

Community Health Plan
Provider Manual

January 2011

Table of Contents

Introduction	4
Welcome to Community Health Plan	4
Who We Are	5
Your Role as a Community Health Plan Provider	5
Directory of Services and Contacts	6
Community Health Plan Contacts	6
Additional Contacts Outside of Community Health Plan	7
Provider Relations	8
Access to Care Standards and Responsibilities	8
Care Standards Documents:.....	9
Credentialing and Recredentialing	9
Practitioner Rights.....	10
Access to Records and Enrollee Health Information	11
Medical Record Documentation Standards	12
General Medical Record Policies	12
Medical Records Audit Document:.....	13
Reporting Changes in Provider Status.....	13
Provider Directory.....	13
State Programs and Medicare	14
Medicare Advantage Providers in the Health Care Setting.....	16
Community Health Plan Eligibility Department.....	17
Eligibility Documents:.....	17
PCP Assignment Procedures.....	17
Involuntary Disenrollment for Healthy Options, Children’s Health Insurance Program, and Basic Health	17
Disenrollment Policy	18
Disenrollment Procedure	19
Involuntary Disenrollment Medicare Advantage Plan	20
Change in residence outside the plan’s service area or temporary absence for more than 6 consecutive months	21
Loss of entitlement to Washington State Medicaid.....	21
Loss of entitlement to Medicare Part A or loss of enrollment in Part B	21
Enrollee is deceased.....	21
Disruptive behavior	22
Fraud and abuse.....	22
Contract termination.....	23
Involuntary Disenrollment Documents:	23
Enrollee ID Cards	23
Language ID Card	24
Enrollee Benefits.....	25
Benefit Information	25
Enrollee Materials.....	25
State Enrollment Materials and Publications	26
Children First.....	26
Enrollee Rights & Responsibilities.....	27
Interpreter Services	28
Medical Provider Responsibilities	28
Other Provider Responsibilities.....	28
Billing & Claims Payment	29
Where to Send Claims	29
Electronic Claims Submission.....	29
Newborn Claims for Healthy Options, Children’s Health Insurance Program, Basic Health, and Basic Health Plus	29

Coordination of Benefits	30
Third Party Liability (Subrogation/Reimbursement)	31
Provider Obligations in Third Party Liability	31
Appeals	32
Enrollee Appeals	32
Glossary	32
Provider Appeals	32
DRG & Fee Schedule Disputes	33
Care Management	34
Utilization Management	34
No Financial Incentives for Decision-Makers	34
Referral Management	35
Referral Form Document:	35
Preapproval (Prior Authorizations)	35
Prior Authorization Documents:	35
Pre-Admission Authorization	36
Hospital Inpatient Notification	36
Hospital Inpatient Notification Document:	37
Concurrent Review	37
Discharge Planning Coordination	37
Emergency Room Care	38
Pre-Existing Condition Review (Basic Health and Washington Health Plan Only)	38
PEC Documents	38
Case Management	39
Case Management Referral Overview for Practitioners	39
What Is Case Management?	39
Who Is Appropriate for Plan-Level Case Management?	39
How Can I Make a Referral to Case Management?	39
What Happens When I Make a Referral?	39
For What Reasons Would an Enrollee's Case Not Be Opened for Plan Level Case Management?	40
What to Expect While an Enrollee's Case Is Open in Plan Level Case Management	40
Why Is a Case Closed to Plan Level Case Management?	40
What Happens After a Case Is Closed to Plan Level Case Management?	40
Member Review and Intervention Program	41
The Role of the Primary Care Provider in MRIP	41
MRIP Documents:	41
The Role of the Pharmacy in MRIP	41
The Role of the Hospital in MRIP	42
Disease Management Program	42
Disease Management Program	43
Disease Management Referral Process	44
Clinical Care Management Criteria	45
Transition of Care	45
Pharmacy Management	45
Drug Formulary and Medication Utilization	45
Prior Authorization, Step Therapy, Nonformulary, and Quantity Override Requests	46
Pharmacy Benefit Exclusions	47
Quality Program	48
Overview	48
Program Scope	48
Program Structure and Leadership	49
Goals	49
Quality Documents:	50

Introduction

Welcome to Community Health Plan

We are pleased you have chosen to participate in our network of dedicated providers and share in our organization's commitment to provide quality care for individuals and families who traditionally face barriers to the care they need. We look forward to supporting you as a Community Health Plan provider.

The Community Health Plan Provider Manual will serve as a reference for you as a provider. The January 2011 version of the Provider Manual includes updates, as well as material that will soon be updated.

The Provider Manual contains content such as:

- Introduction and who we are (this section)
- [Directory of services and contacts](#)
- [Access to care standards](#)
- [Credentialing](#)
- [Access to records and enrollee health information](#)
- [Medical record documentation standards and policies](#)
- [Reporting changes in provider status](#)
- [Eligibility](#)
- [PCP assignment](#)
- [Disenrollment](#)
- [ID cards](#)
- [Enrollee benefits](#)
- [Children First™](#)
- [Enrollee rights and responsibilities](#)
- [Interpreter services](#)
- [Billing and claims payment](#)
- [Appeals](#)
- [DRG and fee schedule disputes](#)
- [Utilization management](#)
 - [Referrals](#)
 - [Prior authorizations](#)
 - [Hospital inpatient notification](#)
 - [Concurrent review](#)
 - [Discharge planning](#)
 - [Emergency room care](#)
 - [PEC review](#)
- [Case management](#)
 - [Referrals](#)
- [Member Review and Intervention Program \(MRIP\)](#)
- [Disease management](#)

- [Clinical care criteria](#)
- [Transition of care](#)
- [Pharmacy management](#)
 - [Formulary](#)
 - [Prior authorization, step therapy, nonformulary, and quantity override requests](#)
 - [Benefit exclusions](#)
- [Quality program](#)

If you have questions regarding any policies and procedures explained in this manual, please contact our Provider Relations team: Phone 1-800-440-1561 toll free or fax 206-613-5018.

Who We Are

Community Health Network of Washington (CHNW) was formed in 1992 by a group of community health centers dedicated to a mission of providing accessible health care. Through its role as a delivery system for insured enrollees of Community Health Plan, CHNW comprises approximately 1,600 primary care providers and 8,000 specialists at more than 300 primary care sites and more than 90 hospitals. CHNW is strengthened by the shared commitment of its providers to deliver accessible managed care that meets the needs and improves the health of our communities.

Created by CHNW, Community Health Plan serves more than 236,000 insured enrollees statewide. As one of the largest providers of the state's health plans, Community Health Plan offers affordable health insurance coverage through public programs including Healthy Options, Basic Health, the State Children's Health Insurance Program (SCHIP), Disability Lifeline, and Medicare.

One feature that distinguishes Community Health Plan from other health care networks is the commitment to providing a medical home for its patients, which results in individualized care. Through the dedication of community health centers and our contracted providers, Community Health Plan is able to establish a closer connection to our customers. This connection helps improve communication and the potential for better clinical outcomes. Families and individuals covered through the state insurance programs often require a broader spectrum of services, such as transportation and interpreter services. When possible, Community Health Plan providers have been committed to meeting these special needs.

Your Role as a Community Health Plan Provider

As a Community Health Plan provider, you have agreed to provide care to enrollees of Community Health Plan. We look forward to supporting you in providing accessible, quality health care that meets the needs your patients—our enrollees. A description of benefits and compensation extended to you are detailed in your provider agreement, in this provider manual and [referenced policies and procedures](#).

Directory of Services and Contacts

Community Health Plan
 720 Olive Way, Suite 300
 Seattle, WA 98101
 Phone 206-521-8830 local or 1-800-440-1561 toll free
 Fax 206-521-8834
www.chpw.org

Please note that most contact numbers are triaged through Customer Service.

Community Health Plan Contacts

Service	Contact
General Customer Service Monday through Friday, 8 am to 5 pm Benefits and eligibility verification, enrollee lists, PCP changes, provider participation status, enrollee and provider complaints	206-521-8830 1-800-440-1561 toll free 1-866-816-2479 TTY/TDD
Medicare Customer Service Sunday through Saturday, 8 am to 8 pm Benefits and eligibility verification, enrollee lists, PCP changes, provider participation status, enrollee and provider complaints.	1-800-942-0247 toll free 1-866-816-2479 TTY/TDD
Provider Relations Monday through Friday, 8 am to 5 pm General questions about the policies and procedures, contract questions, updates to clinic and PCP information, credentialing	206-521-8830 1-800-440-1561 toll free 206-613-5018 fax
Referrals	1-800-440-1561 toll free 206-652-7076 fax
Medical Management Monday through Friday, 8 am to 5 pm Prior authorizations, case management, disease management, care management, pharmacy management, quality improvement, and utilization management. Customer Service toll-free number is available to accept collect calls regarding utilization management (UM) issues. UM staff is accessible to callers who have questions about the UM process. Submission of medical prior authorizations requests Submission of inpatient hospital notifications	206-521-8833 1-800-440-1561 toll free 206-613-8873 fax 206-652-7078 fax

Service	Contact
Appeals & Grievances	206-521-8830 206-613-8983 fax 206-613-8984 fax

Additional Contacts Outside of Community Health Plan

Service	Contact Information
Pharmacy Benefits Manager – Express Scripts, Inc.	
For Basic Health, Healthy Options, CHIP, Disability Lifeline	1-888-256-6132
For Medicare	1-800-417-8164
Eligibility and Claims	http://www.onehealthport.com/
All Claims	Mail all paper claims to: CHP Claims PO Box 269002 Plano, Texas 75026-9002
Electronic Claims	Dell and Adaptis accept professional claims via the Availity clearinghouse. Please use Community Health Plan’s Payer Identifier: CHPWA. If you currently submit claims via Emdeon, you can submit to Community Health Plan electronically via Availity by using the Community Health Plan Emdeon payer ID# of SB613 for 839Ps or 12T30 for 837Is.
Claims Questions Monday–Friday, 8 am to 5 pm	1-800-440-1561
HRSA web site	http://fortress.wa.gov/dshs/maa/
HCA web site	http://www.hca.wa.gov/
CMS web site	http://www.cms.hhs.gov/

Provider Relations

This section outlines a few of the roles and responsibilities of Community Health Plan providers. Specific terms and conditions of your obligations as a Community Health Plan provider can be found in your provider agreement.

