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State Medicaid Rate Cuts: Legal Challenges and Possible Solutions

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The largest recession in recent history has forced many states to drastically cut payments for health care services provided to Medicaid enrollees. Medicaid, which provides coverage to indigent patients, is a jointly funded state/federal program in which the federal government matches a percentage of the funds expended by a state on Medicaid services. Washington's 2009-11 operating budget included an overall 4% reduction in inpatient and outpatient hospital rates, as well as numerous other cuts.[1] Other states have made similar rate reductions. As a result, health care providers in several states have resorted to litigation, seeking to reverse what providers assert are illegal Medicaid rate cuts. Where these challenges have succeeded, however, the question remains: where will the money come from in order to maintain adequate Medicaid payments? In California, as in other states, the answer has been to enact an assessment or tax on providers, funds from which are used to draw down additional federal matching dollars. Such an assessment has the added benefit of allowing the state to take advantage of provisions of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), which provides for enhanced federal matching rates through December 2010.

Federal Law Restricts Medicaid Cuts

The federal Ninth Circuit Court of Appeals, which covers the west coast states, has permitted health care providers to sue states in order to enforce certain requirements of the federal Medicaid Act.[2] Among

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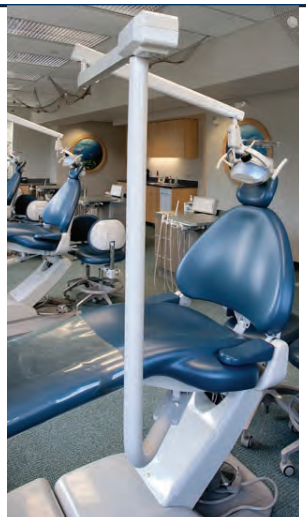

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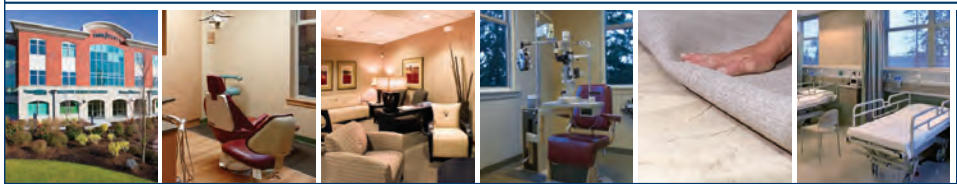

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[1] AJCP. 2009; 131:468-477 [2] JAMA. 2009; 301(10):1060-1062

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these requirements are that states must set reimbursement rates at levels "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that such care and services are available under the [Medicaid state] plan at least to the extent that such care and services are available to the general population in the geographic area."[3] These "quality of care" and "access" requirements, as interpreted and applied by the Ninth Circuit, prohibit states from enacting rate cuts that are purely budget-driven or that fail to consider their impact on Medicaid patients' access to and quality of care.[4] And in setting rates, states must rely on cost studies and establish that the rates they set bear a reasonable relationship to the costs incurred by an efficient provider.

Legal Challenges to Rate Cuts

In a series of recent cases, federal courts have enjoined California's attempts to enact Medicaid cuts.[5] In each of these cases, the courts have found that the state failed to conduct a rate study or to otherwise show that reduced rates were sufficient to meet the requirements of federal law. In Washington, limited, but successful, legal actions have been brought to challenge pharmacy and nursing home rate cuts.[6] As in California, Washington failed to conduct a rate study or make findings concerning whether reduced rates would cover providers' costs and afford Medicaid beneficiaries with adequate access to quality care.

Washington's hospital rate cuts have yet to be challenged. If those cuts are challenged, the state is likely to try to distinguish earlier cases on the basis of a legislative "finding" that was included in the 2009 budget, which states that the rates to be set by the Department of Social and Health Services (DSHS) will comply with the "quality of care" and "access" requirements of the Medicaid Act. This finding was added to the bill on the day after the Ninth Circuit had enjoined California's hospital rate cuts, apparently at the behest of the state Attorney General. It was added *after* the state had determined the gross amount of the cuts, but *before* DSHS had actually determined the methodologies by which the cuts would be implemented. And neither the Legislature nor DSHS conducted an actual study of the impact of the rate cuts.

