

Special Needs Plan and Model of Care Annual Training - 2018



COMMUNITY HEALTH PLAN
of Washington™

CHPW's Mission



- Deliver accessible managed care services
- Meet the needs of, and improve the health of, our communities
- Make managed care participation beneficial for community-responsive providers

Training Goals

- **Understand** the Social Determinants of Health affecting members enrolled in the Special Needs Plan (SNP)
- **Explain** and apply the SNP model in the context of CHPW
- **Comply** with CMS requirements by offering this training to employees, contractors, and care providers

Understand...



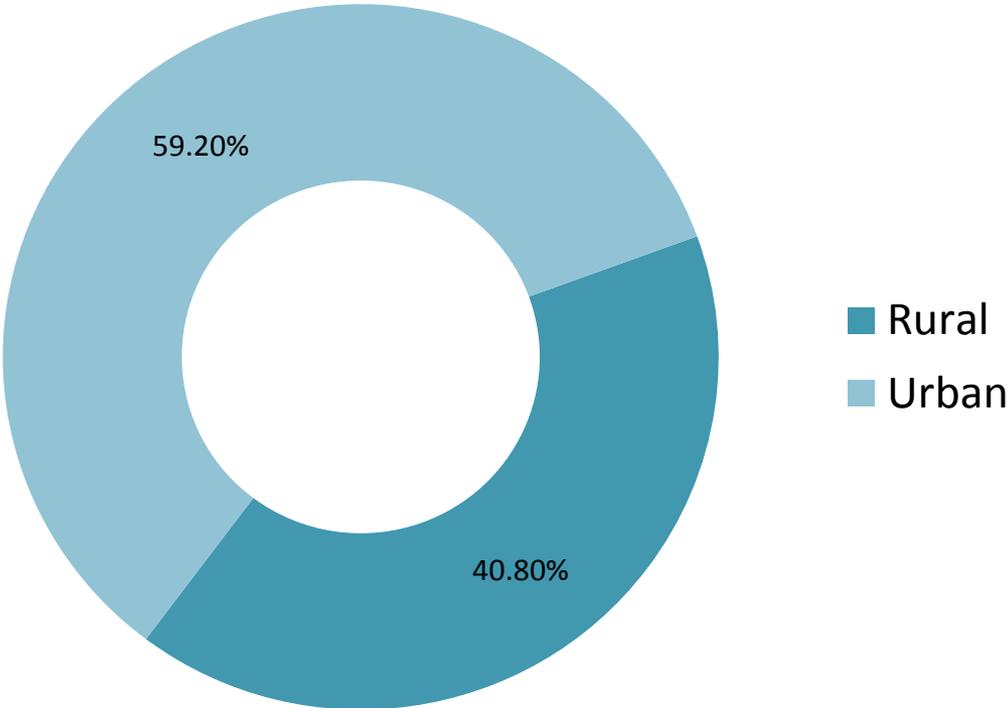
COMMUNITY HEALTH PLAN
of Washington™

Social Determinants of Health

“The social determinants of health are the conditions in which people are born, grow, live, work and age.” — *The World Health Organization (WHO)*



