MAPOC Meeting

December 2023

Agenda

- Call Center Wait Times
- Health Equity at CHNCT
- GTI
- Unwinding
- Peer Support Services

Call Center Wait Times

Agenda

- Overview of CMS Call Center Reporting
- Tiered Telephone Service Delivery Model
- Call Center Wait Time Analysis
- Call Center Mitigation Strategies
- Customer Experience Improvement Updates (Appendix)

CMS Call Center Reporting Requirements

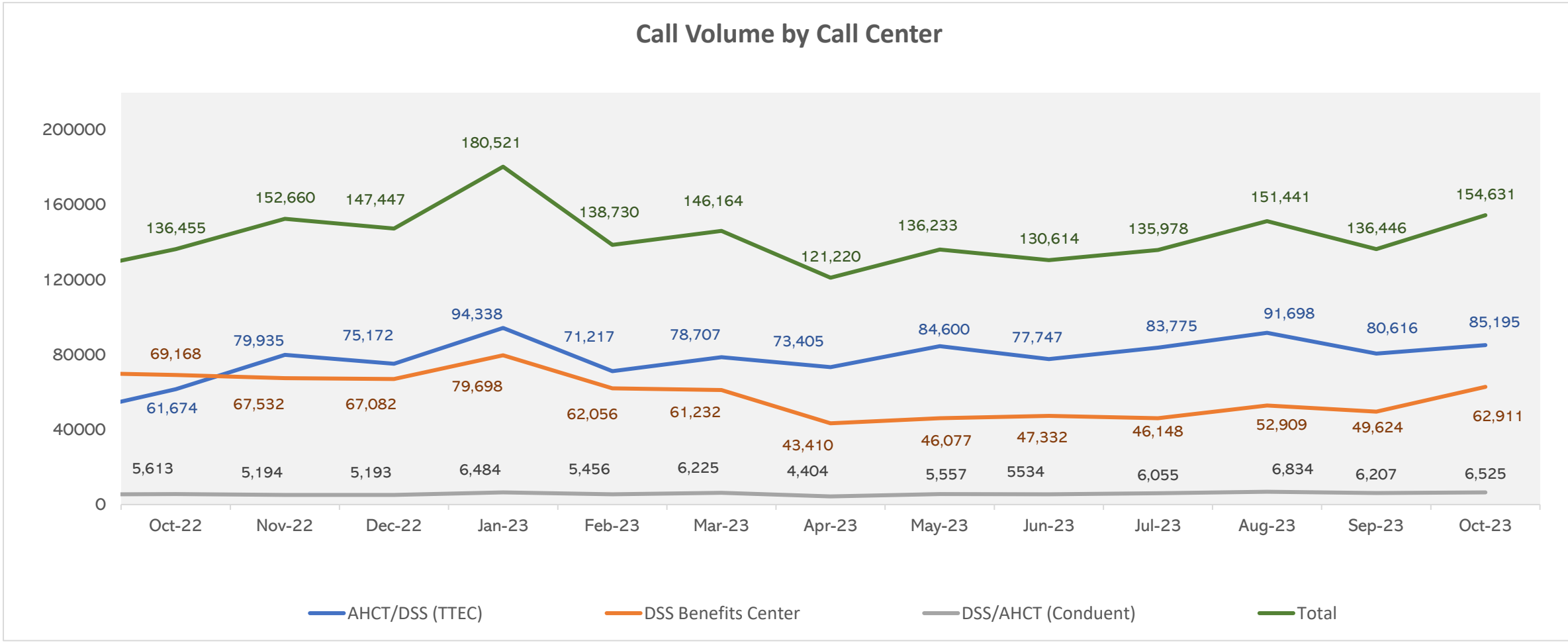
1. CALL VOLUME Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
1		Total Call Center Volume	The total number of calls received by each call center during the calendar month. The top-line total should equal the sum of the call volume at each individual call center reported.

2. CALL CENTER WAIT TIME Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
2		Average Call Center Wait Time	The average wait time in whole minutes for calls received by each call center during the calendar month. If the state tracks wait time in seconds, round increments of 0 to 29 seconds down to the nearest whole minute, and round increments of 30 to 59 seconds up to the nearest whole minute. If the average wait time is less than 29 seconds, enter 0 and provide an explanation in the data limitations field. If average wait time cannot be provided, leave this field blank (missing) and provide an explanation in the data limitations field. The top-line total should be calculated as the weighted average of each individual call center's wait time during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average wait time = call center 1 average wait time * (call center 1 volume/call center total volume) + call center 2 average wait time * (call center 2 volume/call center total volume) + call center 3 average wait time * (call center 3 volume/call center total volume)

CMS Call Center Reporting Requirements

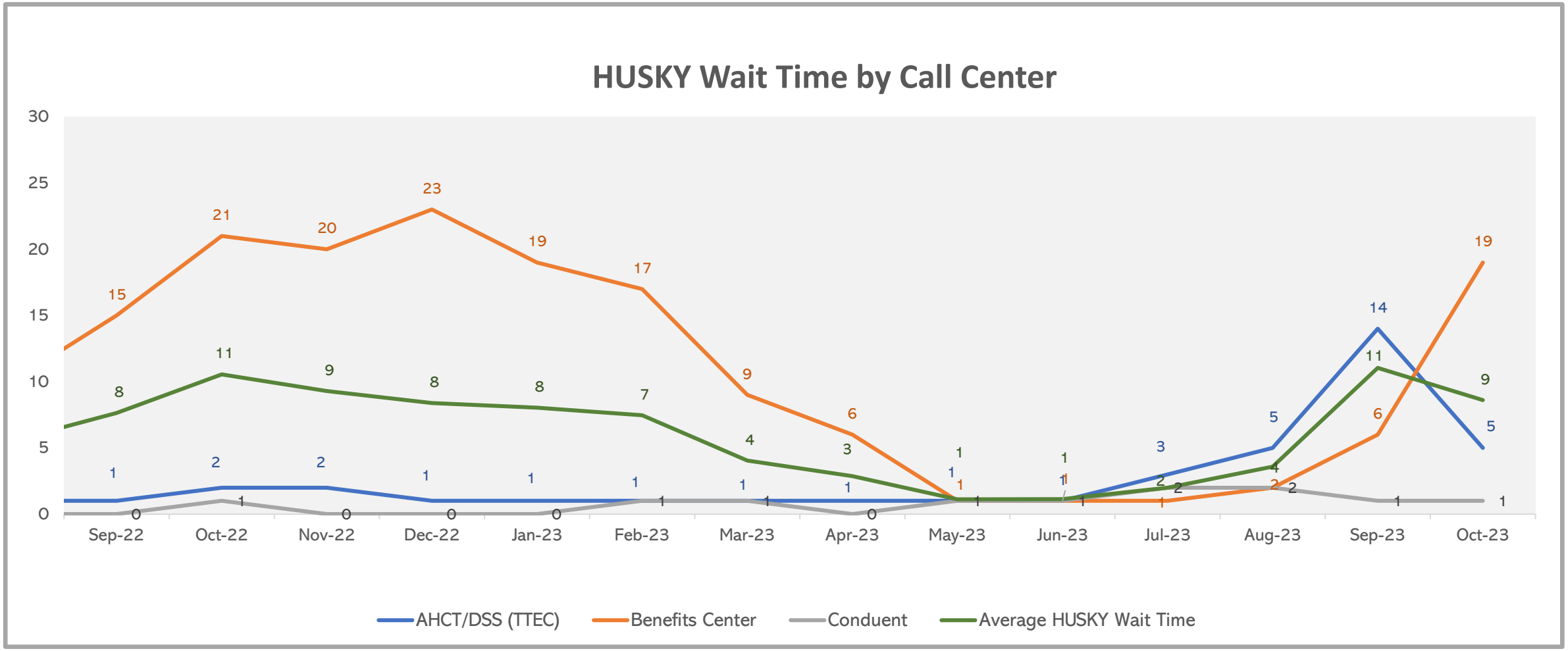
3. ABANDONMENT RATE Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
3		Average Call Center Abandonment Rate	For each call center or helpline reported in Indicator 1, the abandonment rate equals the number of calls abandoned by caller (numerator) divided by total call volume (denominator). The acceptable range for this number is between 0 and 1, with a zero value representing 0% (no calls abandoned), a value of 0.5 representing 50% (half of calls are abandoned), and a value of one representing 100% (all calls abandoned). The top-line total should be calculated as the weighted average of each individual call center's abandonment rate during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average abandonment = call center 1 average abandonment rate * (call center 1 volume/call center total volume) + call center 2 average abandonment rate * (call center 2 volume/call center total volume) + call center 3 average. abandonment rate * (call center 3 volume/call center total volume)