Access to Care Standards and Responsibilities

Community Health Plan enrollees shall have timely access to adequate and appropriate care based on approved accessibility standards. Community Health Plan providers will meet the following access-to-care standards and other responsibilities.

All providers (PCPs, specialists, facilities) must:

- Provide an answering service (or equivalent system) available 24 hours per day, 7 days per week.
- Maintain an appointment system for enrollees' prompt access to health care.
- Maintain continuity of care.
- Inform enrollees of their right to self-refer for certain services.
- Provide or arrange for interpretive services for enrollees who are hearing impaired or whose primary language is not English.
- Obtain informed consent from the enrollee, or from a person authorized to consent on behalf of the enrollee, prior to treatment.
- Provide adult enrollees with written information about advance directives and the right to make anatomical gifts.
- Assist enrollees in receiving health care services not covered by Community Health Plan.
- Medicare Advantage providers must not be opted out of Medicare. (Providers that have opted out of Medicare may be admitted to the network for the other lines of business.)

PCPs (including Ob/Gyn and midwives) and high volume behavioral health must provide:

- Telephone response time to an after-hours urgent phone call no greater than 30 minutes.
- Routine or preventive care appointment accessibility no greater than 30 calendar days.
- Non-urgent, symptomatic office visits are available from the PCP or another provider within ten (10) calendar days.
- Urgent care appointment accessibility no greater than 24 hours. (Emergency services or urgently needed services require no referral or pre-authorization.)
- Emergency care accessibility 24 hours per day, 7 days per week.
- Routine or preventive care appointment accessibility no greater than thirty (30) calendar days.

Behavioral health providers only must provide:

- Care for a non-life threatening emergency within 6 hours.
- An appointment for a routine office visit within 10 business days.
- Urgent care within 48 hours.

Specialists only must provide:

Specialists must provide the enrollee's PCP with a written report within 14 days of the date of service regarding the proposed plan of treatment, including any proposed hospitalization or surgery. This report should also be provided to an enrollee's PCP for self-referred services such as women's health care services. **Failure to provide the PCP with this report may result in nonpayment for services and the specialty care provider cannot bill the enrollee.**

Facilities only must:

- Notify Community Health Plan of all inpatient admissions as described in the "Care Management" section of this manual.
- Have inpatient and emergency services available 24 hours a day, 7 days a week.

Compliance with these standards and responsibilities is monitored during but not limited to office site visits. Any necessary corrective action plans or follow-up are reported to the Credentialing Committee and the Quality Council on a regular basis.

Care Standards Documents:

- [Site Visit Tool](#)
- [Community Health Plan policies and procedures](#)

Credentialing and Recredentialing

The Community Health Plan mission is to deliver accessible, managed care services that meet the needs and improve the health status of our communities, and make managed health care participation beneficial for underserved populations and community-responsive practitioners. In furtherance of that mission, the Community Health Plan Board of Directors has developed a Credentialing Program that meets the criteria set forth in this statement, and that meets the standards for accreditation by the National Committee for Quality Assurance (NCQA).

The Credentialing Program governs the credentialing function and sets forth the criteria, standards, and processes to select and retain qualified health care practitioners to promote quality care to enrollees. The Program also includes the structure and oversight responsibilities of Community Health Plan for any credentialing activities that may be delegated to another practitioner group or health care organization.

The Credentialing Program includes a mechanism for annual evaluation and periodic revision to the policies and procedures as adopted by the Credentialing Committee.

This program lists the credentialing criteria and standards that determine compliance for network participation.

Practitioner Rights

Right to review information to support application. Practitioners who have been or are in the process of being credentialed by Community Health Plan have the right to review credentialing information collected during credentialing, recredentialing, and ongoing review processes.

Practitioners are notified of this right to access in the cover letter that accompanies the Plan's credentialing and recredentialing applications. The cover letter describes the intent of the process and the steps a practitioner must take to review the information collected. This notification is also made available to the practitioner as part of this *Provider Manual*, which is supplied either during the contracting process or after a contract has been implemented and is available on the [Community Health Plan web site](#).

Right to correct erroneous information. If information provided on the application is inconsistent with information obtained via primary source verification, the Community Health Plan Credentialing Specialist will send the practitioner written notification of the discrepancy and request formal written clarification. The letter to the practitioner will include a summary of the information in question and a request to have the information returned in 14 business days. Notification will be sent electronically or return receipt requested and the correspondence will be marked "Confidential" as applicable.

The practitioner does not have the right to correct an application already submitted and attested to be correct and complete. However, the practitioner has a right to submit an addendum to correct erroneous information submitted by another party. If preferred, the practitioner may add an explanation for the erroneous information on his or her application, include a signed, dated statement attesting to the accuracy of the information provided, and then return the information to the Community Health Plan Credentialing Specialist who initiated the query.

Right to be informed of application status. Practitioners may request a review of their credentials file by calling the Credentialing Assistant and scheduling an appointment with the Credentialing Staff.

All reviews must be done in person at Community Health Plan offices. A member of the credentialing staff will accompany the practitioner during the file review.

Items that may be reviewed include:

- Items submitted by the applicant
- Malpractice insurance information
- Licensing boards' information
- American Medical Association (AMA) or American Osteopathic Association (AOA) query response
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) report

Peer review documents and references or other information that is peer review protected will not be shared with the applicant. Community Health Plan is not required to reveal the source of information that is not obtained to meet the primary source verification requirements or when law prohibits disclosure.

Upon request, Community Health Plan will provide the practitioner with the status of his or her application. The practitioner is notified of this right when he or she receives the cover letter that accompanies the Plan's credentialing and recredentialing application. The practitioner may phone the credentialing specialist for this information and the credentialing specialist must explain where the credentialing is in the process. The credentialing specialist may share other information with the practitioner regarding his or her file except for any information that is peer protected.

Access to Records and Enrollee Health Information

Provider shall permit reasonable access to financial records, medical records, and any other records that relate to their Agreement to authorized representatives of Community Health Plan, Payers, the U.S. Department of Health and Human Services, and Medicaid and Medicare fraud investigators.

Access to such records shall be to the extent permitted by law and as necessary to fulfill the terms of their Agreement.

Provider shall permit audits by Community Health Plan of enrollee's medical records for covered services under their Agreement.

Such inspection, audit, and duplication of records shall be allowed upon reasonable notice during regular business hours.

Providers shall have the right to reasonable access to Community Health Plan claim payment records for the purpose of auditing their claim payment history and claim denial pursuant to WAC 284-43-324.

Provider agrees to maintain all enrollee information in a confidential manner. Enrollee information includes, but is not limited to, medical records, claims, benefits, and other administrative data that is personally identifiable to the enrollee. Any disclosure and use of such information will be made only as permitted by applicable statutes, laws, regulations, and other provisions of their Agreement governing the confidentiality of such information.

Medical Record Documentation Standards

It is a policy of Community Health Plan to protect enrollee safety and the privacy and security of enrollee protected health information. Further, it is Community Health Plan's policy to require safeguards for all enrollee medical information including the paper medical record and/or electronic health record against loss, defacement, theft, and tampering, and from use by unauthorized individuals.

General Medical Record Policies

A medical record shall be constructed for each Community Health Plan enrollee and maintained by the practitioner while the enrollee is an active patient. If the enrollee becomes an inactive patient, the medical record can be moved to storage. Current Washington State regulations require practitioners to keep the medical record for 10 years after the last visit if the enrollee is 18 years old or above and for 10 years past the age of majority if the enrollee was a child at the time of the last visit.

All medical records, x-ray films, tissue specimens, slides, and photographs are the property of the practitioner.

It is at the discretion of the practitioner's office to determine the method of filing the medical records; that is, alphabetical order, terminal digit order, or other numbering system. The record itself should be organized to allow easy access to information. For example, the record may be organized with dividers to separate notes and laboratory reports.

All paper based notes, reports, etc. in the medical record must be secured in the enrollee's folder or electronically attached to the enrollee's file/record.

An enrollee's medical record should be kept at each practitioner's office. If the enrollee becomes an inactive patient, the purged medical record may be kept off site. Records should be easily retrievable. All medical records, active and inactive, should be supplied within 30 days of a request. Urgent requests should be met according to the clinical situation.

Compliance with all federal, state, and local regulations pertaining to medical records must be maintained.

All medical record information must be released only by properly trained personnel and only with a HIPAA appropriate patient authorization for release of information form.

Medical Records Audit Document:

[Medical Recordkeeping Tool](#)

Reporting Changes in Provider Status

All Community Health Plan providers are responsible for giving notice at least 30 days in advance of provider changes such as tax identification, billing address, and practice locations. This ensures ample time for the plan to update all systems, notify enrollees, and prevent payment delay.

Primary care providers are also responsible for notifying Community Health Plan when their practice reaches capacity and they can no longer accept new patients. This notice should be in writing and will be effective the first day of the month following 45 days from receipt of the written notice.

All Community Health Plan providers are also responsible for giving notice of intended termination at least 120 days prior to the termination date. This ensures compliance with the Patient Bill of Rights as well as ample time for the plan to notify enrollees. If an enrollee is not notified at least 30 days prior to the termination date of his or her provider, the provider and Community Health Plan are required to continue care with the termination provider for 60 days from the date of actual notice to the enrollee.

