Washington Healthcare News

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Community Health Centers - Growing from Movement to Mainstream

By Desmond Skubi
Healthcare Consultant

Working with community health centers (CHCs) for the past 25 years has convinced me that the existing health center model should be available to everyone in our country. Such a system includes the following qualities:

- Provides a comprehensive scope of services, allowing providers to integrate medical, dental and behavioral health care and enabling services in a culturally and linguistically appropriate manner, creating a health care home;
- Serves their communities with a special commitment to meeting the needs of medically underserved areas and/or populations;
- Treats patients regardless of ability to pay; and
- Is governed by the patients they serve, ensuring community involvement and the commitment to serving local needs

These attributes define the 22 non-profit community and migrant health centers in Washington State which together serve nearly one out of ten Washington residents.

The community health center movement emerged nationwide in the 1960s when grassroots activists were striving to eliminate discrimination and entrenched disparities in income and health. The CHC movement developed similarly in two areas of Washington State. Carolyn Downs Family Medical Center was originally part of a broad spectrum of community services overseen and developed by the Seattle Black Panther party. Other clinics (Country Doctor, 45th St. Clinic, and Georgetown Medical and Dental Clinics) were the offspring of Seattle's community activist movement. Yakima Valley Farmworkers Clinic was birthed in an era of great ferment in the Yakima Valley by people tied to Cesar Chavez's farmworker's union. Tomas Villaneueva, a Clinic founder, recalled an early public meeting in which a grower stated: "Farmworkers don't need a clinic. They have strong backs. All they need is a box of aspirin." Maurice Esquivel, another Clinic founder observed: "The Bible says, 'The poor will always be with you.' That doesn't mean they have to be sick." This grassroots movement spread in Washington State and community clinics opened to provide primary care to the underserved.

In the 1980s, the CHCs were small, community-based and fiercely independent – but the winds of change were sweeping through their worlds. Linda McVeigh and Elizabeth Swain, Executive Directors of the Country Doctor and 45th St. Clinics (respectively), loaded their kids into a van one summer and set off

Please see> Community, P4

Inside This Issue

Washington Healthcare News
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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the Washington Healthcare News and its contents, please reply to dpeel@wahcnews.com. We will be happy to answer your questions in future newsletters.

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	Ancillary Services	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

Community Health Centers - Growing from Movement to Mainstream

<Community
From Page 1

across the state to round up the CHCs. Their ultimate goal was to weld the sometimes contentious group of CHC Executive Directors into a network that could respond to the changes that were in the wind. Washington State envisioned creating universal access to care through a managed care model and converted its Medicaid program to managed care. In a smoky room above the Elks Club in Cle Elum in 1992, the CHC Executive Directors voted to create a nonprofit health insurance company that is now known as Community Health Plan (CHP), and to assess each participating CHC organization $2000 towards the capitalization of the Plan.

At the time, I had just become the Executive Director of the Community Health Center of Snohomish County, financially struggling to pay staff and keep the doors open. I remember two clear things about the time – I had no idea how to come up with the $2000 to help capitalize this new Plan and there was widespread derision from established health care providers concerning the ability of the ragtag collection of CHCs around the state to succeed in such an endeavor. However, the CHCs have proved the critics wrong and today the Community Health Plan (CHP) manages the health care of 225,000 people in Medicaid, Basic Health, PEBB and Medicare programs. More importantly, the non-profit mission of both Community Health Plan and the CHCs allow cost savings to be driven directly back into local communities through expanded access to primary care.

The CHCs maintain a fierce belief in universal access to care. In 2005, they served 203,494 uninsured patients. In order to ensure access to care regardless of ability to pay, they offer a sliding fee scale to uninsured patients – discounting services according to household size and income. Charitable contributions combined with federal, state, local and private grants support these sliding fee scales.

To assure that grants intended to provide care for the uninsured were not needed to subsidize care provided to Medicaid and Medicare patients, CHCs were paid rates for these federal programs based on their cost of providing services. In 2002, cost-based reimbursement was replaced by the prospective payment system. Under the new system, reimbursement rates are increased annually by the Medicare Economic Index – about 3% per year. However, as health care inflation has increased much more than 3% per year, the reimbursement system fails to appropriately pay CHCs for the comprehensive scope of services they provide. CHCs struggle to contain costs as Medicaid and Medicare cost increases exceeding the 3% annual increase must be financed from some other source.

The CHCs serve nearly ten percent of the state's population through over 130 clinics located in 26 counties across Washington State. Primary medical care is a core service and CHCs employ nearly 200 FTE family practice physicians as well as 165 advanced registered nurse practitioners and physician assistants. As they have grown to meet demand, CHCs have added other primary care specialties including internists, pediatricians and obstetricians. Maternal-child health services are a core service directly provided at most of Washington's CHCs. Prenatal care is provided to 18% of the women who give birth in the state, including two thirds of Hispanic women. Pediatricians are increasingly important as nearly 40% of Health Center patients are below the age of 19.

