HUSKY Health Program

Provider Guide

Contents

Important Phone Numbers

Contact	Inquiries Related To	Phone Number
HUSKY Health Program Provider Engagement Services Monday - Friday: 8:00 a.m. - 6:00 p.m. portal.ct.gov/husky	• Member Benefits • Accessing a Connecticut Medical Assistance Program (CMAP) Provider • Participation in CMAP Network • Person-Centered Medical Home (PCMH) Program • General Inquiries	1.800.440.5071
Automated Eligibility Verification System (AEVS) **Automated Voice Response System (AVRS)** Self-Service 24/7	Access via website or phone to verify important DSS client information including: • Client Eligibility • Third Party Insurance • Medicare Coverage • Waiver Program Eligibility • Managed Care Eligibility	AEVS www.ctdssmap.com/CTPortal/Provider/Secure-Site AVRS 1.800.842.8440
HUSKY Health Care Management	Getting assistance from clinical staff at HUSKY Health to improve the health status of high-risk individuals with complex needs, including: • Complex Care Coordination Needs • Complex Medical or Medical/Behavioral Health Needs • High-Risk Pregnancy • High Utilization (ED, Inpatient)	1.800.440.5071 x2024
Medical and Radiology Authorization (including general inquiries and technical support)	• Medical and Radiology Authorization General Inquiries • Medical and Radiology Authorization Portals	**General Inquiries:** 1.800.440.5071 **Medical:** Select option 2 from the menu, then select option 2 again from the sub-menu **Radiology:** Select option 2 from the menu, then select option 1 from the sub-menu **Authorization Portal Technical Support:** 1.877.606.5172 **Medical:** Select option 5 from the menu **Radiology:** Select option 6 from the menu, then select option 2 from the sub-menu

Contact	Inquiries Related To	Phone Number
Gainwell Technologies Provider Assistance Center Monday - Friday: 8:00 a.m. - 5:00 p.m. www.ctdssmap.com	• CMAP Provider Enrollment • Claims	1.800.842.8440
CT Behavioral Health Partnership (CT BHP) Monday - Friday: 9:00 a.m. - 7:00 p.m. www.ctbhp.com	• Behavioral Health Services • Behavioral Health Prior Authorizations • Accessing a Behavioral Health Practitioner	1.877.552.8247
CT Pharmacy Client Assistance Center Monday - Friday: 8:00 a.m. - 5:00 p.m. www.ctdssmap.com	• Pharmacy Services • Pharmacy Prior Authorization • Pharmacy Benefits	1.800.842.8440 Benefit and Claim Questions 1.866.409.8386 24/7 Pharmacy Prior Authorization
CT Dental Health Partnership (CTDHP) Monday - Friday: 8:00 a.m. - 5:00 p.m. www.ctdhp.org	• Dental Services	1.855.283.3682
Non-Emergency Medical Transportation (NEMT) ct.ridewithveyo.com	• Transportation Services - (Non-Emergency Transportation)	1.855.478.7350
Fraud Reporting Hotline	• Reports of Suspected Fraud or Abuse	1.866.700.6109 1.800.842.2155 Fax: 860.424.5900 clientfraud.dss@ct.gov providerfraud.dss@ct.gov
Third Party Liability (HMS - A Gainwell Technologies company) Monday - Friday: 8:00 a.m. - 5:00 p.m.	• Verifying and Inquiring if a Member Has Other Health Insurance	1.866.252.0671 Fax: 1.469.320.5117 ctinsurance@gainwelltechnologies.com

I. Introduction

The HUSKY Health Program

Through a public procurement process, the Department of Social Services (DSS) selected Community Health Network of Connecticut, Inc.® (CHNCT) to be the medical administrative services organization (ASO) for all medical assistance programs (HUSKY A, B, C, D, and Limited Benefits).

As a partner of DSS, the medical ASO is responsible for authorizing and managing medical health services, and providing support services for the HUSKY A, HUSKY B (the state's Children's Health Insurance Program [CHIP]), HUSKY C, HUSKY D, and HUSKY Limited Benefits. The primary objectives of this program are to improve the quality of care and health experience for each member.

The ASO is responsible for providing the following services:

- Member and provider call center
- Provider recruitment and expansion of the Connecticut Medical Assistance Program (CMAP) provider network
- Utilization management
- Intensive Care Management for members with health issues
- Health education
- Referral assistance and appointment scheduling
- Health data analytics/reporting
- Person-Centered Medical Home (PCMH and PCMH+ support and education to provider practices)

Under this program, providers must be enrolled in the CMAP network in order to be reimbursed for covered services provided to HUSKY Health program members.

This guide will provide you with pertinent information on the HUSKY Health program. If you have any questions, our Provider Engagement Services representatives are available Monday through Friday, 8:00 a.m. - 6:00 p.m. by calling 1.800.440.5071, or by visiting the links provided in each section.

The HUSKY Health Program includes the following benefit packages:

HUSKY A – This program includes full Medicaid health benefits for children under the age of 19; and depending on income, parents or a relative caregiver who live in the household; and pregnant individuals.

HUSKY B – Nationally known as CHIP, this program provides health coverage to uninsured children who are U.S. citizens, or qualified non-citizens under the age of 19, in families with income below a certain percentage of the federal poverty level. The HUSKY B Prenatal Care program provides health coverage including prenatal care to pregnant individuals, who are not citizens or who are qualified non-citizens. HUSKY B requires small co-payments and co-insurance for non-preventive services. HUSKY B Prenatal Care does not impose co-payments or co-insurance on pregnancy-related services. The program also requires a monthly premium depending on income and family size.

HUSKY C – HUSKY C covers members who are in the Medicaid Aged, Blind and Disabled (ABD) eligibility categories who meet certain income requirements, including people who have both Medicare and Medicaid.

HUSKY D – HUSKY D is coverage for low income Connecticut residents aged between 19 and 64 who do not have dependent children, are not pregnant, and are not disabled, formerly known as Medicaid Low Income Adult (MLIA).

HUSKY Limited Benefits – The HUSKY Limited Benefits program is coverage for individuals who do not qualify for full Medicaid coverage and meet certain requirements, including: individuals who have been diagnosed with tuberculosis; individuals who are of childbearing age; individuals who are in need of COVID-19 testing and related services; and inmates requiring inpatient services. To obtain more information on HUSKY Limited Benefits, go to https://portal.ct.gov/husky, and click on "***Information for Providers***," followed by "***Medical Management***," and "***Benefit Grids***." Next, click on the Limited Eligibility Grid.

HUSKY Health Program Benefits

The medical ASO manages the medical benefits for HUSKY Health members.