Provider Directory

Our provider directory is available on the Community Health Plan web site at www.chpw.org. Click the Our Providers tab to search for provider, clinic, pharmacy, and hospital information. This listing contains the most current list of all providers contracted with Community Health Plan.

As is the case with all provider listings, this list is subject to change and may not be a complete representation of our network. If a provider that you use is not contracted with Community Health Plan or if you have any questions, please contact your Provider Relations Coordinator via Customer Service at 1-800-440-1561.

The listing on our web site is updated on a monthly basis.

State Programs and Medicare

Community Health Plan participates in Healthy Options and the State Children's Health Insurance Program in the following counties:

Adams	King	Skagit
Benton	Kitsap	Skamania
Chelan	Klickitat	Snohomish
Clark	Lewis	Spokane
Cowlitz	Lincoln	Stevens
Douglas	Mason	Thurston
Ferry	Okanogan	Walla Walla
Franklin	Pacific	Whatcom
Grant	Pend Oreille	Yakima
Island	Pierce	

Community Health Plan participates in Basic Health in the following counties:

Adams	Jefferson	San Juan
Benton	King	Skagit
Chelan	Kitsap	Skamania
Clark	Klickitat	Snohomish
Cowlitz	Lewis	Spokane
Douglas	Lincoln	Stevens
Ferry	Mason	Thurston
Franklin	Okanogan	Walla Walla
Grant	Pacific	Wahkiakum
Grays Harbor	Pend Oreille	Whatcom
Island	Pierce	Yakima

Community Health Plan participates in the Washington Health Program in the following counties:

Adams	Island	Pierce
Asotin	Grant	San Juan
Benton	Jefferson	Skagit
Chelan	King	Skamania
Clallam	Kitsap	Snohomish
Clark	Kittitas	Spokane
Columbia	Klickitat	Stevens
Cowlitz	Lewis	Thurston
Douglas	Lincoln	Wahkiakum
Ferry	Mason	Walla Walla
Franklin	Okanogan	Whatcom
Garfield	Pacific	Whitman
Grays Harbor	Pend Oreille	Yakima

Community Health Plan offers Medicare coverage through its Community HealthFirst™ Medicare Advantage Plan as follows:

HPMS Plan ID	Plan Name	Service Area
005	Medicare Special Needs Plan	26 counties: Adams, Benton, Chelan, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Island, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Yakima
006	Medicare Advantage Plan	8 counties: Island, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Yakima
008	Medicare Advantage Plan with Pharmacy	8 counties: Island, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Yakima
009	Medicare Advantage Plan with Pharmacy	18 counties: Adams, Benton, Chelan, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Lewis, Lincoln, Mason, Okanogan, Pend Oreille, Skagit, Stevens, Walla Walla, Whatcom
010	Medicare Advantage Extra Plan	8 counties: Island, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Yakima
011	Medicare Advantage Premium Plan	6 counties: Chelan, King, Pierce, Skagit, Snohomish, Spokane

Each Community Health Plan product has a specific set of rules governing who is eligible for coverage, the enrollment process, and the termination process. These rules are not established by Community Health Plan, but by DSHS for Healthy Options and the State Children's Health Insurance Program, by HCA for Basic Health, and by CMS for Medicare.

For details about Healthy Options membership and eligibility, please see the [Healthy Options section of the HRSA web site](http://hrsa.dshs.wa.gov/healthyoptions/healthyoptions.htm) (<http://hrsa.dshs.wa.gov/healthyoptions/healthyoptions.htm>).

For details about the Children's Health Insurance Program membership and eligibility, please see the [Children's Health Insurance Program section of the HRSA web site](http://hrsa.dshs.wa.gov/applehealth/index.shtml) (<http://hrsa.dshs.wa.gov/applehealth/index.shtml>).

For details about Basic Health membership and eligibility, please see the [Basic Health section of the Health Care Authority web site](http://www.basicealth.hca.wa.gov/) (<http://www.basicealth.hca.wa.gov/>).

For details about Washington Health Program insurance membership and eligibility, please see the [Washington Health Program site of the Health Care Authority web site](http://www.washingtonhealth.hca.wa.gov/) (<http://www.washingtonhealth.hca.wa.gov/>).

For details about Medicare membership and eligibility, please see the [Medicare section of the Centers for Medicare & Medicaid Services web site](http://www.cms.gov/MedicareGenInfo/) (<http://www.cms.gov/MedicareGenInfo/>).

Community Health Plan will not refuse enrollment or re-enrollment, terminate an enrollee's enrollment, or discriminate against an enrollee in any way because of his or her health status, the expectation of the need for frequent high-cost care, or the existence of a pre-existing physical or mental condition, including pregnancy or hospitalization.

Medicare Advantage Providers in the Health Care Setting

Community Health Plan understands that Medicare beneficiaries look to their health care professionals to provide them with complete information regarding their health care choices.

To the extent of their ability, providers may assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs. Providers are permitted to make available and/or distribute marketing materials for **all plans** with which the provider participates and to display posters or other marketing materials announcing plan contractual relationships.

Our CMS contractual obligations prohibit providers from accepting enrollment applications or offering inducements to persuade beneficiaries to join Medicare Advantage plans. Providers also cannot direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests. In addition, providers cannot offer anything of value to induce a Community Health Plan enrollee to select them as the enrollee's provider.

CMS is concerned with provider marketing activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary's provider.

Because providers are usually unaware of the full range of Medicare Plan options, they should refer their patients to other sources of information:

- Community Health Plan marketing representatives at 1-800-944-1247
- State Health Insurance Assistance Programs (SHIP)
- State Medicaid Office
- Social Security Administration Office, www.medicare.gov, 1-800-MEDICARE
- Providers may distribute *Medicare and You* or *Medicare Compare Information* from the CMS web site, www.medicare.gov.

Community Health Plan Eligibility Department

Eligibility Documents:

- [2011 Clinic PCP Selection Form](#)
- [Provider Add Change Term Form](#)
- [PCP Assignment Policy](#)
- [PCP Enrollment Request Procedure](#)
- [Sample Member List by Clinic/PCP](#)
- [Sample Member List by MSO](#)
- [Sample Member List Additions by MSO](#)
- [Sample Member List Disenrollment by MSO](#)
- [Sample Pregnancy Report by PCP/Clinic](#)

PCP Assignment Procedures

PCP changes need to be made by the enrollee or, if the provider is calling, verified with the enrollee prior to making the change. Enrollees will be assigned only to open providers or clinics unless a closed practice is willing to accept the enrollee.

For more details regarding PCP changes, please refer to the [PCP Assignment policy](#) and [Process Eligibility PCP Enrollment Request procedure](#) on our web site.

PCP changes may be faxed via the [Clinic Selection Form](#) to 206-521-8834.

Involuntary Disenrollment for Healthy Options, Children's Health Insurance Program, and Basic Health

A client may be involuntarily disenrolled from Healthy Options, Basic Health, or Children's Health Insurance Program products under the following conditions:

- The client loses eligibility for a medical eligibility category that allows or requires enrollment; or
- A plan requests disenrollment of a client whose behavior is:
 - Inconsistent with the plan's rules and regulations, such as intentional misconduct; or
 - Such that it becomes medically infeasible to safely or prudently provide medical care.

Disenrollment Policy

The Member Reassignment and Involuntary Disenrollment Policy addresses instances where Community Health Plan enrollees may, due to inappropriate behavior, be reassigned involuntarily to another provider or clinic or disenrolled from Community Health Plan. In the majority of cases, it is the intent of Community Health Plan either to educate the enrollee, or if necessary, to reassign the enrollee to a different site or center, as the appropriate response to enrollee misconduct. Whenever possible, enrollees will be given an opportunity to change or improve inappropriate behavior. However, if an enrollee's behavior is such that the Plan determines it is no longer safe or prudent to offer medical care to the enrollee at any Plan facility, the Plan may, at its discretion, seek enrollee disenrollment from the appropriate state agency.

This policy applies to enrollees who:

- have behavior that is grossly inconsistent with clinic rules and standards;
- refuse to follow a recommended diagnostic treatment plan;
- are intentionally and continually noncompliant or abusive; or
- consistently engage in drug-seeking behavior.

Each case will be reviewed independently according to the procedures below.

Community Health Plan will not at any time request from the State of Washington disenrollment of a client solely due to an adverse change in the client's health or due to the cost of meeting the client's health care needs.

In the event that any Plan-contracted provider is no longer able or willing to continue to provide care for an enrollee, Community Health Plan will arrange for and secure alternative care until such time as another permanent provider can be located by enrollee reassignment, or until the state approves the disenrollment of the enrollee. This care will be covered by Community Health Plan under Plan benefits as outlined in the applicable program contracts (such as Healthy Options, SCHIP, Basic Health, and Medicare) at the time of service.

Enrollees who are to be reassigned involuntarily to another Plan provider will be notified in writing thirty (30) days in advance. This written notice will inform the enrollee of the right to appeal this reassignment, except in cases when the enrollee's conduct presents the threat of immediate harm to others.

Enrollees who appeal any decision to reassign or disenroll will be provided all necessary covered health care arranged through the PCP with the assistance of the appropriate Plan staff until a decision is rendered by Community Health Plan or the appropriate state agency.

Disenrollment Procedure

Requests to reassign or disenroll an enrollee must be processed by using the following Community Health Plan procedure.

Providers at Community Health Plan clinic sites will, in accordance with their internal policies and procedures, document and address instances of enrollee noncompliance or misbehavior. This documentation may include reports of misbehavior from specialty providers. Clinics may request that the Plan reassign or disenroll an enrollee if the enrollee's behavior repeatedly falls under one or all of the following descriptions:

- Enrollee exhibits repeated abusive behaviors toward staff or visitors. This behavior may include yelling; the use of profanity or name-calling; any inappropriate or unwelcome touching; or any threatening words or actions.
- Enrollee refuses to follow the outlined diagnostic treatment plan or continually engages in drug-seeking behavior.
- Enrollee repeatedly refuses to follow the procedures of the clinic or enrollee handbook by continually missing appointments, by inappropriately using the emergency room, or by self-referring to specialists without consulting with the primary care physician.