For uninsured patients, access to necessary prescription drugs used to be a major obstacle to care. In order to address this barrier, CHCs added pharmacies to offer deeply discounted prescription drugs to patients who would otherwise be unable to access them. Today, CHC pharmacies serve established patients regardless of insurance status, but are not accessible by the general public who do not receive primary health services at the clinic. Pharmacists are increasingly integrated into the primary care delivery team and provide valuable clinical insight

Please see> Community, P6

Performance Improvement Systems

Texas Association of Community Health Centers

TACHC

TACHC has recently published updates to its performance improvement manuals, Optimizing Comprehensive Clinical Care (OC3) and Performance Improvement Systems. These manuals assist centers to exceed regulations and minimum standards to create a safe, therapeutic environment for patient care services. Content includes comprehensive program information, sample plans, and template policies and procedures in the following areas:

Management and Operations (M&O) Manual
Compliance; HIPAA Privacy and Security; Federal Tort Claims Act (FTCA)
Information Management (IM) Manual
Information Management and Security; Financial and Business Processes and Records; Medical Records
Human Resources (HR) Manual
Personnel; Staff Credentialing; Center Board and Staff Orientation and Training
Compliance & Performance Improvement (CPI) Manual
Medical and Dental Peer Review; Patient and Staff Safety; Clinical Measures

For additional information about the OC3 and Performance Improvement Systems Manuals, please contact Sandra Benavides-Vaello at sbvaello@tachc.org or by phone at 512.329.5959. To purchase, please visit the TACHC website at www.tachc.org.



Community Health Centers - Growing from Movement to Mainstream

<Community

From Page 4

into care.

Improving oral health is a key goal of CHCs, most of which operate dental clinics. Among low-income adult populations, the amount of dental pathology is overwhelming. More dental providers retire each year than are trained, resulting in a shrinking workforce that complicates access to care. It is estimated that three times more people lack dental insurance than medical insurance, and the disparity is even more pronounced among low income adults. In addition, Medicare does not cover dental services for the elderly. These factors combine to create a crisis in oral health care. In the face of these obstacles, the CHCs strive to enable children to access preventive oral health services which they hope will result in a healthier adult population in the future.

CHCs recognize that behavioral health is fundamental to the well being of individuals and communities. Utilizing brief focused interventions based on principles of cognitive behavioral therapy, CHCs are working to develop competencies and models for the integration of mental health services into primary care. Several clinics also provide psychiatric evaluation and psychotropic drug management services following referrals by primary care providers.

CHCs provide a variety of wrap-around services that assist patients whose health is affected by many challenges that exist in their lives. Assistance is provided to uninsured patients to enroll in insurance programs for which they are eligible. Social work services are provided to connect patients to housing, food and other basic needs. Health education, WIC and nutrition services all play important roles in the delivery of primary care services. Providing these comprehensive wraparound services sets CHCs apart from most health care providers.

Among the most exciting opportunities that CHCs embrace is the transition to Electronic Health Records (EHR). Several organizations have fully implemented EHRs, and many more are in the process. Eight CHCs joined together to jointly purchase and collaboratively operate both practice management and EHR. EHR is viewed as an important initiative to improve the quality of care and to allow them to expand personal care services to also include management of the populations that they serve.

CHCs have grown to become an important part of our health care delivery system. However, they also struggle to keep up with the growing demand. Patient access to specialty care is an obstacle and the significant oral health needs of uninsured adults are overwhelming their limited capacity. They are threatened by Medicaid and Medicare reimbursement rates that do not adequately reflect the cost of providing care. Despite these struggles, CHCs are excited by Washington's commitment to Cover all Kids by 2010 and the growing commitment to health care reform.

As CHCs look to the future they envision a day when a health care home is universally available and that integrates prevention with medical, mental and oral health and enabling services, is governed by the people served, and invests profits to improve the health of the people and communities served. When we reach that day, it will honor the foresight of people like Tomas Villanueva, and Maurice Esquivel – both of whom struggled against the segregation and disparities of another age to give rise to the CHC movement in Washington State.

Desmond Skubi served for 11 years as Executive Director of the Community Health Center of Snohomish County and Pike Market Medical Clinic. He practiced as a certified nurse midwife for 11 years, first practicing at a community health center on the Rosebud Sioux Reservation in South Dakota. He now provides consulting services in strategic and operational planning, business and project management and interim management. In 2007, he served as Interim CEO of the Washington Association of Community and Migrant Health Centers.

An Interview with Larry Loo of Puget Sound Health Partners

Larry Loo is the President and Chief Executive Officer of Puget Sound Health Partners (PSHP). This August 2007 interview was held in Seattle.

Editor: What is your background and how did you come to take the CEO position at PSHP?

Loo: My undergraduate degree is in Nutritional Biochemistry from Cornell University and my graduate degree is in Public Health, Health Policy and Management from Columbia University.

During the early part of my career, I held Analyst and Consultant positions in Underwriting and Product Development at Kaiser Permanente. Since 1999, I've held Assistant Vice President and Director positions at Group Health Cooperative, Premera and Regence.

Of all the care delivery models I've seen, I believe the coordinated care model is most effective from both a quality and efficiency perspective. The opportunity to become the CEO of an organization that not only employed a coordinated care model but was also owned by providers was very appealing to me. A provider backed model allows more control over product delivery.