Providers may access information about HUSKY Health benefits on the HUSKY Health provider website: https://portal.ct.gov/husky. Click on "***Information for Providers***," followed by "***Medical Management***," and "***Benefit Grids***." The Medical Management page provides information, in the form of provider-specific grids, for HUSKY Health benefits and authorization requirements.

For your convenience, detailed benefit grids have been developed by provider type and medical program for the following:

- Acupuncture
- Ambulatory Surgery Clinic
- BHP
- Chiropractor
- Chronic Disease Hospital and Long Term Care
- DHP
- Dialysis Clinic
- DME
- Family Planning
- Home Health
- HUSKY Plus
- Hospice
- Inpatient Hospital
- Laboratory
- Limited Eligibility Benefits
- Medical Clinics
- Naturopath
- Outpatient Hospital
- Physician
- Podiatry
- Radiology
- Rehabilitation Clinic
- Transportation
- Therapy
- Vision

Each benefit grid will provide you with a summary of covered services and exclusions for each program, prior authorization requirements, and any co-payments that may apply.

Behavioral Health

The behavioral health benefit for the HUSKY Health program is administered by the Connecticut Behavioral Health Partnership (CT BHP), Carelon Behavioral Health. The CT BHP may be reached by calling 1.877.552.8247, Monday through Friday, 9:00 a.m. to 7:00 p.m. You can also visit their website at www.ctbhp.com for a summary of the behavioral health benefits for HUSKY Health program members.

Dental Benefits

The dental benefit for the HUSKY Health program is administered by the Connecticut Dental Health Partnership (CT DHP)/Benecare. The CT DHP manages routine dental and orthodontia services. They may be reached by calling 1.855.283.3682, Monday through Friday, 8:00 a.m. to 5:00 p.m. You can also visit their website at www.ctdhp.org.

Pharmacy

Pharmacy services are managed by the Department of Social Services (DSS). To contact the CT Pharmacy Services unit, please call 1.800.842.8440, Monday through Friday, 8:00 a.m. to 5:00 p.m. To obtain information on pharmacy benefits, the preferred drug list, and other important links, go to:
Click "***Information for Providers***," followed by "***Medical Management***," and "***Benefit Grids***." Next, click on "***Physician Grid***" and scroll to "***Prescription Drug Coverage (retail pharmacy)***."

To obtain information regarding the HUSKY Health program's pharmacy benefits that are available to members, please visit www.ctdssmap.com and click on "***Pharmacy Information***."

Specific pharmacy program information may be viewed, including:

- Current Preferred Drug List
- Pharmacy Prior Authorization Program Information and Forms
- Retrospective Drug Utilization Review Program Description
- Pharmacy Program Publications

Non-Emergency Medical Transportation Services

Non-Emergency Medical Transportation services are coordinated by Veyo. To contact Veyo, please call 1.855.478.7350. Transportation is available for HUSKY A, C, D, and Limited Benefit members who have a non-emergent scheduled appointment for a covered service. Information may be periodically sought from providers on member needs for specialized transportation to ensure the delivery of necessary services.
To obtain more information on transportation benefits, go to https://portal.ct.gov/husky, and click on "***Information for Providers***," followed by "***Medical Management***," and "***Benefit Grids***." Next, click on the Transportation Grid.

Assisting Members with Translation Needs

The HUSKY Health program understands how difficult rendering services can be when there are communication barriers, or when English is a second language.

The following services are offered to HUSKY Health members:

- **Telephonic Interpretations:** Member Engagement Services can connect with an interpreter in any language that is preferred by the member.
- **TDD/TTY Access Services:** These services are available for the hearing-impaired. Please call 1.877.659.1252 for a telecommunication device to accept text messages.
- **711 Relay Operator:** Hearing-impaired members may also use the Relay Operator.
- **Services for Members with Visual Disability and Braille Services:** The HUSKY Health program provides visually-impaired members with access to materials translated into Braille.

Providers may contact Provider Engagement Services at 1.800.440.5071 if a member is in need of any translation services.

II. Provider Engagement Services

The goal of CHNCT's Provider Engagement Services Department is to assist providers in reducing their administrative burden, and in recruiting and expanding the CMAP provider network as needed.

This goal is accomplished through the following services:

- Providing support from dedicated regional Provider Engagement Services representatives;
- Assisting with the provider enrollment process;
- Providing program education and technical training through webinars;
- Offering on-site office consultations and Provider Collaboratives;
- Resolution of claims issues; and
- Guidance on DSS policies and procedures.

Activities of the Provider Engagement Services Department include, but are not limited to:

- Assisting CMAP providers with administrative issues, and ensuring that provider support is timely and accurate;
- Maintaining provider demographic information;
- Offering telephonic and on-site consultative services that include program education and technical training and assistance;
- Alerting providers on program updates, policies or procedures; making modifications to the Provider Guide; and issuing provider newsletters and notices via email, fax, and website notifications;
- Assisting with questions on Person-Centered Medical Homes and making appropriate referrals as needed.

Provider Collaborative

CHNCT offers a comprehensive program to support 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 work with 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.

Participating Departments:

- Provider Engagement Services
- Member Engagement Services & Escalation Unit
- Care Management
- Population Health Management
- Quality Management
- DSS Person-Centered Medical Home Program (PCMH)
- Prior Authorization

To take advantage of the services offered by the Provider Collaborative:

Call or email the designated contact in the desired functional area(s) detailed below to schedule an on-site visit or virtual call. For general questions and provider support, please call Provider Engagement Services at 1.800.440.5071, or contact your regional Provider Engagement representative. You can also visit https://portal.ct.gov/husky and click "***Information for Providers***," followed by "***Reports and Resources***," and "***Provider Collaborative***."

Provider Engagement Services Representative Contact Information

Below you will find our dedicated regional Provider Engagement Services representatives and their contact information:

Region 1 – 203.949.4064

Region 2 – 203.949.4163

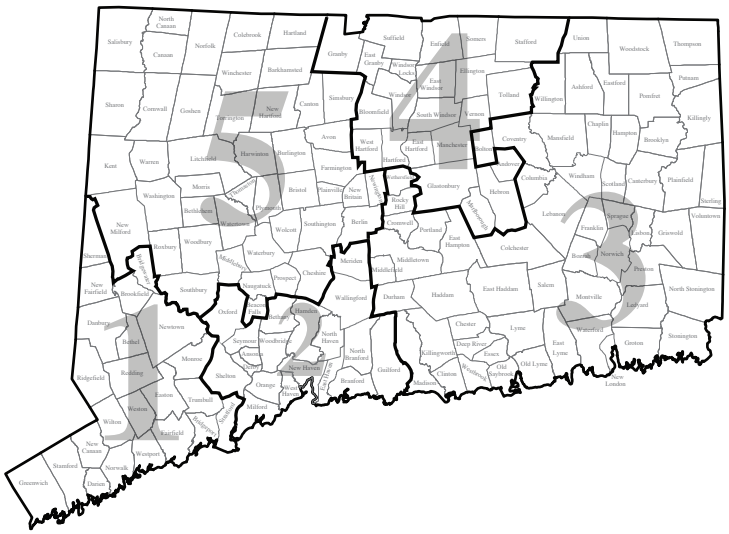
Region 3 – 203.949.6140

Region 4 – 203.949.4106

Region 5 – 203.949.4141

Provider Engagement Services Representative Contact Information

A team of dedicated Provider Engagement Services Representatives are available to assist you by telephone or an on-site office visit. For assistance, please contact the Provider Engagement Representative for your location as listed below.