To initiate a reassignment or disenrollment, the following steps must be followed:

1. When a primary care physician or clinic manager wishes to reassign an enrollee, the appropriate staff member will send a warning letter to the enrollee. This letter will clearly document instances of misbehavior and outline steps of a written plan that the enrollee must follow if he or she wishes to continue to receive health care at the site. Warning letters will be copied to the center's Managed Care Coordinator and the Community Health Plan Provider Relations Coordinator (PRC). The enrollee will be provided written copies of a center's or clinic's written procedures relating to patient behavior.
2. If the enrollee repeats the behavior in question or chooses not to follow the steps outlined, clinic staff, with the approval of the clinic Medical Director, will consult with the assigned PRC at Community Health Plan to request that the enrollee be reassigned or, in the most serious cases, disenrolled from the Plan. Plan staff and clinic or center representatives will determine the feasibility of reassigning the enrollee within the Community Health Plan network.
3. If reassignment is not an option due to the enrollee's location or circumstance, the staff involved will establish a plan for resolution and follow-up that includes enrollee education.
4. If, after reviewing the case, there is agreement that the enrollee should be reassigned to another site or center, the PRC will inform the enrollee in writing of the decision. This letter will provide thirty (30) days notice and will inform the enrollee of his or her right to appeal the decision and the right to a fair hearing under Washington Administrative Code. Also, the letter will outline the enrollee's options for receiving future health care under the Plan. The PRC will work with clinic staff and/or a Community Health Plan Case Manager and/or Program Manager to arrange for the enrollee's future care. At no time will an enrollee be transferred to another clinic or site without the prior agreement of that clinic.

5. If, after reviewing the case, the clinic provider or staff member and the Plan Program Manager determine that the enrollee's behavior is serious enough to warrant disenrollment:
 - a. The Program Manager will notify the enrollee in writing of Community Health Plan's intent to request an involuntary disenrollment from Community Health Plan, including the right to appeal.
 - b. The Program Manager will work with the Provider Relations Coordinator to gather all necessary documentation from the primary care clinic.
 - c. All information provided by the primary care clinic will be forwarded to Community Health Plan Medical Director for review.
 - d. If the Medical Director feels the involuntary disenrollment request is valid (meets WAC requirements) and the necessary documentation has been provided, he or she will submit the documentation along with a letter requesting the disenrollment to the DSHS Exception Case Management (ECM) Section.
 - e. DSHS will make a determination within 30 days of receiving Community Health Plan's request. If approved, DSHS will notify Community Health Plan and the enrollee with a minimum of 10 days notice of termination.
 - f. The enrollee will stay enrolled with Community Health Plan until a decision is made by ECM.

Clinic staff are responsible for:

- Documenting client misbehavior.
- Creating a written action plan for improvement if applicable.
- Providing enrollees with written notice about action the clinic plans to take.
- Providing enrollees with written procedures relating to enrollee responsibility.
- Reporting to law enforcement agencies any criminal behavior.

The Community Health Plan staff is responsible for reviewing documentation and consulting with clinic staff to determine alternatives for providing care for the enrollee. If this is not possible, the Community Health Plan Program Manager serves as liaison to the state when requesting disenrollment.

Involuntary Disenrollment Medicare Advantage Plan

A client may be involuntarily disenrolled from Medicare Advantage Plan under the following conditions (which are described in the following sections):

- Change in residence outside the plan's service area or temporary absence for more than 6 consecutive months
- Loss of entitlement to Washington State Medicaid
- Loss of entitlement to Medicare Part A or loss of enrollment in Part B
- Enrollee is deceased
- Disruptive behavior
- Fraud and abuse
- Contract termination

Change in residence outside the plan's service area or temporary absence for more than 6 consecutive months

The Eligibility Coordinator (EC) will document receipt of a verbal request for disenrollment and will document and stamp the date of receipt on written requests.

When an enrollee or legal representative contacts Community Health Plan with an address change that is outside the service area, the EC will determine the effective date of disenrollment and then mail to the enrollee a Disenrollment Due to Permanent Move letter. The EC will transmit a Disenrollment Transaction to CMS.

When Community Health Plan receives an enrollee's address change from a source other than the enrollee or the enrollee's representative, the EC cannot disenroll until the enrollee or enrollee's representative has confirmed that this out-of-area move is permanent or that six months have passed. The EC will call the enrollee to verify the address change.

If the EC cannot contact the enrollee by a telephone call, the EC will mail the enrollee a Verification of Change in Address letter. If the EC does not receive a response to written attempts from the EC to confirm a permanent out-of-area move by the beginning of the sixth month after sending the letter, the EC will mail to the enrollee an Upcoming Disenrollment Due to Out of Area Over 6 Months letter. The EC will determine the disenrollment effective date and send a Disenrollment Transaction to CMS. When the reply is received from CMS, a Final Confirmation of Disenrollment Due to Out of Area for 6 Months letter will be sent to the enrollee.

Loss of entitlement to Washington State Medicaid

If an enrollee is in a Special Needs Plan and is no longer eligible with Medicaid, the EC will mail the enrollee a Disenrollment from the Special Needs Plan Due to Loss of Medicaid letter. However, the enrollee will be enrolled in the MA-PD plan and given the option of disenrolling or moving to the MA Only plan.

Loss of entitlement to Medicare Part A or loss of enrollment in Part B

When the EC receives a CMS Reply Listing that indicates an enrollee has lost Medicare Part A or Part B benefits, the EC will mail to the enrollee a Disenrollment Due to Loss of Part A or Part B Coverage letter. If an enrollee then contacts us regarding an erroneous disenrollment, the EC will use the Enrollment Reinstatement procedure.

Enrollee is deceased

When the EC receives a CMS Reply Listing that indicates an enrollee is deceased, the EC will mail a Disenrollment Due to Death letter to the estate of the enrollee. If an enrollee then contacts us regarding an erroneous disenrollment, the EC will use the Enrollment Reinstatement procedure.

Disruptive behavior

When the EC determines that an enrollee exhibits behavior that substantially impairs Community Health Plan's ability to arrange or provide care to the disruptive individual or other plan enrollees, the EC will assess the situation. The EC will determine if the enrollee's behavior may be related to the use of medical services or diminished mental capacity. If it is not, the EC will try to resolve the issue with the enrollee and document his or her efforts. The EC will call the Regional Office to discuss the issue with the CMS Plan Manager. If the CMS Plan Manager advises Community Health Plan to proceed with disenrolling the enrollee, the EC will mail to the enrollee a Warning of Potential Disenrollment Due to Disruptive Behavior letter and will work to resolve the issues and document all efforts to do so.

If the disruptive behavior does not end after the EC sends the letter, the EC will mail the enrollee an Intent to Disenroll letter. Then, the EC will send a disenrollment request to CMS with all of the required documentation about the disruptive behavior. Within 20 business days of receiving the documentation, CMS will decide to approve or deny the disenrollment request and CMS will notify Community Health Plan of the decision to approve or deny the disenrollment request.

If the Disenrollment request was denied by CMS, we will send a letter to the enrollee and enrollment will continue.

If the Disenrollment request was approved by CMS, the EC will determine the effective date of disenrollment and mail to the enrollee a Disenrollment for Disruptive Behavior letter. We will then transmit a Disenrollment Transaction to CMS.

Fraud and abuse

Examples of fraud and abuse are when an enrollee:

- Submits fraudulent information on an enrollment form; or
- Allows another person to use his or her enrollment card to obtain services or a prescription drug.

When Community Health Plan receives information that an enrollee has committed fraud and abuse, the EC will call the Regional Office to discuss the issue with the CMS Plan Manager. If the CMS Plan Manager advises Community Health Plan should disenroll the enrollee, the EC will determine the effective date of disenrollment and send a Disenrollment for Fraud and Abuse letter to the enrollee. The EC will then send a Disenrollment Transaction to CMS. At this time the EC will send all supporting documentation to the Inspector General in the CMS Regional Office, and to Community Health Plan's Compliance Officer.

Contract termination

If Community Health Plan determines not to renew its contract with CMS, the EC will mail to the enrollee a Contract Non-Renewal letter at least 90 calendar days before the effective date of the nonrenewal.

If Community Health Plan receives a contract termination from CMS, the EC will mail to the enrollee a Contract Termination by CMS letter at least 30 calendar days before the effective date of termination.

If we receive a contract termination from CMS for immediate termination, the EC will mail a notice of termination to the affected enrollees. CMS establishes the special election period that will be used in the notice of termination.

If Community Health Plan terminates the contract with CMS due to CMS substantially not carrying out the terms of its contract, enrollees will be sent the Contract Termination by Community Health Plan letter 60 days prior to the effective date of termination.

Involuntary Disenrollment Documents:

- [Involuntary disenrollment policy](#)
- [Involuntary disenrollment procedure](#)

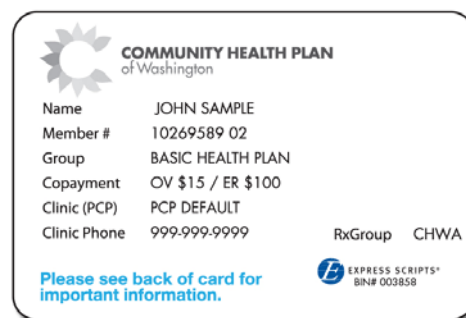
Enrollee ID Cards

These are samples of the new subscriber ID cards. (This one is for Basic Health, but the cards are similar for Healthy Options/CHIP, Disability Lifeline, and Medicare programs.) Enrollees can call 1-800-440-1561 to order a new ID card.

