

**Community Health Plan of Washington, H5826  
Dual-Eligible (Full Benefit) Special Needs Plan**

**Model of Care Score: 85.63%**  
**3-Year Approval**

**January 1, 2012 – December 31, 2014**

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**Target Population**

Community Health Plan of Washington's (CHPW) target population is comprised of members who are typically older, often disabled, with multiple co-morbidities, including cancer, congestive heart failure, hypertension, obesity, dementia, and diabetes. Some require transplant services, skilled nursing, and long term care, while others need hospice and end of life care. The three most prevalent co-morbidities of this population include, type II diabetes, benign hypertension, and hyperlipidemia. These members are also more likely to experience joint degradation, psychotic, schizophrenic and mood disorders, and represent the most vulnerable and frail of all lines of business. This population does not include members with end-stage renal disease (ESRD) unless they are diagnosed with ESRD after they have enrolled.

**Provider Network**

CHPW's network consists of but is not limited to: physicians (MD, DO), physician assistants (PA and PA-C), nurse practitioners (ARNP), podiatrists (DPM), psychologists (PhD), social workers (MSW), marriage and family counselors, licensed mental health counselors, audiologists, chiropractors, dietitians, licensed midwives, nurse midwives, occupational therapists, physical therapists, optometrists, speech pathologists and surgical assistants.

The scope of organizational providers (facilities) covered under this program includes but is not limited to hospitals, home health and hospice agencies, skilled nursing facilities, ambulatory surgery centers and behavioral health (inpatient, residential and ambulatory) facilities which provide services to CHPW members.

**Care Management and Coordination**

CHPW accesses its eligibility data to identify new and existing members enrolled in the Medicare Advantage SNP plan. All new members are screened and assessed using a health risk assessment (HRA) tool within 90 days of enrollment and again after one year, at a minimum. CHPW uses the initial HRA derived member risk score and combines that information with a predictive, claims-derived risk score to establish the initial stratification of members. A member may be assessed more frequently, as determined by their unique clinical situation. The plan makes multiple attempts to contact the member if the HRA is not returned to them by mail. Once completed, the results are entered into the system which delivers an algorithm score electronically.

All CHPW members are reviewed by the interdisciplinary care team (ICT). The membership of the ICT is determined by a member's unique needs as identified via the HRA process and includes primary care physicians (PCP), Ph.D. level behavioral health practitioner, social workers, RNs, the identified point of contact for each member at the plan and the member, as appropriate. Ad hoc members may be invited as pertinent to the member's unique needs, including case managers, health educators, nutritionists, clinical specialists and other primary care home staff. The ICT meets at least weekly but could be more frequently in order to review all members within 90 days of enrollment and at least annually thereafter.

The individual care plan (ICP) is developed by the ICT and the member, whenever feasible. Other pertinent specialists are involved as needed. Every member has an ICP created, whether they are reached and assessed or not. ICP's are created using information from claims, Medicare HCC and MMR risk values, practitioner reported information and member assessments.

ICPs are comprehensive, incorporate best practices for chronic conditions as well as psychosocial needs, and are shared with the member and their PCP or other designated providers. In addition to initial stratification from the HRA, the plan reviews, monitors for changes in condition, and re-stratifies members to ensure that resources are focused appropriately throughout the population. The documented care plan is maintained in an electronic, HIPAA compliant, integrated care management system. The ICP is reviewed at least annually and more frequently as every transition of care triggers a review and update by the ICT.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: <http://healthfirst.chpw.org/>