Region 1	203.949.4064
Region 2	203.949.4163
Region 3	203.949.6140
Region 4	203.949.4106
Region 5	203.949.4141

III. Participating as a HUSKY Health Program Provider

Provider Enrollment

Gainwell Technologies is the fiscal agent under contract with DSS to support the operation of CMAP. Gainwell processes all billing and performing provider enrollment and re-enrollment applications.

In order for a provider to be reimbursed for services rendered to a HUSKY Health member, the provider must be actively enrolled in the CMAP program. Providers may submit an enrollment application via the www.ctdssmap.com website by clicking on "***Provider***," and then "***Provider Enrollment***."

Questions related to provider enrollment may be directed to the Gainwell Provider Assistance Call Center at 1.800.842.8440, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

IV. Verifying Member Eligibility

Eligibility for the HUSKY Health program is based on income and family size. Continuous eligibility applies to children under the age of 19 who are enrolled in the HUSKY Health program for a continuous 12-month period where eligibility is not lost even if there is a change to income level. The continuous eligibility period begins the month following determination or re-determination of eligibility.

A newborn is eligible for HUSKY Health at birth if the mother has coverage. The baby will be enrolled in the same program as the mother. If the newborn's mother is uninsured, or the mother has insurance that will not cover the birth of the baby, the family should apply for HUSKY Health benefits within 30 days of the baby's date of birth.

Verifying Member Eligibility for the HUSKY Health Program

Providers will only be reimbursed for covered services provided to members under the HUSKY Health program who are eligible for benefits at the time the services are provided. Due to possible changes to members' eligibility, providers are advised to verify eligibility each time services are provided. Member eligibility can be verified in the following ways:

The Automated Eligibility Verification System (AEVS)

The Automated Eligibility Verification System (AEVS) provides a comprehensive source of DSS client eligibility information to all enrolled providers to verify member eligibility, such as third party insurance, Medicare coverage, waiver program eligibility, and Medicare-covered services information.

Providers may access the AEVS system by:

- Visiting the DSS CMAP website at www.ctdssmap.com. Under the provider menu, log in to the CMAP secure site; or
- Calling the CMAP Automated Voice Response System (AVRS) at 1.800.842.8440 and selecting the self-service menu option. The AVRS is available 24 hours-a-day, seven days-a-week (except for maintenance) and allows enrolled providers to verify member eligibility.

Gainwell Technologies Provider Electronic Solutions Software

Gainwell provides free software called Provider Electronic Solutions (PES) for the submission of eligibility verification and claim transactions electronically. This software is Health Insurance Portability and Accountability Act (HIPAA) compliant, and is available to all providers who would like to submit electronically. For additional information, please visit www.ctdssmap.com and click on "***Trading Partner***."

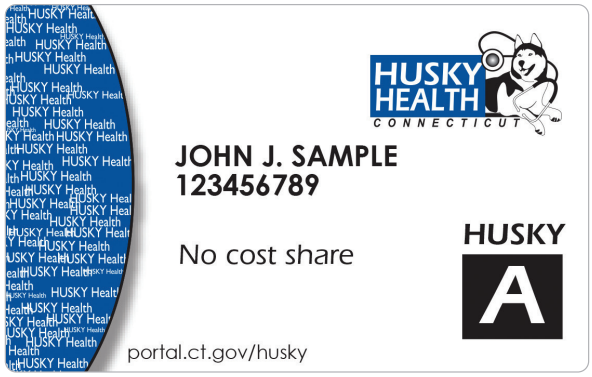
HUSKY Health Program Provider Engagement Services

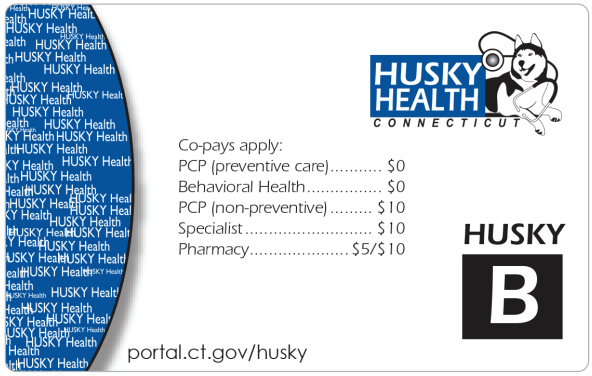
Providers may also call 1.800.440.5071 and speak with a call center representative for help with member eligibility.

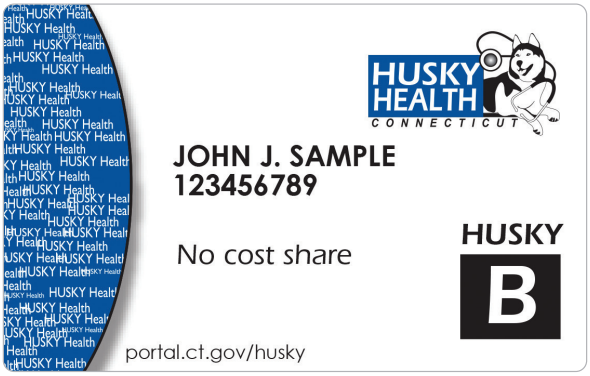
Member Identification Card

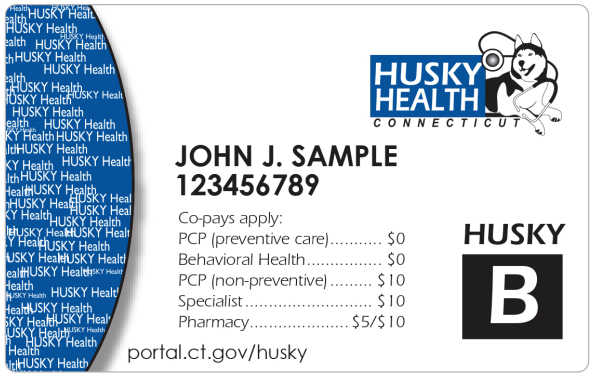
HUSKY Health program members are issued a member identification card shortly after their enrollment. The identification card contains the member's name, member identification number (which is their Medicaid ID number), applicable cost share information (HUSKY B), and the specific HUSKY Health program name. The cards will not list a PCP name. Once a member chooses a PCP, the provider may affix a sticker to the back of the card in the space provided, or simply write the name on the card.

