Washington Healthcare News

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Community Health Centers Proffer a Comprehensive Plan to Provide Care

ACCESS for All America Plan Stands on Success, Expands Primary Care

By Nora Haile
Contributing Editor
Washington Healthcare News

For more than four decades, America's Community Health Centers have put care first, serving those who need care regardless of insurance status or ability to pay. You can find service delivery sites – there are over 6,000 – associated with over 1,100 community, migrant and homeless health centers nationwide, serving more than 17 million people. The Community Health Centers don't want to stop there. They have launched an initiative called the "ACCESS for All America Plan" (ACCESS stands for Affordable Comprehensive Care, Expanded to Strengthen Service). The health center plan proposes to "expand the reach of Community Health Centers to provide care to those without a health care home." That means not only the uninsured or those covered through a public health plan, but also the medically disenfranchised.

You see, medically disenfranchised doesn't necessarily mean "without coverage." It often refers to a care barrier, commonly that there simply aren't enough doctors in a given area to provide adequate care. In fact, a recent study "Access Denied" by the Robert Graham Center and the National Association of Community Health Centers (NACHC) uncovered that many of the 56 million Americans who don't have good access to primary health care, have insurance.

Lil Anderson, NACHC Board Chair, is also Chief Executive Officer and President of RiverStone Health, a provider of quality primary care and public health services in south central Montana. In a recent conversation, Anderson explained, "Coverage is an important facilitator when it comes to care. Unfortunately, coverage does not equal care because coverage does not guarantee access. If we all woke up tomorrow with an insurance card, that still wouldn't mean we all have access to primary care." A disconcerting thought, to say the least. Especially when our health care system could save $67 billion annually if every American used primary care, according to the study "Access Granted: The Primary Care Payoff" developed by NACHC, the

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LETTERS TO THE EDITOR

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Letter from the Publisher and Editor

Dear Reader,

The audit of health care providers by governmental entities is a hot topic. One hospital CEO told me he saw the State Auditor's Office "Performance Audits" as *the* biggest issue facing Washington hospitals over the next few years. Separately, a hospital CFO told me his recent governmental audit will recommend his facility "get smaller" because of its poor financial condition.

The most chilling audit on the horizon is the CMS Medicare Recovery Audit Contractor (RAC) program audits scheduled to begin in the Northwest in 2009. These audits are unusual, and many say unfair, because the contracted auditors receive a portion of any overpayments discovered. It is clear that many providers of health care services will need to engage third party resources to help weather this storm.

Due to the significant impact the RAC program audits will have on northwest health care organizations we have prepared a special section on pages 8 through 16 of this month's edition. We asked three prominent firms to provide an overview of the RAC program and summarize how health care providers should prepare themselves. We are aware some of the content is duplicative but believe the presentation is necessary to allow the authors to provide background that will segue into their view on how organizations can best prepare themselves for these RAC program audits.

Our various governmental entities have the audit bug and won't stop any time soon. Fortunately there is help available and if you haven't already engaged a third party firm to help your organization with the impending RAC program onslaught then contact one of our authors.

David Peel, Publisher and Editor

Washington Healthcare News 2008 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2008	Healthcare Public Policy	December 3, 2007	December 21, 2007
February 2008	Urban Medical Clinics	January 7, 2008	January 25, 2008
March 2008	Rural Hospitals	February 4, 2008	February 22, 2008
April 2008	Insurance Carriers	March 3, 2008	March 21, 2008
May 2008	Healthcare IT	April 7, 2008	April 25, 2008
June 2008	Rural Medical Clinics	May 5, 2008	May 23, 2008
July 2008	Healthcare Facilities	June 2, 2008	June 22, 2008
August 2008	Healthcare Human Resources	July 7, 2008	July 25, 2008
September 2008	Community Health Centers	August 4, 2008	August 22, 2008
October 2008	Third Party Administrators	September 8, 2008	September 26, 2008
November 2008	Insurance Brokers and Agents	October 6, 2008	October 24, 2008
December 2008	Urban Hospitals	November 3, 2008	November 21, 2008

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Community Health Centers Proffer a Comprehensive Plan to Provide Care

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Robert Graham Center and Capital Link.

It's all in the numbers.

Relevant points like access to care become lost in the furor when the numbers of uninsured and underinsured continue to increase. We've all seen the 47 million number related to our uninsured population. Now an online article in the journal *Health Affairs* delivers a startling new number. According to their data analysis of a 2007 Commonwealth Fund survey, the number of underinsured increased 60% to 25 million in the years between 2003 and 2007.

With cries of those millions echoing at every level of government, politicians and think tanks are cranking out plans faster than gas prices rise. However, the ACCESS Plan takes an existing system, proven necessary and successful (health centers saved our health care system up to $18 billion last year alone) and expands upon it. Ambitiously, the plan estimates not only expanding access to more than 30 million Americans by 2015, but also simultaneously saving our health care system up to $40 billion annually by that time as well.

What kind of investment are we talking about? By fiscal year 2015, increases of 12-15% a year in federal appropriations will allow health centers to serve 30 million patients with just more than twice their current $2 billion in annual funding. After that, if appropriations can continue at fifteen percent growth, the plan envisions that by 2020, Health Center patients will total 44 million. But the ultimate goal is that by 2026, they will serve **all** medically disenfranchised patients. The funding not only covers care, but also critical needs such as investment in health information technology (HIT), facility construction and renovation, as well as loans and loan guarantees. When you examine the initiative's growth plan, then set it against the more than $2 trillion spent on health care in 2007, the 47 million uninsured, and the 25 million underinsured, the appeal seems eminently reasonable.

In addition to saving our health care system billions, the expansion further contributes to the economic well-being of the communities fortunate enough to have a CHC, according to the study "Access Granted: The Primary Care Payoff." It's notable that the direct (employment, purchasing power) and indirect (vendors purchasing from vendors) already equals an economic impact of $12.6 billion. In the *Washington Healthcare News* regional distribution alone, the total economic impact of Alaska, Idaho, Montana, Oregon and Washington's CHCs totaled over $1 billion

(based on 2005 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS).

ACCESS is not just an acronym.

Integral to the plan is the ability to expand primary care through workforce development, which addresses the primary care physician shortage in the health center arena, symptomatic of our growing national primary care physician shortage. Part of the plan calls for the National Health Service Corps to be reauthorized and expanded, as well as expanding certain Title VII & VIII health training programs. The final portion of the workforce plan calls for Health Centers to recruit and

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retain health care personnel from their own communities. In this area, NACHC again can draw on successes of many of its member organizations, such as Anderson's RiverStone Health.

The organization already applies many of the "Grow Our Own" principles to its workforce development. Nearly 13 years old, their Montana Family Medicine Residency, is one of sixteen Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) residency programs affiliated with the University of Washington's Department of Family Medicine. Montana's program is recognized as a Center of Excellence in health professional education.