Back



Front



Language ID Card

This mockup is a folded business-sized card that enrollees may carry with them when they have an appointment.

Outside

<p><i>(translated into desired language)</i></p> <p>Important things to know about your appointment:</p> <ul style="list-style-type: none"> • Ask the interpreting service what day and time your appointment is scheduled • Write down your questions before your appointment. • Ask your questions at your appointment. • Ask about instructions for care after your appointment.. <p style="text-align: right;"><i>(back)</i></p>	 <p>COMMUNITY HEALTH PLAN of Washington</p> <p><i>Committed to your health.</i></p> <p style="text-align: right;"><i>(front)</i></p>
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Inside

<p>I need a <INSERT LANGUAGE> interpreter for my appointment. Please write my preferred language and interpreting needs in my chart. Thank you. Practitioner: If you have any questions, please call 1-800-440-1561.</p> <p><i>(in translated language)</i></p> <p>I need a <INSERT LANGUAGE> interpreter for my appointment. Please write my preferred language and interpreting needs in my chart. Thank you. Practitioner: If you have any questions, please call 1-800-440-1561.</p> <p style="text-align: right;"><i>(Inside foldout)</i></p>
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Languages available:

Amharic, Cambodian, Chinese, Hmong, Korean, Laotian, Russian, Samoan, Spanish, Tigrigna, Ukrainian, Vietnamese

Enrollee Benefits

Benefit Information

To learn more about benefits for and copays for Basic Health, Washington Health Program, Healthy Options, Basic Health Plus, SCHIP, and Disability Lifeline, see the benefit grids:

- [Basic Health benefit grid](#)
- [Washington Health Program benefit grid](#)
- [Healthy Options, SCHIP, Basic Health Plus benefit grid](#)
- [Disability Lifeline benefit grid](#)

For information about benefits and copays for Medicare programs, see the benefit grids for:

- [Medicare Advantage Extra \(009\) benefit grid](#)
- [Medicare Advantage Extra \(010\) benefit grid](#)
- [Medicare Advantage Prescription \(008\) benefit grid](#)
- [Medicare Advantage Premium HMO POS \(011\) benefit grid](#)
- [Medicare Advantage Special Needs \(SNP\) \(005\) benefit grid](#)

If you need detailed information about benefits, please call the Customer Service team at 1-800-440-1561.

Enrollee Materials

For State programs (Healthy Options, SCHIP, Basic Health Plus, Basic Health, Washington Health Program, Disability Lifeline) Community Health Plan makes available enrollee benefit materials and posts information on the web site describing plan services and features. The handbooks, other printed materials, and web content contain helpful information about how to use the plan, its benefits, enrollee rights and responsibilities, and more.

In the new member packet, Healthy Options, CHIP, and Basic Health Plus enrollees get:

- A printed [Healthy Options Supplement](#), which contains important benefit and service information, including excerpts from the State-published all-Plan benefit handbook that will be sent to enrollees sometime in 2011.
- Additional up-to-date information such as enrollee privacy and other rights; grievances and appeals; and utilization management practices and policies.
- A listing of information enrollees can find on the Community Health Plan web site.

In the new member packet, Basic Health enrollees get:

- A postcard the enrollee can return to request a free, printed *Basic Health Medical Benefits Summary*.
- A listing of information enrollees can find on the Community Health Plan web site. This information can be downloaded from the web site or will be sent in printed form to anyone who requests it.

In the new member packet, Disability Lifeline enrollees get:

- Two ways to request a printed *Disability Lifeline Medical Benefits Summary*: call Customer Service or pick up a book at their CSO or clinic.
- A listing of information enrollees can find on the Community Health Plan web site. This information can be downloaded from the web site or will be sent in printed form to anyone who requests it.

State Enrollment Materials and Publications

The Health Care Authority and Health and Recovery Services Administration produce enrollment materials and publications for their programs. Please refer to the Health Care Authority and Department of Social and Health Services web sites for order forms and directions:

- [HCA web site](#)
- [DSHS web site](#)

Children First

Children First™ is a program that rewards enrollees for getting the health care they need. The program rewards parents who get health care that prevents injuries and illness— one of the best ways to maintain a child's health.

For more information, see the Children First documents:

- [Children First program web page](#)
- [Children First Prenatal Form](#)
- [Well Child Form](#)

Enrollee Rights & Responsibilities

To achieve optimal results, Community Health Plan considers enrollees to be partners in health care decisions. Enrollees' willingness to furnish information about their health status and history is essential to provide the best possible care and service.

Community Health Plan is committed to providing respectful, considerate, and nonjudgmental care in an atmosphere that values the enrollee's privacy, confidentiality, belief system, and dignity.

For more information, see:

- [The Community Health Plan Notice of Privacy Practices](#)
- [Community Health Plan enrollee rights and responsibilities](#)
- [Community HealthFirst Medicare Advantage enrollee rights and responsibilities](#)
- [Advance directives](#)
- [Preventing fraud and identity theft](#)

Interpreter Services

All enrollees who are eligible for medical assistance through DSHS are eligible for interpreter services, including those who are deaf, deaf-blind, or hard of speaking. A complete guide on HRSA interpreter services may be found on the [DSHS/HRSA web site](#).

Medical Provider Responsibilities

When Health and Recovery Services Administration clients need interpreter services to receive medical or health care services, the medical provider is responsible for:

- Verifying that the patient is an eligible Health and Recovery Services Administration client.
- Checking to see whether the medical service to be provided is covered by the client's medical program.
- Notifying the Health and Recovery Services Administration client that interpreter services are available to the client at no charge.
- Coordinating the interpreter services.
- Following Health and Recovery Services Administration medical service authorization procedures, whenever applicable.
- Notifying the independent interpreter or interpreter agency when interpreter services are required.
- Notifying the interpreter of any changes to scheduled appointments.
- Verifying the interpreter's picture identification with the interpreter.
- Documenting in the client's record that the person is deaf, deaf-blind, hard of hearing, or limited-English speaking (LEP) and that interpreter services were provided. Include the name of the interpreter and what form of identification was presented.

Other Provider Responsibilities

When necessary, the provider may also be responsible for:

- Contacting the Health and Recovery Services Administration (1-800-848-5459) for connection to the AT&T Language Line for no more than 15 minutes, when a limited-English-speaking client requires urgent care that cannot be rescheduled and the medical provider has no other resource for an interpreter.
- Contacting the Washington State Relay Service for TDD connection (1-800-833-6384 VOICE for deaf, or 1-800-833-6388 for deaf) to communicate with a person who is deaf, deaf-blind, or hard of hearing.
- Contacting the Health and Recovery Services Administration (1-800-562-3022) for help in obtaining an interpreter.

Billing & Claims Payment

Where to Send Claims

Mail manual claims to this address:

CHP Claims
P.O. Box 269002
Plano, TX 75026-9002

Electronic Claims Submission

Community Health Plan uses Availity as the primary clearinghouse for claims. The clearinghouse's use of specific edits ensures the accuracy of all claims forwarded.

The Availity clearinghouse offers the convenience of:

- 24 hour availability
- Detailed online submission and error reports

Please contact your software vendor to begin the process of electronic billing.

Newborn Claims for Healthy Options, Children's Health Insurance Program, Basic Health, and Basic Health Plus

Providers should bill for newborn care using the mother's Community Health Plan ID number until the newborn is assigned his or her own Plan ID number.

Claims Documents:

- [HCFA1500 Claim Form and Instructions \(version 6\)](#)
- [UB04 Form and Instructions](#)
- [Sample Remittance Advice](#)
- [Active Message Codes](#)
- [Supporting Documentation Cover Sheet](#)
- [Corrected Claims Cover Sheet](#)

Completed consent forms and 30-day wait period after signature are required for payment of Healthy Options, CHIP, Basic Health Plus, S-Med, and Disability Lifeline claims.

- [Sterilization Client Statement Form](#)
- [Sterilization Consent Form](#)
- [Sterilization Consent Form \(Spanish\)](#)
- [Hysterectomy Consent Form](#)

Coordination of Benefits

Coordination of benefits (COB) becomes necessary when there is more than one source of payment for health services. The payment for such services is coordinated to assure that the insurer who has primary responsibility for coverage pays for the services.

At the time of registration, patients should be asked if they have other insurance coverage. If there is another possible source of insurance identified, this information should be included on the claim form.

Community Health Plan will coordinate benefit payments with any other group plans, Medicaid plan, or Medicare plan that covers the enrollee. Benefit payments will not be coordinated with any individual coverage the enrollee has purchased.

To be processed if an enrollee is covered by more than one health insurance plan, claims must be submitted to Community Health Plan with an Explanation of Benefits statement from the other carrier.

The health plan that is to provide benefits first will do so for all the expenses allowed under its coverage. The other plan will then provide benefits for the remaining allowed expenses.

When Medicare or another governmental program of health care coverage is one of the plans, federal law determines which plan provides benefits first:

- Healthy Options is always the secondary payer.
- Basic Health is always the secondary payer, except when there is dual coverage with Healthy Options or CHAMPUS.

For Medicare, Community Health Plan follows Medicare as Secondary Payer rules.

Otherwise, the following rules determine which plan provides benefits first:

1. When both plans coordinate benefits, the plan covering the person as a subscriber provides benefits first.
2. Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are divorced or separated, the following rules determine which plan pays first:
 - a. Plan of the parent with custody.
 - b. Plan of the spouse of the parent with custody.
 - c. Plan of the parent without custody.
 - d. Plan of the spouse of the parent without custody.If there is a court decree that establishes responsibility for the child's health care, the plan of the parent with that responsibility provides benefits first.
3. If none of these rules establishes which plan provides benefits first:
 - a. The plan that has covered the enrollee the longest time provides benefits first.
 - b. All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid off, if the other plans include this rule.