Below is a sample of an identification card issued to HUSKY Health program members:









NOTE: Possession of a member ID card does not guarantee eligibility and/or payment for services rendered. Member eligibility should be verified as detailed above.

CONNECT Card

The State of Connecticut also issues every active Medicaid recipient a gray CONNECT Card with the recipient's name, Medicaid ID number, and the card issue date. The identification number on the gray CONNECT Card is the same identification number listed on the HUSKY Health program card.

Client eligibility does not appear on the CONNECT Card, and possession of this card does not guarantee client eligibility. Providers may use this card to help determine member eligibility through the AEVS system.

Below is a sample of the CONNECT Card issued by the State of Connecticut:

V. Claim Submission

As the fiscal agent for DSS, Gainwell also processes all claims for the HUSKY Health program.

Gainwell strongly recommends electronic claim submission, which is the most efficient method of submitting claims. Electronic claims are accepted only in HIPAA compliant formats. Providers must have an active Trading Partner Agreement in place with Gainwell in order to exchange HIPAA compliant files. For information regarding the exchange of electronic transactions, including claims, please refer to the Provider Manual, Chapter 6, Electronic Data Interchange (EDI), located on the CMAP website at www.ctdssmap.com. Click "***Information***," followed by "***Publications***," and "***Electronic Data Interchange***."

Gainwell also offers a claim submission tool, which can also be found on the website. This tool is available to all enrolled and active billing providers. For information on how to access the secure web portal account and how to submit claims through the web, please refer to the CMAP website at www.ctdssmap.com. Click "***Information***," followed by "***Publications***," and "***Provider Manual, Chapter 10, Web Portal / AVRS***."

Questions related to claim submissions may be directed to the Gainwell Technologies Provider Assistance Call Center at 1.800.842.8440, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

VI. Health Services

Benefit and Authorization Grids

Benefit and authorization grids provide a general summary of benefits and authorization requirements for the HUSKY Health program, and are located on the HUSKY Health program website. Go to https://portal.ct.gov/husky, click "***Information for Providers***," followed by "***Medical Management***," and "***Prior Authorization***."

For a definitive list of benefits and services requiring authorization, please review the CMAP fee schedules and regulations at www.ctdssmap.com. For fee schedule information, click "***Provider***," followed by "***Provider Fee Schedule Download***."

For regulations, click "***Information***," then "***Publications***," and view Chapter 7.

Prior Authorizations

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 prior authorization process considers the following to determine if the requested service or good is appropriate:

- Person-centered consideration of a member's specific circumstances and special healthcare needs
- Medical necessity of treatment based on the DSS definition of Medical Necessity, evidence-based criteria, and clinical guidelines
- Setting for treatment
- Types and intensity of resources to be used for treatment
- Timeframe and duration of treatment

To process requests for prior authorization, the request must be for members enrolled in the HUSKY Health program, and the ordering and billing provider must be CMAP enrolled. To request medical prior authorization, please visit https://portal.ct.gov/husky and click on "***Information for Providers***," then "***Prior Authorization***," and follow the instructions on the page.

Process to Request Prior Authorization

The process for submitting requests for prior authorization has changed. An updated, secure, medical authorization portal is now available. Prior authorization trainings are available on the HUSKY Health website: https://portal.ct.gov/husky. Click on "***Information for Providers***," then "***Prior Authorization Webinars***" under the "***Prior Authorization***" menu item.

Providers may submit written requests for authorization using the current medical authorization portal. If unable to use the medical authorization portal, providers may submit via fax as noted below. The Utilization Management (UM) Intake Unit is available at 1.800.440.5071 for support and/or to answer questions.

Request Type	Agent	Fax Number
• Notification of emergent admissions • Elective admissions pre-certifications • Outpatient services such as DME, home care, therapies (OT, PT, ST), outpatient surgeries, and professional services	ASO	1.203.265.3994
• Clinical information related to inpatient admissions	ASO	1.203.774.0551
• Synagis® authorizations	ASO	1.203.774.0549
• Advanced imaging services requiring authorization	eviCore	1.888.693.3210

The minimum information required to begin the prior authorization process is:

- Member Name
- Member ID
- Member Date of Birth
- Date(s) of Service
- Diagnosis Code
- Billing Provider/Facility Name and CMAP ID Number
- Admitting/Referring Provider

Additional clinical information is required based on the type of service or good requested. Specific information is available on the HUSKY Health website: https://portal.ct.gov/husky. Click on "***Information for Providers***," followed by "***Policies, Procedures & Guidelines***" under the "***Medical Management***" menu item.

UM clinical staff conduct person-centered, medical necessity reviews using InterQual® criteria, medical policies, and the DSS definition of Medical Necessity. Requests meeting the relevant criteria are approved. If the relevant criteria are not met, requests are sent to a Medical Reviewer for a final determination. UM staff complete the review within the DSS established turnaround time, and send a determination letter or Notice of Action to the provider and member. All NOA/denial letters include instructions regarding the right to appeal.

The following services do not require prior authorization:

- Emergency Department care
- Preventive care
- Family planning
- Routine maternity admissions
- NICU admissions when the newborn is born in the same facility
- Services that are covered by Medicare for dual-eligible members

Care Management

The Care Management program, which includes Intensive Care Management and Transitional Care Management, provides comprehensive care coordination services for members with high-risk or complex needs in collaboration with members, their providers, and multidisciplinary teams. Care Management interventions aim to increase member engagement in ongoing care with a primary care provider, decrease potentially avoidable acute care utilization, and reduce health disparities.

Intensive Care Management: Intensive Care Management focuses on optimizing the health and quality of life of members with complex, co-morbid physical and behavioral health conditions, who are at the highest risk for adverse health outcomes, members with high-risk pregnancies and babies who spent time in the Neonatal Intensive Care Unit after birth, and members with complex care coordination needs, including those obtaining gender-affirming care or organ transplant services. This is accomplished by providing person-centered, culturally competent education, coaching and support; minimizing obstacles to accessing care; and promoting the member's ability to build trust and engage with the care team. Intensive Care Managers incorporate evidence-based practice guidelines to formulate person-centered care plans, and support members in achieving their health goals by enhancing their understanding and ability to participate in recommended care.