The Montana Family Medicine Residency Program, the only graduate medical education program in Montana, addresses the state's physician shortage. The program has as many as 18 residents at any one time, accepting six new medical school graduates each year. Since the program's inception, 70% of the 59 graduates to date – all who passed the Board Certification Exam - began their first practice in Montana. Clinical rotations in CHCs and the two regional health care facilities prepare the participants for practice in a rural setting. Additionally, the recruitment program takes into account the lifestyle of the individual, finding that those with a propensity for community service are more likely to lean toward a profession in the CHCs. These residency graduates are the physicians we all want –doctors who strive for the opportunity to make a direct impact in people's lives. Anderson asserts, "If we can educate them in primary care, then we can recruit, retain and help them find satisfaction working within a Community Health Center or rural practice."

Getting a new perspective.

The ACCESS for All America Plan is ambitious yet commonsensical. When asked if the association is making inroads with policymakers to get the initiative heard and to receive serious consideration, Anderson said "Absolutely." She says there is very positive bi-partisan support and reception of the plan when they present it, because it is a comprehensive plan. "It's a plan based in prevention and primary care – improving health up front instead of spending money on the back end."

When discussing the barriers to care and the cost of coverage, Anderson emphasized the difference between the two, "Health care is a way of life issue. Eating right, exercising, visiting your doctor regularly – that type of commitment needs to be separate from the reimbursement discussion. Perhaps then we could get a little closer to some real solutions." It's difficult, she acknowledges, because an investment in prevention, while logical, is hard to measure for success. "It's almost like trying to measure a negative, because you're trying to measure something you're preventing." In a world where an immediate measurable return on investment is the modus operandi, such a shift in perspective is challenging.

"The difficulty is that right now our system is based on paying for the most expensive care after you're sick instead of paying for preventive care when you're healthy." Like any investment, you pay up front and reap the benefits over the long term.

The fact is, CHCs already play a vital role in our health care system, and if the National Association of Community Health Centers (NACHC) can forge the way, they'll be at the forefront of a much needed solution. Providing a health care home, one that puts care first – primary, proactive, preventive care. That's payoff.

For more information on the ACCESS for All America Plan and related studies, visit nachc.com. The Washington Healthcare News thanks NACHC and NACHC Board Chair Lil Anderson for their time and provision of organizational reference materials.

Nora Haile is a contributing editor to the Washington Healthcare News, as well as principal and owner of NHaile Solutions, LLC, a communications services firm in Seattle, WA. She can be reached at nora@nhaile.com.

Recovery Audit Contractors Are Not Going Away… Will Your Facility Survive the Assault?

By Donna Herbert
President and Founder
Financial Consultants of Alaska and Washington

Medicare processes approximately 1.3 billion claims annually, and it is estimated that 4% of Medicare dollars are paid based on claims that are not in compliance with Medicare coverage, billing, coding, and payment regulations. The federal government estimates **$10.8 billion** in Medicare dollars are **paid improperly**. To help curb the tide of improper payments, Congress authorized the Recovery Audit Program. As an incentive to recover fraudulently paid claims, the auditors are paid a 20% contingency fee based on overpayments collected.

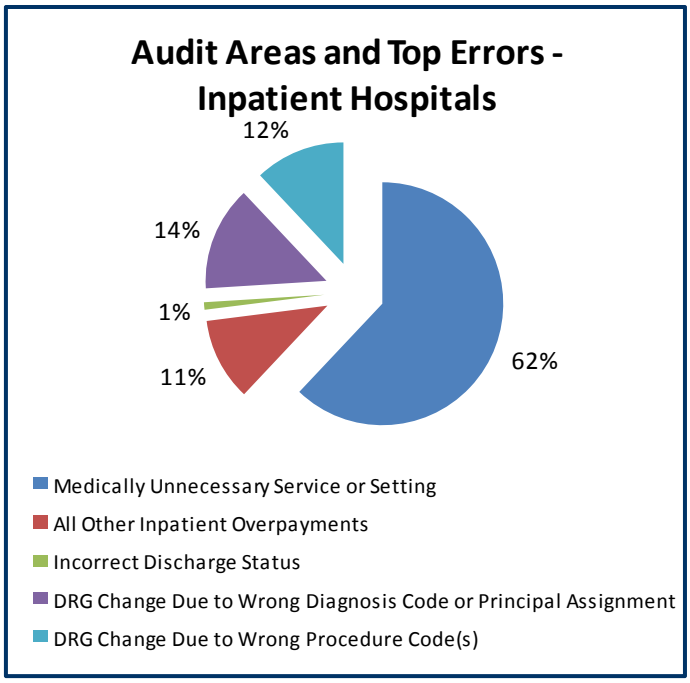
RESULTS OF RAC FRAUD AUDIT 2004-2007 (millions)	
Overpayments Collected	**$992.7**
Less: Underpayments Repaid	**$37.8**
Overturned on Appeal	**$46.0**
RAC Re-reviews	**$14.0**
Cost to Run Program	**$201.3**
Returned to Medicare Trust Fund	**$693.6**

Results from the Recovery Auditors demonstrate more monies were recovered in 2007 than in 2004-2006 combined. Fraud audits are not going away but instead aggressively gaining momentum. The results from the RAC audits have demonstrated to Congress that fraud audits are bringing home the bacon, just as Congress has major pressure to control the health care budget. **CMS has accelerated the Audit timetables and requested RACs begin reviewing claims in all 50 states by late 2008.**

Facilities need to be aware there are multiple layers of fraud audits. Health care providers enrolled in Medicare and Medicaid programs can be audited by multiple agencies: Federal, State, third party payers and contractors. There are ten separate fraud audit programs in process, with more fraud programs added each month.

Due to the multiple layers of audits, providers should expect over-lapping audits, changing standards, and procedural issues. Each of the audits has different time lines for filing an appeal. **Providers need to be vigilant so they don't miss an appeal deadline.**

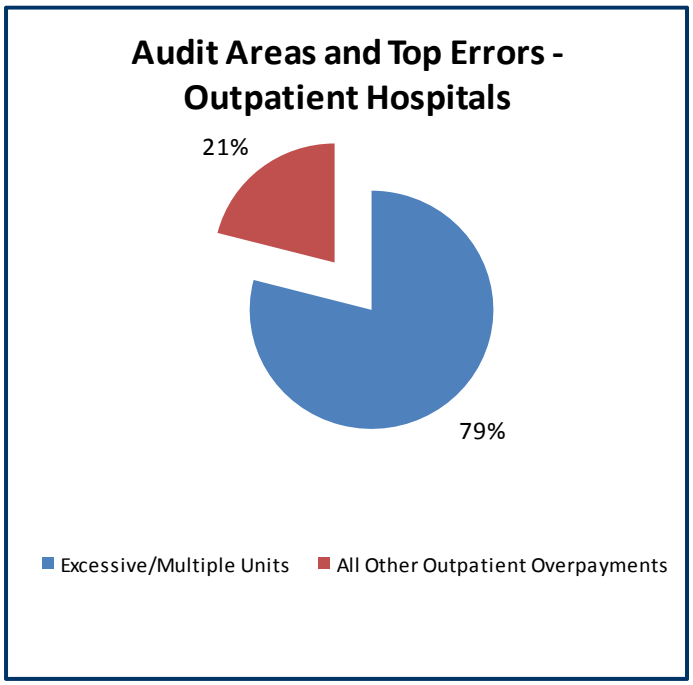
The RACs were given nearly 1.2 billion claims to review. Inpatient hospitals represented 85% of overpayments. Rehabilitation represented 6%, SNF 2%, Outpatient hospitals 4%, Physicians 2% and other facilities 1%.