4. When none of the above rules establishes the order of benefits, then the plan that has covered a subscriber for the longer period of time will provide benefits first.

Third Party Liability (Subrogation/Reimbursement)

Community Health Plan benefits are available to an enrollee who is injured or becomes ill because of a third party's action or omission. Community Health Plan has subrogation rights and other rights to recovery against any third party liable for the illness or injury. This means Community Health Plan:

1. Is entitled to reimbursement from recoveries by the enrollee from the liable third party after the enrollee is fully compensated for his or her loss, and
2. Has the right to pursue claims for damages from the party liable for the injury or illness. Community Health Plan's rights extend to the value of benefits paid by the plan for such an injury or illness.

As a condition of receiving benefits for such an illness or injury, the enrollee and his or her representatives are responsible for cooperating fully with Community Health Plan in recovering the amounts it has paid including, but not limited to:

- Providing information to Community Health Plan concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys.
- Providing reasonable advance notice to Community Health Plan of any trial or other hearing, or any intended settlement, of a claim against any such third party.
- Repaying Community Health Plan from the proceeds of any recovery from or on behalf of any such third party.

Provider Obligations in Third Party Liability

A provider is responsible for notifying Community Health Plan when he or she becomes aware that an enrollee has a right to reimbursement from a third party and to assist in arranging for assignment of such right to Community Health Plan for collection.

The following information, to the extent that the provider is aware, should be reported to Community Health Plan:

- Facts of the enrollee's condition or injury.
- Any changes in the enrollee's condition or injury.
- Name of any person responsible for the enrollee's condition or injury and that person's insurance carrier.

Appeals

Enrollee Appeals

For a description of the grievance and appeal process, please see the information for the enrollee's specific plan:

- [Grievances and Appeals for Basic Health or Washington Health Program, Healthy Options/CHIP/Basic Health Plus, and Disability Lifeline](#)
- [Medicare Advantage Grievances and Appeals](#)

Consent Document:

- [Consent form for appeals](#)

Glossary

Action: A decision by Community Health Plan to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

Appeal: A request for review of an *action*, as defined above.

An enrollee may file an appeal due to an adverse benefit determination or action by Community Health Plan.

An enrollee may file an appeal due to an adverse benefit determination or action by Community Health Plan.

An enrollee appeal may be submitted by the enrollee, a representative acting on behalf of and with permission from the enrollee, or a provider acting on behalf of and with written authorization from the enrollee within the timeframe outlined in the *Medical Benefits Summary* or the *Evidence of Coverage* for the enrollee's specific plan.

When assisting an enrollee with an appeal:

- Review their appeal processes and rights in the *Medical Benefits Summary* or the *Evidence of Coverage* for the enrollee's specific plan.
- For state program enrollees, [obtain a signed authorization form](#)
- For Medicare program enrollees, obtain a signed [appointment of representative form](#)

Provider Appeals

If a provider believes a decision made by Community Health Plan to be incorrect regarding an issue **other than DRG pricing or Fee Schedule determinations** that do not involve enrollee financial responsibility, a provider may appeal that decision.

Provider appeals must be in writing and submitted within 24 months from the date of the notice of denial.

An appeal must include:

- Enrollee name and member ID number
- Claim number (if applicable)
- Date of service
- All pertinent supporting documentation
- Reason for requesting the appeal
- Signed authorization (if filing on behalf of an enrollee)

Submit appeals to:

Community Health Plan
Attention: Appeals Department
720 Olive Way, Suite 300
Seattle, WA 98101
Fax 206-613-8984

DRG & Fee Schedule Disputes

For disputes related to DRG pricing or Fee Schedule determinations, see the Overpayment and Underpayment Recoveries section of your provider agreement or the Dispute Resolution or Overpayment and Underpayment Recoveries section of your facility agreement.

Submit DRG & fee schedule disputes to:

Community Health Plan
Attention: Provider Relations Department
720 Olive Way, Suite 300
Seattle, WA 98101
Fax 206-613-5018

Care Management

Care Management at Community Health Plan is a comprehensive method of client assessment, designed to identify client vulnerability, needs, and goals, that results in the development of an action plan to produce an outcome that is optimal for the client. The goal is to provide client advocacy, a system for coordinating client services, a systematic approach to evaluation of the effectiveness of the client's health maintenance, and most importantly, to support the client-provider relationship.

Community Health Plan uses clinical practice guidelines for chronic diseases (including behavioral health conditions). Evidence-based, peer-reviewed guidelines from nationally recognized agencies are used. The guidelines are reviewed annually by Community Health Plan Medical Directors and by practitioners in the appropriate scopes of practice from the Community Health Network. A list of pertinent guidelines can be found at <http://www.chpw.org/en/provider/docs/index.php>. A paper copy of each guideline is available on request.

The care management process is monitored through the following processes (each of which is described in the following pages):

- No financial incentives
- Referral management
- Preapproval (prior authorization)
- Pre-admission authorization
- Hospital inpatient notification
- Concurrent review
- Discharge planning coordination
- Emergency room care
- Pre-existing condition review
- Case management
- Member Review and Intervention Program
- Disease management
- Clinical care criteria
- Transition of care

Utilization Management

No Financial Incentives for Decision-Makers

Community Health Plan staff and providers okay or deny services, but there are no financial incentives for decision-makers. We do not pay them to decide in a certain way.

We follow these rules:

- Utilization Management decision-makers approve or deny based only on whether the care and service are appropriate and whether the care or service is covered.
- Community Health Plan does not reward providers or others for denying coverage or care.

- Community Health Plan does not offer financial incentives to encourage Utilization Management decision-makers to make decisions that result in an underuse of care or services.

An appropriate peer reviewer (Medical Director, Pharmacist, or Associate Clinical Director) is available to discuss any Utilization Management denial decision by calling Customer Service at 1-800-440-1561. **Policy is available upon request.**

Referral Management

A referral is a primary care provider's written statement of intent to refer an enrollee to specialty care or ancillary services. Plan approval of referrals is not required for Community Health Plan participating providers. Enter referrals to nonparticipating providers in our Care Management Portal at <https://jiva.chpw.org> for review. After they are entered in our system, they can be reviewed and the provider's claim can be paid.

Nonparticipating provider referrals are reviewed and compared to benefits to ensure that:

- The proposed services are not available within our network of participating providers.
- The number of visits does not exceed the approved guidelines.
- The proposed services are medically necessary.
- The services are a covered benefit.

Referral Form Document:

- [CHITA form](#)

Preapproval (Prior Authorizations)

Certain predetermined services – such as home health care, home infusion therapy, certain durable medical equipment, certain medical pharmaceuticals, certain surgical, diagnostic, and imaging procedures – require an approval by Community Health Plan in advance for the claim for these services to be paid.

The Utilization Reviewer uses approved criteria to review the request and clinical information provided to make a determination for the approval. The Utilization Reviewer may approve the services if they meet medical necessity criteria. If not, the case is referred to the Medical Director for review.

A list of procedures and services requiring prior authorization is maintained separately and may change from time to time based on utilization performance against benchmarks, changes in standards of medical care, new technology, or denial rate.

Prior Authorization Documents:

- [Prior Authorization List](#)
- [Prior Authorization Form](#)

Pre-Admission Authorization

For all types of admissions with the exception of psychiatric and substance abuse, the Utilization Reviewer works with the primary care physician, the attending physician, and the hospital representative to determine whether:

- Hospitalization is medically necessary and a covered benefit.
- Another less costly mode of treatment is available and appropriate to manage the enrollee's medical problem.
- A diversion to an alternative care facility or reduction in level of care is appropriate.
- Admission to an inpatient rehabilitation program meets admission criteria.
- Admission to a skilled nursing or subacute rehabilitation program meets admission criteria.

Requests for scheduled admission and/or surgery are submitted to Community Health Plan at least five days in advance of the admission or procedure by entering request information in the Care Management Portal at <https://jiva.chpw.org> or by sending a written or faxed request to 206-652-7078. Community Health Plan reviews requests for hospital admissions each business day. The provider is notified of the determination and an authorization is placed in the payment system.

Hospital Inpatient Notification

Hospitals are required to notify Community Health Plan of all inpatient admissions within one business day of the admission. Notification does not guarantee payment; payment is subject to enrollee's eligibility and contract benefits (including pre-existing condition review for Basic Health enrollees, if applicable) at the time of service, as well as determinations of medical necessity and the presence of a prior authorization if applicable.

Member eligibility may be verified through One Health Port at www.onehealthport.com or through the CHPW care management portal at <https://jiva.chpw.org>. For those organizations that do not have internet access please contact Customer Service at 1-800-440-1561. Benefit information may be viewed on our web site at www.chpw.org.

Hospitals may enter information about hospital admission notifications via the Care Management Portal at <https://jiva.chpw.org>, or you may use Community Health Plan's [Hospital Notification form](#) or you may submit your own form as long as the following information is included:

- Enrollee's full name
- Enrollee's date of birth
- Enrollee's Social Security Number
- Enrollee's Community Health Plan ID number (if known)
- Date and time of admission
- Discharge date (if known)

- Admit type
 - Planned: routine or elective admission
 - Urgent: direct admission or transfer from another facility
 - Emergent: admitted through the emergency department
- Newborn information: sex; date delivered, type of delivery (vaginal or C-section); bed type (regular or special care nursery/NICU)
- Admitting provider name
- Admitting diagnosis
- Facility name
- Facility contact's name, phone, and fax numbers (usually the person responsible for submitting the notification)

The preferred method for notification is the Care Management Portal or notifications may be faxed to 206-652-7078.

Hospital Inpatient Notification Document:

- [Hospital notification fax form](#)

Eligibility, benefit, and medical necessity evaluation may be done prior to admission, concurrently, or through the review of claims, as applicable. For all enrollees, including Medicare beneficiaries, Care Management staff will coordinate delivery of denial notices by hospital Utilization Review (UR) staff.

