

How We Make Sure You Get the Best Health Care



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Quality Improvement Program

The Community Health Plan Quality Program makes sure our service meets clinical and customer service standards. We set some standards ourselves and we comply with those set by government and national organizations that measure quality.

We set and meet our quality standards by using teamwork guided by our mission, vision, values, and goals. The Quality Program is managed by a committee that gets data and recommendations and directs improvement work.

We have programs in place to assess and improve patient safety, clinical quality, and the quality of behavioral health services. We understand that one of the greatest tools in preventing chronic disease and getting appropriate preventive care is knowledge. Our efforts to help you manage your health include programs to manage diabetes and asthma. We help you assess your risk of diseases such as diabetes, encourage you to get proper treatment and care, and inspire you to take charge of your chronic conditions for a lifetime.

To succeed in these efforts, the Quality Program has developed materials to help you better manage your health and to understand your chronic conditions and any complications. Our programs also keep track of how we deliver care to you and provide education for health care staff.

We use HEDIS (Healthcare Effectiveness Data and Information Set) as one set of standards to measure our performance. In 2009, HEDIS results showed that:

- Immunization rates increased by 1% to 3.16%, depending on the type of immunizations—the best results in Washington state.
- Diabetes care improved. Eye exam rates and cholesterol control both improved by 3.16%.
- Asthma control rate improved by 4.83% for all age groups.

Our commitment to you is that we will not stop working to improve until all of our members are very satisfied with our services.

We will continue to work to improve these and other areas in future years. We want you to be able to manage your chronic conditions and learn from the information that we give you. We want to help you work with your doctor to best manage your care and make sure that you get the services that you need.

If you have any questions about or would like more information about the Quality Program, call the Community Health Plan customer service team at 1-800-440-1561 (toll free). If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875.

Care Management

The Utilization Management, Behavioral Health, Case Management, and Disease Management programs are part of Care Management. The Community Health Plan Chief Medical Officer oversees Care Management and Quality Improvement. The Director of Behavioral Health guides the behavioral health team.

Utilization Management: Working to Get You Covered and Necessary Care

The Utilization Management program makes sure that you and your provider use services in a way that promotes the highest quality, most cost-effective care that results in the best health for you. Utilization Management supports Community Health Plan providers in their efforts to provide the right amount and type of services—not too much and not too little. The Plan looks at the research and medical information to decide which services, medications, and treatments are best for you and the most cost effective.

The Community Health Plan model for using services correctly is based on your primary care physician managing all of your health care needs.

The program's goals are to:

- Teach providers how to use health care resources in the most proper and cost-effective way.
- Teach you how to use services effectively.
- Make sure that decisions about service use are fair, and that all providers use the same criteria.

- Promote the highest quality of care.
- Quickly find and solve any problems with how services are used.

Behavioral Health

The Behavioral Health program works with medical providers to coordinate care. Behavioral Health includes mental health care and treatment for alcohol and drug abuse. The Behavioral Health program researches and monitors use of services. This helps you and your providers use resources in the highest quality, most cost-effective way. You may get Behavioral Health care through your care coordinator at the clinic.

Community Health Plan offers our Nurse Advice Line at 1-866-418-1002 if you have behavioral health issues and cannot reach your provider. If you think that the issue might be life threatening, dial 911 or go to the nearest emergency room.

Clinical Criteria

All employees who make clinical decisions regarding a member's care are licensed by the State of Washington. Supervisors of staff who make clinical decisions are also licensed and have at least five years of experience as clinicians. Proof of the current active status of clinical licenses is kept on file at all times.

Community Health Plan decides which treatments are most effective by:

- Looking at what works for our members over time.
- Consulting internal and external doctors and experts, including specialists to help decide about complex cases.
- Using guidelines such as the Milliman Care Guidelines® and the Washington State Health Care Authority Healthy Technology Assessment.
- Keeping track of government agency reports such as those from the FDA (Food and Drug Administration).
- Asking for help from independent review organizations.

Community Health Plan keeps track of how you and your provider use services. If you or your provider use more or less of a particular service than the standard:

- We might refer you to Case Management, which can help you manage complex health conditions. For more information, see [Case Management](#).
- We might refer you for additional services.
- We might refer you to the Member Review and Intervention Program (MRIP). For more information about MRIP, see [Member Review and Intervention Program \(MRIP\)](#).
- We might deny approval for a service or drug if it does not conform to our guidelines.