Finding Solutions

Even when successful, legal challenges to Medicaid cuts do not provide the funds necessary to

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maintain adequate rates. And in these times when state revenues are diminished and the ability to raise general taxes is politically or legally constrained, additional funding for Medicaid is extremely problematic. One solution that has emerged, however, is an assessment on providers that is used exclusively to obtain additional federal matching dollars for Medicaid services. In the wake of its litigation, California adopted an annual provider fee in October 2009, which is expected to generate an additional $2.3 billion in matching federal funds annually.[7] In May 2009, Oregon expanded its existing taxes on hospitals and health insurers, which are expected to generate an additional $700 million annually and will be used to cover nearly all of Oregon's uninsured children and 60,000 low-income adults.[8]

These types of measures must meet certain federal requirements. Generally, such taxes (1) cannot exceed 25% of the state share of Medicaid expenditures, (2) must be broad based and uniformly applied to all providers in a given category (e.g., all hospitals), and (3) states may not directly or indirectly guarantee that providers will be "held harmless" or reimbursed for the exact amount of taxes paid.[9] The hold harmless restriction only applies where the tax rate paid exceeds 5.5% of the revenue received by the taxpayer.[10]

In 2007, at least 43 states and the District of Columbia were using some form of an industry assessment, and approximately 25 states currently have a hospital provider assessment.[11] As we bid farewell to 2009, only time will tell if Washington will join the ranks of a growing number of states using a provider assessment to mitigate the impact of state budget shortfalls on Medicaid services in the upcoming biennium.

Michael Madden is a shareholder and past Managing Partner of the Bennett Bigelow & Leedom, P.S. law firm. Mike has 30 years of trial and appellate experience at all levels of state and federal courts. He has handled an extremely broad range of litigation and currently focuses on defense of class actions, employment matters, medical liability and regulatory matters, and insurance disputes. Mike is a fellow in the American College of Trial Lawyers. Mike can be contacted at 206-622-5511 or mmadden@bbllaw.com.

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Notes:

[1] 2009 Wash. Laws Ch. 564.

[2] *Independent Living Ctr. v. Maxwell-Jolly,* 543 F.3d 1050 (9th Cir. 2008), *cert denied* --- U.S. --- (No. 08-1223 June 22, 2009).

[3] 42 U.S.C. § 1396a(a)(30)(A).

[4] *Orthopaedic Hosp. v. Belshe,* 103 F.3d 1491, 1496 (9th Cir. 1997).

[5] *California Pharmacists Assoc. v. Maxwell-Jolly,* 563 F.3d 847 (9th Cir. 2009); *Independent Living Ctr. v. Shewry,* 543 F.3d 1050 (9th Cir. 2008); *Managed Pharmacy Care v. Maxwell-Jolly,* 603 F.Supp.2d 1230 (C.D. Cal. 2009).

[6] *Washington State Pharmacy Ass'n v. Gregoire,* 2009 WL 1259632 (W.D. Wash. 2009); *Washington Health Care Ass'n v. Dreyfus,* 2009 WL 2432005 (W.D. Wash. 2009).

[7] Press Release, California Hospital Association, *Golden State Hospitals to Gain $2.3B in Matching Medi-Cal Funds* (Oct. 15, 2009).

[8] Diane Lund-Muzikant, *Provider Tax is Settled for Good*, The Lund Report, May 28, 2009.

[9] 42 U.S.C. § 1396b(w); 42 C.F.R. § 433.68. Despite numerous efforts, the Centers for Medicare & Medicaid Services (CMS) has had little success in establishing brightline tests for determining when state payments to taxed providers equate to holding those providers harmless. *See e.g., In the Case of Hawaii Department of Human Services, et al.,* Department of Health and Human Services, Departmental Appeals Board, Appellate Decision, No. 2006-1 (Feb. 22, 2006).

[10] 42 C.F.R. 433.68(f)(3)(i)(A). The applicable percentage increases to 6% after September 30, 2011. Earlier this year, CMS delayed a regulation that would have reduced this requirement to 3%, such that provider taxes that totaled more than 3% facility's revenues would no longer count toward a state's matching contribution. *See* 74 Fed. Reg. 31196 (Jun. 30, 2009).

[11] National Conference of State Legislatures, *Health Care Provider, Industry and Tobacco Taxes and Fees* (2009).

Investment Income: Revenue Enhancement for Pension Plan, Foundation & Endowment Investors

By Ward M. Harris
Managing Director
McHenry Partners

The Demand for More Income

Most liability-driven institutional investors are in a difficult position these days. Pension plans are faced with challenging regulatory and market conditions in the form of increased funding obligations. These reflect actuarial calculations that integrate regulations, assumptions, historical investment returns and expectations and projections for future investment results.

In a similar way, mission-driven, long-term investors such as foundations, endowments, building funds and other tax-qualified investment accounts must align their assets (short or long term) with their liabilities (minimum disbursement requirements, contractual commitments and program funding to fulfill their mission).

Whether funding a future retirement check for workers, providing tuition support for seminary students, delivering healthcare or meals for the homeless, the staff, trustees and managers of these asset pools are severely challenged.

There are three basic reasons:

1. They Pay Too Much

Various data generated from academic and commercial research has consistently shown that smaller investors underperform larger investors in both risk taken and returns generated. One of the biggest factors is that they pay fees significantly higher than their larger peers.