Call Volume



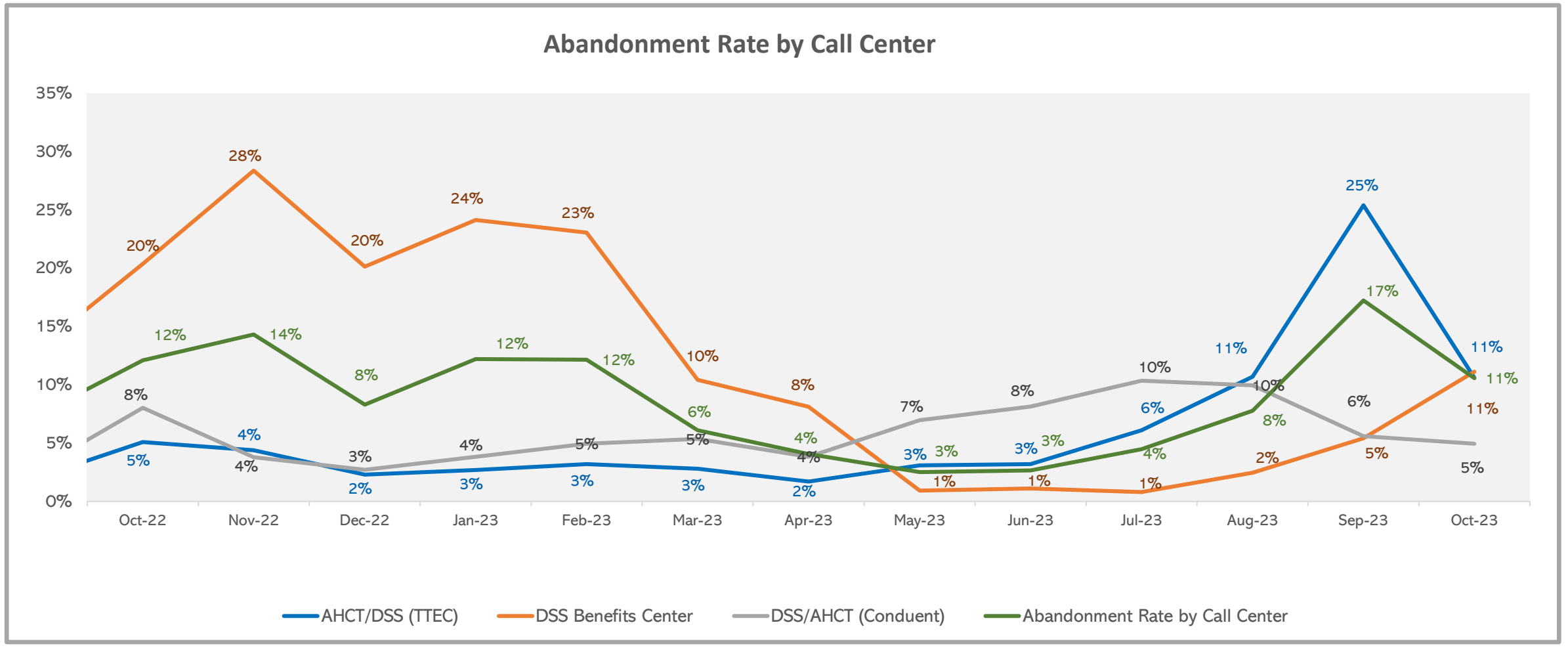
Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded.
The DSS Benefits Center handles 30% of Medicaid/CHIP calls.

Call Wait Time



Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded.
Wait times are measured from the time a caller selects the option to speak with an agent to the moment the caller is connected to one.