Inpatient Focus on Audits:

- Medical necessity
- Observation and admissions

- Transfers and discharges
- One-day stays
- Lack of documentation
- Extensive OR procedures unmatched to principal diagnosis
- Inpatient procedures eligible for outpatient surgical setting
- Unbundling procedure codes to obtain additional reimbursement
- Excisional debridement
- Joint replacement surgery
- Heart failure and shock
- Drugs and biologicals
- Chest pain/back pain
- Billing for items/services before they were delivered/performed
- Billing for non-covered services under a covered procedure code



Outpatient Focus on Audits:

- Excess units
- Multiple claims
- Speech & therapy claims
- Infusion therapy

Critical Access Facilities **are included** in the current Recovery Fraud Audits. One of the areas being focused on in CAH hospitals is observation. Are CAHs admitting patients to observation in order to stay under the 25 bed rule and the 96 hour average? Are providers using observation as overflow units?

One day stays in CAHs are closely monitored, as are the three day qualifying hospital stays prior to admission to a SNF unit. Small facilities are often cited for lack of documentation.

For small rural facilities and CAHs with fewer than 100 employees, overpayments collected on fraud audits averaged just over $1 million.

For just a fraction of the amount being recovered through RAC repayments, a facility can be proactive and avoid being targeted by establishing the necessary internal mechanisms. It has proven to be cost effective to invest in a solid compliance plan, hire an outside expert to conduct external audits, and create a training program for all employees, physicians, and board members. Spend your money to protect yourself not on contingency fees to RACs.

APPEALS

Bear in mind $46 million in claims deemed overpayments in the fraud audits were successfully appealed by the providers. The number of cases appealed and won increases as second and third quarter statistics are added. RACs rely on their data mining programs and often do not look at the medical records or other documentation. The rationale for medical necessity, appropriate setting, and correct coding often cannot be seen without the medical record. **Providers should always appeal any valid claims.**

For compliance and our tips and experience on Fraud Audits see our future articles in the winter editions of the *Washington Healthcare News*.

Donna Herbert is the founder of Financial Consultants of Alaska & Washington (FCAW). Since 1979, she has provided advice and counsel to health care providers in both Alaska and Washington concerning all aspects of budget, finance, and preparation of third-party cost reports. She can be reached at 907-790-1026 or by email at fcaw@fcawreimbursement.com

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It's Here to Stay: The 2009 RAC Program Roll Out

Dana L. Kenny
Health Care Attorney and Partner
Miller Nash LLP

The Centers for Medicare and Medicaid Services ("CMS") is calling the new Recovery Audit Contractor ("RAC") program a success. Billed as a cost-effective way to assess Medicare overpayments and underpayments, and costing about 20 cents on the dollar, the RAC three-state demonstration program infused the Medicare trust fund with an additional $247.4 million in 2007 alone. With these numbers, it's no wonder that CMS and Congress are pushing to implement the RAC program to all 50 states by 2010. For providers, the RAC program underscores the importance of an active compliance program with focus on ongoing monitoring and review of target areas.

Background

In 2005, Congress passed Section 306 of the Medicare Modernization Act, requiring a demonstration project to assess the accuracy of Medicare payments made to health care providers. CMS was required to use the services of RACs to review Medicare and Medicaid payments made to health care providers, looking for both overpayments and underpayments. Overpayments were to be recovered and placed into the Medicare trust fund; underpayments could be recovered by providers.

> ***"CMS revealed that RACs had collected $1.03 billion in improper payments during the three-year demonstration program: $992.7 million in overpayments and $37.8 million in underpayments."***
>
> Dana L. Kenny
> Health Care Attorney and Partner
> Miller Nash LLP

The project involved a three-year demonstration in three states: New York, California, and Florida. While the demonstration project was still underway, Congress directed the Department of Health and Human Services to make the RAC program permanent and nationwide by 2010. In order to meet the 2010 deadline, CMS will implement the RAC program in phases.

The Three-State Demonstration Program

In July 2008, CMS released a status update detailing the progress of the demonstration program wrapping up in New York, California, and Florida. CMS revealed that RACs had collected $1.03 billion in improper payments during the three-year demonstration program: $992.7 million in overpayments and $37.8 million in underpayments. After expenses, appeals, and underpayments repaid to providers, the program returned $693.6 million to the Medicare Trust Fund. According to CMS, hospitals accounted for 95% of overpayments collected by RACs, with 85% from inpatient services, 4% from outpatient services, and 6% from inpatient rehabilitation facilities.

CMS identified the three most common causes of improper payments:

- Payments made for services that were not medically necessary. Targets:
  - ✓ Inpatient admissions for procedures eligible for outpatient surgery
  - ✓ One-day stays
  - ✓ Three-day stays to qualify for skilled nursing facility care
  - ✓ Inpatient rehabilitation

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- Payments made for services that were incorrectly coded. Targets:
  - ✓ Debridement
  - ✓ DRGs designated as complicated or having co-morbidity with only one secondary diagnosis
  - ✓ Correct coding of discharge status for post-acute-care transfer
  - ✓ Unit coding
- Failure to submit documentation when requested or failure to submit enough documentation to support a claim.

Changes to the Permanent RAC Program

The demonstration program has been sharply criticized. Troubling for health care providers in the demonstration program was the fact that RACs were paid on a contingent-fee basis. RACs received a portion of the overpayments they discovered and recovered even if their determination was ultimately overruled. Additionally, RACs were not required to engage the services of a medical director when assessing medical necessity claims. Fortunately, some positive changes have been made in time for the Washington RAC program.

Washington's 2009 Rollout

Come January of 2009, it's Washington's turn. Following are some of the changes that will be made to the RAC program before it hits the Evergreen State:

- RACs will no longer receive their contingency fee when a denial is later overturned.
- RACs will be required to have a medical director to handle medical necessity questions.
- RACs will be able to look back for improper payments for up to three years.
- No claims with a payment date before October 1, 2007, will be reviewed.
- There will be new limits on the number of medical records that RACs can request in any given month.

Preparation

In the meantime, providers should be preparing for the RAC program by focusing on ongoing compliance monitoring and review, such as audits, particularly in the target areas described above. In addition, the American Hospital Association has identified proactive ways to prepare for the RAC program:

- Establish an internal RAC team with coding, financial, and clinical team members.
- Establish a point of contact for both internal and external RAC communications.
- Establish a tracking system for all RAC correspondence.
- Take advantage of RAC training opportunities.
- Identify potential problems through self-audit.