2. They Take Too Much Risk (or the Wrong Risks)

Many small and mid-market pension, foundation and endowment plans are served by vendors (insurance companies, banks, asset managers) that may not present the organization with a full or fair range of options. Often the staff and board members of the organization try to build investment policies and then implement them on their own. Finally, brokers, advisors or consultants may support the organization with information, advice, etc. to invest and manage the portfolio.

Inappropriate investment and asset allocation policies are often the result. The risk/return equation can only be maximized if the investor is well-informed, well-equipped and well-served by its advisor.

3. They Lack Access

Many small and mid-market institutional investors (and their advisors) are not aware of or able to access more sophisticated and easy to implement investment solutions. Enhanced strategies that produce increased incremental income, greater potential for growth and enhanced preservation or protection of principal are available with a little effort, expense and decision risk.

One Example

A well-recognized and proven strategy for investors is a buy-write strategy that involves the "overlay" of an option management program "on top" of an existing portfolio of equities such as the S&P 500 Index.

By selling (writing) options that allow the buyer to purchase the underlying securities at points well above the current market, the pension or foundation can realize an additional income stream from the options sold. Basically, they give up a portion of the portfolio's potential excess return above a given, predetermined point.

The Bottom Line

Would you give up any excess return on your index portfolio (say beyond +25%) in the next 12 months) in return for an additional income of 2% (net of management fees) on the portfolio? Many institutional investors have found this strategy to be valuable in meeting their corporate retirement and mission-driven investment objectives.

Next Month: More on Investment Revenue Enhancement

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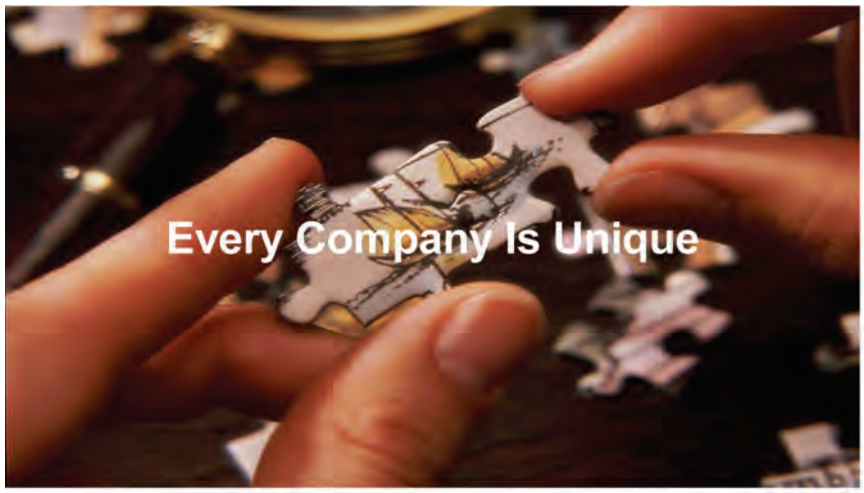

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Regional Health Information Organizations May Now Qualify for Tax-Exempt Status

By Monica Langfeldt
Healthcare and Tax Attorney
Miller Nash, LLP

The tax related developments for Regional Health Information Organizations ("RHIOs") and their attempts to qualify as tax-exempt entities have taken many twists and turns.

Before the American Recovery and Reinvestment Act of 2009 ("ARRA") was enacted, the IRS spent four years contemplating how to deal with applications for tax-exempt status by RHIOs. The purpose of this article is to inform you of the important aspects of the tax rules as applied to RHIOs.

On April 27, 2004, with increasing healthcare costs and looming Medicare bankruptcy, President George W. Bush issued an executive order for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of healthcare with the goal that most Americans will have an electronic health record by 2014.[1]

The first such application from a RHIO was filed in 2005. October 2006 brought an exemption under the federal Stark law and established an Anti-kickback Safe Harbor. The IRS came out with a directive in May 2007 as well as related "Frequently Asked Questions," but these dealt only with hospitals entering into health IT subsidy agreements with their medical staff physicians for providing health IT items and services at a discount.[2] They did not deal with the creation of stand-alone RHIOs and their potential qualification as tax-exempt entities.

In February 2009, ARRA was enacted; less than a month later, the IRS began granting exempt status to RHIOs. As of last month, 33 RHIOs had qualified for tax-exempt status.

