



**COMMUNITY
HEALTH PLAN**
of Washington™

Special Needs Plan and Model of Care Annual Training

CHPW's Mission

The mission of Community Health Plan of WA is to deliver accessible managed care services that meet the needs and improve the health of our communities and make managed care participation beneficial for community-responsive Providers.



CMS Training Requirement

CMS requires Community Health Plan of Washington (CHPW) to provide basic Special Needs Program (SNP) and Model of Care (MOC) training to employed and contracted personnel who coordinate the delivery of care, as well as those Providers who deliver care to our SNP members.



Learning Objectives

- Describe Dual Eligible Special Needs Plan (SNP) components and benefits.
- Understand how members qualify for SNP.
- Describe components of our SNP Model of Care.
- Explain SNP Care Management processes.
- Describe Provider's role.



Special Needs Plans (SNP) Background

- In 2003, Special Needs Plans (SNP) were created as part of the Medicare Modernization Act. SNPs must offer special benefit packages and services that facilitate improved and cost effective care for the well being of aging, vulnerable, and chronically ill individuals.
- SNPs may target one of three populations: Chronic Condition, Dual Eligible, or Institutionalized.
- CHPW covers Dual Eligibles (DE). DEs are individuals who are entitled to Medicare and some level of assistance from Washington Medicaid.

For our Plan, members must be in one of the following Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+)**
- **Qualified Medicare Beneficiary Only (QMB Only)**



Coordination of Medicare and Medicaid

Coordination goals include:

- Members are informed of benefits offered by both programs.
- Members are provided with information on how to maintain Medicaid eligibility.
- Members have access to staff that have knowledge of both programs.
- Plan provides clear communication regarding claims and cost-sharing from both programs.
- Members are informed of rights to pursue appeals and grievances through both programs.
- Members are provided information on how to access providers that accept Medicare and Medicaid.



Dual Eligible SNP Goals

- Improve access to affordable medical, mental health, and social services.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings, providers, and health services.
- Improve access to preventive health services.
- Assure appropriate utilization of services.
- Improve health outcomes.
- Engage Providers in plan support services.



CHPW's Dual Eligible SNP Model of Care (MOC)

- Specialized Provider Network
- Integrated Communication Systems
- Additional Benefits
- Case Management for all Members
- Annual Health Risk Assessments for all Members
- Individualized Care Plan for Each Member
- Interdisciplinary Care Team to Coordinate Care
- Care Transition Management
- Coordination of Medicare and Medicaid Benefits
- Quality Improvement Program
- Chronic Care Improvement Program



Health Services

Benefits and Model of Care (MOC) are designed to optimize the health and well being of aging, vulnerable, and chronically ill individuals by:

- Matching interactions with member needs in their current state of health.
- Identifying care needs through a comprehensive initial assessment and annual reassessments.
- Creating individualized care plans with goals and measurable outcomes.
- Building an interdisciplinary care management team to meet these needs.
- Ensuring members' Providers are involved in care decisions.
- Managing utilization (same as with our other Medicare plans).



Health Integrated

CHPW has contracted with Health Integrated to provide Care Management Services.

- Perform Health Risk Assessments upon enrollment and annually thereafter.
- Develop and manage Individualized Care Plans.
- Coordinate healthcare needs between the member and those involved with their care.



Case Management

- All SNP members are enrolled in case management.
- Each member has an individualized care plan developed.
- Members may opt out of case management but remain assigned to a Case Manager.
- Members are stratified according to their risk profile to focus resources on the most vulnerable.



Interdisciplinary Care Team (ICT)

The ICT meets regularly to manage the medical, cognitive, psychosocial and functional needs of the member. The member and/or caregiver is included on the ICT.

Required Team Members

- Physician – The primary care physician is invited to attend the ICT for care plan review
- Social Services Specialist
- Pharmacist
- Nurse Case / Disease Manager
- Behavioral health specialist

Optional Team Members

- Specialty providers
- Nurse Practitioners
- Pastoral Care
- Palliative Care
- Home Care
- Dietician / Nutritionist



Health Risk Assessments

Initial and annual assessments are conducted telephonically, unless member refuses telephonic and prefers to submit a self-completed paper assessment.

- A comprehensive initial assessment is completed within 90 days of enrollment
- An annual reassessment of the individual's medical, physical, cognitive, psychosocial and functional needs is also provided.



Individualized Care Plan (ICP)

Case Managers create an Individualized Care Plan (ICP). The member and/or caregiver is involved in the development of the care plan. The ICP is:

- Based on the member's HRA and identified problems.
- Prioritized considering member preferences and desired level of involvement in the case management process.
- Updated when there is a change in the member's medical status.
- Communicated when there is a transition to a new care setting, such as the hospital or skilled nursing facility.
- Communicated to each member's caregiver and primary physician.



Chronic Disease Management

Helps members with:

- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)/Asthma
- End Stage Renal Disease (ESRD)
- Diabetes
- Other chronic conditions
- Focused education to members about their disease, self-management/self-care, medication, and nutrition.