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

- To download the form, visit https://portal.ct.gov/husky, click "***Information for Providers***," then "***Provider Forms***" under the "***Reports & Resources***" menu item. Once there, click on "***ICM Referral Form***."

Transitional Care Management: Transitional Care Management focuses on safe and effective care transitions across settings. The Transitional Care team collaborates with members, caregivers, providers, hospital care teams, and community agencies to ensure provider follow-up and services are in place for members following emergency department (ED) or hospital discharge.

The goal of this team is to reduce hospital readmissions with a focus on unattributed members with certain risk factors, including chronic and multi-morbid conditions, who have increased readmission rates and risks.

The team's readmission risk mitigation interventions include:

- Facilitating timely post-discharge follow-up with the provider, either in-person or via telehealth within seven days of discharge. The team works with provider offices to schedule follow-up appointments, and helps to arrange non-emergency medical transportation when needed
- Conducting medication reconciliation to assess the member's ability to take their prescribed medications correctly and consistently, by reviewing claims data, hospital discharge information (if applicable), and member self-reported information
- Evaluating the member's understanding of discharge instructions through the use of "teach back"
- Utilizing evidence-based tools, such as the Asthma Action Plan and Asthma Control Test™ (ACT™), to educate members about warning signs of exacerbation and promote early treatment

For more information on Transitional Care, please click here, or visit https://portal.ct.gov/husky, click "***Information for Providers***," then "***Transitional Care***" under the "***Condition Management Resources***" menu item.

Providers may contact the Transitional Care team at 1.800.859.9889 x2011.

Asthma Control Test is a trademark of QualityMetric Incorporated. The Childhood Asthma Control Test was developed by GSK.

Community Health Workers

CHNCT's certified Community Health Workers (CHWs) serve as ambassadors for the HUSKY Health program, and are committed to building equity through our diversity, inclusion, and community engagement efforts. They work to ensure that all members, regardless of ability, age, cultural background, ethnicity, faith, gender, gender identity, ideology, income, national origin, race, or sexual orientation, have the opportunity to reach a better quality of health.

CHWs provide non-clinical support that, when combined with the clinical support of the ICM team, addresses the needs of the whole-person, rather than looking at members as just their condition or diagnosis. They are knowledgeable about statewide services available to HUSKY Health members, use basic motivational interviewing skills and goal-setting techniques with members, and they identify and offer support for Social Determinants of Health (SDOH) needs.

For information on the CHW Ambassador Program, please visit https://portal.ct.gov/husky and click on "***Information for Providers***," followed by "***Condition Management Resources***," and "***Intensive Care Management***." To speak with a CHW, call 1.800.859.9889, extension 4326, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Provider Reevaluations

A provider may file a Medical Necessity or Administrative Reevaluation. Two levels of reevaluation are available for medical necessity determinations, and one level of review is offered when the reevaluation is administrative in nature.

Reevaluations must be submitted in writing, and may be faxed to 203.265.3830 or mailed to the following address:

CHNCT
ATTN: Appeals Unit
11 Fairfield Boulevard
Wallingford, CT 06492

Medical Necessity Reevaluations

Level One:

The reevaluation request must be initiated, in writing, within 10 calendar days from the date of the denial letter, providing notification of the decision to deny, partially deny, reduce, suspend, or terminate a health service. The medical ASO will conduct a peer review or peer desk review if the provider peer is unavailable. The provider is notified of the decision by phone and in writing.

Level Two:

If the provider is dissatisfied with the first level reevaluation determination, the provider may initiate a second level reevaluation. The provider may request a second level reevaluation in writing within 14 calendar days of the date on the first level reevaluation determination letter. The provider may submit additional documentation in support of the level two reevaluation, including the medical record, within 30 calendar days of the request. The provider will be sent a notice of the determination of the second level of reevaluation no later than five business days after receipt of all information deemed necessary and sufficient to render a determination.

Administrative Reevaluation

A provider may also request reevaluation of a denial based on non-compliance with policies and procedures pertaining to utilization management. The provider may, no later than 10 calendar days of the date on the determination letter, initiate an administrative reevaluation by providing a written rebuttal along with additional information or good cause. The administrative appeal determination is mailed to the provider within seven business days following the date of receipt of the request.

Outcome of Medical Necessity and Administrative Reevaluations

If the reevaluation process is followed and the denial determination is overturned, the medical ASO will authorize services to allow for provider payment of covered services rendered to a member.

If the reevaluation process is not followed or the denial determination is upheld, the medical ASO will not authorize the services that are the subject of the reevaluation.

Appeals for HUSKY B Members

It is the medical ASO's policy that HUSKY B members are educated about, and have access to, a unified process for filing an appeal based on medical necessity, in the event that a good or service is partially or fully denied; suspended; reduced or terminated. Members are advised that they may file an appeal verbally or in writing within 60 calendar days of the denial letter. Appeals received after 60 calendar days are considered untimely, and the member is notified in writing that they have lost the opportunity to appeal.

All appeals will be reviewed fairly and objectively by an independent reviewer. Reviewers are healthcare professionals who are clinical peers, in the same profession, and in a similar specialty that typically manages the medical condition, procedure, or treatment. Appeals mutually deemed appropriate are reviewed in a timeframe appropriate to the circumstances of the situation, but no later than 30 calendar days from the date of receipt of the appeal.

The HUSKY B member may request an opportunity to meet with individuals conducting the internal appeals and/or request the opportunity to submit additional written documentation. If the member wishes to participate in a meeting, it shall be held at a location accessible to the member, or by way of a telephone conference call discussion, whichever the member prefers. Information obtained during this meeting will be taken into consideration by the decision-maker(s) in the final appeal determination. In the absence of a request from the member to meet or submit additional information, the medical ASO shall decide an appeal solely on information available at the time of the request.

The Member Appeals Committee meets on an as-needed basis to review HUSKY B member appeals not overturned at peer review.

There is a process for expedited review of appeal requests, and for external review of appeals by DSS. Within one business day of receiving the appeal, a determination will be made to expedite the review or to perform a review according to the standard 30-day timeframe. An expedited review must be performed when the standard timeframe for determining an appeal could jeopardize the life or health of the member or the member's ability to attain, regain, or maintain maximum function. The review will also be expedited in all cases at the request of the treating physician or PCP functioning within their scope of practice as defined under state law, or by DSS.

HUSKY B External Appeal Process through the Connecticut Department of Social Services:

If the member has exhausted the internal appeals mechanism and has received a final written appeal determination upholding the original denial of the good or service, the member may file an external appeal with DSS within 30 calendar days from the date of the determination letter.