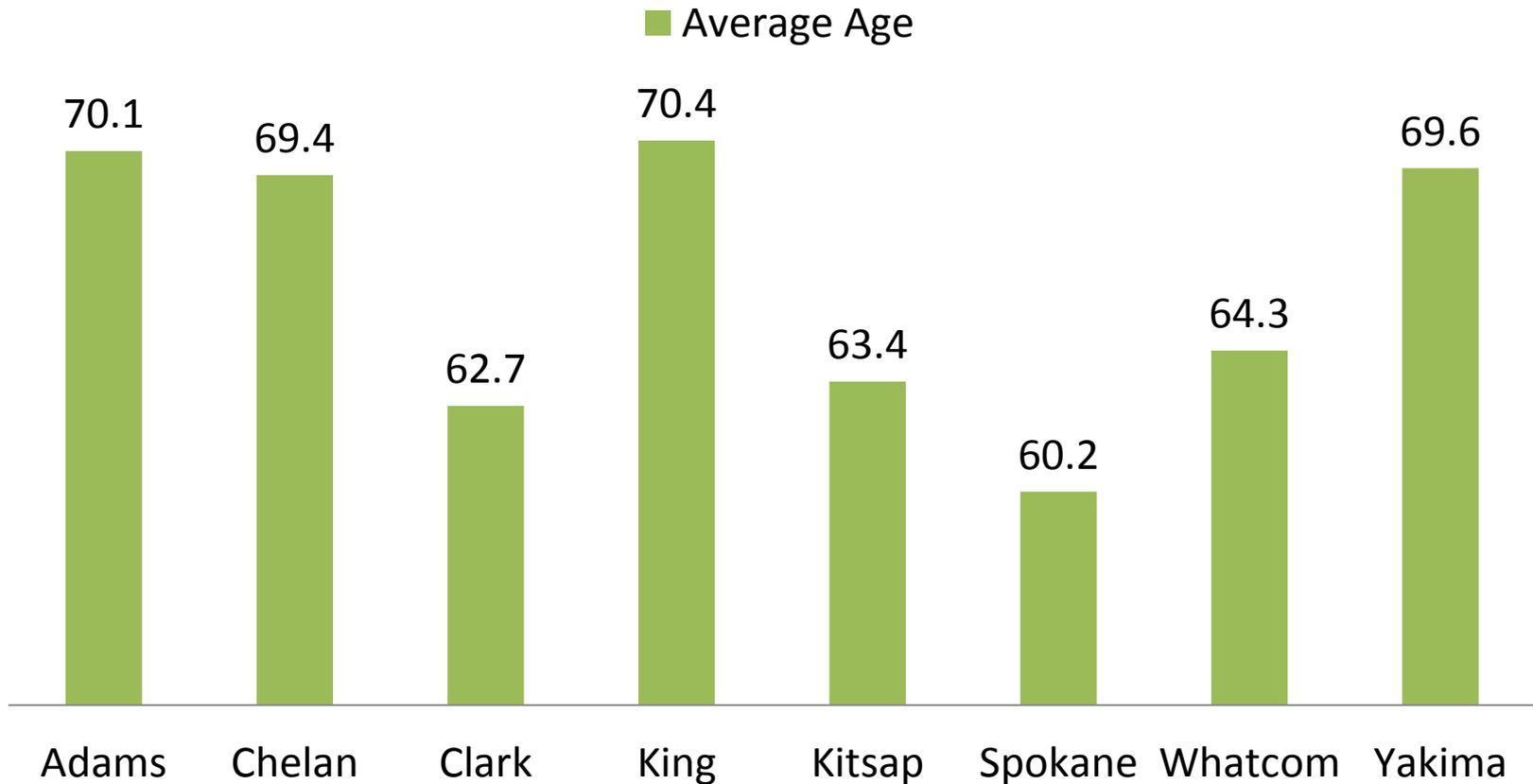
CHPW's SNP Members – *By the Numbers*



Data source: CHPW Enrollment Data as of January 2018



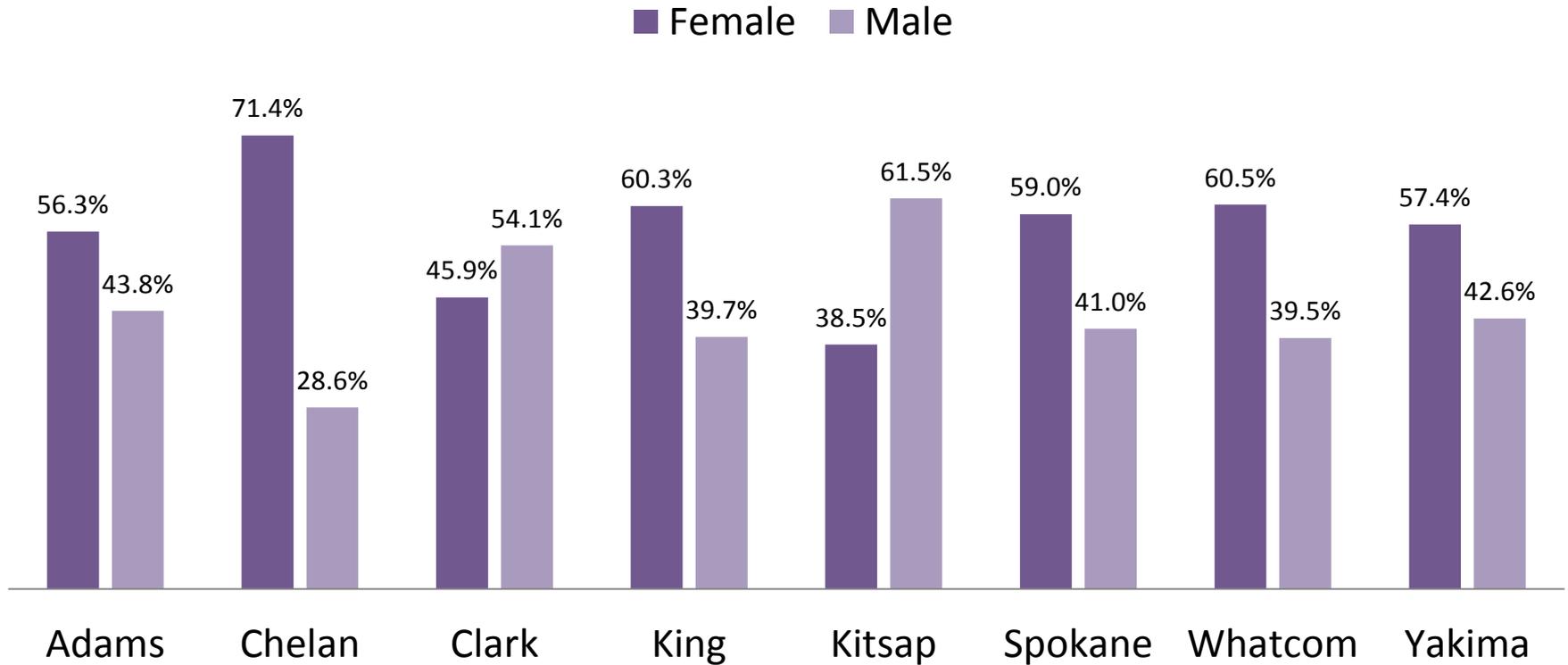
CHPW's SNP Members – *By the Numbers*



Data source: CHPW Enrollment Data as of January 2018



CHPW's SNP Members – *By the Numbers*



Data source: CHPW Enrollment Data as of January 2018



Explain...



COMMUNITY HEALTH PLAN
of Washington™

Background