Outpatient hospital services do not require hospital notification to Community Health Plan, but may require prior authorization.

Concurrent Review

During the inpatient hospitalization, the enrollee's clinical progress is reviewed by a concurrent review coordinator using clinical criteria approved by Community Health Plan. Frequency of reviews varies according to the enrollee's clinical course. Reviews are accomplished through faxed records from the facility, a telephone review with the facility, or via notes and documents submitted to CHPW via the Care Management Portal.

Discharge Planning Coordination

Discharge planning needs are identified through the concurrent review process or by referral from someone on the enrollee's care team. The extent of the concurrent review coordinator's direct role in planning and arranging post discharge care varies with the enrollee's needs and includes a collaborative approach with the hospital staff, care team, enrollee and family, and community resources as appropriate.

Emergency Room Care

No referrals or authorizations are required for treatment for an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the patient, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

Pre-Existing Condition Review (Basic Health and Washington Health Plan Only)

A pre-existing condition waiting period exists for enrollees whose health coverage is provided by Basic Health or Washington health Plan. Generally, the pre-existing condition waiting period is nine months from the day coverage with Community Health Plan begins unless creditable coverage applies. The PEC waiting period applies to all services (including services provided by the PCP) except for maternity care, prescription drugs, and oxygen therapy. A patient's pre-existing condition diagnoses are available for viewing through the Care Management Portal by hovering over the Pre-Existing Condition hyperlink in the My Patients view section.

PEC Documents

- [Waiting period for pre-existing condition](#)
- [Washington Health Program benefit table](#)

The Utilization Management Department is interested in provider feedback for UM processes that can be improved. Please feel free to email any comments or ideas for improvements to Requests-UM@chpw.org or phone Customer Service at 1-800-440-1561.

Case Management

For enrollees meeting criteria for case management, the case managers will develop and implement individualized case management plans. Services for enrollees with multiple or long-term care needs are carefully coordinated and often involve community support services, home health agencies, rehabilitation, therapies, durable medical equipment, and other coordination needs. For a complete description of the Case Management program and how to make a referral, see the rest of this section. If a patient is currently under case management services a blue dot will be displayed next to the member's name in the Care Management Portal.

Case Management Referral Overview for Practitioners

What Is Case Management?

Case management is a process that promotes:

- A patient's access to care
- The containment of costs
- The enhancement of quality services and products
- The identification of alternative care plans
- The increase of a patient's awareness of his disease
- The facilitation of the enrollee's empowerment over his disease

A case manager's role is advocacy, assessment, and coordination of care between multiple providers and the enrollee.

Who Is Appropriate for Plan-Level Case Management?

- Patients with complex or chronic care needs
- Patients with complex discharge planning needs
- Patients with needs that are beyond the available clinic resources

How Can I Make a Referral to Case Management?

Please see [the referral overview on the Community Health Plan web site](#) for clinic staff, referral form, and contact information.

For more information, call the Customer Service team at 1-800-440-1561.

What Happens When I Make a Referral?

1. A case manager contacts the referral source within one (1) business day after receiving the referral. The conversation focuses on the reason for the referral, and a request for documentation and medical records may be made.
2. The case manager reviews the referred enrollee's information and the documentation. The case manager attempts to contact the enrollee directly for a full assessment.

3. Once contact with the patient is made, the case manager completes the assessment to identify if there is a potential for:
 - a. Quality improvement of the patient's health outcomes
 - b. A coordinated plan of care

Case management services are offered to the enrollee at that time. If the enrollee agrees, the enrollee's case is opened in the Case Management program. If the enrollee does not agree, then Case Management services cannot be offered.

For What Reasons Would an Enrollee's Case Not Be Opened for Plan Level Case Management?

- Inability of the case manager to contact the enrollee after multiple (three or more) phone calls and a written request for contact.
- Enrollee does not meet the above criteria.
- Enrollee does not want a case manager involved in their care.

The referral source will be contacted if a case is not opened for plan level case management services.

What to Expect While an Enrollee's Case Is Open in Plan Level Case Management

1. Once the enrollee's case has been opened to case management, an introductory letter is sent to the patient and to the primary care provider.
2. A collaborative care plan is completed that includes input from the providers involved in the enrollee's care, the plan level case manager, and the enrollee.
3. A copy of this care plan is shared with the patient and the patient's identified primary care provider.
4. The enrollee is followed by the case manager until the treatment plan is completed and the enrollee is able to be managed at the primary care level.

Why Is a Case Closed to Plan Level Case Management?

- The enrollee is no longer eligible with the plan.
- The enrollee is stable and all the interventions of the case manager have been completed.

What Happens After a Case Is Closed to Plan Level Case Management?

- A letter closing the case to plan level case management is sent to the primary care provider and the patient.
- A satisfaction survey is mailed to the patient for evaluation of case management services.

Member Review and Intervention Program

The Member Review and Intervention Program (MRIP) is for Healthy Options, SCHIP, and Disability Lifeline enrollees only. It is a Community Health Plan program designed to control overutilization and inappropriate use of medical services by patients. This program allows restriction of patients to certain providers, including primary care providers (PCPs), pharmacies, and hospitals. Washington Administrative Code covering MRIP (WAC 388-501-0135) establishes the Patient Review & Coordination (PRC) program and allows managed care organizations to perform this function.

MRIP focuses on the health and safety of these patients, who are often seen by several different prescribers, have a high number of duplicate medications, use several different pharmacies, and have high emergency room usage. Based on clinical and utilization findings, patients are placed in MRIP for at least two years.

The Role of the Primary Care Provider in MRIP

The PCP plays a key role in managing the patient's health care. When a patient is restricted, the patient's PCP must approve any care that patient receives from other practitioners or specialists, which may include prescriptions for scheduled drugs (CII–CV).

A major focus of MRIP is to educate the patient about:

- Appropriate use of services
- Relevance of office visits
- Accessing resources in the community and within DSHS
- The importance of maintaining one provider to manage and monitor one's health care

Patients who are currently under review for the MRIP program will have an "MRIP" blue hyperlink displayed in the My Patients view in the Care Management Portal.

MRIP Documents:

- [MRIP for providers information](#)
- [MRIP for providers procedure](#)

The Role of the Pharmacy in MRIP

The primary pharmacy is a key player in managing the patient's prescriptions. The pharmacist will be able to alert the patient's PCP, the Community Health Plan MRIP staff, or DSHS' PRC staff of misuse or potential problems with the patient's prescriptions.

All pharmacy policies remain in effect. However, if the patient goes to a non-assigned pharmacy for scheduled drugs (CII–CV), the claim will be rejected.

The pharmacist may refer the patient back to their assigned pharmacy, or may choose at their discretion to fill the prescription drug and ask the patient to pay cash. However, patient reimbursement by Community Health Plan is **not** guaranteed.

The Role of the Hospital in MRIP

The hospital, particularly the emergency room staff, is a key player in assisting the patient's PCP to more effectively manage the patient's care to avoid unnecessary and costly services, especially emergency room services. By being aware of the patient's restriction, the hospital can assist in the coordination of care by referring the patient back to their PCP and/or pharmacy, whether treatment is provided or not.

We welcome referrals. Please contact us at:

Member Review and Intervention Program (MRIP)
Community Health Plan
720 Olive Way, Suite 300
Seattle, WA 98101
Phone 206-521-8833

Enrollees may self refer to the program by calling Customer Service: 1-800-440-1561 for State programs (8 a.m. to 5 p.m. Monday through Friday) and 1-800-942-0247 for Medicare programs (8 a.m. to 8 p.m. every day). Voicemail may be left after hours.

Disease Management Program

Community Health Plan has determined three chronic care programs that are relevant and address the needs of its enrollee population. The programs are diabetes and asthma for all enrollees, with the addition of hypertension for Medicare enrollees.

Disease management components include:

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers
- Patient self-management education (may include primary prevention, behavior modification program, and compliance/surveillance)
- Process and outcomes measurement, evaluation, and management

The Community Health Plan Disease Management program works with a practitioner's patient in several ways. This includes the following actions:

- Promote disease specific education through productive interactions with enrollees.
- Coordinate with practitioners to assure the delivery of key clinical and behavioral elements of care.
- Identify high risk, high cost enrollees with diabetes and/or asthma with complex medical and/or psychosocial needs to assess treatment options and opportunities for improved outcomes.

Disease Management Program

The programs use third-party risk-stratification programs to identify enrollees who qualify for DM programs by using the following data sources:

- Claims or encounter data
- Pharmacy data if applicable
- Health risk appraisal results
- Laboratory results if applicable
- Data collected through the care management or case management process if applicable
- Enrollee and practitioner referral

All newly identified enrollees are automatically enrolled in the program.

The objectives for the Disease Management programs include the following:

- Improve the ability of enrollees to self-manage their disease through the provision of relevant information, tools, and training.
- Increase enrollees' knowledge of their condition and treatment options and delay further progression and related complications.
- Improve health outcomes and compliance with disease-specific evidence-based guidelines.
- Enhance quality of life by encouraging and empowering enrollees with self-management.
- Optimize how enrollees use health care.
- Assist enrollees in accessing care and test results, and achieving recommended levels of control.

All enrollees identified will receive a welcome letter to the Disease Management program and semiannual DM educational materials. Enrollees will receive other education materials based on their need, acuity level, individual care plan, and consultation with PCP.

Community Health Plan provides eligible enrollees with written program information regarding:

- How to use the DM services
- How enrollees become eligible to participate in the programs
- How to opt in or out of the programs

Additionally, educational materials are available to all enrollees. See the [disease management guidelines](#).

The enrollees are systematically identified monthly for each of the programs: low acuity (level I), moderate acuity (level II), and high acuity (level III).

