

ACOs: Will There be Savings to be Shared?

By Stephen Rose
*Health Care Attorney and Owner
Garvey Schubert Barer*



Overview

After months of anticipation and speculation the Centers for Medicare and Medicaid Services issued proposed rules relating to a voluntary Shared Savings Program for Medicare providers and suppliers participating in Accountable Care Organizations (ACOs).¹ Under the Shared Savings Program, providers and suppliers will continue to receive traditional Medicare fee-for-service payments under Parts A and B, and be eligible for additional payments if specified quality and savings requirements are met.

As with other healthcare initiatives

in the past, the premise of ACOs is that they will improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care.² The “savings” created by ACOs participating in the Medicare Shared Savings Program will then be “shared” between the federal government and the ACO. The Shared Savings Program is only one of several programs envisioned by the Affordable Care Act (“PPACA”):

The Affordable Care Act includes a number of provisions designed to improve the quality of Medicare services, support innovation and the establishment of new payment models in the program, better align Medicare payments with provider costs, strengthen program integrity within Medicare, and put Medicare on a firmer financial footing.³

Immediately after the publication of the proposed regulations various commentators warned that those who wanted to participate and meet the ACO implementation date of January 2012 had better

join the mad scramble to comprehend the requirements and prepare to meet the quality and savings requirements or be faced with the very real possibility of not having a seat in this regulatory game of musical chairs.

Providers Begin to Express Concerns

More recently, health care providers and provider organizations have started the process of
Please see> ACOs, P4

Inside This Issue

ACOs: Will There be Savings to be Shared?	1
Healthcare Facilities: Providence Regional Medical Center Everett Opens \$460 Million State-of-the-Art Tower	8
Healthcare Administration: Accountable Care Organizations: The Future of Quality Healthcare?	10
Healthcare Law: Legal Challenges to Medicaid Rate Reductions Frustrated by Proposed Federal Rules	12
Career Opportunities	15
Plan and Hospital Financial Information Available at www.wahcnews.com	

Publisher and Editor

David Peel

Managing Director

Elizabeth Peel

Contributing Editor

Nora Haile

Advertising

Jennifer Sharp

Business Address

631 8th Avenue
Kirkland, WA 98033

Contact Information

Phone: 425-577-1334

Fax: 425-242-0452

E-mail: dpeel@wahcnews.com

Web: wahcnews.com

TO GET YOUR COPY

If you would like to be added to the distribution, go to our web site at wahcnews.com, click on the “subscribe” tab at the top of the page and enter all information requested. Be sure to let us know whether you want the hard copy or the web version.

LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@wahcnews.com.

Letter from the Publisher and Editor



Dear Reader,

The volume of online job postings can indicate the strength of the economy. However, it can also be misleading.

I review **The Conference Board’s Help Wanted Online (HWOL)**™ report each month to see how postings are trending. The number of postings on Healthcare News web sites are at all-time highs so it didn’t surprise when HWOL reported online postings rose 148,800 during May 2011 when compared to April 2011. The hottest categories have fewer unemployed persons than online ads. Computer and math science (.23) and healthcare practitioners and technical (.37) categories have the highest demand when comparing unemployed persons to online ads.

However, while healthcare and computer/math science jobs go begging, postings in other industries are scarce. This probably explains why the *U.S. Department of Labor* has been reporting initial claims for unemployment insurance above 400,000 for the past few months.

For the foreseeable future, there will be high demand in some industries while others languish. Expect healthcare workers to continue to be in short supply so make sure your recruiting budgets are adequately funded.

David Peel, Publisher and Editor

Washington Healthcare News 2011 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2011	Hospitals	December 1, 2010	December 27, 2010
February 2011	ASCs	January 4, 2011	January 24, 2011
March 2011	Hospitals	February 1, 2011	February 21, 2011
April 2011	Insurance	March 1, 2011	March 21, 2011
May 2011	Clinics	April 1, 2011	April 18, 2011
June 2011	Human Resources	May 2, 2011	May 23, 2011
July 2011	Hospitals	June 1, 2011	June 20, 2011
August 2011	Hospitals	July 5, 2011	July 18, 2011
September 2011	Clinics	August 1, 2011	August 22, 2011
October 2011	Human Resources	September 1, 2011	September 19, 2011
November 2011	Hospitals	October 3, 2011	October 24, 2011
December 2011	Clinics	November 1, 2011	November 21, 2011



FORGE A CLEAR PATH THROUGH HEALTHCARE LAW

It's easy to get turned around in the regulatory complexity and reorganization of healthcare law. We make it our business to diligently monitor the ever-changing landscape for you, so you can focus on the medical needs of our communities.

THE POWER OF PARTNERS

GARVEY
SCHUBERT
BARER

Attorneys

GSBLAW.COM

BEIJING

NEW YORK

PORTLAND

SEATTLE

WASHINGTON, D.C.