Additionally, CMS has implemented new programs to help health care providers adjust to the RAC program. A RAC-specific email account is now up and running. The email account is aimed at addressing individual physician questions. CMS and the RACs will conduct provider outreach with visits to local health care providers. Also, CMS, the American Medical Association, the Washington State Medical Association, and the Washington State Hospital Association will be offering educational opportunities to address concerns.

Preparation for the RAC program may seem daunting for providers. Given that claims after October 1, 2007, may be reviewed, providers should focus efforts now on proactively engaging in ongoing monitoring to ensure accuracy of admission, documentation, coding, and billing practices.

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Are You RAC-Ready?

By Barbara Derry, BSN, FACMPE
Crystal Nolan, MHA, FACMPE
Melania Antonio, CPC
Derry, Nolan & Associates

Between 2005 and 2008, the CMS' Recovery Audit Contractors (RAC) demonstration program has recouped $693.6M for the Medicare Trust Fund from three states alone – California, Florida and New York.[i] Now permanent, the program has extended its reach with Washington, Idaho and Oregon slated for inclusion by January 2009 and all other states to follow by 2010. This is the first time that CMS has ever paid a contractor on a contingency-fee basis for claim review and over-payment collection work**.**

In spite of the apparent success of the RAC program and its likely longevity, H.R. Bill 4105, the Medicare Recovery Audit Contractor Program Moratorium Act attempts to affect a one-year moratorium, which seems unlikely. One reason RAC is not going away is that CMS costs, including the contingency fees, are down to approximately 20 cents for every dollar collected.[ii] This type of excellent return on investment is one that physician practices can only dream of reaching due to high costs of labor, employee benefits, malpractice insurance and declining reimbursement from payors. Approximately $2.8 billion, or 3.9%, of Medicare dollars paid did not comply with Medicare coverage, coding, billing or payment rules, according to the November 2007 Medicare Fee For Service Payments Report. Of the overpayments, inpatient hospitals and SNFs comprise 87%, outpatient hospitals 6%, physician practices 2%, Ambulatory, Lab, DME and other at 4%. This is the government's third largest payment error, behind Medicaid ($12.9 billion) and Income Tax ($11.4 billion) respectively.

While 2% may lead physicians to be less concerned about the RAC process, consider this: In the three states cited above, fiscal year 2007 cost the physician sector **$12.2 million in paybacks**, with $4.8 million of that **due to incorrectly coded claims**. The RAC DataWarehouse shows that the top physician services targeted by RAC were pharmaceutical injectables (CA), duplicate claims (CA) and vestibular function tests (FL). We must assume that CMS will target similar or the same services in its extended program, which means specialty practices should be on alert. For instance, an Oncology practice, due to its high incidence of IV Infusions and medication use, could expect close scrutiny for appropriate units of medication and for following medical necessity guidelines. It's important to mention that the RAC auditors appear to be focusing on the same risk areas identified in the Office of Inspector General's work plan.

The audits are not usually done in person but rather through mail and remote dialogue. The RAC auditors use proprietary software and their in-depth knowledge of Medicare's rules and regulations to perform their work. Certified Coders handle coding reviews and Registered Nurses or therapists conduct Medical Necessity Reviews.

To prepare for RAC's arrival in Washington and Oregon, it is imperative that physician practices undertake internal and external billing audits **now** – from registration to reimbursement. A proactive approach reduces compliance risks of overpayment "take backs" that ultimately affect cash flow. Our top eight suggestions:

1. Conduct random chart sampling. Does physician documentation support the E&M level? Check consultations, drugs and procedures billed.
2. Conduct an internal claim and revenue cycle review on high-risk claims.
3. Compare physician/provider coding utilization patterns with peers.
4. Audit duplicate claim processing and fix the problems.

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Are You RAC-Ready?

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5. Create a dynamic audit response team that includes a content expert in CMS billing rules for your specialty.
6. Implement corrective action: educate, educate, educate.
7. Re-audit and sustain process changes.
8. Self-disclose to CMS if you discover billing errors. Beat RAC to the issue.

with the assigned auditor, and have a single point-of-contact who owns and tracks all communications. Work with your legal counsel to make the decision to accept or appeal RAC's findings.

The RAC June 2008 report stated providers chose to appeal 14% of the RAC determinations. Of the 73,000 claims appealed, 33% resulted in decisions favorable to the provider. Given this relatively high success rate it is important to become familiar with the appeal process.

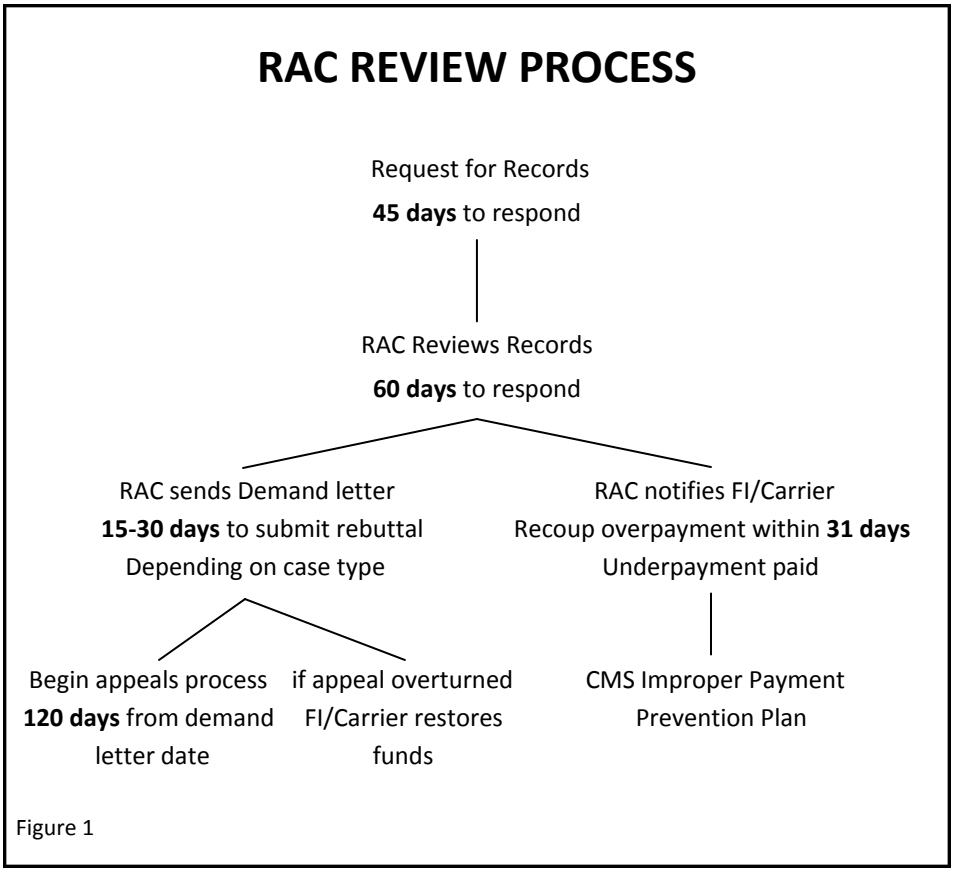

Figure 1

Pre-audits are only part of the preparation. Figure 1 illustrates the RAC review process. Staff needs to know how important it is to respond timely to RAC requests. Develop a friendly and professional communication style

However, the five-step appeal process is onerous: Redetermination, Reconsideration, Involvement of an Administrative Law Judge, Medicare Appeal Council, and Federal Court Review.[iii]

Michael Leavitt (DHHS Secretary) says there are three ways to approach change: "You can fight it and fail, accept it and survive or lead it and prosper." If your organization's leaders decide to be proactive in auditing providers' charge, coding documentation and revenue cycle for accuracy, then they are of the third type. And that means the RAC initiative has served a good purpose: to promote getting your claims billed correctly the **first** time by knowing your data. Investing in prevention, rather than defense, is a much better use of your precious and limited resources.