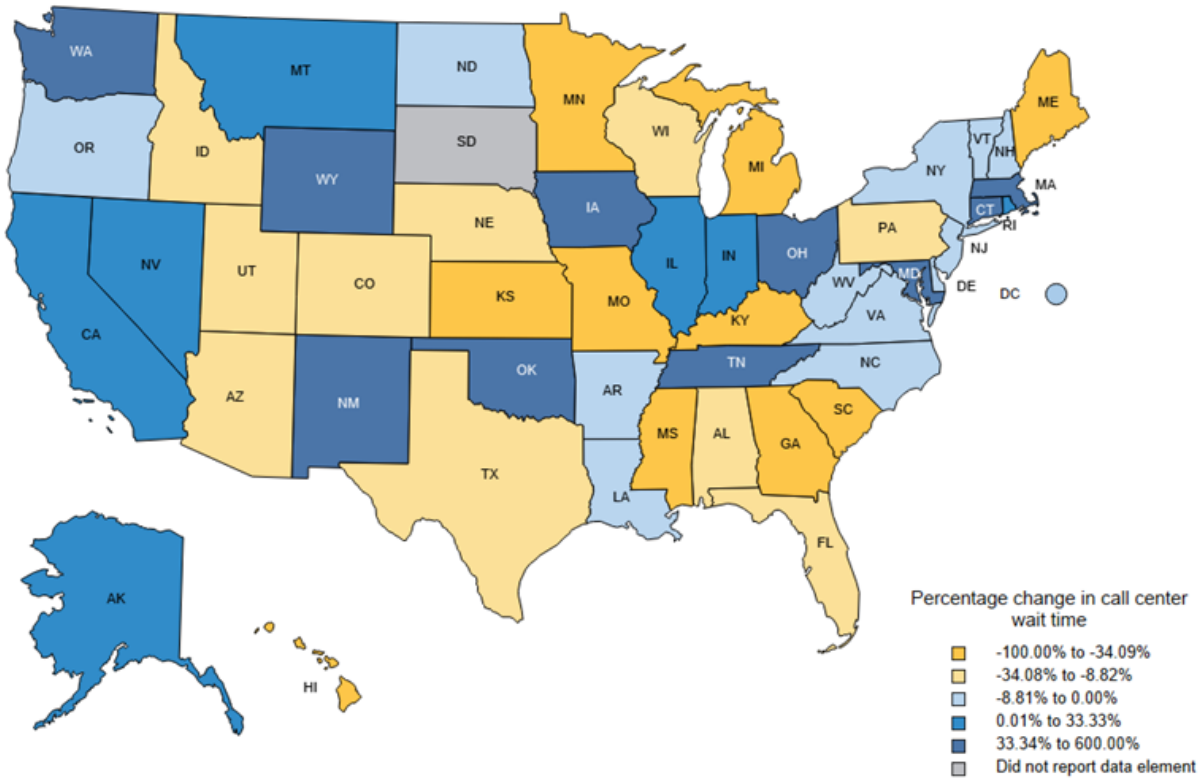
Call Abandonment Rate



Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded.

CMS National Call Wait Time Data

Percentage change in average call center wait time, July 2023 to August 2023



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State	Avg Call Center Wait Time	% Change from Previous Month
AK	16.00	23.08%
AL	3.00	-25.00%
AR	4.00	0.00%
AZ	31.00	-8.82%
CA	4.00	33.33%
CO	12.00	-14.29%
CT	4.00	100.00%
DC	1.00	0.00%
DE	1.00	0.00%
FL	29.00	-29.27%
GA	18.00	-35.71%
HI	11.00	-47.62%
IA	20.00	233.33%
ID	46.00	-11.54%
IL	17.00	6.25%
IN	8.00	33.33%
KS	2.00	-81.82%
KY	8.00	-46.67%
LA	2.00	0.00%
MA	2.00	100.00%
MD	15.00	400.00%
ME	29.00	-34.09%
MI	1.00	-50.00%
MN	4.00	-42.86%
MO	17.00	-37.04%
MS	0.00	-100.00%

State	Avg Call Center Wait Time	% Change from Previous Month
MT	34.00	9.68%
NC	0.00	0.00%
ND	1.00	0.00%
NE	4.00	-20.00%
NH	15.00	0.00%
NJ	2.00	0.00%
NM	35.00	40.00%
NV	21.00	10.53%
NY	0.00	0.00%
OH	7.00	40.00%
OK	3.00	100.00%
OR	27.00	-3.57%
PA	13.00	-13.33%
RI	45.00	4.65%
SC	1.00	-66.67%
SD	NR	NR
TN	15.00	400.00%
TX	11.00	-15.38%
UT	25.00	-13.79%
VA	1.00	0.00%
VT	1.00	0.00%
WA	1.00	100.00%
WI	12.00	-29.41%
WV	11.00	-8.33%
WY	7.00	600.00%
Did not report data element		NR

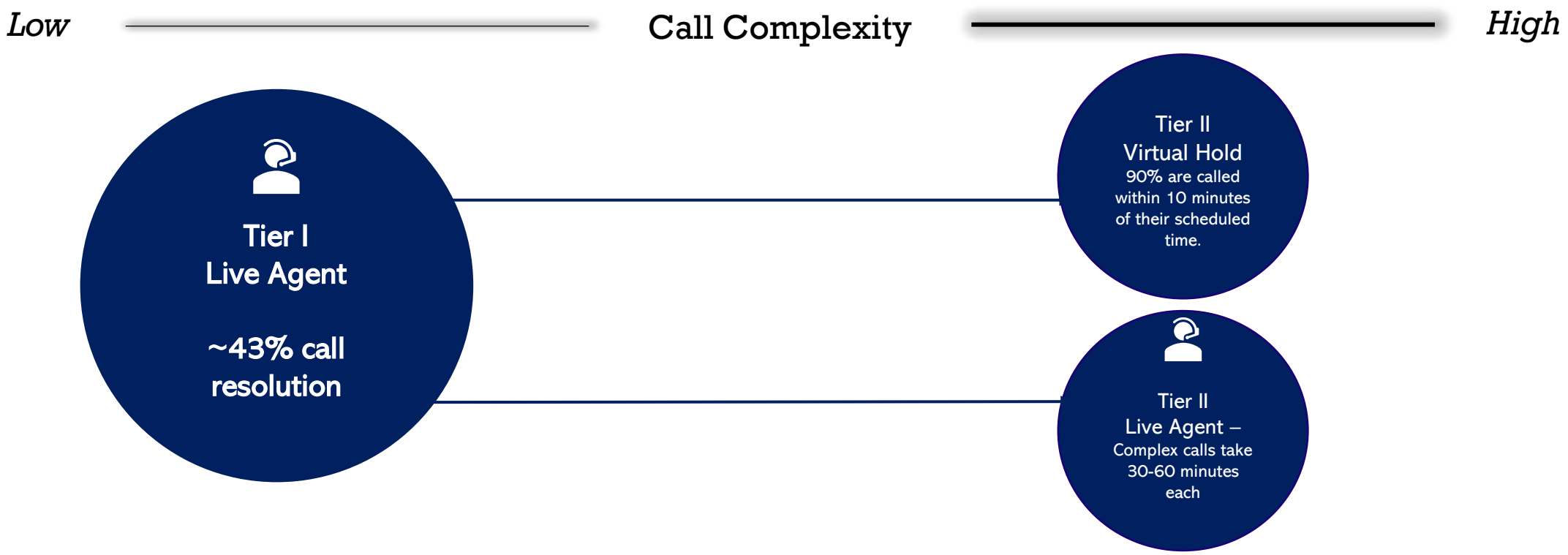
Source: Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data, preliminary data submitted by October 23, 2023, with data through August 2023.
Notes: This analysis includes preliminary Performance Indicator data from 50 states and the District of Columbia. SD does not have call centers and does not report call center metrics. Data notes can be found in the Appendix and state-specific data quality notes can be found in the Medicaid and CHIP CAA Reporting Metrics at Medicaid.gov/unwinding-data.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DSS Benefits Center

Tiered Telephonic Service Delivery Model

In April 2023, DSS introduced a tiered telephonic service delivery model in anticipation of high call volume stemming from eligibility adjustments associated with the PHE unwinding. A tiered model helps to direct and escalate client calls based on need and complexity. All DSS client calls start with a Tier I agent, and when necessary, move up to a Tier II agent.