+IMA

HEALTHCARE
MANAGEMENT
ADMINISTRATORS

SERVICE AND SAVINGS

HMA is committed to maximizing health plan value by lowering claims costs and providing superior customer service.

For the best of both Service and Savings, contact us today:

Oregon

Melody Ortiz

503.808.9287 x6213

Washington

Brooke Vassar

425.289.5227

proposals@accessstpa.com • www.accesshma.com

+IMA | Committed to Value

drilling down through the regulations. Questions are being raised regarding whether it is possible to increase quality of care to a larger population of recipients while simultaneously lowering costs or at least lowering the growth in overall expenditures. Thus far there is not one “cookie-cutter” model for an ACO. The nuts and bolts of what an ACO could look like have been well chronicled by others and will not be reiterated here. Without endorsing or criticizing the positions taken, this article focuses on some of the concerns raised by providers and provider organizations.

As a general statement, it appears that most health care providers support the concept and goals of ACOs but believe that the proposed regulations impose significant impediments to successfully participating in a Shared Savings Program.

For example, the Cleveland Clinic expressed its disappointment with the proposed rules, stating that:

Rather than providing a broad framework that focuses on results as the key criteria of success, the Proposed Rule is replete with (1) prescriptive requirements that have little or nothing to do with outcomes, and (2) many detailed governance and reporting requirements that create significant administrative burdens. Further, we have concluded that the shared savings component (Shared Savings) is structured in such a way that creates real uncertainty about

whether applicants will be able to achieve success.⁴

The letter from the Cleveland Clinic then goes on to list seven more pages of, what the Clinic terms, “recommendation[s] to improve the proposed rule.”⁵

The Medical Group Management Association (“MGMA”) recently commented that the Shared Savings Program detailed in the proposed regulations “. . . may not be viable as a national strategy unless significant program policies are modified when final rules are promulgated.⁶ As an overall observation MGMA notes that the ACO model is a hybrid business model somewhere between the traditional fee for service model and a capitation or similar “all-risk” model. MGMA comments that ACOs purport to provide the best of both ends of the spectrum: cost control and cost certainty from the government’s perspective as a payer and patient and provider freedom of choice. MGMA wonders out loud whether Medicare (and each of its stakeholders) can “have its cake and eat it too” using the ACO model.

Four specific areas of concern raised by MGMA are: (1) The complexity of the ACO program creates a bias against participation; (2) The cost of ACO development and ongoing operations are too high relative to the potential financial benefits; (3) The potential financial benefits are too small and too uncertain; and (4) The regulatory risks under the related joint notices concerning ACOs issued by CMS, the Office of Inspector General, the Federal Trade Commission, and the De-

partment of Justice are substantial and add another disincentive to participation.

Other provider organizations have commented that the proposed regulations do not allow a gradual transition that would allow providers new to care coordination ample time to build the infrastructure needed to function successfully as an ACO or within an ACO. Rather, they state that the proposed regulations demand that all ACO “participants quickly move to taking on downside risk.”⁷ CMS acknowledges that requiring all ACOs to take this risk “. . . would likely inhibit the participation of some interested entities.”⁸ However, CMS believes that requiring participating ACOs to take on downside risk quickly is best for the program because “. . . payment models where ACOs bear a degree of financial risk have the potential to induce more meaningful systematic change in providers’ and suppliers’ behavior.”⁹ The debate here is not whether ACOs should take on downside risk but how soon in their lifecycle that risk should be borne. Many providers believe that if ACOs take on too much risk too soon the ACO may be forced out of business.

Complaints have been registered regarding how CMS will calculate the expenditure benchmark for ACOs. The benchmark will be unique to each ACO. CMS will base the benchmark on estimated Part A and B expenditures for ACO beneficiaries. Some provider groups have argued that a better approach would use blended regional and national expenditures

Please see > ACOs, P6

**Chris Apgar, CISSP
President**

Phone: 503-977-9432

Fax: 503-245-2626

Mobile: 503-816-8555

E-mail:

capgar@apgarandassoc.com



Apgar & Associates, LLC



Quality Compliance Resources

Apgar & Associates, LLC offers the highest quality service assisting health-care organizations establish sound privacy and security programs, meet regulatory requirements, address legal and regulatory issues and assist in planning deployment of health information technology, electronic health records, personal health records and health information exchange planning. Check out Apgar & Associates, LLC's web sites for a full list of services offered.

Check out enhanced virtual compliance officer services for organizations of all sizes

10730 SW 62nd Place

Portland, OR 97219

<http://www.apgarandassoc.com>

ANATOMIC PATHOLOGY & LABORATORIES

WWW.CELLNETIX.COM (866) 236-8296

BREAKING TRADITIONS FOR PATIENTS, PHYSICIANS, AND HOSPITALS



- ➔ 44 BOARD CERTIFIED PATHOLOGISTS
- ➔ OVER 25 SUB-SPECIALTY AREAS OF EXPERTISE
- ➔ OVER 40 YEARS OF PATHOLOGY EXPERIENCE
- ➔ HIS & EMR INTEGRATION



OUR EXPERTISE, YOUR PEACE OF MIND.™

< ACOs, from P4

to create a benchmark.

