



CHNCT Provider Collaborative Program Description

Community Health Network of Connecticut, Inc. (CHNCT), on behalf of the Department of Social Services (DSS) and the HUSKY Health Program, offers a comprehensive program to support Connecticut Medical Assistance Program (CMAP) enrolled providers and their practices. The Provider Collaborative assigns CHNCT subject-matter experts to work with providers and their staff to support the practice’s operational, administrative, and clinical functions as they relate to HUSKY Health.

Practices may use any or all CHNCT departments participating in the Provider Collaborative to receive education and training for services available to providers, their staff and to HUSKY Health members.

CHNCT Participating Departments:

- Provider Engagement Services
- Community Support Services
- Community Practice Transformation (Connecticut’s Person-Centered Medical Home Program)
- Member Engagement Services
- Prior Authorization
- Medical Economics & Quality Management
- Intensive Care Management
- Network Management
- Transitional Care

To take advantage of the services the Provider Collaborative offers:

Call or email the designated contact in the desired functional area(s) detailed below to schedule an onsite visit. For general questions and provider support, please call Provider Engagement Services at 1.800.440.5701 or contact your Regional Provider Engagement Representative.

For providers interested in becoming CMAP enrolled and leveraging all of the resources provided by CHNCT, please call 1.800.440.5071.

PROVIDER ENGAGEMENT SERVICES

Contact Information:

Rich Spencer
Director, Provider Engagement Services
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The HUSKY Health Program Provider Engagement Services Department is comprised of provider support staff, including Regional Representatives who are available to work with each provider practice in person. Our goal is to establish an open dialogue with providers and their staff to promote positive relationships through communication and education, and to reduce practice administrative burden when possible.

Each regional representative is available to provide exceptional onsite technical assistance and responsiveness to any concerns identified by provider practices. Providers may request assistance to address any issues with the HUSKY Health Program and our regional representatives will coordinate, as



needed, with all program partners including CHNCT, DSS, and Hewlett Packard Enterprise. Provider Engagement Services collaborates with providers to bring resolution to issues as quickly as possible. We are prepared to discuss any questions providers have, including:

- Changes made to State and Federal Medicaid programs
- DSS bulletins on medical and administrative policies and procedures affecting practices
- Hewlett Packard Enterprise provider enrollment, attestation, profile updates, and claims resolution
- Reducing missed appointments

MEMBER ENGAGEMENT SERVICES & ESCALATION UNIT

Contact Information:

For Providers: 1.800.440.5071

For Members: 1.800.859.9889

Member Engagement Services provides the first line of service for members and providers for any questions they may have. Member Engagement Services is available to help providers and their patients Monday through Friday from 8 a.m. to 6 p.m. Providers should call 1.800.440.5071, and members should call the toll-free number on the back of their ID cards.

Member Engagement Services provides assistance with all of the following and more:

- Educating callers on HUSKY benefits
- Locating CMAP-enrolled providers and offering appointment assistance to members seeking care
- Answering questions regarding member eligibility and escalating urgent eligibility issues for resolution
- Referring to the Connecticut Dental Health Partnership, Connecticut Behavioral Health Partnership, LogistiCare, pharmacies, and other program partners
- Referring to community resources for food assistance, utility assistance, shelter, and other non-medical needs
- Outreaching to members with a history of missed appointments
- Referring to the Escalation Unit or Intensive Care Management (ICM) as needed

The Member Engagement Escalation Unit has special expertise with helping HUSKY members access care. The Escalation Unit provides the extra attention a member or provider may need to obtain timely access to specialty services.

The Escalation Unit works directly with providers, members and their families to:

- Locate hard-to-find providers
- Provide appointment assistance and assistance coordinating transportation to medical appointments when needed
- Transition to an alternate provider when indicated
- Access community resources for food assistance, utility assistance, shelter, and other non-medical needs
- Facilitate the transfer of clinical records and any other documentation needed to obtain care with a specialist



- Work with Department of Children and Families (DCF) to help coordinate care for children
- Refer to ICM as needed
- Keep providers and members informed of our efforts

Providers are encouraged to contact the Escalation Unit directly when members need additional help addressing access to care issues. To initiate services with the Escalation Unit, call or fax a completed Escalation Referral form.