Why did it take the IRS so long to approve the applications? And what language did ARRA contain that suddenly allowed the IRS to overcome four years of doubt in less than a month? In order to understand what happened, it is important to examine some of the basis for healthcare-related tax exemption, which include: promotion of health, lessening the burdens of government, and scientific research, or a combination of all the above. Although the IRS received the first application for exemption in 2005, followed by several more in 2006, it did not act on them until ARRA was enacted. Initially, all applications for RHIO exemptions were transferred from the IRS Cincinnati Office to IRS National Office in DC for processing ~ a typical move if the IRS does not know how to respond under current law or if policy issues are raised. Initially, the IRS focused on private benefit issues, as well as the types of information being shared and whether users would be charged to access the information. The unresolved issues focused on whether the funding, technology infrastructure, and support services needed for a RHIO would be an activity which would support stand alone or integral-part tax-exempt status for a new entity under IRC § 501(c)(3), or if the activity was conducted by an existing tax-exempt entity, would the activities give rise to unrelated business income. The private inurement and private benefit issues also remain.

Although the issues still exist, ARRA finally provided the IRS with a solid basis for granting tax-exempt status. According to the conference report accompanying ARRA, "As a result of the incentives and appropriations for health information technology provided in this bill, it is expected that

nonprofit organizations may be formed to facilitate the electronic use and exchange of health-related information consistent with standards adopted by the Department of Health and Human Services (HHS), and that such organizations may seek exemption from income tax as organizations described in IRC § 501(c)(3). Consequently, if a nonprofit organization otherwise organized and operated exclusively for exempt purposes described in IRC § 501(c)(3) engages in activities to facilitate the electronic use or exchange of health-related information to advance the purposes of the bill, consistent with the standards adopted by HHS, such activities will be considered activities that substantially further an exempt purpose under IRC § 501(c)(3), specifically the purpose of lessening the burdens of government. Private benefit attributable to cost savings realized from the conduct of such activities will be viewed as incidental to the accomplishment of the nonprofit organization's exempt purpose."

The conference report goes a long way to pave the way for RHIOs' tax-exempt status. But a RHIO planning to apply for such status would do well to state as many charitable reasons for the exemption as possible and not rely solely on "lessening the burdens of government." The reasons should include promotion of health, integral-party theory, scientific research, and education. And the RHIO should fully explain how and why the private benefit will not exceed incidental and that the private benefit is a logical by-product of a charitable purpose.

Monica Langfeldt is a healthcare and tax attorney and partner at Miller Nash LLP, a multi-specialty law firm with offices in Seattle and Vancouver Washington and Portland and Central Oregon. Ms. Langfeldt can be reached at monica.langfeldt@millernash.com.

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[1] Exec. Order No. 13,335, 3 C.F.R. § 160 (2004-2005), reprinted in 42 U.S.C. § #300u (2009).

[2] www.irs.gov.

Collaborative Relationships Between Providers & Health Plans Are Key

By Rich Maturi
Senior Vice President,
Healthcare Delivery Services
Premera Blue Cross

Dave Brooks, the CEO of Providence Regional Medical Center in Everett, had an excellent column in last month's edition regarding a national event recognizing the delivery of low-cost, high quality healthcare in the Everett area. The Washington, DC event "How Do They Do That: Low-Cost, High-Quality Healthcare in America" offered some real lessons about how to improve healthcare; obviously a timely topic.

What I was reminded of while preparing for and participating in the event was the profound importance of health plans and providers working together to improve healthcare delivery. It was an honor to represent Premera while joining Providence and The Everett Clinic in Washington, DC.

We believe it is essential to have productive, collaborative relationships with providers. It would not be possible to achieve "low-cost, high-quality" care otherwise. In fact, there are some other visible ways in which Premera is partnering with local providers, beyond this great event in which we all participated:

The Quality Score Card:

Premera's Quality Score Card contains quality and clinical performance data as well as patient satisfaction scores for some of the state's most-prominent medical groups. These 15 multi-specialty groups – which collectively serve more than a quarter million Premera members – publicly support and participate in the program.

This was the first Washington score card developed collaboratively by a health plan and multi-specialty medical groups and it has since set a standard for quality assessment in the state. We believe this program is a tremendous example of the amplified value of our collaborative relationships with providers.

Since 2002, the Quality Score Card continues to demonstrate strong value because provider organizations have themselves seen the importance of information sharing and have actually encouraged more sharing rather than less. Building on a foundation of trust, the Score Card has inspired meaningful discussions with providers across the state about measuring and reporting quality. It is now an important and pioneering statewide indicator of quality care.

New programs to realign incentives in healthcare delivery:

A significant portion of the conversation in the healthcare reform debate has been centered on reforming payment structures to reward healthier patient outcomes rather than volume of services delivered. In terms of federal reform, the most logical place for that to happen is Medicare. While Premera supports such reform, such payment system reform may or may not be a substantive component of what Congress produces, but we in the private sector should and are moving forward now.

Indeed, Premera is not waiting for legislation to drive change. We are working with prominent providers across Washington to implement programs that will realign incentives in a variety of clinical settings.

The first initiative, an outcomes-based payment program with Swedish Health Services for their Community Health Medical Home in Seattle's Ballard neighborhood, was implemented in November. Similarly, in Everett we are working with The Everett Clinic and Providence on a number of new initiatives to improve access to primary care, management of chronic

disease, reduce avoidable hospital readmissions, and promote access to palliative care.

