Welcome to the 2021 Fall Provider Workshop

Presentations will begin momentarily
Fall 2021 Provider Workshops

Peer Recovery Support Services Update

Keith King, Program Manager
Substance Use Disorder Waiver Services
Peer Recovery Support Services

Procedure Code: H0038

Service Unit: 15 Minutes
Service Limits: 16 units per Calendar Day
Prior Authorization: Required
Telehealth: Available
Client Limitations: May not exceed 20 members per Peer Recovery Support Services

Note: Group Peer Recovery Support services are not covered services.
A peer is an individual who shares the direct experience of addiction and recovery.

Recovery support services are nonclinical services that assist individuals to recover from alcohol or drug problems.

A peer recovery support specialist (PRSS) is a person who uses his or her own lived experience of recovery from addiction, in addition to skills learned in a formal training, to deliver services in substance use disorder (SUD) settings to promote mind-body recovery and resiliency.

A peer recovery support specialist is qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of substance abuse disorders.
PRSS Requirements

PRSS requirements include:

▪ Self-identify as an individual with life experience of being diagnosed with a serious mental illness or substance use disorder which meets federal definitions;

▪ Must be well established in their own recovery; currently in recovery for a minimum of two years and not have received SUD treatment for the preceding six months, except for Medication Assisted Treatment (MAT). (Note: MAT is considered a part of recovery);

▪ Have a high school diploma or GED equivalency;

▪ The individual must be employed by either a Comprehensive Behavioral Health Center (CBHC) or Licensed Behavioral Health Center (LBHC);

▪ Certification as a peer recovery support specialist,

▪ Complete Peer Recovery Support Specialist application which includes the Attestation of Recovery Statement and three letters of reference:
The PRSS requirements include:

▪ Must be supervised by a Master’s degree individual that is employed by the same provider,
▪ Must not be a family member of the individual receiving the peer support services,
▪ Continuing education of 30 hours must be completed every 2 years in the competency domains, which must include six hours in ethics.
▪ Complete 40 contact hours of volunteer work or paid work at an agency or provider prior to Medicaid services being rendered.
▪ Complete Fingerprint-Based Background Check. See Please see Chapter 504, *Substance Use Disorder Services*, Section 504.4 for Fingerprint-Based Background Check information,
▪ Applicants must complete the PRSS Webinar with an 80% or higher score to be certified or be certified through the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP).
Beginning October 1, 2020, the Bureau for Medical Services (BMS) will accept either the BMS certification or the WVCBAPP Peer Recovery Certification.

BMS will provide reimbursement for services provided by individuals with either certification until October 1, 2022.

Beginning October 1, 2022 (the end of the transition period), only PRSS with a WVCBAPP Peer Recovery Certification will be eligible to be reimbursed by West Virginia Medicaid.

Beginning September 30, 2022, BMS will no longer provide its PRSS certification process, nor will it accept the BMS certification for reimbursement after that date.
WVCBAPP Peer Recovery Certification

- WVCBAPP is a voluntary board whose purpose is to certify the qualifications and competence of the persons who are engaged in professional addictions services, be it treatment or prevention. WVCBAPP is a member of the International Certification & Reciprocity Consortium on Alcohol and Other Drug Abuse (IC & RC), and as such adheres to the IC & RC requirements for certification of addictions counselors, prevention specialists, and clinical supervisors.

- Information for WVCBAPP can be on their website at: www.wvcbapp.org

Currently, only 7.7% of individuals holding a BMS certification also have a WVCBAPP certification.
The PRSS application is included on the SUD Waiver webpage under SUD forms: dhhr.wv.gov/bms/Programs/WaiverPrograms/SUDWaiver/Pages/SUD-Forms.aspx

PRSS Webinar: www.onlinelearning.wv.gov/student/home.html

PRSS employers should keep all documents on file including the PRSS application, certificate and attestation of recovery, letters of reference, the employees’ educational record, work history, etc.

The PRSS employer is responsible for ensuring that employee provider PRSS services maintain appropriate CEU hours for their certification.
Resources

- Information on SUD Waiver services can be found in Chapter 504 of the West Virginia Medicaid Provider Manual: dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx
- SUD Waiver webpage: dhhr.wv.gov/bms/Programs/WaiverPrograms/SUDWaiver/Pages/default.aspx
- Information about the American Society of Addiction Medicine (ASAM®) criteria: www.asam.org/resources/the-asam-criteria/about
Keith King, Program Manager
1115 Substance Use Disorder Waiver Program

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 352-4307
Fax: (304) 558-4398
Email: Keith.King@wv.gov
Website: https://dhhr.wv.gov/bms/Pages/default.aspx
2021 Fall Provider Workshop

WV BMS, WVCHIP, Gainwell Technologies

November 2021
The Health PAS-Online portals give the provider access to a variety of functions to assist in managing their enrollment and claim submissions for WV Medicaid members.