Barbara Derry, Crystal Nolan and Melania Antonio of Derry, Nolan & Associates help Pacific Northwest medical practices, clinics and other health care organizations improve operational and financial health. The firm's proven health care and practice management methods focus on using resources effectively to drive profitability. Visit www.derrynolan.com or call 425.774.4893 to schedule your free, one-hour initial consultation.

[i] www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf. June 2008, page 2.

[ii] Ibid., page 3.

[iii] HCPRO, Inc., "Revenue Cycle Management Practice", William Malm, ND, RN, May 2008, pages 1-8.

Download the supporting diagram "Revenue Cycle Risk Management" at www.derrynolan.com/sitenews/media.php.

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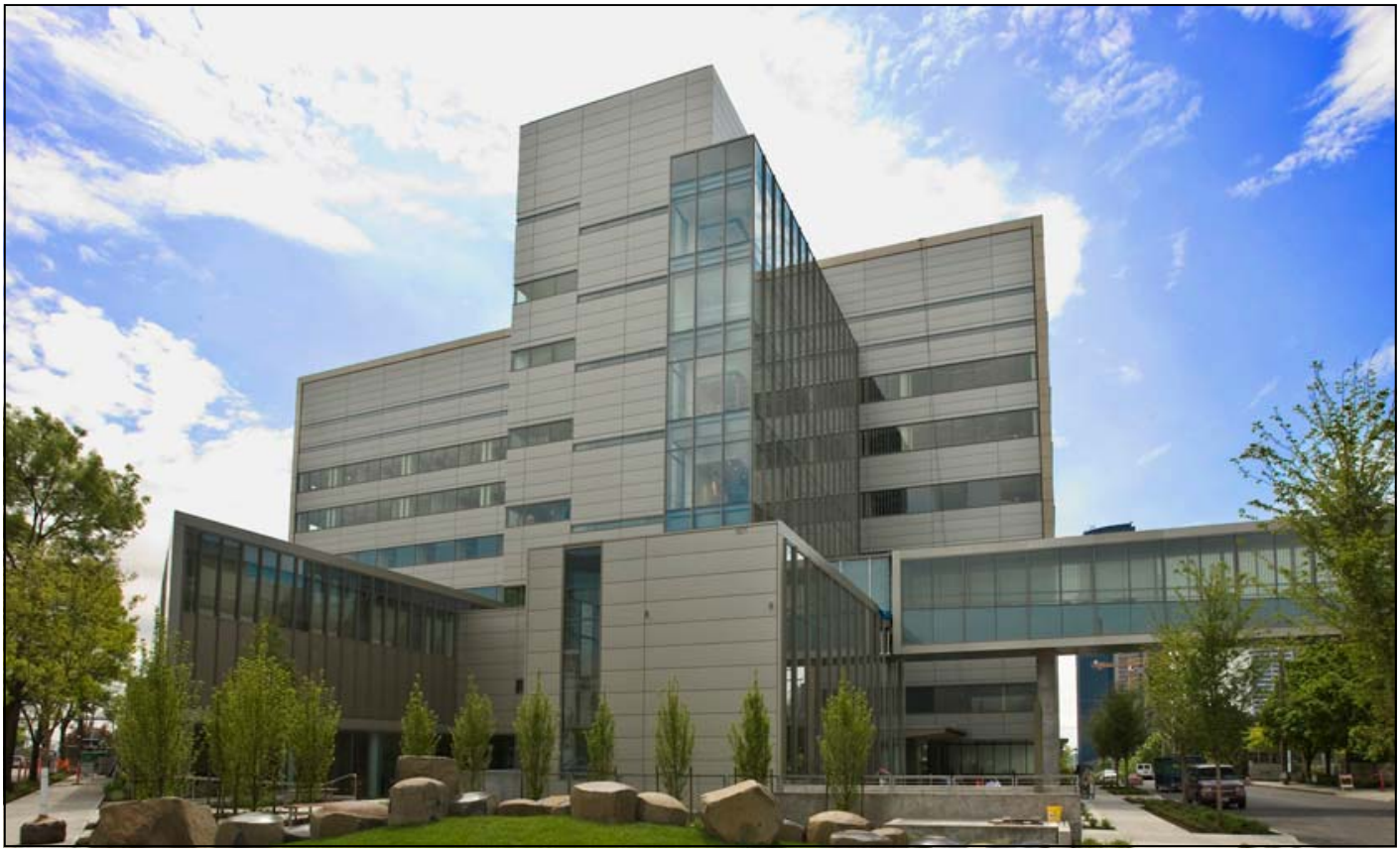
Swedish Orthopedic Institute – a "One Stop Shop" for Orthopedic Resources

By Roberta Greenwood
Contributing Writer

Prominently located on First Hill in Seattle at 601 Broadway, Swedish Orthopedic Institute (SOI) opened its doors on June 23rd, 2008. This innovative facility, celebrated for its fully integrated approach, has seven clinical floors, ten operating rooms, and eighty-four inpatient rooms. As such, SOI is the largest orthopedic specialty center in the Northwest region and one of the largest in the nation.

According to Dr. James Crutcher, chief of the Department of Orthopedics at Swedish, SOI meets the needs of a burgeoning, aging population. "Northwest people are active," Crutcher says, "and they want to continue to be active." With the demand for orthopedic surgical procedures growing – especially knee and hip replacements, Crutcher says this "specialty center" will provide an enhanced arena for high volume surgeries and procedures. Twenty-five to thirty procedures are expected to be conducted daily, across a wide array of orthopedic needs, with more than fifty-four surgeons affiliated with the institute. Heidi Aylsworth, SOI administrative director, emphasizes that SOI was constructed so that all relevant health-care teams can work together easily. "We had an incredible team – physicians, staff, patients – working together to design a facility that would speed recovery and increase patient satisfaction," she explains.

Please see> Swedish, P22



The Swedish Orthopedic Institute Facility in Seattle, WA

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Affordable Health Insurance: Why Are Any of Us Uninsured?

By Sue Ferrari
Client Service Manager
FCG Benefits

In the United States, health care and subsequently health insurance cost too much. The potential solutions being debated are very complex. However, while there are many reform proposals and even more political opinions, this much is clear: there are a large number of very good and very affordable health insurance policies available to any resident of the State of Washington who cares to apply and can afford a small premium.