Conclusion

As with any potential decision, health care providers must assess the pros and cons associated with joining or creating an ACO or refusing to do so. ACOs have been heavily promoted as a panacea for control of health care spending while increasing health outcomes; a world view that is yet to be proven. However, some of the criticism may be equally flawed.

A decision whether to participate in the Shared Savings Program and the provider's selection of an ACO to join, are weighty decisions that require a careful consideration with a full appreciation of both the costs and the benefits evaluated in the context of your specific situation.

Stephen Rose has more than 25 years representing healthcare providers in matters relating to Medicare/Medicaid reimbursements, government audits, and corporate compliance plans. He can be reached at srose@gsblaw.com or 206.816.1375.

¹76 Fed. Reg. 19528-19654 (April 7, 2011).

²Id. at 19531.

³Id. at 19530.

⁴Letter from Delos M. Cosgrove, President and CEO, Cleveland Clinic to Donald Berwick, M.D., Administrator, CMS (May 26, 2011) (<http://www.medicitynews.com/wordpress/wp-content/uploads/Cleveland-Clinic-ACO-letter.pdf>).

⁵Id.

⁶Letter from William F. Jessee, M.D. for MGMA to Donald Berwick, M.D., Administrator, CMS (June 1, 2011) (<http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1366447>).

⁷76 Fed. Reg. at p. 19618 (April 7, 2011).

⁸Id.

⁹Id.

When it's your license, your hospital privileges, employment, or your provider status at stake, you need ***your lawyer.***



MALPRACTICE DEFENSE, DISCIPLINARY INVESTIGATIONS & ACTIONS,
HOSPITAL PRIVILEGING, EMPLOYMENT ISSUES, PROVIDER PLAN DISPUTES

Contact: Thomas H. Fain
206-749-0094
701 Fifth Ave., Suite 4650
Seattle, WA 98104 www.favfirm.com



FAIN
ANDERSON
VANDERHOEF, PLLC

Time to bring in outside help?
The **Consultant Marketplace**, located on the **Washington Healthcare News** web site, is where over 50 companies that specialize in providing services or products to healthcare organizations are found.
To learn more, visit wahcnews.com/consultant

Washington Healthcare News[®]
wahcnews.com Articles, Interviews and Statistics for the Healthcare Executive



Over 33,000 healthcare leaders receive Healthcare News publications each month. As a healthcare organization, doesn't it make sense to target recruiting efforts 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 425-577-1334 or dpeel@wahcnews.com

Washington Healthcare News®

wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

Providence Regional Medical Center Everett Opens \$460 Million State-of-the-Art Tower

By David Brooks
*Chief Executive Officer
Providence Regional Medical
Center Everett*

Providence Regional Medical Center in Everett will take its award-winning healthcare to the next level June 14 when it opens a new \$460 million, state-of-the-art medical tower, the largest and most

comprehensive building project in our hospital's 150-year history.

The 12-story Marshall and Katherine Cymbaluk Medical Tower, one of the largest private investment projects ever in Snohomish County, is the centerpiece of a comprehensive plan to ensure Providence Regional remains well equipped

to provide first-class health care in our growing community.

The new tower was designed around Providence's patient-and family-centered care philosophy, with comfort, privacy and convenience in mind. By combining cutting-edge technology with patient-centric care, Providence aims



*Providence Regional Medical Center Everett's
12-Story Marshall and Katherine Cymbaluk Medical Tower*

to set a new standard for the way patients and their families experience hospital care in America.

The facility, which houses many Providence services, features \$60 million in the latest medical equipment and is designed to adapt to technology as it evolves in the future. It dedicates an entire floor - larger than an NFL football field - to emergency services, which includes 79 private treatment rooms including four trauma rooms. CT and X-ray services are also located within the department to provide quick access to imaging capabilities.

More than \$20 million in diagnostic imaging equipment, including two MRI scanning machines and four CT scanners, are housed on the diagnostic imaging floor. The department has a unique design that will accommodate both inpatient and outpatient imaging needs. Electronic medical records allow doctors and staff from multiple organizations to share information in real time, which speeds diagnosis and treatment.

Two floors of the tower are dedicated to both surgical and interventional procedures and two floors will house 48 patient rooms dedicated to intensive care, which include six dialysis stations. Each of the top three floors has 56 patient rooms for medical or post-surgical patients.

We worked closely with our Patient and Family Advisory Council when designing the tower and, as a result, incorporated several elements not typically found at a hospital. For example, most rooms have a special ‘family zone’ area, complete with a sleeper sofa and storage area for patients’ family

members to stay with them.