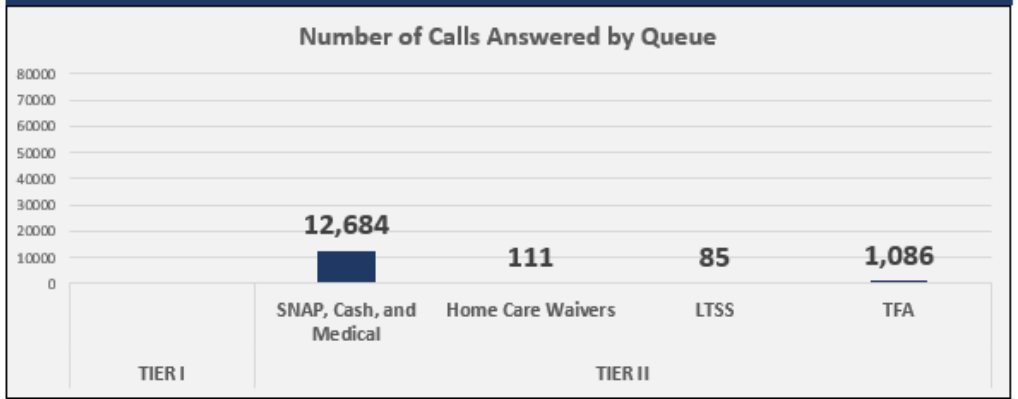
- Did you receive my application/documents?
- I lost my EBT card, can I get a new one?
- Where can I get a copy of a budget sheet?
- What is the status of my case?
- What is my benefit amount and effective date?
- What additional information do I need?

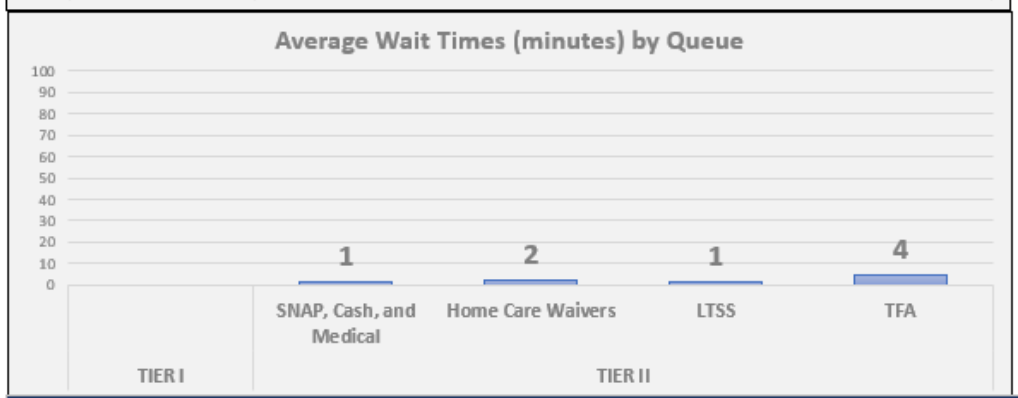
- Phone Interviews for SNAP, and cash assistance applications and renewals.
- Processing changes reported over the phone.
- Processing of submitted documents such as applications, renewals and changes.
- Address and process complex client case inquiries.

DSS Benefit Centers Call Data - August 2023

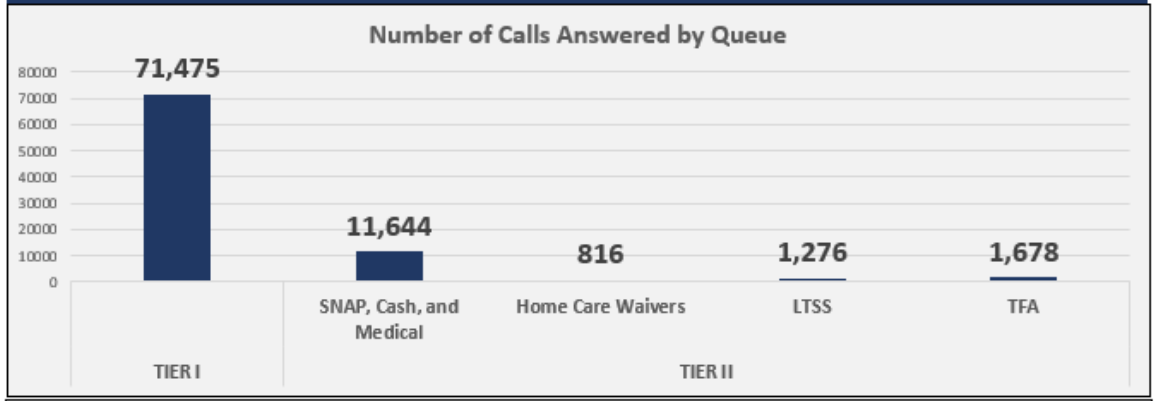
Total Number of Calls Answered in Tier I - 71,475
Total Number of Calls Answered in Tier II - 29,380

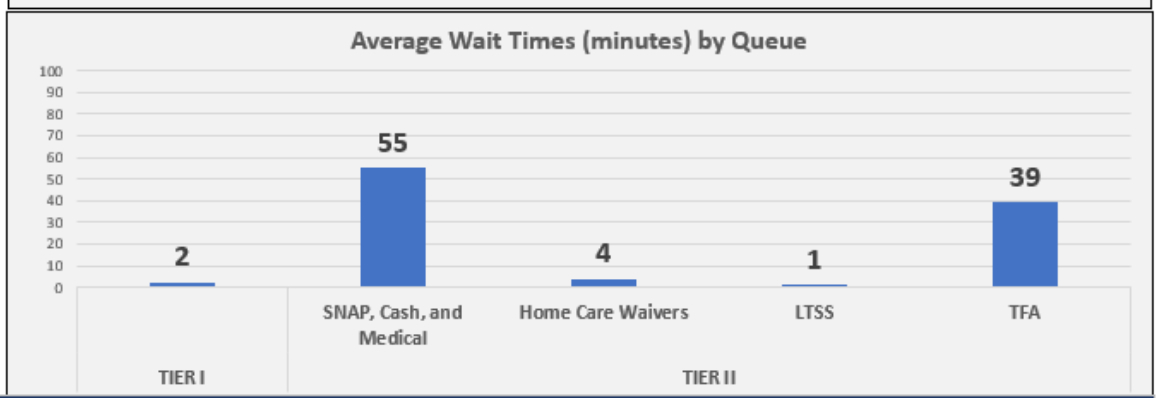
CALLBACKS (VHT - VIRTUAL HOLD TECHNOLOGY)





CALLS HOLDING IN QUEUE (Non-VHT)