Editor: Who owns PSHP?

Loo: PSHP is owned by three equal parties:

- Northwest Physicians Network
- Highline Medical Services Organization
- Physicians of Southwest Washington

All three organizations are headquartered in Washington State. They have been heavily involved in coordinated care programs for many years. When combined, the organizations offer 800 doctors.

Editor: What is the Mission of PSHP?

Loo: The Mission of PSHP is to:

- Be the local industry leader in supporting health care delivery
- Promote our members' health through local provider innovation
- Be responsible stewards of health care resources
- Be an active partner in improving the health of our communities

Editor: What products will you offer now? How about the future?

Loo: Subject to final approval by the Centers for Medicare and Medicaid Services (CMS) we will be offering Medicare Advantage (MA) HMO products in King, Pierce and Thurston Counties. PSHP has a Health Care Services Contractor (HCSC) license so other types of products are available if desired in the future.

Editor: What is your marketing strategy?

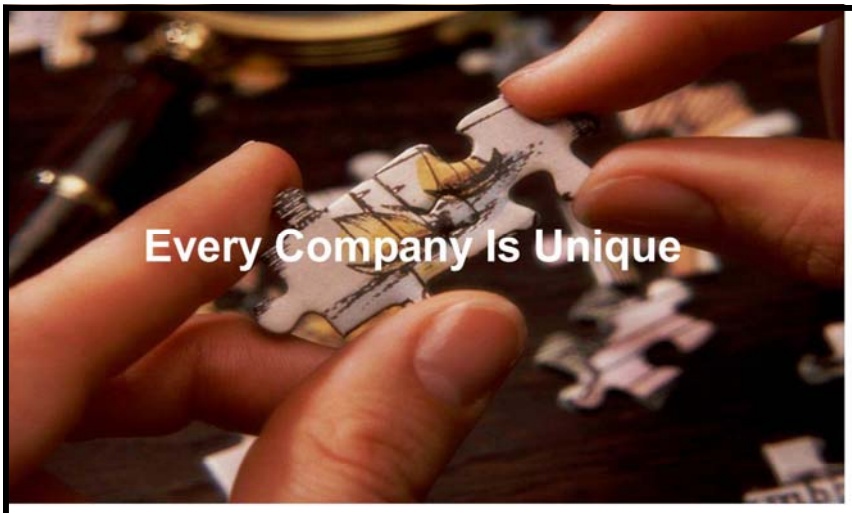
Loo: We will use a direct sales force that will emphasize the benefits of belonging to a provider owned health plan. To that extent, the physician/patient relationship will be emphasized. We are focused in just a few Counties and we believe that there is a place for a local, provider owned organization.

Editor: There are large, well established carriers in the Washington State market. How will you compete against them and what is your expected enrollment?

Loo: Our enrollment projections are modest, realistic and in line with the expectations of our owners. There will always be the larger carriers that get the lion's share of the business. We will do well in our own niche and space.

Editor: MA enrollment hasn't grown substantially over the last few years. Will this change?

Loo: In the near term, no. However, baby boomers are on the cusp of retirement. Employers are discontinuing employer sponsored retirement plans. Washington State also expects over 4% more retirees than the US average. These factors will increase the number of Medicare beneficiaries and, consequently, the MA population.



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Washington State Medical Office Building Listings

Property Name	City	Size (sf)	Rate (NNN)	Class	Location/Features
Fairview Research Center	Seattle	94,700	Negotiable	B	South Lake Union
Gateway Center	Kirkland	70,000	$32.50	B	
Evergreen Plaza	Kirkland	60,133	$22.50	B	Adjacent to Evergreen Hospital
Olympus Medical Building	Tacoma	48,000	$28.19	B	Downtown Tacoma, near Allenmore
Fed Way Center	Federal Way	43,500	$25.00	A	Adjacent to St. Francis Hospital
M Street	Seattle	41,129	$32.50	A	On First Hill near hospitals
720 Olive	Seattle	38,565	$22.00	A	Downtown Seattle
Bothell Professional Building	Bothell	36,774	$27.00	B	Fall 2007 completion
Mill Creek Commons	Mill Creek	30,000	$23.00	B	Near Mill Creek Town Center
Gig Harbor Urgent Care	Gig Harbor	30,000	$24.70	B	Built in 1990
Puyallup Medical Center	Puyallup	28,000	Negotiable		Near Good Samaritan Hospital
14818 179th Avenue SE	Monroe	26,104	Negotiable	B	Near Kelsey Place Retail Center
McMurray Medical Office Bldg.	Seattle	25,123	$26.00	A	Near Northwest hospital
Lynnwood Financial Center II	Lynnwood	20,875	$16.50	B	Near Alderwood Mall
1717 Building	Everett	20,000	$25.00	A	On Providence Colby campus
Medical Dental Building	Seattle	18,793	$34.50	B	Downtown Seattle near Westlake
Alderwood Professional Bldg	Lynnwood	18,317	$13.76	B	Near Alderwood Mall
The Pathways @ Newcastle	Newcastle	17,552	$26.00	B	Proposed. Breaks ground in April
Jefferson Tower	Seattle	16,278	$25.00	B	On Swedish campus
Newcastle Professional Center	Newcastle	16,000	$26.00	B	
Commons Professional Center	Bellevue	13,369	$24.00	B	Renovated project near Overlake
Broadway Medical Center	Seattle	12,284	$30.00	B	On First Hill in Seattle
Silver Lake Pavillion	Everett	11,500	$22.00	B	
Meridian South Prof. Center	Kent	10,905	$25.00	A	East Kent/Covington area
Emerald Professional Center	Seattle	9,703	$18.00	B	
Baze Professional Center	Renton	7,550	$26.00	B	New construction
Oakesdale Center - Bldg. E	Renton	7,536	$15.00	B	Freeway access
Canterwood Business Park	Gig Harbor	8,000	$20.00	B	Near St. Antony's Hospital
138-206 S. 3rd Place	Renton	6,427	$11.00		1/2 block off Rainier Avenue So.
Providence Rockefeller Bldg.	Everett	5,000	$22.00	A	On Providence Colby campus