- Complete the “Reach for Escalation” form at www.huskyhealth.com, click “**For Providers,**” “**Provider Bulletins & Forms,**” then “**Escalation Referral Form;**” fax to 203.265.3197 or email to reachforescalation@chnct.org
- Call us at 1.800.440.5071 and ask for the Escalation Unit

INTENSIVE CARE MANAGEMENT

Contact Information:

For ICM Referrals:

Phone: 1.800.440.5071 x2024

The Intensive Care Management (ICM) program provides comprehensive care coordination services in collaboration with members, their providers, and multidisciplinary teams. The program supports HUSKY members with achieving their health goals through coaching and encouraging participation with the provider prescribed treatment plan. ICM Care Managers incorporate evidence-based practice guidelines from the American Congress of Obstetricians and Gynecologists;¹ the American Diabetes Association;² the National Heart, Lung and Blood Institute;³ and the Agency for Healthcare Research and Quality⁴ to formulate person-centered care plans through:

- Assessing, planning, implementation, and monitoring
- Coaching that centers around the needs and strengths of the individual
- Collaborating with providers
- Promoting advocacy of options, services, and coordination of care activities
- Evaluating and optimizing outcomes

Intensive Care Managers work directly with members with chronic and multi-morbid conditions, including members with concomitant behavioral health conditions. ICM also provides services for prenatal and postpartum care, as well as care coordination for babies in Neonatal Intensive Care Units. The primary goals of the program are to improve health outcomes for members and to foster a person-centered approach that helps members achieve their health goals. ICM empowers members to make fully informed decisions about their care options by offering members needed information, education, support, and coaching.

ICM collaborates with providers to reduce member hospital readmissions and emergency department (ED) over-utilization by facilitating effective transitions of care, reinforcing treatment plans, promoting awareness of progress to treatment goals, and managing potential barriers to successful outcomes.

- New in 2016, ICM has a Care Manager embedded in a single high use ED, to improve collaboration with the members’ PCPs and connection to services to further reduce ED over-utilization



Upon receipt of a referral to the ICM Program, the assigned ICM Care Manager does all of the following:

- Conducts a face-to-face visit with the member to complete a comprehensive, holistic assessment including screens for depression, domestic violence, basic resource needs and social determinants of health, along with an assessment for functional and perceived stress
- Assesses for barriers to care and gaps in care
- Completes medication reconciliation to promote the member's understanding of the importance and benefits of taking meds as prescribed
- Coordinates care for the member through collaboration with the PCP, specialists, and support agencies for community resources
- Assesses health literacy level
- Provides culturally sensitive member education
- Emphasizes importance of provider follow-up
- Reinforces understanding and benefits of following prescribed treatment plan
- Provides appointment reminders and help with transportation to and from appointments when needed

Providers may refer members to ICM by calling 1.800.440.5071 x2024, or by faxing in a completed ICM Referral Form.

- The form may be downloaded by going to www.huskyhealth.com, clicking on "**For Providers,**" "**Provider Bulletins & Forms,**" then "**ICM Referral Form**" on the right side of the screen.

¹ American Congress of Obstetricians and Gynecologists at:

<http://www.acog.org/Resources-And-Publications/Practice-Bulletins-List>

² American Diabetes Association at: http://care.diabetesjournals.org/content/39/Supplement_1

³ National Heart, Lung and Blood Institute at: <http://www.nhlbi.nih.gov/health/health-topics>

⁴ Agency for Healthcare Research and Quality, National Guideline Clearinghouse at: <http://www.guideline.gov/>

COMMUNITY SUPPORT SERVICES

Contact Information:

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Manager, Community Support Services

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CHNCT is dedicated to building healthier communities by helping members obtain the support services they need.

The Community Support Services Program, as a part of ICM, empowers families to improve their healthcare and stabilize their living situations in the community by referring them to community organizations, medical home providers, and other resources. Community Health Workers (CHWs) are front line staff who cultivate and maintain awareness of the cultures and values of the communities they serve. They also facilitate member access to community resources including, but not limited to, nutrition services, shelter, utility assistance, and clothing assistance. CHWs work closely with ICM Care Managers to help members navigate their health care system and maintain healthy behaviors in support of the management of their chronic conditions in culturally relevant ways. CHWs complement the work of ICM care manager services.



CHWs outreach to members and conduct visits either in their homes or at a comfortable, public meeting place. During face-to-face visits, CHWs assess member and family social, emotional, and physical healthcare needs and provide help finding resources within the community to meet member socioeconomic needs. CHWs develop positive and supportive relationships with members to ensure that they remain actively engaged with their PCP by keeping appointments, participating with care plans, and adhering to medication regimens.

CHWs educate members on their use of the HUSKY Health Program and serve as member advocates. Through their work with CHWs, members become better equipped to address their health care and socioeconomic needs as active participants with their own care plan goals.

MEDICAL ECONOMICS & QUALITY MANAGEMENT

Contact Information:

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CHNCT maintains the highest standard of measurable quality metrics. The Medical Economics and Quality Management department is responsible for data reporting, data analysis, clinical evaluation of health outcomes, and implementation of provider interventions focused on improving the health of the members we serve. The department is comprised of analysts, nurses, project managers, and other personnel.