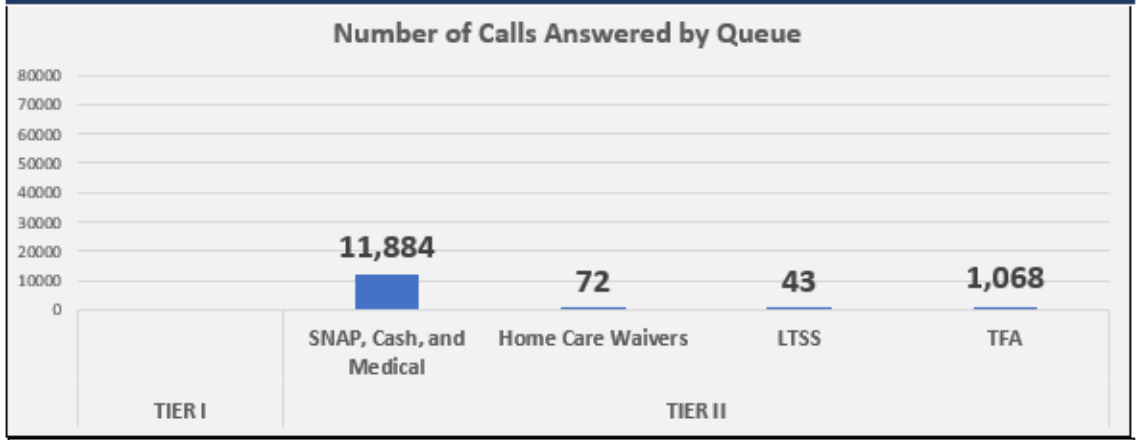


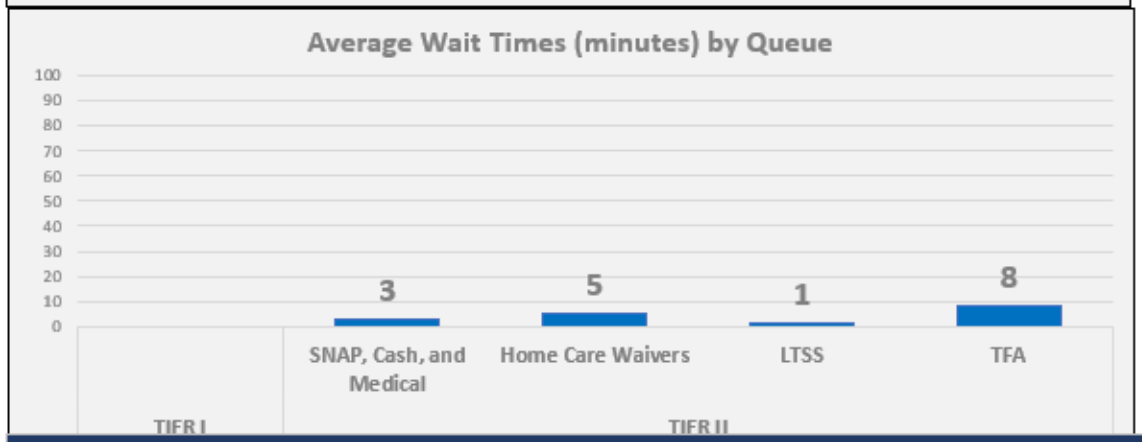
Notes:
(1) Calls answered by Tier II are transfers from Tier I to Tier II to speak with eligibility specialists.
(2) Callbacks & Appointments (VHT) feature not offered to Tier I Calls
(2) The Generalist Queue has 24 sub-queues; Tier I has 2 queues; Community Options, LTSS, and TFA have 4 sub-queues in each for a total of 38 queues separated for English and Spanish languages, and Callbacks and Calls holding in queue. Clients who press "Zero" are routed to

DSS Benefit Centers Call Data - October 2023

Total Number of Calls Answered in Tier I - 67,108
Total Number of Calls Answered in Tier II - 22,159

CALLBACKS (VHT - VIRTUAL HOLD TECHNOLOGY)





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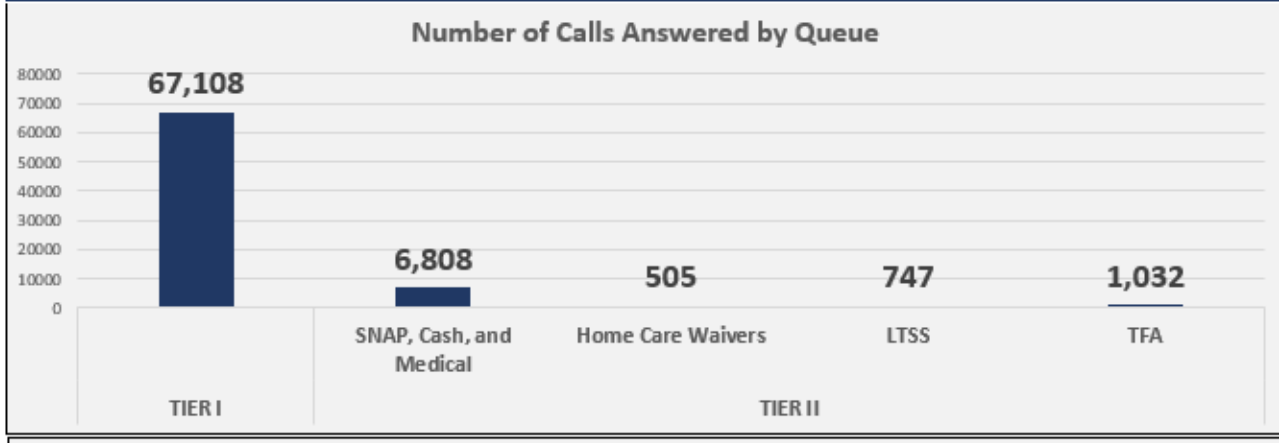

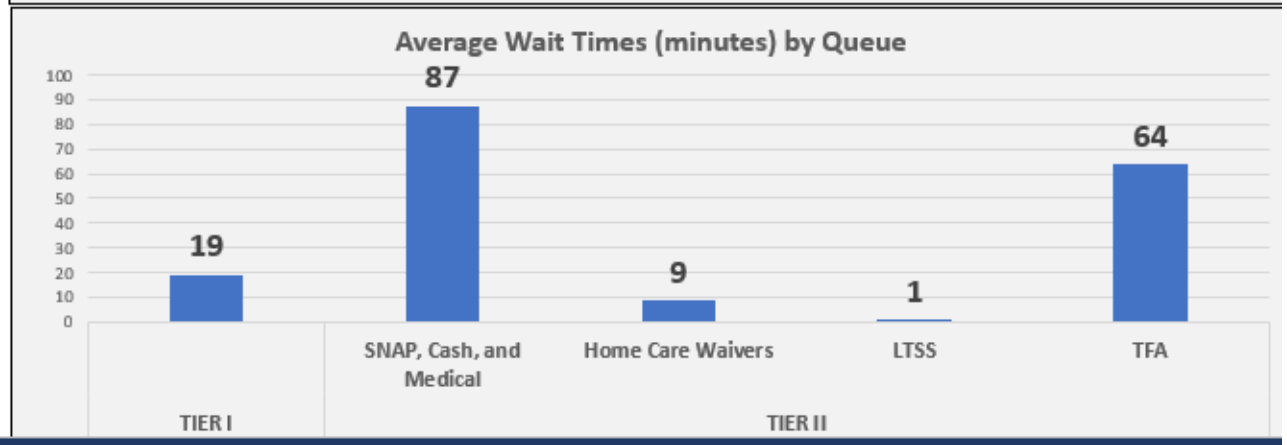

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Call Center Mitigation Strategies