Source: Grubb & Ellis Company, Commercial Broker's Association and Costar. Includes both completed, under construction and proposed properties.

Branding 101: Understanding the Basics

By Don Morgan
Director of Marketing
Palazzo Intercreative

Pick up just about any business periodical and you can find an article about the power of branding. All agree that building a strong brand identity is the best way to differentiate your product or service offering.

Many people see a brand as simply a collection of tangible images – the name, logo, slogan, etc. But the truth is that a brand is much more than this. Professor David A. Aaker, Chairman Emeritus of the Haas School of Business at Berkeley says that "a brand is a promise. It's a pledge made to your customer that you will give them something for choosing your product or service . . . this time and every time you interact with them."

Many marketers don't understand that branding happens in every interaction and point of contact between a company and its target customer. They work hard on their advertising and web design, but don't realize that a brand is also communicated in how your staff answers the phone and how easy the web site is to navigate. It's the sum total of any and every experience people have with the company.

We believe that a brand's strength springs from the core values that the company stands for. So in addition to thoroughly studying the consumer, the category and the competitive environment, we use Discovery Sessions and other techniques to identify those core values.

In our experience, most companies do a poor job of informing their employees about the relevant messages and values that will make their brand succeed. A notable exception to this is McDonald's. Every owner and manager must attend Hamburger University in Chicago, where they not only learn the operations side of running a franchise; they also study the importance of providing a consistent experience for the customer. Few customers would say that McDonald's makes the best hamburgers, yet they dominate the fast food marketplace in part because the customer knows what to expect.

"Many marketers don't understand that branding happens in every interaction and point of contact between a company and it's target customer"

This devotion to consistency was most apparent when McDonald's began marketing in Russia. McDonald's execs felt that native Russian potatoes did not deliver the same crispness and flavor that McDonald's is famous for serving. So they delayed their introduction into Russia for two years, imported their own seed potatoes, and waited until they got it right before opening the first restaurant. That is a great story and a great testament to the power and need for consistently delivering on every aspect of the brand promise.

A strong brand strategy must meet these four key criteria: it must be unique or distinctive; it must be relevant to their rational and emotional needs; it must be believable; and, it must be true. If your brand strategy falls short on any of these key elements, you risk over-promising on what you can deliver. And if the reality of what you deliver is not consistent with the expectations created by your message strategy, you lose that customer. And all of the potential customers they share that disappointing experience with.

Don Morgan is Director of Marketing for Palazzo Intercreative, a full-service Seattle advertising agency that specializes in healthcare. ***For more information, contact Don via e-mail at don@palazzo.com.***

Good News for People with Medicare

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8am to 8pm
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Puget Sound Health Partners offers Medicare Advantage Plans and contracts with the Federal Government as a Medicare approved HMO. You must be entitled to Medicare Part A and enrolled in Medicare Part B and reside in the plan service area. You must continue to pay your Medicare Part B premium. Benefits, premiums, cost sharing and limitations may vary by county or plan.

Henry Schein, Inc. wins Medical Supplies Contract

By David Peel
Publisher
Washington Healthcare News

The Northwest Community Health Center Group Purchasing Network (GPN) has awarded Henry Schein Medical Supplies (www.henryschein.com) a contract to offer their Network members Medical Supplies at discounted rates. The Washington Association of Community & Migrant Health Centers (WACMHC) operates GPN in conjunction with the Alaska and Oregon Primary Care Associations. Twenty eight different organizations in a four state region benefit from the discounted rates.

Bob Morrison, the Chief Financial Officer of WACMHC, worked in conjunction with members of the Centers and Associations to negotiate terms. Mr. Morrison notes, "Henry Schein understands the difference between negotiating with a Group Purchasing Organization and an individual clinic. The GPN negotiates on behalf of all our members, not just the large clinics, and Henry Schein's experience in similar negotiations let us come to terms quickly and efficiently."