The Medical Economics team conducts data analysis and provides reports to other departments within CHNCT including Finance, Utilization Management, Intensive Care Management, and Network Management, as well as to DSS and other stakeholders. These reports include information on performance measures and predictive/qualitative analytics for claims-based risk, unit costs, and utilization. Reports are used for a variety of purposes targeted at analyzing quality health measures, determining trends and trend drivers, and improving health outcomes for the HUSKY Health population. The Medical Economics team is also responsible for the management and submission of quality health measure data to DSS and to the National Committee for Quality Assurance (NCQA), as required.

The Quality Management (QM) team is responsible for the implementation of the CHNCT QM Program, accreditation activities, and appeals and grievances through collaboration with other CHNCT departments. The QM team collaborates with the Medical Economics team to:

- Analyze and report on health outcome measures data
- Monitor health outcome measures used to determine member and/or provider interventions, as necessary
- Conduct root cause analyses, create plans for improvement, implement interventions, assess performance improvement, and provide clinical observations based on the outcome of interventions



The CHNCT QM Program contributes to improving health outcome measures by developing, implementing, and analyzing interventions. Measure standards include Healthcare Effectiveness Data and Information Set (HEDIS), Adult Core, Children’s Health Insurance Program Reauthorization Act (CHIPRA), and DSS Custom Measures. The QM team works closely with the Medical Economics team to collect data, abstract information from charts, develop reports, and report project statuses related to health outcome measures.

The QM team is also responsible for ensuring contract and accreditation requirements are met. QM staff work with CHNCT departments to develop and implement policies and processes related to quality management standards set by Utilization Review Accreditation Commission (URAC), NCQA, Centers for Medicare and Medicaid Services, and DSS. The QM team assumes a lead role in the identification, drafting, and execution of annual quality improvement projects, as required by URAC, DSS, and other regulatory agencies as required.

The Appeals and Grievance teams, as part of QM, work to ensure that proper standards are followed regarding the safety, quality of care, and overall quality of service provided to HUSKY Health members for medical services. This includes, but is not limited to; resolution of member complaints/grievances; investigation of quality of care issues; track and trending of provider grievances; resolution of member appeals, provider appeals, and provider administrative appeals; and when necessary, member referrals to other CHNCT departments for additional services.

The Appeals team is responsible for processing HUSKY member appeals, provider appeals, and provider administrative appeals. Appeals may be initiated by members; CMAP providers; vendors; or rendering facilities, sites, or agencies. The Grievance team is responsible for the investigation of member grievances, provider grievances, and quality of care issues. Quality of care issues include adverse events and critical incidents.



COMMUNITY PRACTICE TRANSFORMATION PROGRAM & NETWORK MANAGEMENT

Contact Information:

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The Community Practice Transformation Program assists primary care practices with their applications to the PCMH and/or DSS Glide Path programs to become PCMH recognized practices. The CHNCT Community Practice Transformation Program includes our Community Practice Transformation Specialist (CPTS) team, comprised of healthcare and business professionals who work throughout five regions of the state, as well as Regional Network Managers (RNMs). CPTS staff are specially trained in Nationally Accredited PCMH Standards and maintain NCQA PCMH Content Expert Certifications.

The CPTS team provides education and support to the practices regarding NCQA PCMH recognition and the DSS PCMH and Glide Path programs. This applies to both the Glide Path Program and NCQA PCMH Renewal. The team accomplishes this by working with individual practice schedules and facilitating the



recognition process in-person at practice visits, by e-mail, and by phone according to the practice’s needs. The CPTS assigned to a practice is available throughout the program to offer advice and guidance on the PCMH process and obtaining recognition. The support from a CPTS is invaluable and, unlike most private PCMH recognition consultants, is available at no cost to the practice.

The CPTS team provides resources to assist practices with reaching PCMH goals. Resources may include introducing the Administrative Service Organization’s internal support programs to assist with care management and care coordination. Education is provided to practices on team concepts that support a division of care coordination duties among clinical and non-clinical staff as well as identifying and closing gaps in care. The Community Practice Transformation Program leads practices to integrate care coordination within a PCMH Model of Care. This process supports increased value by decreasing healthcare spending, providing better access, and enhancing care experiences for patients, families, and the healthcare team. The CPTS team coordinates with the RNM team to provide actionable data to assist with identifying and managing patients with high utilization issues, chronic conditions, and psychosocial needs. Both teams also provide education to providers on how to use that data for Quality Improvement.

The RNMs are assigned by territory throughout Connecticut to provide training and support for primary care practices to use analytical tools for Medicaid population management. Hands-on education for using reporting tools is available to administrative staff and Clinical Care Management teams of Federally Qualified Health Centers (FQHC), Person-Centered Medical Homes (PCMH), and Glide Path practices, as well as other Medicaid providers with attributed members. Reports may be used by providers to identify their members with gaps in care who may benefit from care coordination to help improve health outcomes.