The member will be instructed to submit the completed form to DSS by faxing it to 860.424.5206, or mailing it to:

State of Connecticut – Department of Social Services (DSS)
Division of Health Services, Medical and Clinical Consultant Team
HUSKY B & HUSKY Plus External Appeals – 9th Floor
55 Farmington Avenue
Hartford, CT 06015

Appeals for HUSKY A, HUSKY C, HUSKY D, and Limited Benefit Members

It is the medical ASO's policy that HUSKY A, HUSKY C, HUSKY D, and Limited Benefit members are educated about, and have access to, a unified process for filing medical necessity appeals, and requesting Department of Social Services (DSS) administrative hearings in the event that the medical ASO fails to respond within 14 calendar days to a request for goods/services, or partially denies, fully denies, suspends, reduces, or terminates authorization of the provision of goods/services. Members are advised that they may file an appeal, in writing or verbally, within 60 days of the date of the notice of action.

Staff advises any member who verbally requests an appeal, that in order to receive an administrative hearing before DSS, the member must file a signed Appeal/Administrative Hearing Request form or submit a letter in writing within 60 days of the date on the notice of action. The timeframe for processing the appeal will begin once the verbal appeal or written form is received.

The member will be instructed to submit the completed Appeal/Administrative Hearing Request form to DSS by faxing it to 860.424.5729, or mailing it to:

State of Connecticut – Department of Social Services (DSS)
Office of Legal Counsel, Regulation, & Administrative Hearings – HUSKY A, C, D Appeals
55 Farmington Ave.
11th Floor
Hartford, CT 06105

All appeals will be reviewed fairly and objectively by appropriate medical ASO decision-makers. The timeframe of the review is appropriate to the exigencies of the situation, and is completed no later than the date of the DSS administrative hearing and/or 30 calendar days from the filing of the Appeal/Administrative Hearing request, whichever is earlier.

There is a process for expedited review of appeal requests. The medical ASO will determine, within one business day of receiving the appeal, whether to expedite the review or perform it according to the standard 30-day timeframe. An expedited review must be performed when the standard timeframe for determining an appeal could jeopardize the life or health of the member or the member's ability to attain, regain, or maintain maximum function. The medical ASO will expedite its review in all cases in which such a review is requested by the member's treating physician or PCP, or by DSS.

An appeal will be decided on the basis of written documentation available, including written comments, documents, records, and any other information the member wishes to submit. All information is taken into account without regard as to whether it was submitted and considered in the initial consideration of the case, unless the member has requested an opportunity to also meet with the individual(s) making the determination. If the member wishes to meet the individual(s) making the determination, a meeting can be arranged by phone or at a location accessible to the member. DSS office locations may be available for video conferencing with the approval of the applicable DSS Regional Office.

In the instance of a first level appeal, the medical ASO implements the decision of the first level clinical appeal if it overturns the initial denial. If the member is not satisfied with the results of the appeal determination, or if the appeal decision is not issued by the date the administrative hearing is scheduled, (or within 30 days of the filing of the appeal, whichever is earlier), the administrative hearing is held as scheduled. The medical ASO will authorize the disputed services if DSS reverses the decision to deny, terminate, or suspend services.

VII. Quality Management

DSS Person-Centered Medical Home (PCMH) Program - Clinical Practice Transformation Specialists

The Clinical Practice Transformation Specialists (CPTS) and other PCMH program staff are a vital component of the CHNCT Quality Management (QM) program. They are responsible for assisting primary care practices with their applications and reporting requirements to the DSS Person-Centered Medical Home (PCMH) and/or DSS Glide Path programs to become PCMH recognized practices. The CPTS team is trained specifically on Nationally Accredited PCMH Standards and maintain NCQA PCMH Content Expert Certification™. Their skill set also includes quality improvement and practice transformation activities to support primary care providers in improving patient health outcomes at the practice level.

Education and support to practices regarding NCQA PCMH recognition and The Joint Commission (TJC) PCMH certification process are provided to those practices enrolled in the DSS PCMH and Glide Path programs. CMAP primary care practices are provided with training and assistance on the various analytical tools and reports available for Medicaid population health management by CHNCT. Providers use these tools and reports to identify their members with gaps in care, as well as those who may benefit from care coordination. Practice outreach to members may help to improve health outcomes by encouraging needed services from the established relationship that is cultivated through the PCMH care model. In addition, CPTS staff support all CMAP practices with the quality improvement processes and interventions. The PCMH program staff contact primary care practices that qualify for the DSS PCMH program to introduce the PCMH model of care, including specific information on NCQA PCMH recognition and the DSS PCMH program. For more information on becoming a PCMH, please click here, or visit https://portal.ct.gov/husky, click "***Information for Providers***," then "***Person-Centered Medical Home***."

Patient Safety - Quality of Care and Adverse Incident Reporting

Monitoring adverse events is an essential component of patient safety. The World Health Organization (WHO) defines an adverse event as an incident that results in preventable harm to a patient. According to research, "Medicaid patients are less likely to be treated in adherence with process-of-care guidelines, face a higher risk of inpatient mortality for common medical conditions and surgical procedures, and are more likely to experience adverse safety events."[1] It is the medical ASO's policy that patient safety concerns and adverse events are reported to the medical ASO's Quality Management (QM) Department for investigation, review, action, and follow-up.

Adverse events are identified internally through an automation process using clinical algorithms and claims data. In addition, CHNCT clinical staff may identify patient safety concerns and adverse events through a

[1] *Spencer CS, Roberts ET, Gaskin DJ. Differences in the rates of patient safety events by payer: implications for providers and policymakers. Med Care. 2015; 53 (6):524-529. doi:10.1097/MLR.0000000000000363. Retrieved August 4, 2021.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4431906/

desktop review from member rendered inpatient and outpatient services, where referrals are submitted to the QM department using the CHNCT care management platform. Members, external entities and non-clinical CHNCT staff may also submit events for investigation through MES and/or the member grievance process. Referrals are made to the QM department for investigation of any potential quality of care issues related to the grievance.

The QM nurses request and review the necessary documentation from the provider and/or facility to compose a summary of the case, which is then submitted to an MD medical reviewer for review and case determinations. The medical reviewer assigns a severity level ranging from a level 0 (no concern) to a level 4 (high concern), and an event code to all quality-of-care issues and adverse incidents reviewed. The event codes are used for reporting purposes and are categorized into five areas: Behavioral Health, Clinical Medical Facility, Facility Process, Medications, and Surgery/Procedures. All case determinations are validated by the VP of Clinical Affairs and/or the CMO prior to closure. Depending upon the outcome of the case, the proper course of action is initiated. Peer-review physician discussions or non-clinical matters may be referred to Provider Engagement Services for one-on-one follow up with the provider. In the event the investigation reveals a particularly egregious finding, critical incident, or significant event, the matter is forwarded to the medical ASO's Compliance Department and communicated to DSS or the Connecticut Department of Public Health as applicable.