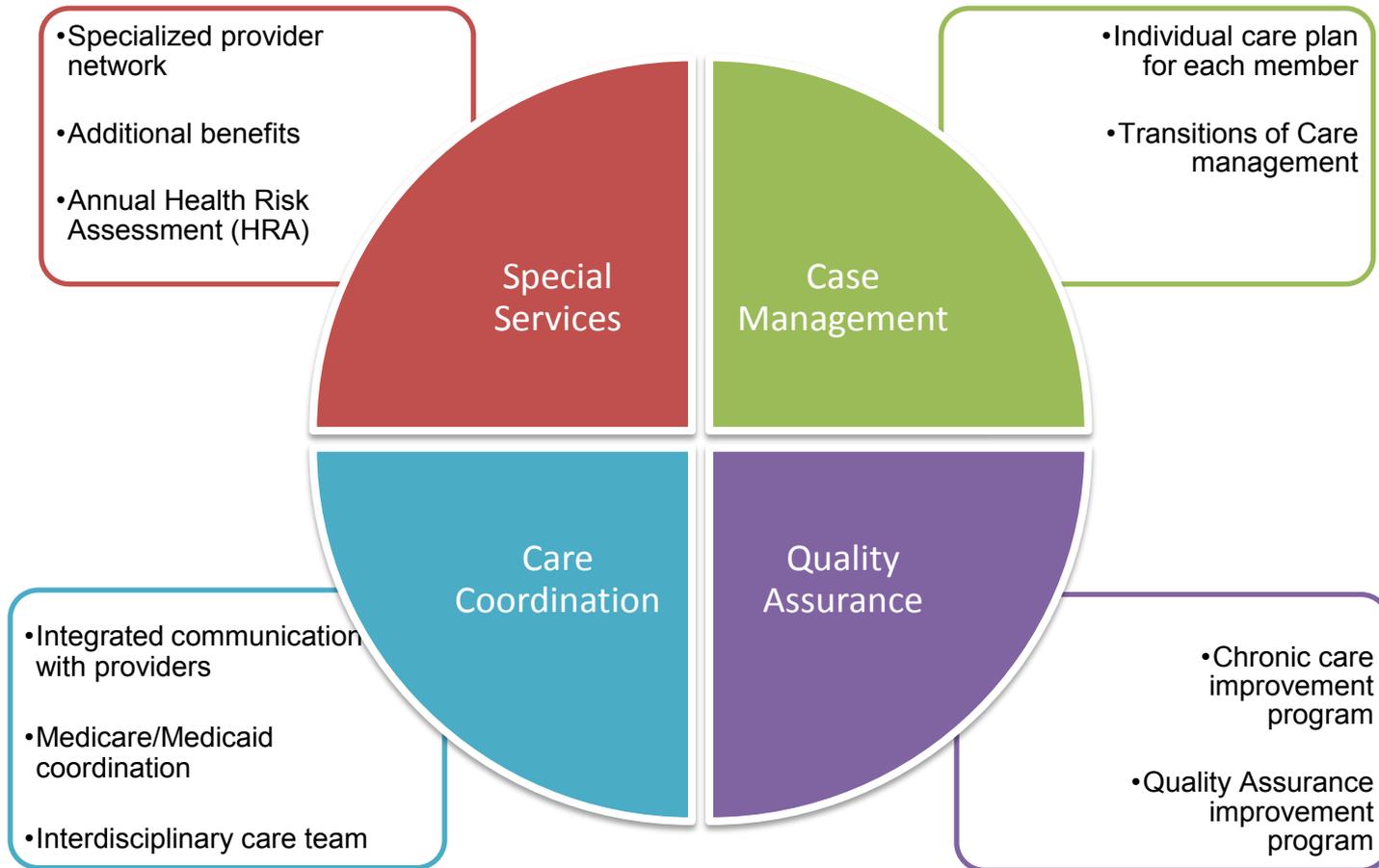
- In 2003, SNPs were created as part of the Medicare Modernization Act. SNPs must offer special benefit packages and services that facilitate improved and cost effective care for the well being of aging, vulnerable, and chronically ill individuals.
- SNPs may target one of three populations: Chronic 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 SNP Plan, members must be in one of the following Medicaid categories:

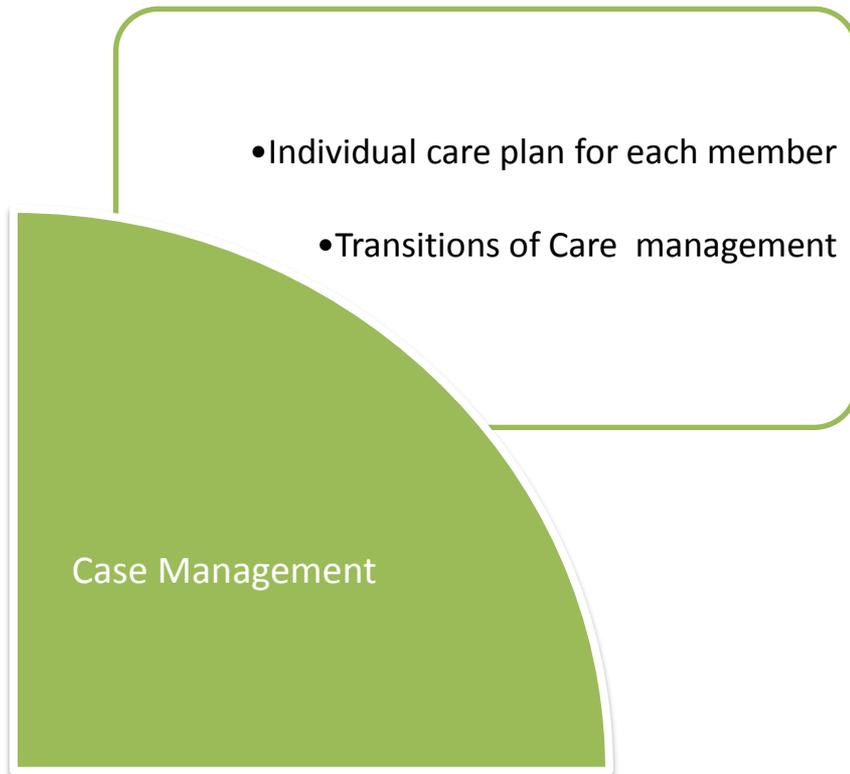
- **Qualified Medicare Beneficiary Plus (QMB+)**
- **Qualified Medicare Beneficiary Only (QMB Only)**

These two categories of dual eligible beneficiaries are not financially responsible for cost sharing for Medicare Parts A or B, unless they have spenddown as determined by the State of Washington

Services for SNP Members



Coordination of Medicare and Medicaid



Goals:

- 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 with 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

Individualized Care Plan (ICP)

Case Managers create an Individualized Care Plan (ICP) and maintain updated records in Jiva as changes are made. 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 (SNF).
- Communicated to each member's caregiver and primary physician.

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.