These are important steps forward to improving healthcare – though federal reform remains necessary. Premera supports healthcare reform, including guaranteed access to coverage without concern for pre-existing conditions. Likewise, reform should also take serious steps to reduce medical costs through support for Medicare payment reform, a focus on prevention and wellness, and investment in comparative effectiveness research.

Even as Congress moves forward with related efforts, great care must be taken to avoid unintended consequences that may cause more problems than they solve. Poorly crafted insurance market reforms could inadvertently send premiums soaring. Likewise, using a government-run "public plan" to expand a Medicare system that underpays providers would have equally troubling impacts in Washington State – as leaders in the physician and hospital community have noted, including in a significant July 24 article in the Puget Sound Business Journal detailing such concerns.

While healthcare reform remains a complex challenge, collaborative relationships between health plans and providers are working now, regardless of what happens in Congress. While success is happening, particularly thanks to the good work of key partners such as Providence and The Everett Clinic, achieving real change is neither easy nor rapid. It's clear from our experience collaborating with leading providers that low-cost, high-quality is not only achievable, it is a result we must continually strive for in the years to come.

Rich Maturi is Senior Vice President for Healthcare Delivery Services at Premera Blue Cross.

Essentials of Provider Reimbursement: Inpatient Hospital

By Dwight Johnson FHFMA
Executive Director,
Provider Contracting
Coopersmith Health Law Group

No healthcare organization goes very far without understanding how it is paid. Even if you aren't the one negotiating reimbursement, it's helpful to know the essentials. Reimbursement is a frequent topic at senior management meetings and you don't want to be left out of the discussion.

This article is about the different types of payments that inpatient hospitals receive when contracting with insurance carriers.

Diagnosis Related Groupings

Diagnosis Related Groupings (DRG's) provide the foundation for classifying inpatients and measuring case mix. A single DRG is assigned to each inpatient stay. DRG's utilize principal diagnosis, additional diagnoses, principal and additional procedures if present, age, sex, and discharge status. Diagnoses and procedures assigned using ICD-9-CM codes determine DRG assignment. It is critical that accurate ICD-9-CM coding of every inpatient claim occurs for correct DRG assignment and subsequent reimbursement.

Virtually all principal diagnoses fall into one of 25 Major Diagnostic Categories (MDC's) corresponding to a single organ system. Some groupings are very costly and complex, so they are placed in a separate grouping based on procedures, not principal diagnoses. These DRG's include both solid organ and bone marrow transplants and Extracorporeal Membrane Oxygenation (ECMO), for example.

Patients are classified by operating room procedure, if present. A surgical hierarchy exists within each MDC and patients with multiple procedures are assigned to the highest acuity DRG.

If a procedure is not present, a claim is categorized as medical. In the DRG system and its variants, including AP-DRG's and MS-DRG's, each claim is additionally analyzed for age, sex, discharge status and/or the presence of a comorbidity or complication, and the DRG is assigned. The DRG variants perform a more precise analysis than DRG's.

Hospitals are paid a fixed amount for each claim, arrived at by multiplying the specific DRG weight by the base rate or conversion factor that is typically hospital specific. Each DRG weight will vary by acuity and as a reflection of the resource consumption projected for that DRG. DRG's with groups of patients who are expected to consume more resources will have a higher weight.

In general, all cases that group to the same DRG in the same hospital will generate identical reimbursement regardless of the length of stay.

Per Diem Reimbursement

Per diem reimbursement is the payment of a fixed amount per inpatient day. Per diem contracts typically utilize medical, surgical, and ICU/CCU per diems, with the rest of the pricing being a combination of case rates and percent of charge amounts. Carriers will try to match per diems to costs, lowering reimbursement as costs decrease with length of stay. Obstetrics is a prime example, where the acuity and cost tends to be in the early days of the stay, with later days typically consisting of monitoring. In these cases, per diem contracts usually pay less per day as the stay progresses.

Per diems may be dying out. They were the carriers attempt to keep reimbursement down by lowering lengths of stay. The problem is that an army of nurses must stay in constant contact with hospitals to ensure lengths of stay are as low as possible. The costs associated with hiring and retaining nurses often

offsets any savings the carriers can achieve by monitoring utilization. Therefore, a number of formerly per diem based carriers have quietly migrated to fixed pricing in recent years.

Per Case Reimbursement

Per case reimbursement is only used by carriers that do not want to make the investment in a DRG based grouping methodology. Per case amounts are broken out typically into medical, surgical, ICU/CCU, and OB categories. Per case pricing does not have the sophisticated adjusting for acuity and severity that DRG's have, so it can be costlier to the carriers.