According to Mr. Morrison, "We initially chose Henry Schein as a potential supplier because of its size and reputation. After substantial analysis, which included several centers comparing Henry Schein's proposal against their actual purchases, the GPN estimates centers that order through Henry Schein will save between 15% and 23% over their current arrangements."

Henry Schein, Inc. is a Fortune 500® company as well as the largest distributor of healthcare products and services to office-based practitioners in the North American and European markets.

The company serves 500,000 customers in more than 200 countries. A centralized and automated distribution network provides customers in more than 200 countries with a comprehensive stock of more than 70,000 national and Henry Schein private-brand products, with more than 100,000 additional products available as special-order items.

> *"The GPN estimates centers that order through Henry Schein will save between 15% and 23% over their current arrangements"*
>
> **Bob Morrison**
> *Chief Financial Officer*
> *WACMHC*

Henry Schein also offers a wide range of innovative value-added practice solutions for healthcare professionals, such as Financial Services, Capital Equipment Programs, Privilege/Loyalty Programs, and EMR/PMT solutions to name a few.

Headquartered in Melville, N.Y., Henry Schein employs nearly 12,000 people with operations in 19 countries. The Company's net sales reached a record $5.15 billion in 2006.

According to Chris Verhulst, Manager of the Western Zone of the Company, "We are very proud of our accomplishments as a leading healthcare product and services supplier and are equally proud of our "Healthy Children, Healthy Lifestyles" program, an access to care initiative. We work with the statewide and local leadership of Community Health Centers to focus on key undiagnosed diseases and risk factors affecting our country's medically underserved children, such as asthma, diabetes, hypertension, obesity, and oral health problems. Over 2,000 children and parents attended program events this year, enjoying educational elements geared to parents and fun physical activities for kids."

Centers and Clinics interested in learning more about Henry Schein can contact Francis Lanni, Henry Schein Field Sales Consultant, at (360) 450-9491. Centers that would like to become more familiar with the terms of the GPN Contract with Henry Schein can reach Bob Morrison of WACMHC at (360) 786-9722.

What to Expect from a Medicare Advantage Audit

By Diana Smitheman
Principal
Smitheman Consulting

If you are health plan and have a Medicare Advantage contract with the Centers for Medicare and Medicaid Services (CMS), you will be audited. The best time to prepare for that audit is when you begin doing business. CMS publishes its audit guidelines on its website at www.cms.hhs.gov. The Part D audit guide is also available on the CMS site.

The first and best preparation for a CMS audit is to begin internal quarterly audits of the areas that CMS will be auditing using the CMS audit guide and work sheets. This type of audit should be done for all areas for which CMS has worksheets in the audit guide.

The second preparatory step is to have each department review the audit guide and note those sections that are pertinent. If something is unclear, there are regulatory and manual references for each of the sections. This should be done every six months.

Self Reporting

CMS encourages plans to self-report deficiencies that the plan has identified.. This shows to CMS that the plan has taken the due diligence to conduct its own internal audit. While there is no specific advantage, other than promoting the spirit of cooperation with CMS, to reporting issues before CMS finds them, there is an opportunity to provide a narrative and corrective action plan. If the issue is serious enough that it would cause an organization to think about self-reporting, CMS will generally find it during the audit anyway.

The third (and panic time) for preparing for the CMS audit is when CMS announces that it is coming. As part of that visit, CMS will request a universe for each of the various samples for a time period (usually 6 months) and will pull samples from those universes. CMS will request that the samples be sent to the regional office in advance of the site visit. Be very careful to give CMS the correct universes.

Once CMS has selected the sample, pull the sample and photocopy the information. It is important for the plan to complete at least one of the samples for each category to make sure that all of the information that CMS needs is included with the sample. For example, if you just send the final letter on an appeal request, it is not clear what happened with the request when it was received, what information was requested, and whether or not an appropriate decision was made, and, if denied, the information showing that the file went to the Independent Review Entity, if required. With claims, it is often necessary to print notes from the systems files in order for CMS to follow the decision making process. Denial codes should be given to CMS with denied claims.

Sample Review Results

When CMS requests an explanation for a sample that it has reviewed, the plan must be sure to give complete information. If it is clear that the claim, appeal, etc. has an error, then the response should acknowledge the error and state what is being done to correct it (claim is being reprocessed, etc.)

CMS Onsite Review

When CMS reviewers come onsite, have a room set aside for their use during the review. If at all possible, this should be a room where they can work with no interruptions. All of the policies and procedures and any other requested documents (other than confidential documents which can be furnished when requested) related to the review should be in the space. The policies and procedures should be reviewed to make sure that they are up to date with any recent changes.

CMS will want someone from your staff to be a scribe and record the interviews. An entrance meeting should be scheduled and

Continued on next page

Continued from prior page

all management staff should attend and be introduced. Ask CMS what kind of presentations they would like. Often, they like to have an overview of the company and certain topics covered. It is helpful to have staff who will be interacting with the CMS staff wear name tags. Be sure that all the interviewees are available and that their schedules are flexible. Some interviews take longer than others and cause CMS to modify the schedule. Their time onsite is short and needs to be accommodated.

