of CIDA Architects. This concept ensured a facility that balanced exam rooms, nurses' stations and patient waiting rooms with open space and natural light from outer windows. Additionally, designing a dual delivery system for utilities throughout the building eliminated the costly need to shut down functioning systems as new tenants moved into the building – making it a much more attractive and cost-effective venture for clients.

"We've worked with JCW on several new building projects," says Welsh. "They've demonstrated a solid track record of producing quality projects on time and on budget." This longstanding record of delivering projects on time and on budget satisfies clients as well as financial institutions. Understanding that tenant ownership can be instrumental in the long term success of a facility, Jenquin and JCW promote ownership of their sites; historically their clients own upwards of 65% of the completed facilities. Using a "Proforma for Development" as a planning tool, JCW can demonstrate all of the costs attributed to a project as well as the financial returns. Completed while the project is in the conceptual stage, this decreases the chance

Company Snapshot

Description	Company Information
Key executive	Marc Jenquin, President
Primary services	Construction/development/ownership of health care facilities
Service area	The Pacific Northwest
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of investing money in a deal that won't prove profitable. Additionally, shared tenancy reduces financial stresses and spreads the responsibility for making decisions – something that Jenquin says his clients and the banks appreciate.

While JCW specializes in new construction and site development, the firm also performs remodels – a task that can transform low-functioning office space into a state-of-the-art facility. Handling tasks that range from phased remodels to furniture and equipment upgrades, JCW customizes each facility to meet specific needs. "Most doctors have specialized requests," explains Jenquin. "We do the up-front work to prepare a space that meets those individualized needs. We do that by listening to them and understanding their requests. Then, we deliver it in a seamless fashion." These remodels serve two functions: they directly increase referrals and they improve retention of current clientele. Utilizing technology integration, appropriate lighting, effective work flow models, unique and efficient work stations and labs, JCW delivers a custom construction plan that ensures a functional and attractive environment for both patient and practitioner alike.

Providing a work flow that accommodates the doctor as well as everyone involved demands coordination, communication and a strategy that diminishes down time and lost productivity. JCW uses methodologies which allow them to arrange schedules and manage construction so that minimal disruption is possible. They oversee all aspects of the project so clients can focus on their own, unique business operations.

Just as clients desire to grow their business, JCW, Inc. is dedicated to improving the services they offer and are also now taking necessary steps to learn about green building projects. Embracing new technologies, collaborating with architects, engineers, banks and clients, and fostering working relationships with dental and medical suppliers, space planners and local inspectors ensures that JCW, Inc. is well positioned to deliver the new or remodeled medical facility that each client demands.

Located at 6521 SE Crosswhite Way, Portland, Oregon, JCW, Inc. serves the Pacific Northwest, Nevada and Arizona as a premier General Contractor. To learn more about JCW, Inc. contact Jennifer Sharp, Marketing/Business Development, at (503) 761- 4523 or jennifers@jcwteam.com. Their web site is www.jcwteam.com.

Walla Walla Medical Pavilion: Delivering Comprehensive Care to Women

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

Opened in April 2008, the Walla Walla Medical Pavilion was designed to provide quality, personalized care in a peaceful and spa-like setting. Located on the campus of Walla Walla General Hospital (WWGH) at 1025 South 2nd Avenue, the Pavilion is home to a majority of women's services, including obstetrics and gynecology, infertility treatments, ultrasound and mammography, continence therapy and gynecological surgery. The unique design of the structure complements state-of-the-art diagnostic services and innovative procedures, appealing to patients and practitioners with its peaceful and serene setting.

Renata Presby, architect for Meier Enterprises, Inc., explains that the main goal of the project was to design a structure that would "step out of the box of the traditional medical facility." Using natural light, water features, earth-tone colors and warm building materials, Presby says that the Pavilion engages all the human senses and was intended to combine aspects of the mind and body in a natural setting which will promote healing.

At 11, 200 square feet, the Pavilion contains three separate operations: OB/GYN services, physicians' practice, and a digital mammography center. A single reception area services the entire building, making check-in efficient and simple for patients; parking is located near the front door. There is an additional children's waiting area and a variety of support services are available, including bilingual services, free pregnancy testing, massage therapy and an educational program for new mothers. Private changing areas and bathrooms, comfortable furniture and a bright garden also bring additional comfort to the women who seek medical support at the Pavilion.