Percent of Charges Reimbursement

This type of reimbursement is usually employed by carriers only where the other cost controlling methodologies are not in their interest. This is most often the case with financially challenged rural hospitals. Lowering reimbursement to these hospitals presents risk to the carriers as the demise of a rural hospital would leave nowhere for the carrier's members to receive hospital care. The only other circumstance compelling percent of charge use is when a hospital has commanding leverage over the carriers. The only pediatric specialty hospital in a major metropolitan setting with an aggressive negotiator, for example, can usually demand and get a high percentage of charges, again because the carriers have nowhere else locally to send their membership.

Outlier Protection

Additional payments are made when charges and therefore costs exceed fixed reimbursement by negotiated threshold amounts. There are a number of outlier methodologies. They often center around charges compared to payments, but can also correlate to total patient days, or cost data in the case of governmental carriers.

Dwight Johnson is the Executive Director of Provider Contracting at Coopersmith Health Law Group. Dwight has an extensive background in provider contracting. His experience includes six years as the Assistant Director of Provider Contracting at Regence BlueShield, where he was responsible for all provider contracting, and five years with Premera BlueCross where he was responsible for all hospital and ancillary contracting in Washington and Alaska. He can be reached at 206-343-1000 or dwight@coopersmithlaw.com.

Closing the Physician Retirement Gap

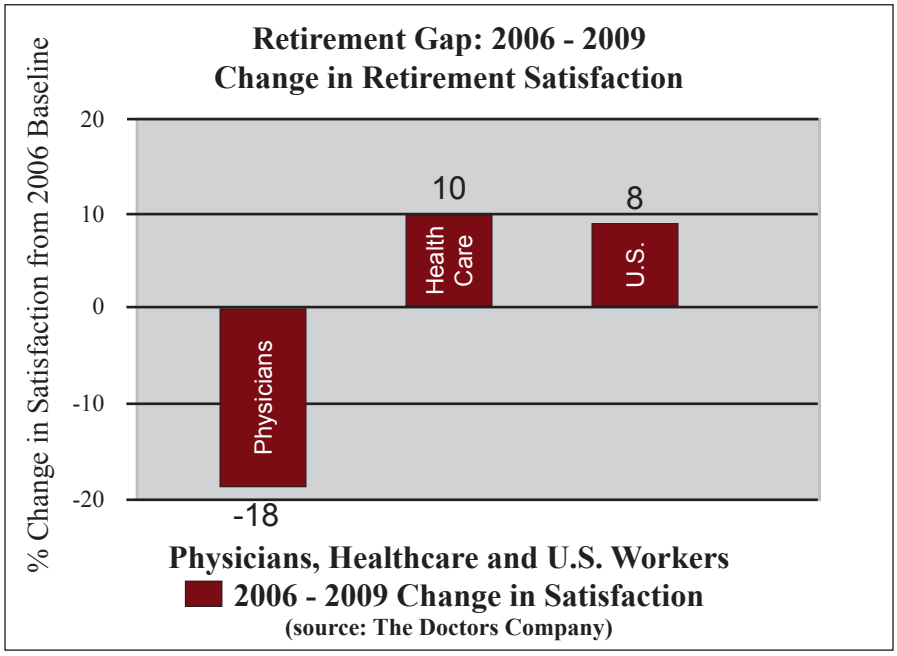
By James T. Dorigan, Jr.
Regional Operating Officer and Senior Vice President
The Doctors Company

The Doctors Company, which insures over 20,000 physicians in California and nearly 2,000 in Washington, this month will pay out over $1 million in Tribute Plan Funds. Physician-owned and physician led, The Doctors Company was founded to defend, protect and reward doctors who advance the practice of good medicine.

The Tribute Plan was launched in 2007 as a way to reward physicians who dedicate themselves to superior patient care and keeping claims low.

Recent studies indicate that the Tribute Plan may work to counter a troubling trend. According to a study commissioned by The Doctors Company and conducted by Watson Wyatt (See chart below), physicians are increasingly unhappy with their retirement choices. Physician satisfaction dropped by 18 percent between 2006 and 2009. At the same time, employees in healthcare and throughout other sectors expressed increasing satisfaction with retirement options.

For practice managers and leaders of health systems, the Tribute plan is an ideal way to address this growing dissatisfaction. As one physician member told us "The Tribute Plan is a nice added bonus that I can look forward to when I retire."



Here is how the Tribute Plan works:

Dr. Taylor is an internist whose medical group is covered by The Doctors Company. His $20,000 annual premium will result in an estimated Tribute Plan balance of $81,000 when he retires with The Doctors Company in 35 years.

Dr. Smith is a cardiologist who joined The Doctors Company in January 2007. Her annual premium is $25,000. She can expect her Tribute Plan balance to be over $30,000 when she retires after 15 years.

What is the story behind the Tribute Plan?