The exit meeting should include all of the management staff whose areas were involved in the review. During the exit, CMS will give initial results of the review. If there are gross misunderstandings, this is a good time to address them. Otherwise, listen to what they have to say and begin figuring out how to address any deficiencies.

CMS Review Results

CMS will issue a final report and list all of the findings. They will expect a response to each of the findings. Generally, you should not argue with the findings but address how the deficiencies will be corrected. The corrective action plan should include things like staff training (if there were deficiencies that would benefit from that), dates, correcting individual cases. The corrective action plan should be detailed. Just stating that the deficiency will be fixed is not enough. CMS will want to know how and when.

If you disagree with the finding and believe that CMS does not have a regulatory basis for the finding or that CMS does not understand the issue, then you should carefully research the issue citing whatever references you can find and politely state that you don't understand the issue and could CMS please clarify and give references for the basis of the finding.

Generally, you will find that, while CMS will strictly adhere to the required standards, CMS will assist in any way it can to help you meet those standards.

Diana Smitheman is the Principal of Smitheman Consulting. She was formerly the Director for Medicare and Medicaid managed care in the Seattle Regional office of CMS. Ms. Smitheman can be reached at smithemankd@msn.com.

Community and Migrant Health Centers - Northwest Style

By Barbara Malich
President
Northwest Regional Primary Care Association

From the Aleutian Chain in Alaska, to downtown Seattle, community health centers are responding to the health care challenges facing residents of our northwest communities. Since 1976 when the first federally qualified health centers (FQHCs) were identified in the region, community and migrant health centers have steadily spread. Today there are 79 community health center organizations in the region (Washington-23, Oregon-22, Idaho-10, and Alaska-24).

Most community health centers emerged from local clinics dedicated to filling a niche as a free clinic but are now committed to providing access to health care services for those people at greatest risk of falling "through the cracks" in our fractured health care system.

There are several unique characteristics defining community/ migrant health centers including:

- A patient majority community based Board of Directors also reflecting the demographic characteristics of the service area
- Division of administrative duties with clinical, financial, and corporate leadership providing dedicated expertise to each area
- Provision of services assuring access for uninsured patients on a self-pay basis calculated by creation of a sliding scale that considers both income level and family size.

More recently, there has also been increased emphasis on integration of services well beyond primary care including dental/oral health, pharmacy and behavioral health.

In some rural communities the local community health center is the only game in town. In more suburban and metropolitan areas FQHCs are part of a vital fabric of community based healthcare services.

CHALLENGES

The challenges faced by community health centers are not dissimilar from those faced across the health care system: critical shortages in recruitment and retention of health care professionals, increasing administrative burdens, the promise advancements in technology represent, and maintaining the balance between the needs of patients while still recognizing our regulated relationship with state and federal governments.

In an effort to address the workforce development challenges the Northwest Regional Primary Care Association (NWRPCA) is providing training and developing additional program initiatives to enhance the capacity of member community health centers to effectively recruit and retain health care professionals. Another initiative is the Northwest Community Health Leadership Institute, a new 6-month graduate level certificate program in community health center management and leadership offered through the University of Washington.

Our settings are often challenging, our patients are often disenfranchised, and our resources limited.

Why would we do this work, you may ask? The effective community/migrant health center depends on a mission-driven board, a leadership team dedicated to improving access to care for local communities, and a high level of engagement with colleagues across the region. When you know you are making a difference in patients' lives every day---our jobs offer tremendous personal gratification.

If you would like further information about working in community/ migrant health centers in the Pacific Northwest, please contact the NWRPCA in Seattle (206-783-3004), or www.nwrpca.org .

Barbara Malich also serves as CEO of Peninsula Community Health Services with clinics in Bremerton, Port Orchard and Poulsbo, WA.

Healthcare Opinions expressed by Ms. Malich are not necessarily the opinions of the Washington Healthcare News.

A Nation in Decay

By Jim Dwyer
President and CEO
Washington Dental Service

The tragic death of a Maryland boy from a common cavity made headlines across the country recently, raising questions about how this could happen in the world's most prosperous country. The truth is that this child died because our dental system failed him, and it continues to fail millions of other children.

Our nation is in the midst of a growing oral health crisis that is largely ignored. Among its primary victims are children. In fact, there is no disease in America as widespread as childhood cavities.

Good oral health is integral to overall health. You can't have one without the other.

The shame is that cavities are nearly 100 percent preventable, and the cost of prevention is minimal. In comparison, treating a child with severe dental decay in a hospital can cost up to $4,000.

Unfortunately, we are heading in the wrong direction. A state survey in 2005 found the rate of tooth decay among Washington children is growing. It is higher today than at any time in the past 12 years. One in five elementary school-aged children has untreated decay.

At least three major changes are needed to address the rising oral health crisis among children: 1) put more focus on prevention; 2) improve access to dental care; and, 3) reform and expand dental insurance coverage.

Prevention is paramount. For generations, dental schools have done a great job teaching their students to be surgeons – how to treat cavities, infections and other oral ailments in people over age three. The standard of care must be: all children receive an oral exam by a dentist or primary care physician by their first birthday.