Walla Walla Medical Pavilion at Walla Walla General Hospital

According to Presby, interviews were conducted with the Health Center Staff to identify their needs; based on their requirements the structure was designed to deliver improved patient and staff traffic flow, arrange space according to privacy priorities, and provide a warm, healing environment for not only patients but also visiting family and friends. Jeanese LeFore, a local Walla Walla business owner concurs, adding "The new Medical Pavilion at Walla Walla General Hospital fills a need for a facility that provides care - for body, mind, and soul – for women of all ages."

It's an entirely new way to experience health care in Walla Walla and continues the tradition of community service that Walla Walla General Hospital started in 1899. Over 100 physicians provide health care service at WWGH, which is part of Adventist Health – a 20-hospital, not-for-profit system sponsored by the Seventh Day Adventist Church. Valuing "human dignity and individuality, absolute integrity in all relationships and dealings, and delivering excellence in clinical and service quality" WWGH supports the overall mission of Adventist Health: "To Restore Peace, Hope and Health as Jesus Christ would do." The Medical Pavilion continues to expand this community support by offering all women an opportunity to avail themselves of quality, holistic care.

Meier Enterprises Inc., worked with the Department of Health to ensure all DOH requirements were satisfied and engineered the architectural, structural, mechanical and electrical systems to maximize the welcoming features of the facility. Even the sprinkler system was integrated into the wood wrapped beam design in the main lobby so it wouldn't detract from the unique ceiling design. Exterior materials reflect the raw elements seen throughout the Walla Walla valley and the stone, glass and wood materials enhance the natural lighting that floods the building.

The Medical Pavilion was designed to reflect WWGH's commitment to the health, comfort and peace of mind of all its clients. As Lee Hughes, MD, a physician at the Pavilion explains, "Water, light, touch and beauty are all important factors in promoting a sense of physical and psychological well-being. The design of this building promotes the health of patients by tying into nature's healing environment."

Robert Greenwood is a Contributing Writer for the Washington Healthcare News. She can be reached at rgreenwood@wahcnews.com.

Tough Times Require Cooperation, Not Competition

By Caitlin Cameron
Chief Executive Officer
CellNetix Pathology & Laboratories

In times of increasing financial pressure, a need to squeeze ever more patient care out of constantly shrinking dollars, and downward pressure on financial and other aspects of the health care industry, we as providers of care are under enormous pressure to find new and better ways to provide top-quality care at very low cost to an expanding and needy population.

Never in our lifetime have we faced such a time of great need and shrinking ability to provide for it. Hospitals are seeing a decrease not only in "luxury" procedures but in basic yet higher-profit procedures at the same time they see a dramatic increase in visits to the Emergency Room by those who cannot pay and have no other alternative. This trickles down to all of us who serve patients throughout the health care industry, a need we gladly serve – yet it impacts our ability to serve the rest of the population as well.

So what do we do now? Cooperation – not competition – provides a better vehicle for success for companies and patients.

How do I know? We did it. CellNetix Pathology & Laboratories, the largest anatomic pathology laboratory in the west, is relatively new, having been created three years ago from a merger of long-standing pathology groups. Our beginning and continued rapid growth speaks to our commitment to a cooperative business model with our clients, clinicians, clinics, hospitals, and the patients we all serve.

CellNetix was formed by pathologists (board certified in anatomic and/or clinical pathology, and most with additional board certification or fellowship training in 26 sub-specialty areas) who didn't think their patients were getting the best quality of care in a system that was focused on quantity and on making more money for someone else. The trend in pathology has been consolidation by huge national labs that emphasize assembly-line-like conditions of reviewing as many tests as quickly as possible by generalist pathologists who might see a skin lesion one moment, then a pap test, and then a breast tissue biopsy. The goal is increased revenues – not improved care or to provide quality care at a reasonable price.

But one pathologist or one small lab can't change the paradigm, because the tools of our trade are expensive. It takes a significant investment to implement a barcode-driven lab information system, or to purchase rapid tissue processors, automated handling, and so on. And with genetic testing playing an ever more important role in health care, the necessary technology becomes more sophisticated and more expensive.