The QM Department collects and trends information to identify provider practice patterns. Resulting information may be used to guide future quality improvement activities. QM findings are reported quarterly to the quality oversight committees.

Member Satisfaction Survey

A member satisfaction survey is performed annually to assess both adult and child member satisfaction with the HUSKY Health program and provider experience. The survey is also designed to evaluate the Person-Centered Medical Home program.

The survey tool utilized is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). It covers topics that focus on aspects of quality, including but not limited to: access to healthcare services, provider communication skills, specialized services, healthcare choices, and timeliness of services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Member Rights and Responsibilities

The medical ASO is committed to treating all HUSKY Health program members with respect and dignity. CMAP providers are also expected to respect a member's rights.

Members have the right to:

- Be treated with respect, dignity and regard for their privacy
- Get care or information about their care in a timely manner
- Choose or change their provider
- Receive active assistance in obtaining an appointment with a specialist
- Take an active part in planning their care and treatment decisions
- Receive complete and comprehensive information about their treatment options, regardless of cost or benefit coverage, and have the opportunity to discuss those options with their provider
- Receive complete and comprehensive information on any financial incentives that might influence the care that they receive from their provider
- Refuse treatment, except when that treatment is required by law
- Receive a second opinion
- Receive interpretation services
- Request and review their medical records with their provider
- Make an advanced directive
- Confidently exercise their rights
- Receive services regardless of race, color, religion, gender, sexual orientation, age, cultural and ethnic background, or status as a HUSKY Health recipient
- Make a complaint, grievance, and appeal
- Be free from retaliation
- Learn about their medical benefits and how to use them
- Correct or change their Protected Health Information and restrict how it is used
- Contact their provider to advocate for medical services
- File an appeal if an authorization of good or services is partially or fully denied, suspended, reduced or terminated

Members have the responsibility to:

- Give their providers and the ASO information they need to better serve them
- Choose a primary care provider (PCP)
- Get regular preventive care
- Follow the plan of care that they agreed upon with their providers
- Discuss their care with their PCP before seeking care from a specialist unless it is an emergency, pregnancy-related or for family planning
- Keep their appointments, or let their provider know at least 24 hours in advance if they need to cancel or reschedule
- Respect the dignity and privacy of others
- Carry their HUSKY Health cards
- Notify the HUSKY Health ASO and their DSS worker if they change their address or phone number

Confidentiality of Medical Records

The confidentiality of HUSKY Health members' medical records is very important to us. We have many policies and procedures in place to protect the unauthorized disclosure of member health information.

As a CMAP provider, you are required by your Enrollment Agreement with DSS to abide by and comply with all federal and state statutes, regulations, and policies pertaining to your participation in the program. This includes complying with all relevant provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA), and laws and regulations regarding the disclosure of family planning, HIV, behavioral health, and substance abuse treatment records.

CMAP providers have a responsibility to maintain the confidentiality of a HUSKY Health program member's medical record, including but not limited to:

- Member's name, address, and social security number;
- Medical services provided;
- Medical data, including diagnosis and past medical history;
- Any information received for verifying income eligibility; and
- Any information received in connection with the identification of legally liable third party resources.

CMAP providers may disclose a HUSKY Health program member's medical information:

- To other providers in connection with their treatment of the member;
- To DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;
- In connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of, or billing for, services covered by the Connecticut Medical Assistance Program;
- As required to obtain reimbursement for services rendered to members;
- As otherwise required by state or federal law; and
- With the member's written consent, to other persons or entities designated by the member or legal guardian, or, in the event that the member is a minor, from the member's parents or legal guardian.

Upon request, you must disclose all records relating to services provided and payments claimed to: the Secretary of Health and Human Services; DSS; and/or the State Medicaid Fraud Control Unit, in accordance with applicable state and federal law. If you have authorized a third party to act on your behalf, you must submit written verification of this authorization to DSS.

For more information on Member Rights and Responsibilities, please visit https://portal.ct.gov/husky and click on "***Information for Providers***," followed by "***Reports & Resources***," then "***Consumer Protection***."

HEDIS®

CHNCT annually collects the Healthcare Effectiveness Data and Information Set (HEDIS®). This is a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). NCQA also establishes a very specific process for obtaining the data, which is monitored through stringent audit requirements.

HEDIS® MY 2022 is comprised of 96 measures across six domains of care: effectiveness of care, access/availability of care, experience of care, utilization and risk adjusted utilization, health plan descriptive information, and measures reported using electronic clinical data systems (ECDS). Some of the measures are derived only from claims data and are known as administrative measures. The completeness and accuracy of the information submitted on a claim by the provider is therefore critically important to a successful HEDIS® data collection.

Other measures are designated as hybrid measures because they require a combination of data from claims (administrative) and data only found in clinical records/charts. The hybrid sample size is 411 randomly selected members for each hybrid measure.

Once the sample is identified, clinical records are requested from providers. The record request is measure-specific and may be for a particular service such as immunizations or, alternatively, may cover a date range within which a service may have been rendered. Nurses trained specifically for HEDIS® chart abstractions will read the medical records, and identify and document the seminal dates and services needed to successfully complete the measure.

Requests for medical records may be disruptive to a busy medical practice. Therefore, we are prepared to retrieve the records at the convenience of the practice through read-only remote electronic medical record (EMR) access. If the practice prefers to send the records, they may be forwarded by mail, secure facsimile, or electronically via secure email. Because the timing of the record abstractions is determined by the overall HEDIS® project pursuant to NCQA requirements, there is a relatively short opportunity to locate, request, coordinate, obtain, and abstract all hybrid records. As such, the provider's support and cooperation are paramount and very much appreciated.

For more information on HEDIS® and health measures, please visit https://portal.ct.gov/husky and click on "***Information for Providers***," followed by "***Reports & Resources***," then "***Health Measures***."

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Early Periodic Screenings, Diagnostic and Treatment Services (EPSDT)

CHNCT ensures that members (children and their caregivers) are aware of the requirements of EPSDT. HUSKY Health provides eligible members with physical, mental, vision, hearing, and dental services, along with other screenings/tests needed to treat and prevent health problems and conditions. We have adopted the American Academy of Pediatrics (AAP) / Bright Futures™ Recommendations for Preventive Pediatric Health Care (also referred to as the Bright Futures™ / AAP Periodicity Schedule). CHNCT has a multi-pronged approach to informing all HUSKY Health members of EPSDT services and how they can access them.