Of equal importance, the tower is designed to be a calming, healing environment for patients, family members and visitors alike. The building brings nature and the outdoors inside, with features that include a two-story atrium lobby, patient rooms with sweeping views on all sides of the building and a rooftop viewing garden with native plants, grasses and trees. It also

features family lounges with internet access, and the surgery waiting areas provide a kitchen, playroom and resource center for all.

The doctors, nurses and other caregivers at our new tower will provide the industry-leading care Providence is known for – but we expect our warm, welcoming approach to serving patients and their families is what will truly set us apart.



Legal strategies for the healthcare challenges ahead.

Your healthcare business is operating in an increasingly complex environment. Miller Nash’s team of healthcare attorneys has the knowledge and depth of experience to successfully address the unprecedented challenges and expanding responsibilities you face.

Please contact Bob Walerius | bob.walerius@millernash.com

Regulatory Compliance | Board Governance | Medical Staff | Fair Hearings
Mergers & Joint Ventures | Physician Recruitment & Contracting | HIPAA Privacy Laws
Health Information Technology | Physician Credentialing | Stark/Fraud & Abuse
Litigation & Dispute Resolution Business Formation & Transactions
Labor and Employment | Real Estate

SEATTLE
WASHINGTON

VANCOUVER
WASHINGTON

PORTLAND
OREGON

CENTRAL OREGON



MILLER NASH^{LLP}
ATTORNEYS AT LAW

TEL 206.622.8484

WWW.MILLERNASH.COM

Accountable Care Organizations: The Future of Quality Healthcare?

By **Loy Maslen**

*RN, BSN, NNP-BC, CPUM Associate
Quality Improvement and Education
Consultant
Derry Nolan & Associates, LLC*



Healthcare reform is about accountability for care. As a nurse, should someone ask me if I provide quality care, I would answer, “Absolutely.” But if they ask me, “What is your data to support that claim of quality care?” Then I may need to say, “I’ll be right back with you on that.”

That’s where the ACO comes in. ACOs are a type of payment and delivery reform model that begins to tie provider reimbursements to quality metrics (measures of quality indicators) and reductions in the total cost of care (performance

and process improvement) for an assigned population of people; i.e. Medicare patients.

The Center for Medicare and Medicaid Services (CMS) is asking healthcare providers to be accountable to the care provided. That includes administration, governance, and implementation either within the scope of our roles or in our employment positions. It also encompasses the obligation to report, explain and be answerable for any resulting consequences.

Initiated by the goals of the Affordable Care Act to improve care while lowering its cost, ACOs will help make quality a habit in healthcare. Those ACOs that meet required quality performance standards have the potential to receive payments from the Medicare Shared Savings Program, which “promotes accountability for a patient population, coordinates items and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”¹

From an operational perspective, as well as from a clinical one, the ACO model makes sense. Today’s healthcare organizations are often fraught with inefficient workflows and faulty communication habits,

causing quality and outcomes to suffer. To combat these issues, a recognized ACO will need to meet indicators and data derived from five key areas:

1. Patient and providers’ experience of care (patient and staff satisfaction scores)
2. Care coordination (information sharing across the continuum of care)
3. Patient safety (reporting, analysis and error prevention)
4. Preventive health (treatments to minimize illness and hospital admissions)
5. At risk population, frail and elderly health (using proven care standards to assist with care provision)

The overall quality performance score will be calculated on 65 quality metrics within those five defined key areas, equally weighted. CMS will define the quality performance benchmarks based on Medicare Fee-For-Service (FFS), Medicare Advantage or ACO performance data over time.

Note that the ACO is eligible for monetary compensation **only** if it demonstrates to CMS that it has

fulfilled the required quality performance elements and achieves the other regulatory performance criteria. Mature organizations exist that already meet the measures required. Those organizations not only meet the clinical measures, but are also likely made up of high performance teams.

Creating High Performance Teams

Healthcare is complex, so approaching issues as a cohesive group working together to achieve a goal allows for creativity, sharing expertise, developing new skills, increasing personal autonomy and influencing decisions. Such teams can only come together through eliminating barriers encountered in everyday communications. Communication excellence is the key to unlocking team performance

and quality outcomes.

Communication should be a simple concept, particularly in healthcare. Patients talk to doctors, nurses and other staff members. Healthcare providers talk to each other. Unfortunately, the barriers that frequently block understandable exchanges create gaps. Those gaps in quality communication limit quality service to patients and staff alike. The natural progression? Patient and staff dissatisfaction and frustration.

Failure to address these communication issues in healthcare leads to inefficiency, ineffective and potentially unsafe care, rework, a diminished capacity for **team** performance and unintended outcomes. Simply improving and standardizing parts of our communication strategies can eliminate these types

of costly wastes.