RNMs also promote and recruit primary care practices to enroll in the DSS Glide Path program which helps a practice become PCMH recognized. PCMH is the DSS preferred model for primary care delivery to Medicaid beneficiaries. Primary Care Practices interested in becoming a PCMH will be visited by an RNM for an introduction to and overview of the PCMH model of primary care, including specific information on National Committee for Quality Assurance (NCQA) recognition and the DSS PCMH program. RNMs provide support to practices during the application process by helping with the completion of all forms and conducting a readiness evaluation. PCMH practices and practices in the Glide Path Program both receive enhanced payments; proper completion of forms is essential to ensure all data provided aligns with the information in the Hewlett Packard Enterprise system (Medicaid’s fiscal agent) to ensure timely payment. RNMs review PCMH applications for accuracy of practice information with Hewlett Packard Enterprise and submit the applications to DSS.

PRIOR AUTHORIZATION DEPARTMENT

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The HUSKY Health Prior Authorization department works to ensure that:

- Members receive services in a timely manner



- Services are medically necessary to address the member’s individualized needs

The process of medical necessity determination includes consideration of a member’s specific circumstances and special health care needs, adherence with the DSS definition of medical necessity, and application of evidence-based clinical standards of care.

The Prior Authorization process considers the following to determine if the requested service or good is appropriate:

- Medical necessity of treatment
- Setting for treatment
- Types and intensity of resources to be used for treatment
- Time frame and duration for treatment

The Prior Authorization team is comprised of both clinical reviewers and non-clinical support staff. All prior authorization reviews use a service-oriented approach that supports providers for the delivery of appropriate care, reduces administrative burden for the provider, and improves the patient experience by promoting efficiency.

Prior to entering requests for authorization, staff review member history to verify member eligibility under the program; determine whether a requested service is a duplication of, or in conflict with, an existing authorization; and verify the services requested are covered under the plan. Clinical reviewers then employ evidence-based decision-making and a service-oriented approach to support providers in delivering appropriate care to members.

Services covered under HUSKY Health and their corresponding prior authorization requirements can be found on the DSS website; go to www.ctdssmap.com, click on “**Information**,” “**Publications**,” then “**Chapter 9 Prior Authorizations**.”

In order to process requests for prior authorization, the request must be for members enrolled in the HUSKY Health Program and the billing provider must be CMAP-enrolled. To request medical prior authorization, the provider may use one of three methods:

- Phone: 1.800.440.5071 and follow the prompts
- Fax: 203.265.3994 using completed forms available by going to www.huskyhealth.com, clicking “**For Providers**,” “**Provider Bulletins & Forms**,” and downloading the desired form
- Online: Using the Clear Coverage portal for medical requests and the CAREPortal for radiology requests

The provider is able to follow the authorization request from entry to completion using any one of these methods for submission.

CHNCT adheres to all standards of timeliness of decision-making as indicated by DSS and Utilization Review Accreditation Commission (URAC).

TRANSITIONAL CARE

Contact Information:

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The Transitional Care team consists of Emergency Discharge Care Managers (EDCMs) and Inpatient Discharge Care Managers (IDCMs) who collaborate with members, ICM, caregivers, interdisciplinary medical and behavioral healthcare teams, and other community resources for members who are in the ED or inpatient setting at hospitals.

IDCMs interface with members on site at many large and mid-size hospitals throughout the state, or by phone. Members with chronic diseases, and complex medical and/or psychosocial needs, regardless of readmission history are targeted for IDCM care coordination services. IDCMs focus on managing barriers to care and address access to care issues as needed. As IDCMs work with members, they also collaborate with hospital staff for insight into specific care needs and the development of a comprehensive care plan upon discharge. These members will benefit from the services that the ICM program provides.

EDCMs identify members with chronic diseases and multiple ED visits. CHNCT receives instant notification of members who go to the ED and they then work with the ED Case Management staff to establish a plan of care and follow up with providers. These members may also receive referrals to the ICM program.

CHNCT promotes post hospital follow-up care by working to ensure that members see their PCP within 7 days of discharge. The IDCM and EDCM nurses work with provider offices to schedule follow-up appointments and help arrange non-emergency medical transportation when needed.

Transitional Care nurses outreach to HUSKY members soon after hospital discharge. They perform telephonic assessments and medication reconciliation to identify members who may benefit from ICM services. As part of the post-discharge outreach call, Transitional Care nurses review and reinforce post-discharge medication regimens with members. Medication reconciliation letters are sent to member PCPs which summarize member medications upon discharge and any identified member education needs. The goal is to maximize member ability to self-manage and to facilitate follow-up care post discharge.