The promises of cooperation and a more egalitarian workplace prompted our three pathology practices to dig into their own pockets for the upfront investment money to merge and form CellNetix. The result is that the art and science of pathology has been turned upside down. The merger has enabled us to build a beautiful state-of-the-art lab with the newest equipment and technologies. It is 48,000 square feet of sophisticated and complicated equipment and high-tech systems, backed by bar coding and other technologies that enhance quality control. The original three practices could not have afforded this investment on their own. Only by seeing each other as potential partners – not as competition – could they cooperate, come together, and build something powerful for the greater good.

At this point, you might wonder if the merger that formed CellNetix isn't just another example of consolidation. But there is a key difference: local control and

local decision-making. By adopting a business model that is decentralized and allows autonomy and decision-making at the local level, our community-based pathologists are fully integrated into each local health care system, and are supported by a centralized, state-of-the-art lab and management system.

Local pathologists take our cooperation model the important step further – that of partnering with our many clients to create cooperative, strong partnerships focused on quality, cost-effective patient care. Thus, not only are we able to implement a better model here within our own four walls, we can expand those walls – even become a pathology group without walls – and partner with clinicians, hospitals, and others to better serve patients.

After years of competing for crumbs, I believe it's time for health care professionals to turn away from ego-driven competition and find more ways to cooperate, especially if the decision-making is kept local. By partnering together with our fellow physicians and with our clients, we can find ways to reduce unit cost, overall cost, and partnership costs while maintaining – and yes, it is possible, improving – patient care. By utilizing partnership and cooperation, we can all succeed.

Caitlin Cameron is the CEO of CellNetix Pathology & Laboratories, a private pathology and laboratory company headquartered in Seattle that serves hospitals, clients and patients throughout the greater Puget Sound region. CellNetix's centralized Seattle facility performs histology, cytology, immunohistochemistry and molecular diagnostic testing, as well as houses pathology and executive functions. With over 160 employees, CellNetix serves 11 major hospitals and hundreds of large and small physician practices and clinics with a very strong focus on local support and local relationships.

Career Opportunities

UW Physicians
UW Medicine

Human Resources Director

This position is responsible for all Human Resources functions for University of Washington Physicians (UWP), a not-for-profit corporation of approximately 270 administrative employees, approximately 165 staff members are represented by a collective bargaining unit. The Director of Human Resources works closely with the UWP Executive Director and other UWP administrative Directors to assure that employment-related policies, corporate policies and practices, and infrastructure are in place and effective to assure consistent and appropriate employment and compensation practices at UWP.

Required Qualifications:
Bachelor's Degree in Business Administration, Human Resources or other relevant discipline; Four years of direct management experience for human resource functions in a similarly sized (100-500 person) organization. Senior Professional in Human Resources (SPHR) certification preferred.

To apply and see other requirements: Visit our web site at www.uwphysicians.org, click on "Careers at UW Physicians" and submit cover letter and resume.

Nurse Manager

Seeking enthusiastic leader with strong leadership skills to facilitate day-to-day patient care operations for our 40-bed hospital focusing on extended critical care.

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e-mail resume to:
valbano@regionalhospital.org
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jobs@regionalhospital.org
www.regionalhospital.org

The Vancouver Clinic

Manager
Operations Development

This key role is responsible for the on-going development, standardization and measurement of administrative process within clinical operations. This includes but is not limited to, project management, operations analysis, new department development, facilitation of meetings and training programs. This position is also the back-up Clinic Manager when needed to cover extended absences or vacancies.

Requirements:

Three years of experience in clinic management/supervision or medical office operations. A combination of education and experience equal to a Bachelor's degree. Masters degree preferred. Experience in project management, operational data analysis, accounting, purchasing, planning, organizing, supervision and management sufficient to assume responsibility for operations of a health care clinic.

To Apply:

To apply and see additional requirements visit **www.thevancouverclinic.com**.

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(position #083199)

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(position #082931)

District Manager - Behavioral Health
(position #083198)

Pathology Manager
(position #082222)

Practice Team Manager Seattle
(position #082767)

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GroupHealth

Family Health Centers

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Deering and Associates, has been retained to assist the Family Health Center's of Okanogan in recruiting for their Chief Financial Officer.