Eligibility Workforce Processing

Leverage increased productivity of ~230 new eligibility hires transitioning out of training

50 additional Tier 1 staff supporting PHE Unwinding by 12/15

Maintain 5% vacancy levels for eligibility staff

Maximize the use of scheduled callbacks

Maximize Federal Waivers

Streamlined recertification procedures for SNAP

Waived certification interviews for SNAP

Adjusted procedures for address changes (combined programs)

Self-Service Options

Promote use of existing self-service platforms available to clients to submit new/renewal applications, obtain eligibility decisions and status, find common forms, and common FAQ's

Alerts and Reminders

Send proactive alerts and reminders for important actions required by clients – renewals, verification documents, upcoming appointments

Create and send targeted campaigns to promote use of self-service options

Community Partners

Identify community partners that can provide more assistance to clients with new applications, and program education

Health Equity at CHNCT

Equity Initiatives

Presentation to the
Medical Assistance Program Oversight Council
(MAPOC)

November 9, 2023

Community Health Network of Connecticut, Inc.

Health Equity at CHNCT

CHNCT operates from an equity lens to set the tone for the entire organization. Advancing health equity is key for improving access to care for the underserved and vulnerable populations we serve. We have incorporated health equity into all aspects of our operations.

Our Commitment

- CHNCT's mission is to improve the health of underserved and vulnerable populations by providing equitable and culturally appropriate access to high quality and comprehensive healthcare to all Connecticut residents.

Our Goal

- Our goal is to provide opportunities for our members to attain their highest possible level of health, be treated equally and offered the same services regardless of ethnicity, sexual preference, or the language they speak.

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Our Approach

We are working with the Association for Community Affiliated Plans (ACAP) and the Center for Health Care Strategies (CHCS) to develop our strategic health equity plan based on their national framework.

About ACAP

- CHNCT is a member of ACAP, the national trade association which represents not-for-profit Safety Net Health Plans.
- ACAP's 80 Safety Net Health Plans and partner plans cover more than 25 million people through Medicaid, Medicare, Marketplaces and other public health coverage programs.
- ACAP provides opportunities for its plans to collaborate, share best practices and participate in various learning collaboratives on topics such as Social Determinants of Health (SDOH) and Health Equity.

About CHCS

- CHCS is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid.
- CHCS works to improve health outcomes for the millions of people in the U.S. who face serious barriers to well-being, like poverty, complex health and social needs, and systemic racism.
- For more than 25 years, CHCS has collaborated with Medicaid and related health and human services agencies in states across the country to shape how health care services are designed, financed, and delivered.

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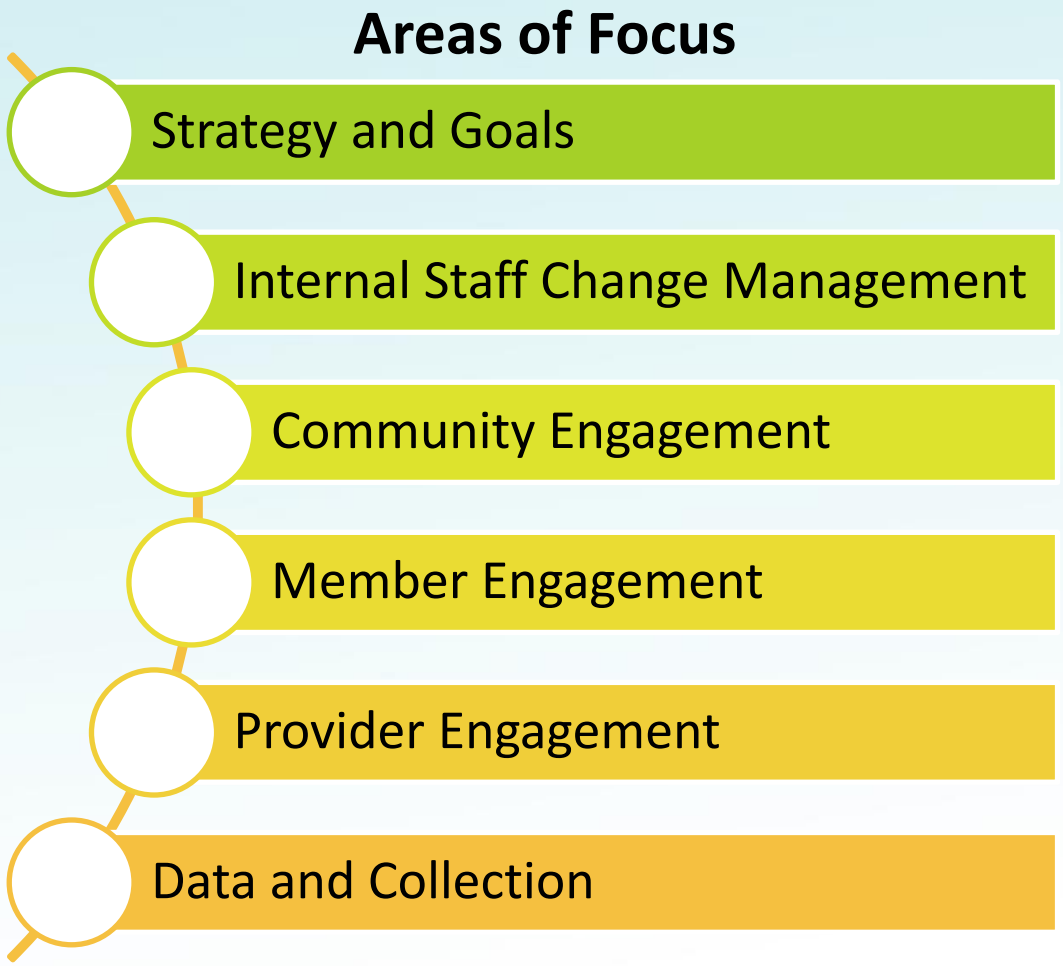
Our Approach (cont.)