Could a solution be that simple? Please hear me out…

The Individual Health Care publication from the Office of the Insurance Commissioner (found online at: http://www.insurance.wa.gov/publications/index.shtml#health/) shows more than 100 policies available with many having premiums below $100 per month. There are 11 Lifewise policies, 19 Regence Blue Shield, 17 Asuris Northwest, 7 Premera, 8 Group Health Cooperative, and 28 Kitsap Physician Service policies.

For those living in border counties, there are 15 Regence of Oregon and 2 Regence Blue Shield of Idaho policies. If you visit this website, notice how all the premiums are published! These are individual – not group – medical policies. They have age-rated premiums that are regulated by the State. You personally own the coverage and your rate increases are identical to everyone else with the same policy. You cannot be charged more or cancelled because of your health.

> ***"Individual policies and HRAs are surprisingly overlooked as a solution for many who are going without coverage and are one health crises away from bankruptcy."***
>
> Sue Ferrari
> Client Service Manager
> FCG Benefits

According to the 2007 Employer Health Benefits Survey from the Kaiser Foundation, the average annual premium for single (employee only) coverage under employer-sponsored group plans is $4,479 and $12,106 for a family. With individual policies, however, the average is $1,776 for single coverage and $4,128 for a family.

So why are so few people covered by these policies?

First, individual policies are not the same as group plans. Though individual policies are significantly better these days, they still are not quite as rich as group plans in certain areas – like prescriptions. Second, few insurance agents or brokers promote individual policies. My firm only started servicing individual policies 5 years ago as a way to help employees who could not afford group COBRA premiums. Lastly, and of most significance, individual policies are medically underwritten. That means unless you qualify for an exemption (and many people do), you must complete the State of Washington's Standard Health Questionnaire and are subject to approval by the insurer. Group plans can't do that, and that is the primary reason they cost so much more than individual policies.

Still, only 8% of applicants were declined for an individual policy in 2007, and those who are denied due to poor health immediately qualify for the Washington State Health Insurance Pool.

This is all great, but most people get health coverage through their employer. Yet the costly burden of group coverage is forcing many employers to cut benefits, pass on ever increasing payroll deductions, or drop their group plan entirely. This is where the far less expensive individual policies may come into play.

Here is what most employers suffocating beneath group medical premiums don't know: Health Reimbursement Arrangements allow employers to claim the

same tax advantages on individual policies as they have always taken with ERISA qualified group plans (IRS Notice 2002-45).

There are restrictions, but the HRAs are designed to allow an employer to set a fixed monthly contribution (for example $300/month), write it off, and allow employees to choose their own individual policy that meets their needs. No group plan, no renewal, no medical premium increases for the employer!

The use of individual policies is, of course, not a complete solution to the health insurance crisis and will not work for everyone. But individual policies and HRAs are surprisingly overlooked as a solution for many who are going without coverage and are one health crisis away from bankruptcy.

I encourage anyone who is interested to review the Washington State Insurance Commissioner's website at www.insurance.wa.gov. Click on *Consumers* then *Helpful Publications*.

If you would like to compare specific policies and apply online then visit www.fcgbenefits.com/personalhealth.php. This is my company's website and it's a great place to start.

Sue Ferrari, Client Service Manager of FCG Benefits, specializes in Employee Benefits and Individual Health Insurance. She can be reached at sue@fcgbenefits.com.

Swedish Orthopedic Institute – a "One Stop Shop" for Orthopedic Resources

<Swedish

From page 18

"What we're seeing, even in our first days of operation, are patients discharging on day three who are more alert, more active and ready to go home."

The architectural firm NBBJ designed the eleven-story, 372,000 SF facility so as to provide a "one stop shop" – patients are offered pre-surgical education and training, surgery, in-patient care, and after-care – without the need to transfer to another facility. "We have many mobility challenged patients," Aylsworth explains. "The efficiency of this building is extremely helpful in their recovery." In addition to the eighty-four inpatient beds and ten operating rooms, there are fifteen pre-operating/stage 2 recovery beds, thirteen post-anesthesia care unit beds, an outpatient pharmacy, conference rooms, café and parking structure. A centralized clinical communication center encourages staff communication and collaboration while the building design provides nearly all patients and staff access to natural light, which speeds healing.

Aylsworth stresses the state-of-the-art care available at the facility will increase its value to patients and staff as well. "We promised the community a dedicated facility that represents the gold standard in orthopedic care and we've created exactly that. Physicians and staff here will have access to the latest in medical technology and information systems in an efficient yet patient-centered environment." Vocera, a communication technology that allows each physician and staff member to communicate without the need of a cell phone or pager, increases the accessibility of all team members while patients have access to clinical education and training. Built on a birthing suite model, patients and their families rest in light-infused surroundings; rooms include a full-size sleeping couch, wireless internet service access, DVD players, flat-screen TV's and room service-style food delivery. Even the flooring was designed to encourage recovery; distance markers are incorporated into the surface, allowing patients to measure how far they walk during recovery. The physical therapy suite includes a gym that's similar to any fitness gym, states Aylsworth, and windows on all four walls increase patient satisfaction and usage. "We're seeing an increase in socialization – which again, leads to increased patient satisfaction and speeds recovery," she says. Noise levels (the number one complaint of patients surveyed) have been reduced through increased acoustical ratings between rooms and other structural features.

Designed in accordance with the Green Guidelines for Healthcare, SOI was built using sustainable material, increasing efficiency and lowering energy costs and the pre-fabricated metal is 100% reusable. "From every standpoint, SOI is one of the most sophisticated health care facilities on the West Coast," says Kristina Ryhn, NBBJ's lead architect on the project. "State-of-the-art technology is coupled with standardized room planning to advance patient care and safety, while daylight-infused spaces, natural materials and rich colors enhance the experience for patients and their families."

With more than 5,000 orthopedic-related surgeries performed annually (including 2,200 joint replacements and 1,800 spine cases) the need for a specialty center in Seattle became increasingly clear. "There's new evidence coming out in the medical literature showing that patients at specialized orthopedic facilities have better clinical outcomes," explains Crutcher. Additionally, Crutcher notes that Swedish will now better showcase its orthopedic expertise on a national scale – enhancing staff recruitment and increasing outcomes-based research.

"The connections felt between our physicians, staff and patients demonstrate what the efficiency of this building provides," concludes Aylsworth. "Delivered on time and on budget, SOI combined the talents and skills of all our partners to design and deliver comprehensive, innovative, personalized care for patients seeking orthopedic procedures in the Pacific Northwest."

Roberta Greenwood is a contributing writer and can be reached at rgreenwood@wahcnews.com.