Consider this: the products of healthcare systems are services. Therefore, measuring healthcare quality must extend beyond clinical measures. Organizations must also measure patient perceptions and experiences. So, although service quality is usually measured by five dimensions:

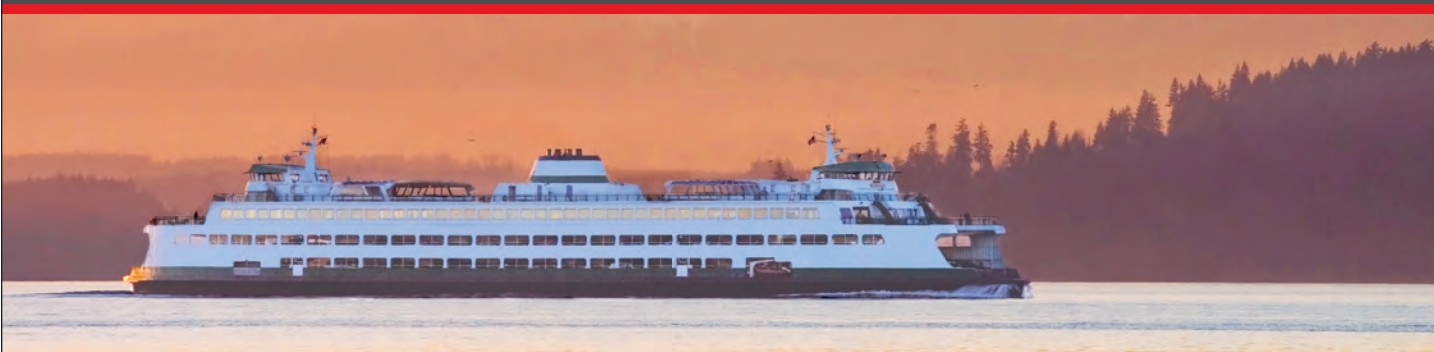
1. Tangibles
2. Reliability
3. Responsiveness
4. Assurance
5. Empathy

We will add two more:

6. Accessibility

Please see> **Quality, P14**

EVERYONE BENEFITS FROM SOUND LEGAL ADVICE



OUR BREADTH OF EXPERIENCE keeps our clients focused on their mission—providing quality care to their patients. Serving health care clients for over 75 years, we provide sound and practical advice to health care professionals, clinics, and institutions in such areas as labor and employment, risk management, regulatory compliance and licensing, business transaction and litigation services.

FOR MORE INFORMATION CONTACT **MARY SPILLANE**: 206.628.6656



Legal Challenges to Medicaid Rate Reductions Frustrated by Proposed Federal Rules

By **Renee M. Howard**
Shareholder
Bennett Bigelow & Leedom, P.S.



Providers who participate in Medicaid should familiarize themselves with proposed federal regulations published on May 6, 2011 that, if adopted, would substantially impede their ability to challenge Medicaid rate reductions in court. Interested parties may submit comments to the proposed rules, which must be received by the Centers for Medicare and Medicaid Services (“CMS”) no later than 5 pm EST on July 5, 2011.¹

The proposed rules interpret a federal Medicaid law that limits how state Medicaid programs can set payment rates. That law, known as

“Section 30(A)” of the Medicaid Act, requires state Medicaid Plans to utilize “methods and procedures” that “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and service are available to the general population in the geographic area.”² These payment-related requirements are known as the “quality” and “access” standards.

In recent years, various types of providers have brought successful legal challenges to Medicaid rate cuts that do not comply with Section 30(A) quality and access requirements. While providers cannot get money damages in these lawsuits, they have been able to block state Medicaid programs from implementing rate cuts that violate Section 30(A).

Since 1997, federal courts in Washington and elsewhere in the Ninth Circuit have required states, in order to comply with Section 30(A), to conduct “responsible cost studies” to ensure Medicaid rates will be “reasonably related” to provider costs, and to conduct such cost studies prior to setting the new rates. *Orthopedic Hosp. v.*

Belshe, 103 F.3d 1491, 1497 (9th Cir. 1997).³ Based on this requirement, many health care providers have successfully challenged budget-driven Medicaid rate reductions on the basis that the state did not conduct a responsible cost study prior to developing a new rate (or that the study itself was inadequate), and that the providers would be financially harmed if such rate went into effect.

The proposed rules would substantially alter this legal standard. Rather than require cost studies, the rules would allow states to conduct a more flexible access analysis that examines three factors: (1) enrollee needs; (2) availability of care and providers; and (3) utilization of services. Clarifying that the relationship of rates to provider costs is no longer the primary focus of an “access” analysis, CMS noted: “Depending on State circumstances, cost-based studies may not always be informative or necessary. In addition, because many State payment rates are not specifically calculated based on provider cost considerations, it can be burdensome and not particularly productive to rely solely on that one factor as a measure of access.”⁴ Going a step further, CMS suggests that a Medicaid rate can satisfy Section 30(A) requirements

irrespective of the payment level: “If beneficiaries are able to gain access to care . . . then clearly the standards of the Act have been met regardless of other factors, including payment levels.”⁵

The singular focus on “access” to Medicaid services is problematic for providers such as hospitals, which must provide some measure of treatment to all who come to the emergency department regardless of insurance status or payment rates. Indeed, the framework in the proposed rules was developed based on a study that focused on primary and specialty care providers and services, and did not specifically address hospital, ancillary, and long-term care services.⁶ The rules also do not address Section 30(A)’s second requirement that states must ensure “that payments are consistent with efficiency, economy, and quality of care,” in addition to ensuring access to services.