Low acuity, level I:

These enrollees have, for example, mild to moderate asthma or well controlled diabetes. They are connected to their PCP, who coordinates their care, and are informed and active in the management of their condition. They are connected to their community resources.

Intervention: They will receive semi-annual disease-specific educational information.

Moderate acuity, level II:

These enrollees with a chronic condition would benefit from disease, medication, or safety education. They may have comorbid conditions. Their connection to their PCP or community resources may be fragmented. There may be cultural, language, psychosocial, or transportation barriers to care. There is some medical plan of care or medication non-adherence concern.

Intervention:

- Follow-up letter generated to PCP post Health Risk Assessment (HRA).
- Patient clinical needs-specific education materials sent.
- Referral as necessary by DM team to community resources.
- If indicated, the enrollee is referred to plan level case management services.

High acuity, level III:

The HRA DM psychosocial assessment data confirms these enrollees have a severe and/or deteriorating chronic condition, multiple comorbidities, complex care needs, and multiple medications.

They may require DME and/or custodial care. They may be poorly connected to their PCP and specialists, who may not be collaborating on a care plan. There are cultural, language, psychosocial, or transportation barriers to obtaining services. Community resources have not been accessed. ER use may be high and hospitalizations may be frequent. Care plan and medication non-adherence may be present and could be life threatening.

Intervention:

- Follow-up letter generated to PCP post HRA.
- Summary of findings and recommendations is created and sent to the PCP.
- Patient-specific clinical education materials sent.
- Community resources referral and entitlement assessment.
- If indicated, the enrollee is referred to plan level case management services.

Disease Management Referral Process

Enrollees can be referred to Community Health Plan Disease Management by faxing the referral form to 206-652-7073.

The [referral form](#) can be found on the Community Health Plan web site.

Clinical Care Management Criteria

Community Health Plan has elected to use Milliman Care Guidelines 14th edition as the criteria for use as guidelines, benchmarks, and comparison criteria in the Care Management program. Equal weight is given to guidelines and individual case information. Community Health Plan's medical directors will take into consideration the enrollee's age, social situation, comorbidities, and availability of services within the community when making utilization review determinations. These guidelines are available through the Care Management Portal at <https://jova.chpw.org>.

Transition of Care

From time to time, enrollee benefits may expire during a course of treatment through termination of the contract, disenrollment, or exhaustion of available benefits. The Care Management staff will work with enrollees to assist in transitioning to other care when necessary. They will make contact with community agencies or make referrals to public assistance as appropriate and authorized by the enrollee.

Pharmacy Management

Drug Formulary and Medication Utilization

Healthy Options, CHIP, Disability Lifeline, and Basic Health

The Community Health Plan drug formulary is developed by the Community Health Plan Pharmacy and Therapeutics Committee. The formulary is available in book format, [searchable on the www.chpw.org web site](http://www.chpw.org), and also by downloading onto a PDA from epocrates.com.

For all Community Health Plan enrollees, submit prior authorization, step therapy, and non-formulary medication requests as well as requests for quantity overrides for review to Community Health Plan's pharmacy benefit manager, Express Scripts Inc. (ESI). All requests will be resolved by ESI within 48 hours.

Note: ESI requires a Community Health Plan member number to process requests. You may obtain a member number from Community Health Plan Customer Service at 1-800-440-1561 or through One Health Port.

Medicare Advantage Plan

The Community HealthFirst drug formulary is developed by the ESI Pharmacy and Therapeutics Committee. The formulary is available in book format, [on the HealthFirst web site](http://www.healthfirst.com), and also by downloading onto a PDA from epocrates.com.

For all Community HealthFirst Part D beneficiaries, submit prior authorization, step therapy, and non-formulary medication requests as well as requests for quantity overrides for review to ESI. All requests will be resolved by ESI within 72 hours.

Note: ESI requires a Community HealthFirst beneficiary number to process requests. You may obtain a member number from Community HealthFirst Customer Service at 1-800-942-0247.

Notification Regarding Formulary Changes: For updates regarding periodic changes to the formulary and other pharmaceutical management programs please see the [enrollee pharmacy web page](#).

Prior Authorization, Step Therapy, Nonformulary, and Quantity Override Requests

Healthy Options, CHIP, Disability Lifeline, and Basic Health

To request a prior authorization, step therapy, nonformulary, or quantity limit override, please call ESI at 1-888-256-6132, 24 hours a day, 7 days a week, and speak to a prior authorization service specialist. This specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

If the drug is denied by ESI, you may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by ESI, to:

Community Health Plan
Attn: Appeals Coordinator
720 Olive Way, Suite 300
Seattle, WA. 98101
Fax 206-613-8983

Expedited appeals are reserved for emergency situations only. Call 1-800-440-1561.

Medicare Advantage Plan

To request a prior authorization, step therapy, nonformulary, or quantity limit override, please call ESI at 1-800-417-8164, 24 hours a day, 7 days a week, and speak to a prior authorization service specialist. The specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

If the drug is denied by ESI, you may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by Express Scripts, to:

Community Health Plan
Attn: Community HealthFirst Appeals
720 Olive Way, Suite 300
Seattle, WA. 98101
Fax 206-613-8983

Expedited appeals are reserved for emergency situations only. Call 1-800-942-0247.

Pharmacy Benefit Exclusions

Healthy Options, CHIP, Disability Lifeline, and Basic Health

Certain medications are benefit exclusions and are not covered under any circumstances.

These include:

- Non-FDA approved drug products
- Experimental and investigational (E & I) drugs
- Compounded drugs with non-FDA approved ingredients
- Drugs for weight loss or appetite suppression
- Drugs for impotence or sexual dysfunction
- Drugs to treat cosmetic conditions
- Infertility drugs

Prescriptions for Healthy Options, CHIP, and Basic Health Plus enrollees written by Regional Support Network (RSN) providers are **not** covered if these enrollees meet RSN access standards: They are covered and billed through HRSA as a fee-for-service item. (The pharmacy help line for HRSA is 1-800-365-4944.)

Medicare Advantage Plan

Certain medications are not covered by Part D.

These include:

- Benzodiazepines
- Barbiturates
- Drugs for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or for hair growth
- Drugs used for symptomatic relief of cough and colds
- Drugs for erectile dysfunction
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products
- Nonprescription or over-the-counter (OTC) drugs
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated test and monitoring services be purchased exclusively from the manufacturer or its designee

Quality Program

Overview

Community Health Plan's Quality Improvement Program is committed to assuring that the health plan's enrollees have access to health care that meets the Institute of Medicine (IOM) aims of being safe, effective, patient-centered, timely, efficient, and equitable.

The purpose of the Quality Improvement program description is to:

- Define the scope, goals, and objectives of the program
- Present the methods used in improvement activities
- Outline the structure of the program
- Delineate the oversight and guidance of the program.

The Quality Improvement Program is approved annually by the Board of Directors.

The key to the success of this program is the recognition that a major contribution to our communities is support of strong relationships between patients and their families and their providers and care teams. The work of all at Community Health Plan directly or indirectly supports this relationship.

Program Scope

Community Health Plan monitors, measures, and analyzes the key aspects of care and service. It then uses this information to create specific quality improvement initiatives and other interventions for improvement. These areas of focus include:

- Access to care
- Availability of services
- Enrollee experience
- HEDIS® and CAHPS® results
- Assessment of provider satisfaction
- Utilization trends

The assessment of care and service is compatible with evidence-based objectives and national standards.

Executive and department leadership is responsible for quality improvement within their departments as well as collaborating in quality improvement activities across the organization. The departments create annual work plans that present planned initiatives and ongoing activities with a brief description of the work, the time for completion, the individual responsible for the activity, and the committee responsible for oversight. These work plans together compose the organization's Quality Improvement work plan.

Program Structure and Leadership

Board of Directors. The Community Health Plan Board of Directors maintains the authority and responsibility for the care and service delivered to enrollees. The Board of Directors assigns the authority for oversight of the Quality Improvement Program to the Chief Medical Officer. The Board annually approves the Quality Improvement Program Description.

Chief Medical Officer/Senior Vice-President. The Chief Medical Officer/Senior Vice President (CMO) is a Washington State licensed, board certified physician. The Chief Medical Officer oversees Community Health Plan's Quality Improvement Program. The CMO is a standing member of the Quality Council. The CMO is responsible for the delivery of medical and behavioral healthcare through oversight of the Pharmacy, Care Management, and Quality Departments, and the Medical Directors.

Medical Directors of the Health Plan. The Medical Directors are Washington State licensed, board certified physicians. The Medical Directors provide assistance to the CMO in providing clinical guidance and direction to the organization. This includes evaluation of new medical technologies, developing criteria for standards of performance to evaluate provider compliance with clinical practice and preventive health guidelines, and providing oversight to physician reviewer and consultant activities. The Medical Directors communicate with practitioners regarding features of the Utilization Management, Case Management, and other clinical programs as needed. A Medical Director chairs the Pharmacy and Therapeutics Committee and the Credentialing Committee, manages the adverse event reporting process, supports peer review and disciplinary action, and attends the Utilization Subcommittee.

Quality Council. The Quality Council oversees the development of the Community Health Plan Quality Improvement Program Description, Quality Improvement Work Plan and Quality Improvement Annual Evaluation. The Council is responsible to the Board of Directors. The Council establishes the scope of the QI program and prioritizes activities based on a whole system view of the health plan's clinical activities, service, and operations.

Goals

1. Improve the clinical measures (HEDIS rates) for asthma, diabetes, depression, well child exams, and immunizations.
2. Improve service quality as measured by CAHPS for access to care measures and Plan customer service.
3. Improve operational efficiency for health plan operations.
4. Improve coordination of care and patient safety.

Quality Documents:

- Continuity of care procedure
- Community Health Plan clinical quality patient safety medical management procedure
- Patient complaint resolution form