New or Recently Promoted Healthcare Leaders

Last Name	Middle Name	First Name	Title	Effective Date	Organization	New or Promoted Leader
Albano SPHR		Valerie	Director, Human Resources	03/08	The Regional Hospital	Promoted
AuBuchon MD	P.	James	President and CEO	09/08	Puget Sound Blood Center	New
Batayola		Teresita	Chief Executive Officer	04/08	International Community Health Services	Promoted
Brooks		Sandra	Director Emergency Trauma Services	05/08	PeaceHealth St. Joseph Hospital	New
Brown MD	J.	George	President and CEO	09/08	Legacy Health System	New
Clark		Elizabeth	Executive Director Cardiovascular Services	05/08	PeaceHealth St. Joseph Hospital	New
Dooley		Meta	SVP, Strategic Planning & Bus. Dev.	07/08	Franciscan Health System	New
Feng		Yuwei	Clinic Operations Director	04/08	International Community Health Services	Promoted
Hensley		Jonathan	President	08/08	Regence BlueShield & Asuris Northwest Health	New
Jacobs		Janelle	Quality Improvement Director	04/08	International Community Health Services	Promoted
Klein		Cindy	VP, Human Resources	06/08	PeaceHealth St. Joseph Hospital	New
Laine MD		Erick	VP, PeaceHealth Med. Grp. Whatcom Reg.	07/08	PeaceHealth Whatcom Region	New
Lavizzo MD		Evelyn	Administrative Director	07/08	Odessa Brown Children's Clinic	New
Lee		Cheryl	Controller	04/08	International Community Health Services	Promoted
McKee		Michael	Health Services Director	04/08	International Community Health Services	Promoted
Shahbazian		Hermes	Chief Finance Officer	04/08	International Community Health Services	Promoted
Whalen MHA		Eileen	Executive Director	10/08	Harborview Medical Center	New

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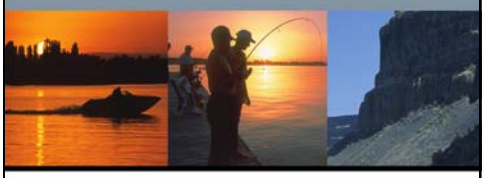

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Charge Capture Coding Business Analyst

The Charge Capture Coding Business Analyst is responsible for documenting and evaluating charge capture work flow processes and coding requirements. Maintains a detailed understanding of current systems, system tools, and business policies in order to improve the accuracy and efficiency of the charge capture phase of the revenue cycle.

Requirements: A Bachelor's degree or minimum of five years of operational business experience in charge capture processing and charge edit management in an academic health care environment. Comprehensive system knowledge of medical billing systems and processes related to patient accounts, claim form requirements, coding rules and fee schedules.

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

ICHS International Community Health Services

Medical Director

International Community Health Services (ICHS) is recruiting for a Medical Director to plan, lead, direct and manage our primary medical services, including Acupuncture, Chinese Traditional Medicine clinic, laboratories, and pharmacies. This position reports to the Chief Executive Officer and is a member of the Executive Leadership for the agency.

ICHS is a non-profit medical and dental community health center serving Asian and Pacific Islander (API) populations and other communities in Seattle and King County. ICHS is the largest API community health center in Washington State and serves over 15,000 patients each year and employs 250 people.

ICHS operates two medical and dental clinics, one in the International District and another in Holly Park.

The ideal candidate for this position must possess passion and commitment to community and public health; highly-developed interpersonal and communications skills and can effectively work with people from diverse cultural and socio-economic backgrounds; minimum three years management/ administrative experience; ability to lead a team of diverse health care providers; experience developing, implementing and assuring compliance with clinical protocols; collaborative leadership qualities; experience in leading multi-disciplinary clinical teams; current Washington State MD license in good standing; and experience working with API communities preferred.

Please send CV to ICHS, Attn: Human Resources, P O Box 3007, Seattle, WA 98114-3007; FAX 206.490.4011, or e mail to charlesh@ichs.com

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Chief Financial Officer

Community Health Center (CHC) of Snohomish County seeks a dynamic Chief Financial Officer to provide financial leadership for our rapidly growing and highly successful practice network of medical clinics, dental clinics and on site pharmacies. As a member of the Directors Team, the CFO contributes to the successful achievement of the organization's mission and strategic initiatives by providing leadership, direction and oversight for Accounting, Payroll, Patient Accounts, Purchasing and Information Systems.

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Preferred: Master's degree in Finance, Accounting or related field; CPA; Experience in medical group practice or community health center; experience and knowledge of Federal/State tax guidelines and laws as they relate to non-profit organizations; familiarity with grant funding; Certified Healthcare Financial Professional (CHFP) and knowledge of Microsoft Dynamics software.

Join a team that loves what it does and cares about those it serves. Community Health Center of Snohomish County is a non-profit organization whose mission is "*to reach out to those who face obstacles to health care and improve the health of our diverse community.*"

CHC offers a competitive salary and benefits package. For immediate consideration, please send cover letter, resume and/or CV to Dewey Miller, Deering and Associates, reachable by e-mail at dewey.miller@comcast.net.

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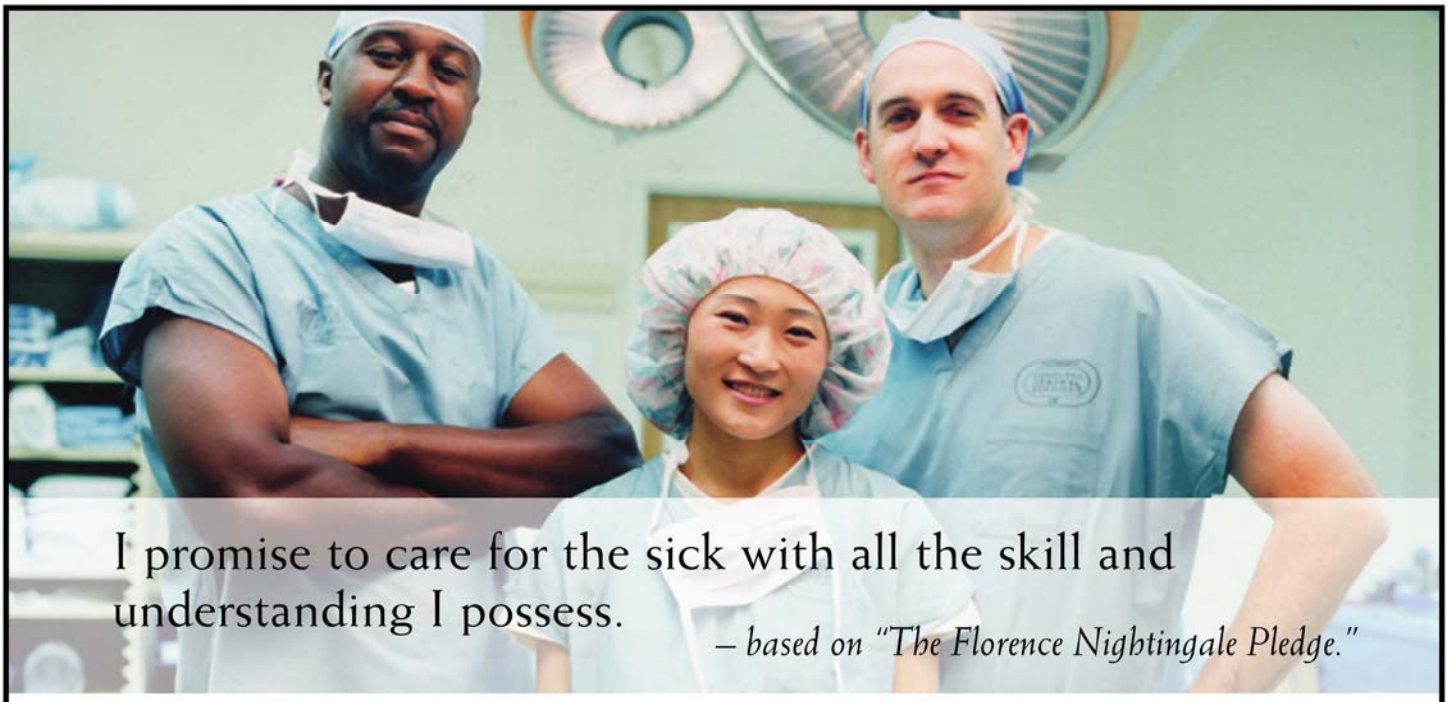

