

Important Information for Providers about Changes in the HUSKY Program

You may have read or heard that the HUSKY medical program (Both A and B) is going through some changes. The HUSKY program will be phasing out WellCare/PreferredOne and HealthNet by March 31, 2008. Soon, HUSKY A members enrolled in these health plans will be asked to change to either Community Health Network (CHNCT), Anthem BlueCare Family Plan or traditional Fee-For-Service Medicaid. All HUSKY B clients in WellCare/Preferred One will be asked to choose either BlueCare Family Plan or CHNCT.

If you are currently not participating with CHNCT, BlueCare Family Plan or Fee-for-Service Medicaid but wish to continue seeing your patients that were enrolled in one of our outgoing plans, you should consider enrolling with one or all of the plans. To learn more or to enroll, please call or email:

Community Health Network of CT

11 Fairfield Boulevard
Wallingford, CT 06492
Attn: Kevin Colvin
Phone: 203-949-4138
Email: kcolvin@chnct.org

Anthem BlueCare Family Plan (BCFP)

370 Bassett Road
North Haven, CT 06473
Attn: Helen Adams
Phone: 203-234-5857
Email: Helen.Adams@anthem.com

Fee-For-Service Medicaid

EDS is responsible for processing the enrollment of providers. An enrollment application can be obtained by contacting the EDS Provider Assistance Center at (800) 842-8440 (in-state toll free) or (860) 269-2028 in the local Farmington, CT area between the hours of 8:30 A.M. - 5:00 P.M. Monday through Friday, or by writing to:

EDS
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104

Below are answers to some questions you may have.

What credentialing process will I need to go through to join one of the plans?

CHNCT and BlueCare Family Plan will honor the credentialing process used by any of the outgoing plans that you were in. Any new providers who seek to participate in CHNCT, BlueCare Family Plan or our Fee-For-Service Medicaid Program will need to meet the requirements for enrollment as a Medicaid provider.

I'm an OB/GYN, how do I bill for a pregnant woman who changes plans during this time? Do I bill the global rate or do I have to split bill, and if so how?

We strongly encourage pregnant women and their providers to transition together to the same plan. If an OB/GYN has started to bill on a per visit basis in one of the exiting plans, he or she should continue to bill separately for office visits and the delivery in the new plan. If the provider did not bill for separate visits in the old plan and was expecting to bill for a global fee in the new plan, they should notify the Plan and bill accordingly. If the provider was prepaid for the global fee in the exiting plan, they should not bill the new plan.

Will the FQHCs have to change how they bill the HUSKY population?

Not immediately. Notice will be given in advance of when the FQHCs will be required to bill and receive reimbursement based on the State's Medicaid encounter rate.

Different plans require different provider numbers for billing purposes. Which number(s) do I use for the different plans?

All services billed to all payers (CHN, BCFP, HealthNet and FFS Medicaid) should be billed under your National Provider Identifier (NPI).

If I received prior authorization from one of the outgoing plans for a service that may not be provided until after the patient changes plans, will I get paid?

Yes. CHN and BlueCare Family Plan will honor any prior authorization from the outgoing plans. In the event that the claim is denied in error, due to "no PA on file", you should first contact CHN with the prior authorization documentation before resubmitting the claim. When there is a new service request, it will be reviewed in accordance with the Department's protocol for prior authorization. For services provided under Medicaid FFS please refer to the appropriate fee schedule and policy for your respective practice for prior authorization requirements.

I have a small HUSKY patient base, do I have to be enrolled with CHNCT, BlueCare Family Plan or FFS Medicaid in order to continue seeing the same patients and to get paid?

Yes. If you would like to continue to see your patients on a long term basis, you must enroll with either CHNCT, BlueCare Family Plan or Fee-For-Service Medicaid in order to be paid. However if you are currently enrolled with HealthNet or Wellcare/PreferredOne, BlueCare Family Plan and CHNCT will pay claims you submit to them for their members during the transition period. During this time you are encouraged to formally enroll. You must be enrolled in Medicaid in order to be paid for your Medicaid patients that are enrolled in FFS Medicaid.

Will the Department be updating it's fees for hospitals and physicians?

The fee amounts have been updated and will be retroactive to October 1, 2007 for hospitals and January 1, 2008 for physicians.

To whom do I submit requests for prior certifications or authorizations?

Providers should continue to submit prior authorization requests to the patient's plan of record. The requests should be sent to the following:

Community Health Network

Provider Line – 1-800-440-5071 Choose Option #2

BlueCare Family Plan

1-800-238-2227

Fee-For-Service Medicaid

Refer to the Provider Billing Manuals located at www.ctmedicalprogram.com for instructions on requesting and submitting prior authorization requests.

I have heard that pharmacy will no longer be covered by the HUSKY health plans. What does that mean?

Effective February 1, 2008, pharmacy benefits for all of the Department's medical assistance programs, including HUSKY A, HUSKY B and SAGA will come under the Departments' Medicaid Fee-For-Service pharmacy program.

With this change you will be working from a different list of approved drugs. If a drug that you are currently prescribing is not on the Department of Social Services' Preferred Drug List (PDL), you may still be able to prescribe it, but it may require prior approval. The Department's PDL can be found on the Web at www.ctdssmap.com, click on "Pharmacy Information", then scroll down and click on "Preferred Drug List".

Prior authorization is required :

For drugs that are prescribed that are not on our PDL

For brand name drugs when a generic equivalent is available

To refill prescriptions when less than 75% of the existing prescription of the same drug has been used.

Specific information concerning PA can be obtained at www.ctdssmap.com, click on "Pharmacy Information" then scroll down to the "Pharmacy Prior Authorization Program". PA forms may also be obtained from this site. To request prior authorization, contact the EDS Pharmacy Prior Authorization Center at 1-866-409-8386 (toll free) or 860-269-2030 (local Farmington, CT).

If your patient needs a drug that requires prior authorization, he or she can get a one-time supply of up to 30 days from their pharmacist. When a pharmacist dispenses a temporary supply, they should inform the prescribing provider so that they will know that prior authorization will be required for any subsequent refills.