Today's well-trained dentists advise patients on healthy diet and good oral hygiene habits, for both children and adults, and tailor prevention programs to their individual needs. The risk of cavities in children can be virtually eliminated through preventive techniques such as sealants and fluoride varnish treatments.

We are also getting away from the "treat everyone the same" paradigm of traditional benefit plans. Some people need their teeth cleaned every three months, for example, while others can go a year. We need to design oral health prevention and treatment plans specific to an individual's disease burden and risks, and leave behind the one-size fits all approach.

Second, we need to expand access to oral health care, especially for children.

Helping to make dental care more available to children locally is the goal of the ABCD program – Access to Baby and Child Dentistry – which is a collaboration among local health departments, dental societies, the Washington Dental Service Foundation, and the University of Washington.

The program is advocating a preventive approach to improving the oral health of young children in low-income families by training general dentists to treat young children. Nearly 900 dentists statewide have been trained in early pediatric techniques through the ABCD program.

Another obstacle to oral health care is a shortage of dentists, especially in rural areas and lower-income communities. To respond effectively to this challenge, we need to find ways to leverage the number of dentists we have.

One idea is to cross-train primary care and family practice doctors and pediatricians. Today, a baby typically has up to 12 medical exams in his or her first three years.

Why not have medical professionals scan for oral health disease and risks, apply fluoride treatments, instruct parents in proper oral care, and refer them to a dentist as necessary?

Finally, we need to fix dental

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insurance. Everyone, especially children, needs access to oral healthcare, not just people with dental insurance.

The current model of providing health insurance for the poor is broken and inadequate for dealing with childhood dental disease.

Right now 100 million Americans – one out of three – lack dental insurance. Without insurance many families can't afford regular dentist visits, and wait until problems are far worse and costly to treat.

A big step forward was taken just this year with legislative approval of Governor Gregoire's proposal, "Cover All Kids," that provides for 32,000 more kids to be eligible for health care in Washington including dental services.

Yet ultimately—to be successful—the entire community needs to embrace the issue of dental disease, not just oral health care professionals. Dental care is an integral part of healthcare and should be viewed that way by government and employers. For too long, dental care has taken a back seat to medical care. You need both to have excellent overall health.

The good news is that dental disease is nearly preventable, and the cost of prevention is minimal. This means solutions are easily within our reach if policy makers, elected officials and employers view cavities with the seriousness given to any other infection in the body. The only thing missing is the will to implement the solutions.

It shouldn't take the death of a child to sound the alarm bell, but it's crucial that we heed the warning and respond. We know the steps to take, we know it is cost effective and we know the benefits.

Jim Dwyer is President and CEO of Washington Dental Service, a Washington State domestic health carrier serving over 900,000 individuals.

Healthcare Opinions expressed by Mr. Dwyer are not necessarily the opinions of the Washington Healthcare News.

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KPS Health Plans

Controller Position

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"Keeping Healthy those who Feed the World"