The Tribute Plan is a significant reward that underscores The Doctors Company's mission to advance, protect, and reward the practice of good medicine. As a member-owned, doctor-led organization, we believe that if we work together to promote outstanding patient care and keep claims low, we all win.

Our national medical liability carrier has grown to insure more than 46,000 member physicians, has $2.8 billion in assets under management, and over $1 billion in member surplus.

Physicians have responded well to the plan. According to a 2009 survey of The Doctors Company's members, the Tribute Plan is credited for a 43 percent in-

crease in satisfaction for the company's efforts to reward members for their loyalty. It has also shown to have improved member loyalty, with 97 percent stating that they are likely to renew with the company, and 95 percent likely to stay with the company until they retire.

Overall, doctors are positive about the Tribute Plan. One private practitioner said he was "thrilled that there is a financial award." Another said "No one else in the industry rewards physicians like The Doctors Company."

We believe that this higher standard of member rewards empowers us to fulfill our critical mission and to share our success with our members.

For more information on this innovative member benefit, visit our web site at www.thedoctors.com/tribute.

James T. Dorigan, Jr. is the senior vice president, regional operating officer of The Doctors Company, and the chief executive officer of Northwest Physicians Insurance Company, a wholly owned subsidiary. He is the former chief executive officer of Northwest Physicians Mutual Insurance Company. He is a former board member of the National Federation of Independent Business, The Foundation for Medical Excellence and served on the (Oregon) Governor's Task Force on Medical Professional Liability Insurance.

Tribute Plan Projections at 15 Years.

	Annual Premiums		Estimated Balance at 15 Years
Physician A	$20,000	15 Years	$24,000
Physician B	$60,000	15 Years	$72,000
Physician C	$90,000	15 Years	$109,000

*Projections are not intended to be a forecast of future events or a guarantee of future balance amounts.

Portland's Providence St. Vincent Medical Center Introduces the iMRI

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

Providence St. Vincent, located at 9135 SW Barnes Road, Portland, Oregon, became the first medical center on the West Coast to introduce a fully integrated operating room with a movable iMRI. Joining sixteen other facilities worldwide, Providence St. Vincent Medical Center (PSVMC) introduced the world's most advanced neurosurgical imaging system (the IMRISneuro) and began a successful surgical schedule the first week in October, 2009.

According to Dr. Oisin O'Neill, neurosurgeon at the Providence Brain Institute, the iMRI has already improved the quality of patient care and will change the outcome for hundreds of thousands of patients over its lifetime. "Everyone has been delighted with the way the new intraoperative MRI has performed," O'Neill explains. "It has helped us remove tumors perfectly."

The iMRI allows physicians to take real-time, three-dimensional images of the brain during surgery, enhancing the ability to completely remove tumors in deep areas of the brain. Before the installation of the iMRI, patients were moved to another room for imaging; the ceiling-mounted iMRI permits surgeons to safely image patients in the operating room – and navigate more precisely during surgery as well.

Side View of the iMRI

According to neurosurgeon Daniel Rohrer, MD, medical director of Cranial Services, Providence Brain Institute, the almost 8-ton magnet gives surgeons the capability to update navigation during surgery, enhancing the removal of tumors and confirming that no complications exist prior to the patients exit from the operating suite. The large-bore 1.5 Tesla mobile MRI is further integrated with microscopy and three-dimensional image guidance, and allows surgical access to the patient which is never compromised. "This device will allow us to deliver the safest, most appropriate surgery to our patients at Providence St. Vincent," says Rohrer. "The ability to confirm the precision of our tumor removal offers a huge improvement to the post-surgical outcome for many patients."

According to Bonnie W. Smith, administrative director of the Providence Brain Institute, the decision to install the iMRI continued their focus on building a nationally recognized "center of excellence." She explains that after completing much due diligence, the decision to install this state-of-the-art technology,