For more information about approvals, see "About Prior Authorizations and Referrals."

For more information about how to appeal denials, see "Grievances and Appeals."

‘Medically Necessary’

Medically necessary health care services are used to evaluate, diagnose, or treat an illness, injury, or disease or its symptoms.

A medically necessary service must be:

- In line with standards of practice, based on scientific research and clinical findings by other doctors.
- An effective treatment for the patient’s illness, injury, or disease.
- No more expensive than other equally effective services.
- Not primarily for the patient’s or the doctor’s convenience.

Evaluation of New Technology

Community Health Plan is committed to keeping up with news and research about new tests, drugs, treatments, and devices and new ways to use current procedures, drugs, and devices.

A provider or member can ask the Plan to cover a new technology. A Community Health Plan doctor leads the review of the new technology and may ask an outside reviewer to give an opinion, too.

For more information about how the Community Health Plan uses research and outside experts to decide, see [Clinical Criteria](#).

New technologies are approved based on standards that protect patient safety. To learn more about the decision process or the specific standards, please call our Utilization Management team. See [Contact Utilization Management](#).

Policy Prohibiting Financial Incentives

Community Health Plan staff and providers okay or deny services. We use information from your doctor to do this. We also look at medical standards. We do not offer decision-makers money to decide either way. We do not stop using providers if they disagree with our decisions. Our decisions are fair and equal.

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 under-using care or services.

Contact Utilization Management

If you have a question about a utilization management issue or want to learn more about utilization management processes, please talk to our staff. To contact the Utilization Management staff, call the Community Health Plan customer service team at 1-800-440-1561 (toll free). If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875. If you are calling from a location that does not accept toll-free calling, Community Health Plan will accept your collect call.

If you need information about any health issue and you cannot reach your provider, you can call our Nurse Advice Line at 1-866-418-1002 toll free, 24 hours a day and seven days a week. For more information about the Nurse Advice Line, see "24-Hour Nurse Advice Line."

Case Management

Case managers work with you and your provider to help manage your care if you become very sick. Case Management is a voluntary program. You do not have to be in it. You may be referred to Community Health Plan Case Management in a number of ways:

- Your provider or clinic staff may refer you to our case management services.
- We may see the need based on a hospital stay, a survey, or a review of your medical bills.
- You may also refer yourself for case management by calling the customer service number below.

If you have any questions about this program, call the Community Health Plan customer service team at 1-800-440-1561 (toll free). If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875.

Disease Management

Community Health Plan offers a free disease management program for members with chronic (long-term) diseases such as asthma and diabetes. The nurses and social workers will work closely with your PCP on the best care plan. When you are in this program you will get materials about your condition.

Disease management is a voluntary program. You do not have to be in it.

You can be referred to Community Health Plan Disease Management in a number of ways:

- Your provider or clinic staff may refer you to our disease management services.
- We might see the need based on a hospital stay, a survey, or a review of your medical bills.
- You can refer yourself for disease management by calling the customer service number below.

If you have any questions about this program, call the Community Health Plan customer service team at 1-800-440-1561 (toll free). If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875.

Member Review and Intervention Program (MRIP)

Community Health Plan's Member Review and Intervention Program (MRIP) helps members to use their medical services safely and appropriately.

Some members get care from several different doctors. They have a high number of the same medications. They use different pharmacies. They use the emergency room a lot. Sometimes the care is not coordinated and can be dangerous. Sometimes we place these people in MRIP because of these problems.

Members who are selected for MRIP must choose one primary care provider, pharmacy, and hospital. If the member does not choose providers, Community Health Plan will choose them for the member. Members in MRIP must go to these providers only. If a member in MRIP goes to any other provider, the member must pay for the service.

One primary care provider makes sure medical care and prescriptions are coordinated for the health and safety of the member. MRIP makes this possible.

Members stay in the MRIP program for at least two years. This is determined by state law (Washington Administrative Code 388-501-0135) if it applies.

Community Health Plan will contact you if you are being considered for this program.