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If you or anyone you know might be interested in this opportunity, please reply in the strictest confidence with a resume to Deering and Associates by calling toll free (888) 321-6016 or email at dewey.miller@comcast.net.

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UW Physicians
UW Medicine

Manager, Charge Capture Quality

The Charge Capture Quality Manager will develop and maintain the education and quality review functions for Charge Capture coding staff.

Required Qualifications:

Bachelor's degree or an equivalent combination of education and experience; 5 years in a multi-specialty medical billing environment with at least 4 years supervisory experience. 3 years preparing and presenting coding training materials to provider and staff groups of various sizes; 7 years experience in medical terminology, CPT, ICD, and HCPCS, in addition to knowledge of payer coding, billing, documentation, and reimbursement standards; CCS-P or CPC. Preferred Qualifications: Knowledge of and experience with EPIC (Prelude Registration and Resolute billing software); experience in an academic health care setting.

To apply and see other requirements: Visit our web site at www.uwphysicians.org, click on "Careers at UW Physicians" and submit cover letter and resume.

WILLAMETTE FALLS HOSPITAL

Quality Improvement Director

Williamette Falls Hospital is seeking a Quality Improvement Director who will serve as the liaison to external agencies such as JCAHO, OMPRO, State Facilities and Licensing. This position is accountable for Planning, Development and Implementation of Quality, Resource Management, Risk Management and Quality Improvement programs.

Requirements

Candidate must have at least five years of progressively more responsible experience in Quality Management in the health care field and demonstrated strong leadership and management skills.

To apply and see other requirements visit our web site at www.willamettefallshospital.org or fax your resume to 503-557-2101. Please call Lisa Powell, VP Human Resources at 503-557-2142 if you have questions. No recruiters please.

UW Physicians
UW Medicine

Trainer

Develop, maintain and present effective skills training, technical instruction, and educational materials for staff members in our Patient Accounts & Inquiry, Patient Financial Services and Insurance Followup Departments. Skills training includes, but is not limited to: proper handling of inquiries from patients and insurance companies, obtaining payment on outstanding balances, effective and efficient resolution of denied and outstanding claims and applying payment and denial information to patient accounts. Technical instruction includes efficient utilization of Epic billing products, allied products in support of billing, and vendor websites.

Required Qualifications:

High School Diploma or Equivalency; Two years preparing and presenting training materials to individuals and to staff groups of various sizes or completion of a certified training curriculum; experience in claims management, denial management, and the appeal process for insurance billing. Bachelor's degree or an equivalent combination of education and experience; coding certification and Knowledge of EPIC software system preferred.

To apply and see other requirements: Visit our web site at www.uwphysicians.org, click on "Careers at UW Physicians" and submit cover letter and resume.

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Plan and Hospital Financial Information

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Financial Results for the 20 Largest Health Plans in the Northwest (Ranked by Total Revenues)[1]