Member Engagement Services (MES) conducts outreach, including welcome calls. During these calls, MES staff will welcome members to the program, help them select PCPs for themselves and their family, and stress the importance of well-visits and required screenings. Members also receive a welcome packet of new member information via email or postal mail (for those without an email on file). This includes a program guide, which provides information on services available and coverage for preventive and well-care visits. Additionally, email and automated call reminders are sent to members for EPSDT services such as developmental and behavioral health screenings, newborn screening, scheduling a child's wellness visit, immunizations, and lead screening. Members are directed to additional EPSDT information on the HUSKY Health website under "***Information for Members***," and then "***Medical***" under the "***Member Benefits***" menu item.

For more information on EPSDT, please visit https://portal.ct.gov/husky and click on "***Information for Providers***," followed by "***Person-Centered Medical Home***," then "***EPSDT***."

IX. Web-based Provider Services

The HUSKY Health program is dedicated to helping providers achieve efficiency in all areas of their daily administrative functions. The medical ASO offers several online support services through its secure web portal, providing easy access to helpful program information.

Providers may access the main provider page by visiting https://portal.ct.gov/husky and clicking "*Information for Providers*."

The HUSKY Health program provider website offers access to the following information:

- Provider Guide
- An online searchable directory for members and providers to identify CMAP enrolled providers
- Provider notices, newsletters, and alerts, including links to DSS Provider Bulletins
- Person-Centered Medical Home material detailing program qualifications, application and instructions, including PCMH Glide Path option
- Secure web portal to access primary care member panel and utilization reports
- Benefit and prior authorization requirements grids, and instructions on submitting authorization requests
- Schedule of provider events, webinars, and trainings
- Health education materials
- Links to other important websites (CT BHP, CT DHP, Non-Emergency Medical Transportation, and Pharmacy Services)

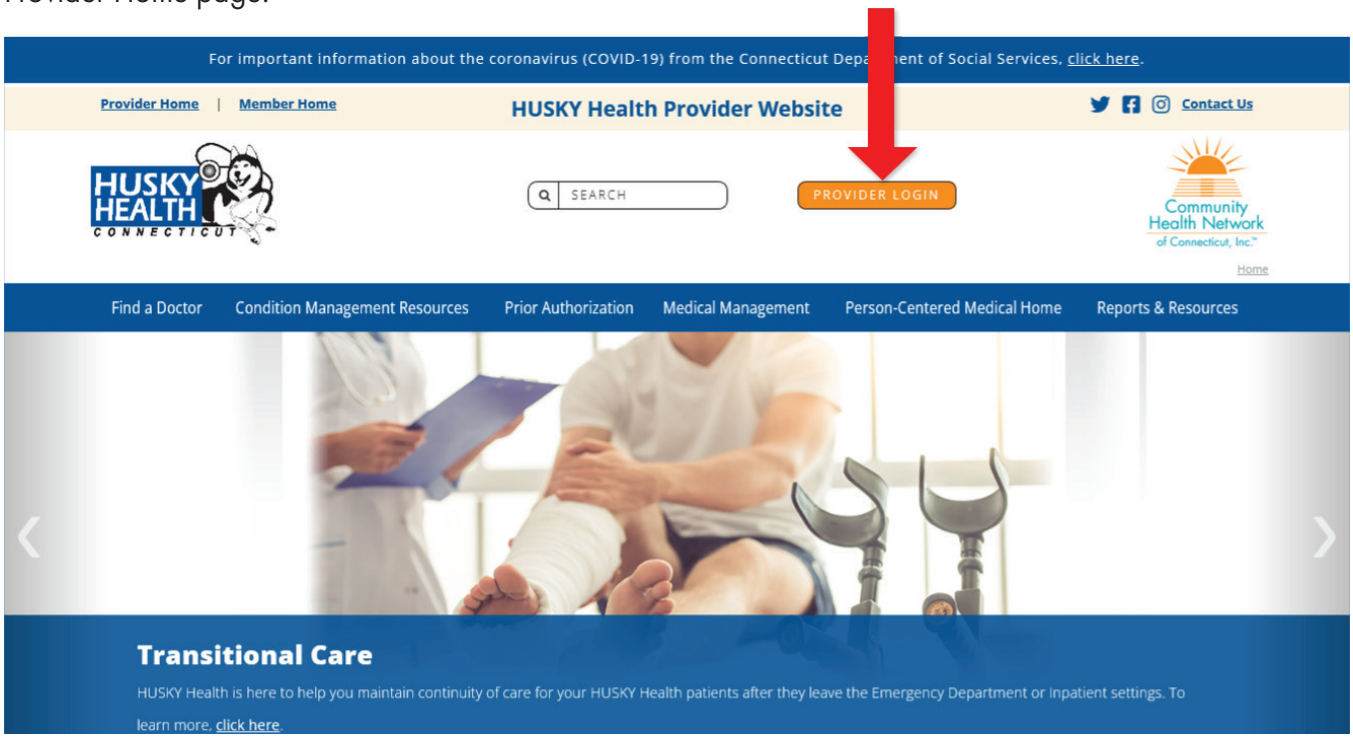
Secure Provider Web Portal

The secure provider web portal allows providers to:

- Register for online access
- View information regarding health measures
- Access patient reports
- Submit and view authorizations
- Fill out the Member Missed Appointment Form
- Register for the Obstetrical Pay for Performance Practice program (OBP4P)
- Check eligibility on the State of Connecticut's Automated Eligibility Verification System (AEVS)
- Find a doctor
- Access the public HUSKY Health provider homepage

You can also visit the CultureVision™ website — your free access to an easy-to-use database that gives you information on culturally competent patient care.

You can access the secure provider portal by clicking on the **Provider Login** button on the HUSKY Health Provider Home page.



The Provider Home page contains tabs that allow the provider/user to access the following:

- Health Measures and HEDIS® Overview Information
- Primary Care Provider (PCP) or usual source of care attribution and utilization reports based on member's attribution to provider
- Links to Medical and Radiology Authorization Portals
- Member Missed Appointment Form
- Obstetrical Pay for Performance Program (OBP4P)
- Reference materials for additional provider information

Additional information on the provider portal includes:

- State of Connecticut's Automated Eligibility Verification System (AEVS)
- Find a Doctor
- HUSKY Health Provider Home page
- CultureVisionTM
- Provider Engagement Services and web support contact information
- Links to Provider Engagement Services representatives

For instructions on how to sign up for portal access, download the "How to Sign Up for a HUSKY Secure Provider Portal Account" help guide, which will walk you through the sign-up process.