Partnering with CGHC

CGHC works collaboratively with providers to ensure that our members receive the highest quality, most cost-effective care possible. Our network highlights integrated care systems that focus on improving the health of the community by providing the right care in the right setting at the right time. As a provider partnered with us, you are a part of our Envision network, which is offered for both individual and small group coverage.

We value the partners in our Envision Network and hope to make all providers aware of the many resources we have available to streamline your experience and benefit your CGHC patients. Please enjoy the relaunch of our bi-annual provider newsletter, packed with valuable information and tools!
At CGHC, we strive to promote self-service for our providers' convenience. Our provider portal is available for all providers to access information on member benefits, eligibility, claims status, and completed prior authorizations.

If you are not already registered for the provider portal, it is important to do so. Some important tips:

1. If you are with an independent provider organization, you can register with your Facility or Clinic Tax ID Number (TIN), as outlined on the Provider Self Service Training Guide.

2. If, however, you are a part of a health system (such as Aurora, Bellin, or ThedaCare), you will need to contact the designated portal administrator within your organization to request access. Once your administrator approves your request, they will forward your information to CGHC to complete the necessary set-up process so that you may access multiple TINs under a single account and username.

DID YOU KNOW?

- Provider Portal access
- Provider Manual
- Prior Authorization Search (codes) function
- List of zero-cost preventive drugs and services
- Clinical practice guidelines
- Prescription, Medical, and Administration forms
- and more!

Our website is always evolving, and we consistently add new functionality and informative pieces to improve navigation and assist with the provider experience.
CHANGES & UPDATES

For 2020 CGHC has made some changes and updates to the website that impact providers.

Our Member ID Cards
Our 2020 Member ID cards have been updated and no longer include the person code. Instead, all family members will be identified with the same ID number. When using CGHC’s phone IVR to check member eligibility, you simply need the 10 digit member ID and patient’s date of birth.

Our Provider Manual
Our 2020 provider manual can be viewed on our website here. It outlines all CGHC provider guidelines and processes.

Our Prior Authorization Search Tool allows providers to search the codes of all covered health services that require prior authorization with CGHC. It can be found on our website here and can be used by clicking the "Search Now" button that appears below. This tool is consistently updated as new services are required for Prior Authorization.

Preventive Medical and Rx
CGHC plans cover many preventive services, both medical and Rx, for our members, but not all preventive services are eligible at zero cost to CGHC members under the Affordable Care Act (ACA). To assist providers with understanding zero cost preventive services for CGHC members, we’ve created these resources:
Medical: Preventive Services list
Can be found at CGCares.org/preventive
Rx: $0 drug list
Can be found at CGCares.org/formulary

EPO PLANS & REFERRALS

All CGHC Individual Plans (member IDs starting with 0 or I), are Exclusive Provider Organization (EPO) plans. EPO plans have no out-of-network (OON) benefit, except in case of an emergency or if an approved EPO referral has been granted because the care is not available in-network. In EPO plans, CGHC members are able to see in-network Primary Care Providers (PCPs) or specialists without a written referral.

If your patient needs care that you believe is not available in-network, you must submit an EPO referral request and wait for CGHC approval to refer your patient to that out-of-network provider. You can find more information on the EPO referral process in our EPO FAQ, which is located on the website under "Resources for Providers."

Please note, that our Small Group Plans (member IDs starting with S) are Preferred Provider Organization (PPO) plans, so the referral requirements for out-of-network care do not apply to those members.
HEDIS QUALITY MEASURES

Each year, all Qualified Health Plans offering plans on the Federal Marketplace must submit their HEDIS (Healthcare Effectiveness Data and Information Set) and QHPEES (Qualified Health Plan Enrollee Experience Survey) information to CMS. HEDIS quality measures and member experience scores are heavily reliant on our provider partners.

Clinical Quality Management (HEDIS) 66.67%
- Asthma Care 5.56%
- Behavioral Health 5.56%
- Cardiovascular Care 5.56%
- Diabetes Care 5.56%
- Patient Safety 22.22%
- Checking for Cancer 5.56%
- Maternal Health 5.56%
- Staying Healthy - Adult 5.56%
- Staying Healthy - Child 5.56%

Enrollee Experience (QHP Survey) 16.67%
- Access & Care Coordination 8.33%
- Doctor and Care 8.33%

Plan Efficiency, Affordability & Management 16.67%
- Efficient Care (HEDIS) 8.33%
- Enrollee Experience with Health Plan (QHPEES) 8.33%

KEY TAKEAWAYS

We rely on our provider partners to provide accessible, quality health care services to our members. This is monitored via the HEDIS quality measures and QHP Enrollee Experience Survey (QHPEES) data which are converted into a CMS 5 Star Rating System:

- 25% of our star rating is based solely on the behaviors of our provider partners (gray boxes)
- The Clinical Quality Management HEDIS measures (66.67% of star rating) are heavily influenced by our provider partners
- Opportunity to work together - making sure our members get their recommended health services and stay compliant with medications
- 2020 provider partner focus: Patient Safety (outlined in blue)
  - Plan All Cause Readmissions
  - INR Monitoring for patients on Warfarin