Finally, the proposed rules would make it difficult for providers to establish that a state failed to satisfy Section 30(A) access requirements, as the rules give CMS discretion to deny a State Plan Amendment only where a state fails to conduct an access analysis altogether and not where the access review is methodologically unsound or reveals deficiencies.⁷ For example, if a state’s access review identifies access issues, instead of denying the State Plan Amendment, the proposed rules permit the state to submit a corrective action plan, and take up to twelve months to remediate the deficiency.

Given these issues, Medicaid providers should critically examine

the proposed rules and consider submitting comments to ensure that the final rules provide meaningful protections against budget-driven rate cuts.

Renee is experienced in representing a wide range of health care providers and suppliers, including hospitals and health systems, academic medical centers, physicians, imaging centers, and medical suppliers and distributors. She

has represented health care clients in litigation and government investigations implicating the federal False Claims Act, the federal Anti-Kickback Statute and physician self-referral (“Stark”) laws, state Medicaid issues, and health care licensing matters. Renee also assists clients with internal investigations of allegations of fraud or other noncompliance with state or federal health care laws, and re-

Please see> Medicaid, P14

Health Insurance

Options and Advice from the
Local Experts at EmSpring.

*No worries:
We know how they all fit.*



EMSPRING

KIRKLAND (425) 818-0726
218 Main Street

YAKIMA (509) 575-6497
3911 Castlevale Rd, Suite 209

SPOKANE (877) 550-0088
601 Main Street

WWW.EMSPRING.COM

Health Reimbursement Arrangements (HRA) | Health Savings Accounts (HSA)

Dan Fisher | Sue Ferrari | Kathy Rheume | Carol Wagar, CPA | Ed Haines

< **Medicaid, from P13**

sponding to Medicare, Medicaid and third party payor audits. Renee regularly advises clients on Medicare and Medicaid reimbursement and payment issues, structuring financial relationships under fraud and abuse and self-referral laws,

and other health care compliance matters. She can be reached at rhoward@bbllaw.com.

¹The proposed rules are available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf> (76 Fed. Reg. 26342 (May 6, 2011)).

²42 U.S.C. § 1396a(a)(30)(A).

³Holding reaffirmed in *Indep. Living Ctr. v.*

Maxwell-Jolly, 572 F.3d 644 (9th Cir. 2009).

⁴76 Fed. Reg. at 26344.

⁵*Id.* at 26350.

⁶Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP (March 2011), Ch. 4, p.126, *available at* http://www.macpac.gov/reports/MACPAC_March2011_web.pdf?attredirects=0&d=1.

⁷Proposed 42 C.F.R. § 447.204(b).