Case Management

- All SNP members are enrolled in Case Management.
- Each member has an Individualized Care Plan developed and stored within Jiva.
- Members may opt out of Case Management but remain assigned to a Case Manager.
- Members are stratified according to their risk profile in order to focus resources on the most vulnerable.
- Case Managers can adjust care plan if the Member is not accomplishing the established goals

Dual Eligible SNP Goals

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.

Care Coordination

- Integrated communication with providers
- Medicare/Medicaid coordination
- Interdisciplinary care team

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. Composition of the ICT is based on the Member's needs. Results are documented in Member's file.

Required Team Members

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

Optional Team Members

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

Health Services

- Specialized provider network
- Additional benefits
- Annual Health Risk Assessment (HRA)

Special 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 Team to meet these needs.
- Ensuring members are involved in care decisions.
- Managing utilization of services to ensure the right care, at the right time and in the right setting.

Working With Our Provider Partners

CHPW's SNP Model of Care offers an opportunity to work together for the benefit of the member 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 the Individualized Care Plan.
- Documentation of interactions in Jiva for future needs

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



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.



Health Risk Assessments (HRA)

Initial and annual assessments are initially conducted telephonically. If unable to reach the member by phone, the HRA is mailed to the member

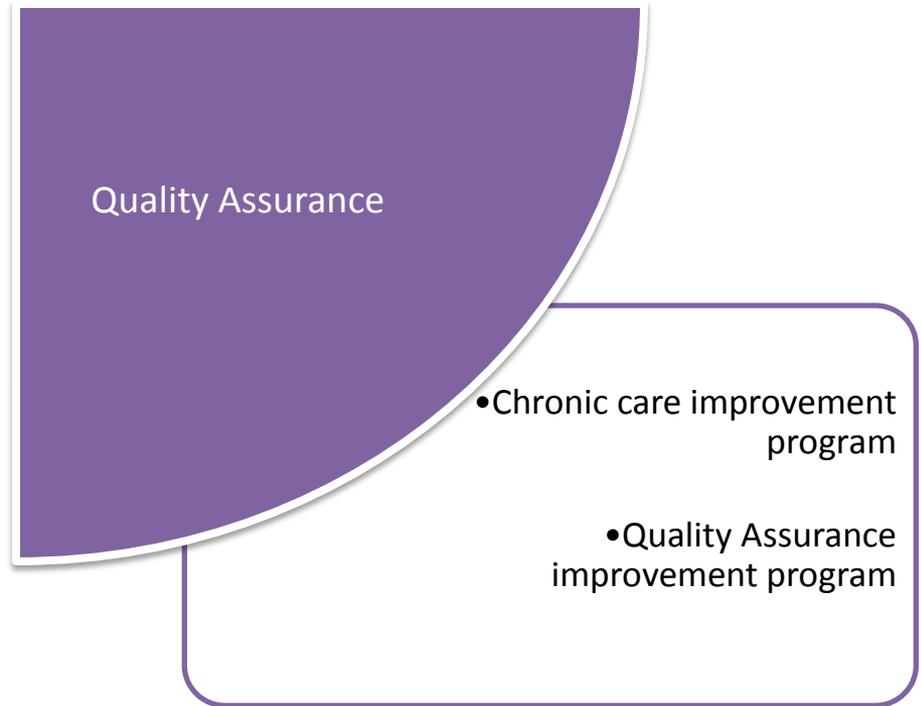
- A comprehensive initial assessment is completed within 90 days of enrollment HRA
- An annual reassessment of the individual's medical, physical, cognitive, psychosocial and functional needs is also provided.



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 evaluates program effectiveness
- Collecting data to evaluate if SNP goals are met



Quality Measures: HEDIS®

- HEDIS (Health Effectiveness Data Information Set) is a nationally used set of performance measures to capture the quality of the care and services provided to our members.
- HEDIS must be reported by plans that offer Medicare (including SNP) and Medicaid lines of business.
- HEDIS is reported annually to the National Committee for Quality Assurance (NCQA), CMS, and the State. CHPW also reports some results publicly.

SNP Specific HEDIS® Measures

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.



Comply...



COMMUNITY HEALTH PLAN
of Washington™

Congratulations!

By completing this annual training, you have done your part to help CHPW maintain compliance with CMS standards!



COMMUNITY HEALTH PLAN
of Washington™

Member Contact Information

Community HealthFirst (Medicare) Customer Services

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

Thank You!

Please Attest that you have completed the Special Needs Plan
and Model of Care Provider Training

[Attest Now](#)



COMMUNITY HEALTH PLAN
of Washington™