Plan Name	State of Domicile	Total Revenues YTD 09-30-08	Net Income YTD 09-30-08	Net Income/ Total Revenues 09-30-08	Statutory Capital as of 09-30-08	Enrollment as of 09-30-08
Regence BCBS of OR	OR	$2,026,653,692	$3,457,310	0.2%	$520,930,342	992,444
Premera Blue Cross	WA	$1,945,039,655	$25,525,729	1.3%	$766,636,771	682,973
Group Health Cooperative	WA	$1,765,415,812	$96,482,351	5.5%	$757,452,891	393,770
Kaiser Foundation HP of the NW	OR	$1,740,884,081	$19,889,740	1.1%	$512,806,614	467,554
Regence BlueShield	WA	$1,707,960,696	($1,633,945)	(0.0%)	$866,325,811	797,907
Blue Cross of Idaho Health Service	ID	$746,106,080	$32,077,384	4.3%	$271,721,412	453,488
Providence Health Plan	OR	$648,771,413	$21,946,889	3.4%	$346,184,219	186,687
Molina Healthcare of WA	WA	$530,985,564	$32,157,200	6.1%	$108,636,089	294,697
Community Health Plan of WA	WA	$396,149,038	($4,398,953)	(1.1%)	$69,075,689	234,488
Blue Cross Blue Shield of MT	MT	$386,517,423	$16,318,265	4.2%	$130,597,866	225,384
Regence BlueShield of ID	ID	$381,808,729	$3,698,593	1.0%	$124,470,985	210,975
PacificSource Health Plans	OR	$362,298,604	$2,743,340	0.8%	$103,828,098	143,004
Group Health Options	WA	$347,727,908	$833,037	2.3%	$31,525,288	126,948
PacifiCare of WA	WA	$329,247,499	$40,409,405	12.3%	$246,465,221	45,085
Health Net Health Plan of OR	OR	$315,988,534	$2,055,404	0.7%	$58,601,671	127,287
PacifiCare of OR	OR	$210,446,433	$25,157,314	12.0%	$41,770,891	29,682
LifeWise Health Plan of OR	OR	$207,538,113	($7,075,045)	(3.4%)	$62,727,445	88,503
Arcadian Health Plan	WA	$170,973,915	$3,494,152	2.0%	$29,761,142	25,558
LifeWise Health Plan of WA	WA	$156,012,122	$4,146,411	3.5%	$35,797,243	87,990
Asuris Northwest Health	WA	$142,195,001	($568,459)	(0.4%)	$33,775,833	77,879

Financial Results for the 20 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]

Hospital Name	State	Total Charges YTD 06-30-08	Total Margin YTD 06-30-08	Total Margin/ Total Charges 06-30-08	Total Discharges YTD 06-30-08	Total Days YTD 06-30-08
Swedish Medical Center	WA	$1,112,359,629	$30,481,757	2.7%	16,788	71,651
Providence St. Vincent Medical Ctr.	OR	$625,328,000	$15,205,000	2.4%	15,703	72,176
Sacred Heart Medical Ctr.-Spokane	WA	$793,130,352	$18,565,356	2.3%	15,592	80,956
OHSU Hospital	OR	$781,280,865	$21,370,108	2.7%	14,412	75,924
Sacred Heart Medical Ctr.-Eugene	OR	$396,014,607	$58,682,163	14.8%	13,292	59,506
Providence Reg. Med. Ctr. Everett	WA	$612,910,831	$14,037,759	2.3%	12,615	52,485
Providence Portland Medical Center	OR	$497,421,000	$7,271,000	1.5%	11,613	53,587
St. Joseph Medical Center - Tacoma	WA	$780,278,685	$30,051,839	3.9%	11,568	49,931
Southwest WA Medical Ctr.	WA	$532,241,570	($952,680)	(0.2%)	10,185	44,329
Salem Hospital	OR	$376,426,331	$20,322,670	5.4%	10,159	44,817
University of WA Medical Center	WA	$498,269,767	$23,083,396	4.6%	10,068	55,560
Providence St. Peter Hospital	WA	$491,611,998	$14,669,615	3.0%	9,762	43,449
Overlake Hospital Medical Center	WA	$359,822,955	$12,204,702	3.4%	9,578	33,820
Legacy Emanuel Hosp. & Health Ctr.	OR	$462,141,824	$1,606,698	0.3%	9,544	53,242
Harborview Medical Center	WA	$591,210,000	$8,738,000	1.5%	9,227	67,903
Tacoma General Allenmore Hospital	WA	$820,646,323	$31,181,987	3.8%	9,202	42,281
Harrison Medical Center	WA	$305,208,551	$14,330,084	4.7%	8,947	34,522
Virginia Mason Medical Center	WA	$609,017,270	$11,577,223	1.9%	8,634	41,776
Valley Medical Center	WA	$396,424,833	$1,240,102	.3%	8,354	28,317
St. Joseph Hospital - Bellingham	WA	$290,139,319	$6,528,884	2.3%	7,983	32,824

[1]Source: National Association of Insurance Commissioners. [2]Sources: WA State Department of Health; OR Health Policy & Research.

Over 6,000 health care leaders in the Northwest receive the Washington Healthcare News each month. As a health care organization, doesn't it make sense to target recruiting to the people most qualified to fill your jobs?

To learn about ways the Washington Healthcare News can help recruit your new leaders contact David Peel at dpeel@wahcnews.com or 425-577-1334.

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