Please see> iMRI, P20

<iMRI, from P18

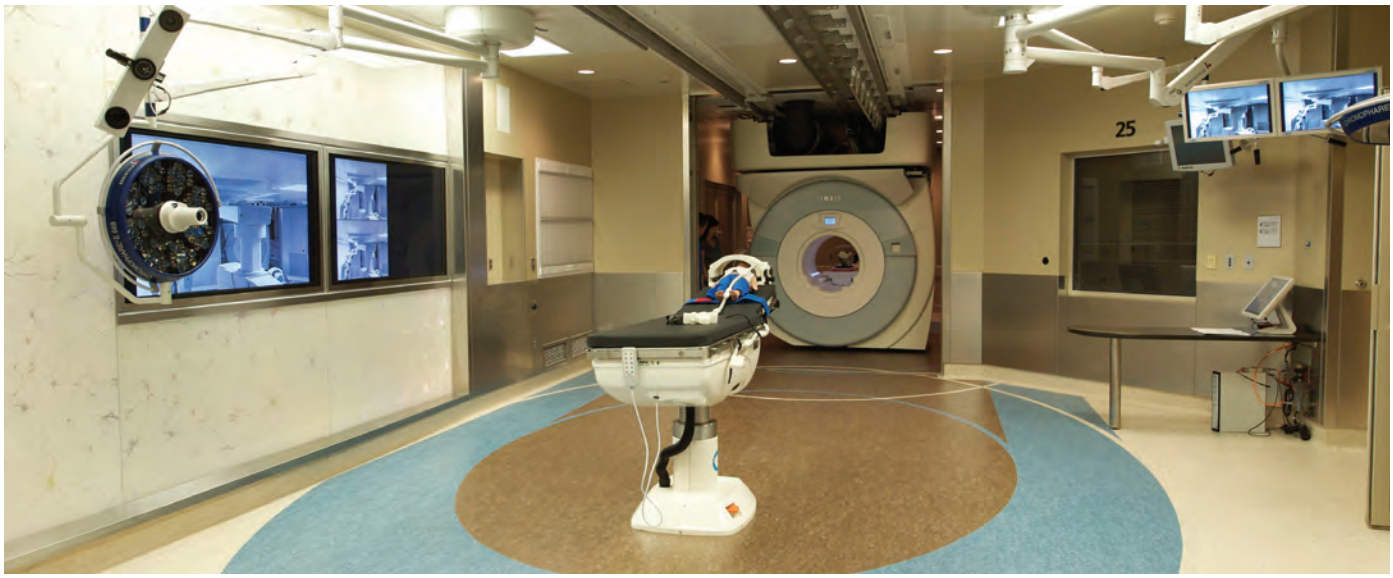
to be utilized by specialty trained neurosurgeons, offers the opportunity to provide clinical services poised to be recognized nationally. "This all-donor supported project provides Providence Brain Institute the ability to add to our other leading-edge technologies – such as the Gamma Knife Perfexion and the neuro-biplane laboratory – to provide the highest level of patient care in the Pacific Northwest."

ent – the iMRI will balance its cost with tremendous social good."

The installation of the iMRI at PSVMC continues the 153-year commitment of Providence Health in providing the best medical treatment and patient outcome, says chief executive Janice Burger. Smith agrees and cites the intraoperative suite as a treatment modality that will bring countless practicing surgeons from west of the Mississippi and the Far East for

mounted gantry (rail). All equipment in the room is non-ferrous, which eliminates the need to remove equipment being used to assist or treat the patient during the imaging procedure. The surgeon can view generated digital images on a monitor in the operating suite and determine if the surgery is proceeding correctly.

Dr. Pankaj Gore, neurosurgeon and co-medical director of Cranial Services at Providence Brain



Front View of the iMRI

Rohrer says that the iMRI will be used predominately for cranial and cervical surgeries – initially for tumor removal and intracranial surgery for the treatment of epilepsy. "Our surgeons will have the capability to do the best job for the patient during the first surgery," Rohrer says. "Other centers using this technology report their surgeons have changed their decision-making process during surgery anywhere from 35 – 40%. If we can cut back on re-ops, incur fewer post-surgical complications and perform our work to the highest standards of safety for the pat-

training. "We will act as a "luminary site," explains Smith. "PSVMC is already recognized as one of the best hospitals in the country and this neurological suite will only further enhance our reputation."

According to Rohrer the surgical suite that houses the iMRI is the most advanced neurological suite in the United States. It includes the newest systems which enhance work flow during surgery; the iMRI, housed in a holding room adjacent to the fully-shielded operating suite, is positioned over the patient by way of a ceiling

Institute cites the preparation and training of the staff members at Providence St. Vincent Medical Center's Departments of Surgery and Radiology as key to the success of the iMRI. "As expected," he concludes, "the intropeative MRI is proving to be a very useful technology. Three cases have been performed so far in the suite and all have been extremely successful."

Providence St. Vincent Medical Center is renowned for it's many centers of excellence. For more information, visit www.providence.org/oregon

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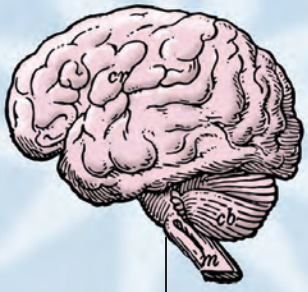

Tuesday evening, 7:59 PM.

Watch *MacGyver* rerun.

Go to fridge for two scoops of butterscotch ice cream.

MacGyver uses fire extinguisher as jet pack to zoom over wall. (Saw it twice before.)

Walk dog.

Decide to take the long route up the hill, past the high school.

3100 steps on pedometer. Enter information into your personal online Premera Health Tracker.

You feel great. Your doc's happy.

Dog wags tail.

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