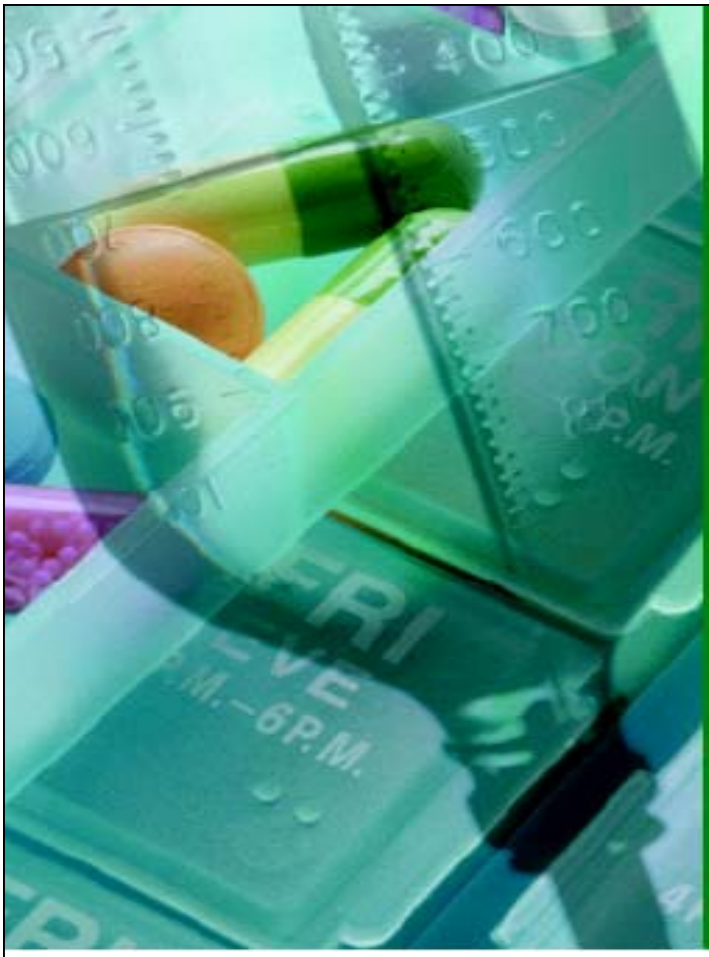
MEDICAL DIRECTOR

Columbia Basin Health Association (CBHA) was founded in Othello, Washington in 1973, and is a financially stable Best Practices JCAHO Accredited Community/Migrant Health Center located in the beautiful Columbia Basin of Eastern Washington. If you like the outdoors, wine country, and want a busy, satisfying medical practice, CBHA is the place for you. Othello is located approximately 2 ½ hours east of Seattle and 1 ½ hours southwest of Spokane, so professional and university sports, city entertainment and cultural programs are just a short trip. We are currently recruiting for a dynamic primary care physician to provide clinical leadership as Medical Director to join our team of 12 physicians and 8 PA-C's in 3 new, modern clinics with state of the art technology, including EMR, on-site lab, radiology, and specialty support. In addition to a 60% part-time clinical practice, the Medical Director will provide leadership, direction and oversight for the medical staff, and direct efforts in medical quality improvement, peer review, clinical programs and standards, medical staff recruitment and participation in health disparities collaboratives. Requirements include: demonstrated leadership ability, a team orientation, excellent written and oral communication skills, and effective working relationships with individuals of various cultural, ethnic and socioeconomic backgrounds, a minimum of 3 years primary care practice experience including 2+ years of supervisory experience, a valid license to practice medicine in the State of Washington and board certification in FP, IM, Ob/Gyn or Peds. We offer an attractive compensation package with outstanding benefits. For more information call (509) 488-5356 or for immediate consideration please submit a cover letter and resume to: Columbia Basin Health Association, 140 E. Main St., Othello, WA 99344 or by e-mail to careers@cbha.org. Visit our website at www.cbha.org

Plan and Hospital Financial Information

YTD Net Income and Members through 06/30/07 for the Largest Health Plans in Washington State[1]					
Plan Name	**Net Income**	**Members**	**Plan Name**	**Net Income**	**Members**
Health Plans:			LifeWise Health Plans of AZ.	($9,231,510)	31,046
Regence BlueShield	$29,565,755	881,930	Arcadian Health Plan[2]	($3,817,207)	56,422
Premera Blue Cross	$48,171,581	721,478	Timber Prod. Manuf. Trust	$377,251	9,891
Group Health Cooperative	$53,974,606	408,288	Washington Employers Trust	($1,684,941)	9,009
Molina Healthcare of WA	$20,446,537	287,170	Aetna Health, Inc.	$2,235,760	6,848
Community HP of WA	$1,544,901	234,213	Washington State Auto Ins.	$1,169,085	2,218
Group Health Options	($364,979)	99,525	Puget Sound Health Partners	($527,339)	0
Asuris Northwest Health	($166,260)	89,364	**Vision or Dental Plans:**		
LifeWise Health Plan of WA	$20,773	85,562	Washington Dental Service	$6,793,546	900,255
Pacificare	$21,434,547	52,723	Vision Service Plan	$3,788,708	528,873
KPS Health Plans	($1,452,940)	45,383	Willamette Dental	$320,844	69,624
Columbia United Providers	($1,472,764)	35,893	Dental Health Services	($661,030)	25,390
YTD Margin and Days through 03/31/07 for the Largest Hospitals in Washington State[3]					
Hospital Name	**Margin**	**Days**	**Hospital Name**	**Margin**	**Days**
Sacred Heart Medical Center	$8,504,127	38,228	St. Joseph Hospital Bellingham	$4,422,963	15,067
Swedish Medical Center	$13,583,043	36,087	Good Samaritan Comm. Health	$12,803,617	14,110
Harborview Medical Center	($1,841,000)	33,547	Valley Medical Center	$6,846,596	13,535
Providence Everett Med Ctr.	$9,738,570	25,758	Yakima Valley Memorial	$2,373,048	12,698
University of WA Med Ctr.	$4,928,142	23,544	Highline Community Hospital	$5,407,816	11,590
St. Joseph Medical Center	$16,170,050	23,149	Swedish Cherry Hill Campus	($3,233,612)	10,871
Virginia Mason Medical Ctr.	$5,365,713	21,983	Northwest Hospital	$901,542	10,562
Southwest WA Med Ctr.	$3,158,879	21,914	Holy Family Hospital	$1,292,926	10,491
Tacoma General Hospital	$14,136,029	21,182	Central Washington Hospital	$3,037,997	10,341
Providence St. Peter Hospital	$7,251,992	21,019	Kadlec Medical Center	$4,349,182	10,308
Deaconess Medical Center	$681,977	17,518	Peacehealth St. John Med Ctr.	$7,669,017	9,734
Children's Hospital	$6,112,002	17,101	Stevens Healthcare	$1,553,271	8,871
Harrison Medical Center	$8,396,843	16,447	Auburn Regional Medical Ctr.	($33,617)	8,293
Overlake Hospital Med. Ctr.	$3,459,795	15,336	Legacy Salmon Creek Hospital	($3,123,279)	8,156

[1]Per filings with the WA State Office of Insurance Commissioner. [2]Potential enrollment reporting error. [3]Per filings with the WA State Department of Health.



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Director of Operations HMO/PPO Administration
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