< **Quality, from P11**

7. Communication

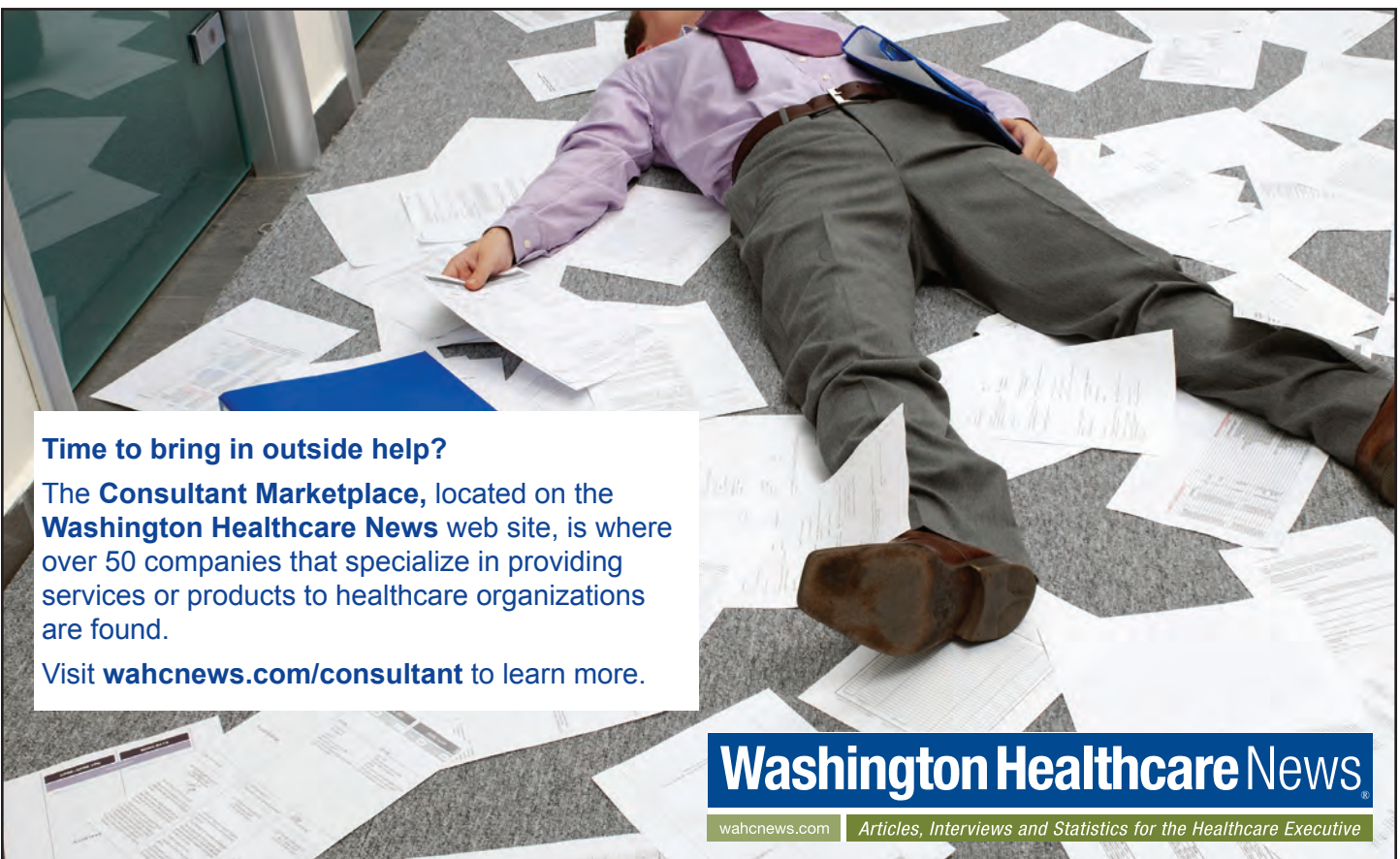
The high performance teams that grow from achieving these measures experience bonus benefits: job satisfaction and communication improves, mutual respect grows. If your healthcare organization can build such high performance teams, you will naturally evolve to improved quality and outcomes. Your healthcare organization can meet ACO performance criteria. But first, we must begin to truly communicate, laying the

foundation for the high performance teams that will make quality a habit.

Loy Maslen, RN, BSN, NNP-BC, CPUM Associate, is a quality improvement and education consultant with Derry, Nolan & Associates, bringing over 30 years of diverse healthcare experience to inpatient and outpatient organizations. A TeamSTEPPS™ Master Trainer and VitalSmarts™ Crucial Conversations Master Trainer, Maslen helps clients learn effective evidence-based communica-

tions to improve teamwork and performance outcomes. She holds the firm belief that an ACO begins with partnerships between patient, family, providers and staff, applying standard structure and process to drive improved quality outcomes while simultaneously decreasing costs and eliminating waste. Maslen can be reached at loy@derrynolan.com or (425) 774-4893.

¹<http://www.modernhealthcare.com/assets/pdf/CH7349848.PDF>, page 4, Section B. Statutory Basis for the Medicare Shared Savings Program.



Time to bring in outside help?

The **Consultant Marketplace**, located on the **Washington Healthcare News** web site, is where over 50 companies that specialize in providing services or products to healthcare organizations are found.

Visit wahcnews.com/consultant to learn more.

Washington Healthcare News
wahcnews.com | Articles, Interviews and Statistics for the Healthcare Executive

Career Opportunities

To advertise call 425-577-1334
Visit wahcnews.com to see all available jobs.



Controller

(Wenatchee, WA)

The Controller will provide leadership for the Finance Department and will maintain agency financial information, prepare financial reports, maintain and balance accounting ledgers and provide direct oversight of the Purchasing, Accounts Payable, Cash Receipts, Payroll and General Ledger functions. The Controller is responsible for maintaining compliance with external stakeholders by ensuring the accuracy and timeliness of required reporting.

CVCH is a dynamic community health center with fully integrated EMR. Our services include Medical, Dental and Behavioral Health services with our main clinic in Wenatchee and a site in Chelan. We serve 20,000+ people in a geographically stunning part of the world and are proud to be a progressive group of mission-focused employees committed to serving the underserved. We are leaders in the Medical Home Model, are Joint Commission accredited and are routinely recognized as one of the highest quality Community Health Centers in Washington.

The successful candidate will have a Bachelor's degree in Accounting with five years accounting and supervisory experience. CPA preferred. Visit our website at www.cvch.org.

To apply, contact Sarah Wilkinson, HR, @ 509-664-3587 or swilkinson@cvch.org



Director, Human Resources

Jefferson Healthcare, in Port Townsend, Washington, is recruiting for a Director, Human Resources.

Jefferson Healthcare is a full service, publicly owned, 37 bed, self supporting acute care hospital.

The hospital has approximately 350 employees and four clinics.