At **Swedish Medical Center** in **Seattle**, our drive to deliver the best care possible goes beyond a commitment we make to our patients. It's a promise we make to ourselves. Our commitment, dedication, and trust in one another give us a powerful foundation, enabling us to feel supported and to make the right decisions. For almost 100 years this is the way we've served our community. As we head into a new era of focused growth, Swedish is looking for leaders who can deliver on that promise.

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- Manager, Neuroscience Research and Education
- Manager, Perinatal Medicine
- Manager, Revenue Coordination
- Manager, Surgical Services – Heart and Vascular Surgery

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Requirements: Bachelor's Degree in Computer Science or related field or equivalent work experience. 2-3 years of supervisory experience managing systems engineers. 5-10 years hands-on experience with Intel server hardware, storage subsystems and back-up systems. 5-10 years of hands-on systems and network administration experience in a diverse enterprise computing environment. Thorough knowledge of MS Windows Server configuration and administration, including TCP/IP networking and protocols is required. Strong project management and mentoring skills.

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Business Analyst/Compliance Data Specialist

The Business Analyst/Compliance Data Specialist (referred to internally as Compliance Data Specialist) is the key position responsible for the organizing, managing and trending data for both project and operational purposes within the UWP Compliance Department. The position is a key resource for the entire compliance team, who will depend on the technical and analytical skills of this position. In addition to these skills, an ideal person in this role will be able to communicate effectively, translating complex data into manageable information. Good planning for & forecasting of needs will minimize the need for tight deadlines, which occur periodically. The successful candidate will have an exciting opportunity to work with data in various formats and sources and will help define this new position for UWP.

Requirements: Bachelor's degree or an equivalent combination of education and experience. Knowledge of medical terminology, CPT, ICD, and HCPCS, in addition to knowledge of payer coding, billing, documentation, and reimbursement standards. Direct experience in a healthcare billing organization preferred. PC Proficiency with Windows based software, Microsoft Office Suite products with proficiency in Microsoft Access and Microsoft Project in a network environment; proficient at Internet research. Knowledge and experience with MD Audit Compliance Data System preferred.

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

Plan and Hospital Financial Information

Financial Results for the 15 Largest Health Plans in the Pacific Northwest (Ranked by Total Revenues)[1]

Plan Name	State of Domicile	Total Revenues Qtr End 03-31-08	Net Income Qtr End 03-31-08	Statutory Capital As of 03-31-08	Enrollment As of 03-31-08
Regence BCBS of Oregon	Oregon	$664,297,147	$12,497,497	$548,550,374	1,011,613
Premera Blue Cross	Washington	$640,285,347	$17,391,917	$775,781,448	711,199
Group Health Cooperative	Washington	$587,664,637	$28,109,047	$726,108,841	397,763
Kaiser Foundation HP of the NW	Oregon	$582,850,617	$6,287,125	$499,062,450	471,903
Regence BlueShield	Washington	$568,759,264	$285,070	$888,050,920	822,735
Blue Cross of Idaho Health Service	Idaho	$246,170,232	$11,148,211	$261,163,325	429,978
Providence Health Plan	Oregon	$215,001,106	$2,891,546	$338,309,273	183,527
Molina Healthcare of Washington	Washington	$175,044,293	$8,318,143	$121,745,281	289,207
Blue Cross Blue Shield of Montana	Montana	$130,291,715	$1,111,145	$144,612,952	229,725
Community Health Plan of WA	Washington	$129,151,418	$1,422,070	$78,834,043	227,328
Regence BlueShield of Idaho	Idaho	$124,914,311	$931,619	$124,629,528	210,793
Pacificsource Health Plans	Oregon	$121,126,455	$785,151	$112,095,216	147,890
PacifiCare of Washington, Inc.	Washington	$117,194,761	$15,965,846	$244,986,575	45,835
Health Net Health Plan of Oregon	Oregon	$104,431,497	$1,575,659	$68,320,647	125,597
LifeWise Health Plan of Oregon	Oregon	$74,446,969	($2,740,257)	$67,511,870	105,236

Financial Results for the 15 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]

Hospital Name	State	Total Charges Qtr End 03-31-08	Total Margin Qtr End 03-31-08	Total Discharges Qtr End 03-31-08	Total Days Qtr End 03-31-08
Swedish Medical Center-Seattle	Washington	$561,587,425	$9,149,369	8,349	36,910
Sacred Heart Medical Ctr.-Spokane	Washington	$391,071,302	$2,804,485	7,931	40,831
Providence St. Vincent Medical Ctr.	Oregon	$308,877,000	$30,000,000	7,850	36,663
OHSU Hospital	Oregon	$382,207,044	$13,346,812	7,198	38,864
Sacred Heart Medical Ctr.-Eugene	Oregon	$199,002,616	$13,446,846	6,686	30,219
Providence Everett Medical Center	Washington	$315,975,769	$5,601,930	6,298	26,651
St. Joseph Medical Center—Tacoma	Washington	$385,415,876	$17,297,432	5,784	24,572
Providence Portland Medical Center	Oregon	$247,235,000	$1,935,000	5,714	26,717
Southwest Washington Medical Ctr.	Washington	$264,391,255	$2,051,919	5,040	21,783
University of Washington Med Ctr.	Washington	$250,246,553	$8,970,394	5,024	28,076
Salem Hospital	Oregon	$182,601,633	$10,147,269	5,018	23,144
Providence St. Peter Hospital	Washington	$242,327,750	$8,983,621	4,961	22,124
Legacy Emanuel Hosp. & Health Ctr.	Oregon	$221,483,935	($1,080,819)	4,837	26,914
Tacoma General Allenmore Hospital	Washington	$408,358,844	$16,572,683	4,600	21,430
Harborview Medical Center	Washington	$295,731,000	$6,989,000	4,543	34,057

[1]Source: National Association of Insurance Commissioners. [2]Sources: Washington State Department of Health, Oregon Health Policy & Research.

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