Management of Care Transitions

Members are faced with significant challenges when moving from one setting to another. The management of transitions is focused on supporting members with their treatment plan as they move from one setting to another to prevent re-admission.

- The Inpatient Concurrent Review and Care Coordination processes allow identification of transition of care needs.
- Clinical staff coordinate with providers to assist members in the hospital, skilled nursing facility or other setting to access care at the most appropriate level.
- The SNP Case Managers and Social Workers ensure that members have appropriate follow-up care after transition to any new setting.



Quality Improvement Program

Health plans who administer a Special Needs Plan (SNP) must conduct a Quality Improvement Program (QIP) to monitor health outcomes and implementation of the MOC:

- Collecting SNP specific HEDIS® measures.
- Meeting NCQA SNP Structure and Process standards.
- Conducting a Quality Improvement Program (QIP) annually that focuses on improving a clinical service aspect that is relevant to the SNP population (i.e., Fall Prevention).
- Providing a Chronic Care Improvement Program (CCIP) for chronic disease that identifies eligible members, intervenes to improve disease management and evaluate program effectiveness.
- Collecting data to evaluate if SNP goals are met.



CMS / NCQA Improvement Measures

NCQA gradually phased in six SNP standards and sixteen HEDIS® measures for SNP members. The SNP standards evaluate Plan performance in several key areas:

- **SNP 1** – Case Management
- **SNP 2** – Improving Member Satisfaction
- **SNP 3** – Clinical Quality Improvements
- **SNP 4** – Managing Transitions
- **SNP 5** – Institutional SNP
- **SNP 6** – Coordinating Medicare and Medicaid Coverage



Special Needs Plan (SNP) Specific HEDIS® Measures

- Colorectal Cancer Screening
- Care for Older Adults
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management
- Antidepressant Medication Management
- Follow-up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge
- Potentially Harmful Drug-Disease Interactions in the Elderly
- User of High-Risk Medications in the Elderly
- Plan All-Cause Readmissions
- Board Certification



SNP Performance Evaluation

CHPW evaluates performance using quality indicators that are objective (i.e., health and functional status and member satisfaction).

CHPW collects, analyzes, and reports quality outcome measurements (HEDIS, HOS, and CAHPS) to CMS.



Working With Our Provider Partners

CHPW's SNP Model of Care offers an opportunity for us to work together for the benefit of our member/your patient, by:

- Frequent and enhanced communication.
- Focusing on each individual member's special needs.
- Delivering case management programs to assist with the patient's non-medical needs.
- Supporting your plan of care.

CHPW's Provider partners are an invaluable part of the SNP Management Team.



Your Role As The Provider

- Provide services consistent with your medical judgment and experience.
- Assist members in obtaining both Medicare and Medicaid benefits, including Medicaid-only covered services.
- Assist members in accessing Providers who participate in the CHPW and Medicaid/WA Apple Health networks.
- Refer members with detailed questions about how their benefits work to our Customer Service Center. Please see following slide for Community HealthFirst (Medicare) Customer Service contact information.

Submit claims directly (preferably electronically) to:

- **Community HealthFirst Plan (primary – CHPW’s Medicare Advantage)**
- **Medicaid (secondary - WA Apple Health)**



Contact Information

Community HealthFirst (Medicare) Customer Services		
Plan Served	Receive answers on the following:	Contact numbers:
	<ul style="list-style-type: none"> ▪ Appeals & Grievances 	 (800) 942-0247 Customer Service
	<ul style="list-style-type: none"> ▪ Claims Status ▪ Eligibility Verification ▪ General Information 	 TTY/TDD Dial relay 7-1-1
	<ul style="list-style-type: none"> ▪ Hospital Notifications 	 (206) 652-7050 Customer Service Fax
	<ul style="list-style-type: none"> ▪ Member Benefits ▪ PCP Changes ▪ Prior Authorization 	 customer care@chpw.org
	Status	



Your Role As The Provider

In support of our Care Plan Management service:

- Communicate with CHPW SNP Case Managers, members of the Interdisciplinary Care Team (**ICT**), members, and caregivers.
- Collaborate with CHPW on the Individualized Care Plan (**ICP**).
- Access **ICP** information online.
- Review and respond to patient-specific communications.
- Maintain **ICP** in member's medical record.
- Participate in **ICT**.
- Assist members with the referral process (consider using CHPW's Care Management Portal (JIVA) for more efficient referral submissions).
- Submit authorizations consistent with CHPW requirements.



Special Needs Plan and Model of Care Training for Provider Network

CHPW's Providers will have access to SNP-MOC training annually through the following options:

- On-line at: www.chpw.org – on Home Page:
 - Click “For Provider”
 - Click “Orientation, Training and Education”
- On-site Training
- *CHPW staff are also trained annually.*



Attestation Required

Thank you for completing the Special Needs Plan and Model of Care Annual Training. Please take a moment to submit the required attestation by clicking the following link:

[Attest Now!](#)



Thank you for completing your training.
We hope that you found the information
helpful!