- In July of 2022, ACAP launched the Health Equity Learning Collaborative in partnership with CHCS and 15 health plans
- This two-year collaborative includes virtual group learning opportunities to help plans design and implement strategic plans for addressing health equity within their organizations
- Using their framework, CHNCT completed an organizational health equity assessment to begin the process, which informed our health equity strategic plan



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Our Organizational Support

Health Equity Council: Led by our Director of Health Equity and includes CHNCT leadership

- Provides direction on CHNCT's strategy, priorities and opportunities to help advance our goals as an organization, improve the health and lives of our members and reduce health inequities

Health Equity, Diversity and Inclusion Team: Led by our CEO, this is a diverse team including staff of all levels, races/ethnicities, LGBTQ+ representation, and a HUSKY Health member with lived experience

- Identifies and discusses diversity, equity and inclusion and health equity issues and concerns
- Makes recommendations for policy changes, staff training, member interventions and program development/modifications

Culturally and Linguistically Appropriate Services (CLAS) Workgroup: Led by our Director of Health Equity, consists of staff from different areas of the organization

- Focuses on ensuring CHNCT provides culturally competent services to its members

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HEALTH EQUITY STRATEGIC INITIATIVES

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Strategy and Goals

- ***Incorporating Diversity, Equity, and Inclusion in all Workplace Practices.*** To further support our mission and values in being a diverse and inclusive organization:

  - Developed a strategic health equity plan that defines our commitment to health equity and sets our overall goals and priorities

  - Developing and implementing internal policies and department-specific trainings that actively promote equity throughout CHNCT

Internal Staff Change Management

- ***Building a Supportive, Diverse and Inclusive Workforce.*** CHNCT's Human Resources department is committed to creating an environment that represents the communities and members we serve, where all employees feel valued.
  - Identifying and reviewing current workplace policies, programs, and practices that relate to diversity and inclusion
  - Continue providing Diversity, Equity & Inclusion training for all employees, with specialized training for executive leadership
  - Connecting with organizations with diverse membership to expand our recruiting efforts for employment opportunities

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Community Engagement

- ***Helping members navigate through health barriers.*** Through our Community Health Worker (CHW) Ambassador Program, our certified CHWs provide community-based outreach, advocacy, culturally-based education, and health promotion.

* Regionally based CHWs who live and work in the same neighborhoods as our members
* Assisting with finding members Primary Care Providers and scheduling appointments
* Connecting members to SDOH resources and care management when needed
* Helping HUSKY Health members recently released from prison through CHNCT's Community Transition Program with the needed medical and SDOH support for a successful transition back into the community
* Connecting with members at Community Engagement HUBs. HUBs are neighborhood spaces at community locations throughout the state where members can get **h**elp **u**nderstanding their **b**enefits

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Community Engagement (cont.)

- ***Expanding our partnerships and programs.***
  - **HUB Program:** The Community Engagement team is expanding our partnerships and the HUB Program in New London, Hartford and Windham counties to create additional opportunities for Community Health Workers (CHWs) to connect with HUSKY Health members.
    - Our Partners and Sites include:
      - American Job Centers, WIC Offices, Community Action Agencies, Board of Education and Connecticut Foodshare – Mobile Food Pantry sites
  - **Community Transition Program*:*** The Community Engagement team will continue its efforts with expanding the Community Transition Program statewide by engaging urban re-entry collaboratives.

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Community Engagement (cont.)

- ***Providing community level engagement through health education programs.*** Through our Community Engagement HUB Program, CHNCT has established statewide partnerships with various public-school systems, family resource centers, mobile food pantries, soup kitchens, etc. CHNCT is engaging with Boards of Education and other partners to deliver at least 25 tailored nutrition education programs on-site.

- Our nutritional programs are held virtually or in-person at: health fairs, community events, parent/teacher nights, after-school programs, summer camps, and back to school events
- Community Health Educators (CHEs) are responsible for increasing healthy living behaviors by providing health education to members as well as other community audiences
- CHEs provide resource materials for health conditions such as obesity, hypertension, heart disease, stroke, and diabetes
- They also provide referrals to help members utilize the HUSKY Health program in a way that best addresses their unique SDOH needs

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Member Engagement

- ***Incorporating consumer voices in our health equity work***. CHNCT continues to work with internal departments to involve consumer voices to advocate for health equity.
  - A HUSKY Health member will be joining our Health Equity, Diversity & Inclusion Team to provide input on our efforts.
  - CHNCT's Member Advisory Workgroup was developed in 2012 and is comprised of approximately 30+ culturally diverse HUSKY Health members who reside across Connecticut.
    - This workgroup is a partner to both CHNCT and DSS and helps provide direct input on policies, new benefits and services, program development, and interventions.
    - The Director of Health Equity attends the Member Advisory Workgroup meetings to obtain feedback from our members on our health equity initiatives.

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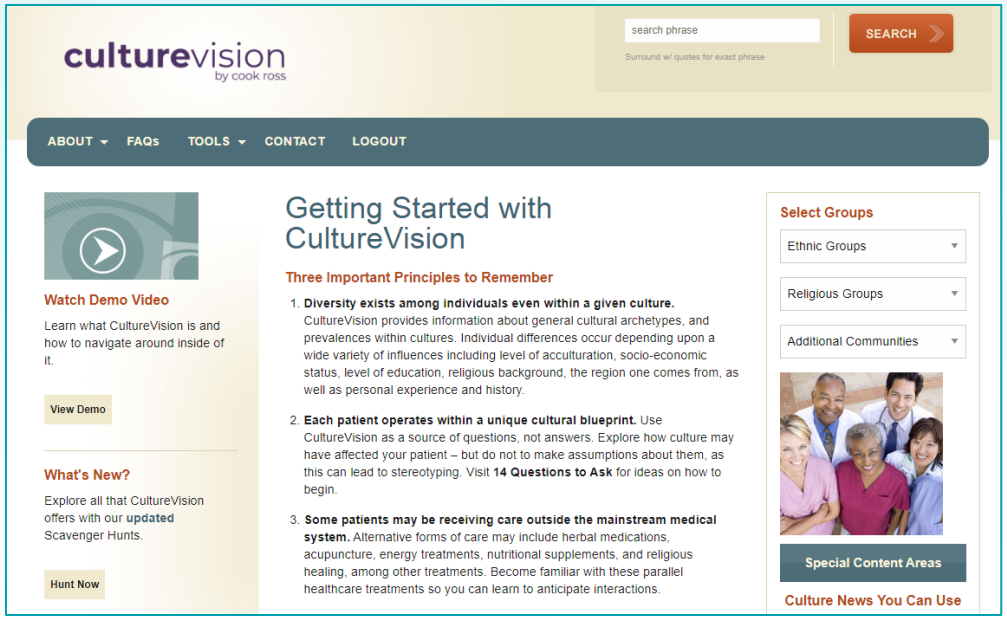
Member Engagement (cont.)

- ***Advancing Health Equity through Culturally and Linguistically Appropriate Services (CLAS).*** CHNCT has policies, procedures and training in place to ensure we provide culturally and linguistically appropriate services to our members today.
  - **Staff Training:** All staff receive cultural competency training, which includes an overview of CultureVision™ by Cook Ross
    - CultureVision™ is an online database that provides access to information about 75 ethnic groups, religious groups, and additional communities for use in providing culturally competent patient care.
    - Additional communities include, but are not limited to: Blind/Low Vision, Deaf/Hard of Hearing, and Physical Disability
  - **Provider Access to CultureVision™:** CHNCT provides free access to CultureVision™ for HUSKY Health providers through our secure provider portal on the HUSKY Health website
    - Providers are educated on the availability of this tool



Member Engagement (cont.)