Jefferson Healthcare has all of the standard acute care services plus Cardiac Rehab, Chemotherapy, Pulmonary Rehab, Rehabilitation Services, Support Groups and a Surgical Center.

The Director, Human Resources supervises a staff of five employees.

A Bachelor's Degree in Human Resources is required. Five or more years of progressive Human Resources experience in a healthcare facility as a Director or Assistant Director is also required.

Labor relations experience along with PHR or SPHR is preferred.

Jefferson Healthcare is very well managed in an idyllic setting.

For more information please contact:

George C. Deering
President
Deering and Associates
(425) 264-0865 (Office)
(888) 321-6016 (Toll Free)



Healthcare Sales Executive

(Portland, OR)

This position is primarily responsible for building and executing tactical and strategic sales plans for HMA's Oregon territory. The Sales Executive must demonstrate a consistent focus on achieving or surpassing goals and a proven record of excellence. He or She must show a passion for continuous improvement, and demonstrate personal motivation, energy, creativity and adaptability while pursuing goals. The Sales Executive should inspire others through their own vigorous drive to achieve, motivating groups by communicating a compelling vision and translating that vision into clear, actionable goals and objectives. They work closely and collaboratively with Client Services team members, and seek out and share the latest information on successful industry and business practices.

Successful Candidate will have: Experience selling products with complex funding arrangements including Administrative Services Only, ASC, minimum premium, prospective, and retrospective financial arrangements is required. Familiarity with industry trends in health care insurance, as well as federal and relevant state legislative and regulatory issues. Currently licensed (in Life and Disability) and have a valid state driver's license with a good driving record and proof of auto insurance. Demonstrates selling skills such as call planning, needs identification, overcoming objections, closing, and follow-up. Works effectively under short deadlines. Additional requirements apply.

Healthcare Management Administrators (HMA) believes in delivering superior value to our many self-funded Northwest clients by combining competitive rates with superior service. If you would like to learn more about our organization, please E-mail your resume, cover letter and salary history to: recruiter@accessspa.com Faxed resumes are welcome at 305/574-0443. Be sure to visit our website at www.accesshma.com.



PeaceHealth

Dedicated to Exceptional Medicine and Compassionate Care

PHMG Clinical Practice Program Manager

PeaceHealth's Lower Columbia Region, in Longview, Washington, includes St. John Medical Center, a 200-bed acute care and Level III trauma center community hospital, and PeaceHealth Medical Group, a multi-specialty physician practice. We are an integral part of a nationally recognized not-for-profit health care system known for its innovations in patient-centered care, patient safety, and health care technologies. We currently are recruiting for a **Clinical Practice Program Manager** for our Primary Care Clinics within PeaceHealth Medical Group:

In this role, you will support our primary care clinics by managing the clinical practice program operations and staff performance on clinical-related policies and processes in conjunction with the Clinic Managers. Will also ensure compliance with all regulatory guidelines and facilitate the development, implementation and evaluation of clinical best practices, as well as, collaborating with clinic leadership on ensuring consistent delivery of patient care.

Require a minimum of an AA degree in Nursing, strong clinic nursing experience, as well as project management and process improvement experience.

With its ideal location just 40 miles north of Portland and a short drive from the beautiful Pacific Coast and several different mountain adventures, Longview is a small city with an urban flair. Longview's 37,000 friendly neighbors enjoy the pace and natural beauty of a family-first community that benefits from the amenities of nearby Portland and Seattle.

We offer a competitive salary range and a comprehensive benefits plan. Interested candidates may apply online via our website at www.peacehealth.org. Resumes may be submitted in addition to application, to: Lwishard@peacehealth.org.

EOE



Chelan Clinic Administrator

(Chelan, WA)

The Clinic Administrator will provide leadership at our Chelan Clinic and future clinic site in East Wenatchee to ensure effective day-to-day operations and supervision of support staff. This position will work collaboratively with CVCH managers to ensure that all program goals are achieved in support of our mission to provide healthcare with compassion and respect for all.

CVCH provides Medical, Dental, Behavioral Health, Diabetes Education and WIC services. We serve 20,000+ people in a geographically stunning part of the world and are proud to be a progressive group of mission-focused employees committed to serving the underserved. Our center is Joint Commission accredited and is routinely recognized as one of the highest quality Community Health Centers in the state of Washington.

The ideal candidate will have a Master's degree in Healthcare, MPH or MHA, with two years supervisory experience in healthcare. Bachelor's Degree in Healthcare or related field with appropriate experience will be considered.

To learn more about CVCH, visit our website at www.cvch.org.

To apply contact, Sarah Wilkinson, Human Resources @ 509-664-3587 or swilkinson@cvch.org

Prsrt Std
US Postage
Paid
Olympic Presort



We Know Healthcare and That's Not All...

We know the issues you face in healthcare and trial practice.
We know how to address them. So you can focus on your business.



Bennett Bigelow & Leedom, P.S.