- ***Supporting Black Maternal Health.*** The Care Management (CM) department provides education on the Centers for Disease Control and Prevention's (CDC) *Hear Her*™ Campaign with every perinatal member enrolled in CM, with enhanced efforts to reach Black/African American, Hispanic and other high-risk individuals at greatest risk for adverse pregnancy outcomes. CM offers Perinatal Learning Groups on the *Hear Her*™ Campaign (Listen, Learn, Speak Up) to educate members and their support persons about reportable warning signs.

- ***Targeted Care Management Programs to Address Disparities.*** Using a person-centered approach, CHNCT's CM includes condition management programs provided by a multidisciplinary team targeted at equitable access to care and improving the member's ability to optimally participate in healthcare.
  - **Diabetes Management Program** to achieve improvements in blood glucose levels for unattributed or high-risk Black/African American and Hispanic members with diabetes and an HbA1c level of 9% or greater
  - **Hypertension Program** with a goal of connecting unattributed or high-risk Black/African American members with hypertension to a primary care provider or specialist
  - **Complex Care Coordination for Members Receiving Gender-Affirming Care** to help guide members through the process

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Member Engagement (cont.)

Diabetes Management Program

- Supporting improvement in members' self-management of their diabetes through evidence-based, person-centered practices
- Coaching by nurses on diabetes and diabetes management
- Sharing educational tools and resources, including customizable action plans

Hypertension Program

- Condition-specific coaching by nurses
- Promoting family/caregiver participation in coaching, diet counseling, medication management support, and care transitions to support positive outcomes
- Working with members to address barriers to engaging in care with a provider such as effective communication or transportation needs

Gender-Affirming Care

- Person-centered interventions that address medical, behavioral and health-related social needs
- Assisting members with navigating benefits and documentation requirements
- Helping members make necessary arrangements, including obtaining appointments

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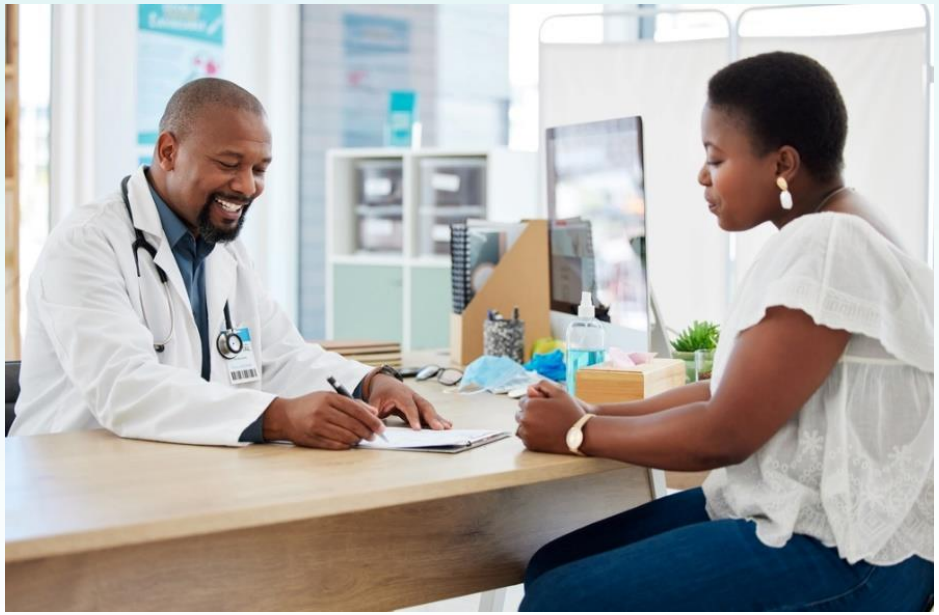
Provider Engagement

- ***Improving Members' Ability to Access Equitable Care.*** The Provider Engagement Services team is working to improve access to diverse providers who members are comfortable with based on their race, ethnicity, and those who offer LGBTQ+ supportive clinicians and services.
  - Building a process that allows providers to submit their race, ethnicity and indicate if their practice offers LGBTQ+ supportive services and clinicians to CHNCT
    - This information will be displayed in the provider directory
  - Conducting a mystery shopper survey and assessing whether using ethnic-sounding names and/or identifying as part of the LGBTQ+ community has an impact on appointment availability or timeliness
    - Based on results, Provider Engagement will develop corrective action plans as needed
  - Continuing to recruit and retain providers who provide gender-affirming care to ensure that LGBTQ+ community members seeking gender-affirming services have access to care



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Provider Engagement (cont.)

- ***Increasing engagement with provider partners in health equity initiatives.*** Through our Provider Engagement and Clinical Practice Transformation Specialist (CPTS) teams, CHNCT continues to explore options to address health equity and identify best practices with the provider community.

- Collaborating with Person-Centered Medical Homes, Federally Qualified Health Centers and Glide Path practices on specific Quality Improvement initiatives that address health equity opportunities among their attributed HUSKY Health members
- Soliciting feedback from the provider community on health equity initiatives
  - CHNCT's Provider Advisory Workgroup
  - During on-site visits with providers

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Provider Engagement (cont.)

- ***Designing targeted interventions to help improve member outcomes.*** CHNCT stratifies all health measures by race, ethnicity and geographic area. Through our data analysis, CHNCT identifies disparities and gaps in care in geographic areas and develops interventions.
  - Currently, our Quality Management team has developed interventions to address specific disparities in the following:
    - Emergency Department Utilization for non-emergent services among Hispanic members residing in Bridgeport and New Britain
    - Child Immunization Rates for Black/African American members residing in Bridgeport
  - Intervention example:
    - Our Clinical Practice Transformation Specialists work with HUSKY Health pediatric/family practice providers in Bridgeport on quality improvement initiatives to increase childhood immunization rates by targeting members who have not received their immunizations

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Data and Collection

- ***Enhancing Data and Collection Efforts to Advance Health Equity.*** Improving our data will allow us to further assess member health outcomes, identify disparities, and develop targeted interventions.

*
  - Developing a plan to collect race and ethnicity data from HUSKY Health members who have not self-identified during the enrollment process
    - Information will be obtained during calls with members, through our Health Risk Questionnaire and by allowing members to provide this information on our secure member portal

*
  - Stratifying health measures by disability status
    - CHNCT is working on defining data standards for identifying disability status using eligibility, claims and self-reported data

*
  - Stratifying two quality measures by language to identify disparities: HEDIS® Adults' Access to Preventive/Ambulatory Health Services and HEDIS® Child and Adolescent Well-Care Visits
    - CHNCT selected these measures because they both address access to primary care, cover most of the membership, and provide the largest data set for detailed analysis

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

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Questions?

GTI

Unwinding

Peer Support Services

Peer Support Services

- **What are Peer Support Services**
  - Lived experience (mental health/SUD)
  - Educate/support/navigate
  - Manifest possibilities
- **How does Medicaid cover peer supports?**
  - Behavioral health ASO (Carelon)
    - ASD/Family/Adult/First Episode Psychosis Peers
  - 1115 SUD Waiver
    - Residential programs
- **DMHAS**
  - Hires and provides grant funding for peer support services