Available Functions:

- View Medicaid News/Announcements
- Verify Member Eligibility
- View/Submit Claims
- View Authorizations
- Check/Update Enrollment
- View Claims Reports
- Access Reference Materials
- Submit Grievance/Appeal Requests
Health PAS-Online – Verify Member Eligibility

Verify Member Eligibility:

• Select the appropriate Billing Provider in the drop-down box

• Find Member by entering two of the following criteria:
  – Member Identification (ID)
  – Name (Last and First)
  – Date of Birth
  – Social Security Number
Health PAS-Online – Verify Member Eligibility

Verify Member Eligibility (cont.)

- Eligibility Inquiry – verifies eligibility based on a selected date of service
- Enrollments – verifies which Benefit Plan the member is enrolled in
- Copay – shows what copays the member has for selected date of service
- Other Insurance – shows any coordination of benefits
- PCP/Medical Home – lists the MCO the member is enrolled with.
Health PAS-Online – View and Submit Claims

View and Submit Claims:

• Claim Status

• From the home page, select Form Entry form the menu bar, then View & Submit Claims
  – Enter the Billing Provider’s NPI to view a list of the last 40 claims submitted under the billing provider
Health PAS-Online – View/Submit Claims

• How to Submit a Claim:
• Select a Billing Provider
  – On the Claim Status screen, select the Billing Provider (agency) from the drop-down box to select the provider if not auto-populated.
  – Click New Claim
Health PAS-Online – View/Submit Claims

How to Submit a Claim (cont.):

• Claims Member Search
  – Select the applicable Claim Type for billing
    o Professional, Dental or Institutional
  – Enter the Member information under Find Member
    o The members information requires two identifying pieces of information such as first name, last name and DOB or first name, last name and SSN.
  – Click SUBMIT
Health PAS-Online – View/Submit Claims

How to Submit a Claim (cont.):

• Claims Submission
  – Enter the required claims data fields with a red asterisk
    o Claims
    o Diagnosis
    o Services
    o Additional Information
  – Click Submit
Health PAS-Online – View/Submit Claims

How to Submit a Claim (cont.):

• Claims Summary
  – The Claim ID will populate on the Claims Summary screen.
  – From this screen the user can Adjudicate Claim, Edit a Claim, Add an Attachment, or create a New Claim. Adjudicating the claim is not required, however it does give the submitter the opportunity to identify any claim denials and allows for correction with the Edit Claim.
## Health PAS-Online - Emails, Phone Numbers, Mailing Addresses

<table>
<thead>
<tr>
<th>Department</th>
<th>Toll Free</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
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<tr>
<td>Provider Services</td>
<td>(888)483.0793</td>
<td>(304)348.3380</td>
<td><a href="mailto:wvmmis@dxc.com">wvmmis@dxc.com</a></td>
<td><a href="mailto:wvproviderfieldrepresentative@dxc.com">wvproviderfieldrepresentative@dxc.com</a></td>
<td>PO Box 2002</td>
<td>Charleston</td>
<td>WV</td>
<td>25327-2002</td>
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<tr>
<td>Provider Enrollment</td>
<td>(888)483.0793x4</td>
<td>(304)340.2763</td>
<td><a href="mailto:wvproviderenrollment@dxc.com">wvproviderenrollment@dxc.com</a></td>
<td></td>
<td>PO Box 625</td>
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<td>EDI Helpdesk</td>
<td>(888)483.0793x6</td>
<td>(304)348.3380</td>
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<td>WVCHIP</td>
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<td><a href="mailto:wvmmis@dxc.com">wvmmis@dxc.com</a></td>
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<td>WV</td>
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Questions
HHAeXchange Update

Fall 2021 West Virginia Provider Workshops

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Agenda

- EVV Overview
- Provider EVV Compliance Reporting
- Billing Go-Live & FAQ
EVV Overview
The 21st Century CURES Act requires that the following data elements be captured and verified through Electronic Visit Verification:

- Type of Service Performed
- Individual Receiving the Service
- Date of the Service
- Location of the Service Delivery
- Individual Providing the Service
- Time the Service Begins and Ends
What Providers Need to Know

➢ Cures Act Mandate in effect as of January 1st, 2021

➢ West Virginia providers have had access to HHAeXchange since March 1st, 2021
  ➢ Once Caregivers are enrolled with Gainwell, each provider is expected to begin confirming visits using EVV

➢ HHAeXchange is the State Fee-for-Service EVV and Aggregation Vendor

➢ The state has provided a free EVV solution through HHAeXchange and collect all visit data, regardless of the EVV system being used
  ➢ If your agency uses another EVV vendor, that is great! However, you are still required to send all visit data for services in scope to HHAeXchange for aggregation purposes
  ➢ Need to set up an EDI connection to send your data? Contact edisupport@hhaexchange.com
How Can I Find My Compliance Percentage?

➢ Within the HHAeXchange portal there are a series of EVV reports available, which can be accessed at any time to check your agency’s compliance with the Cures Act.
Recommended Approach to Increasing Compliance

➢ The “Exception by Caregiver” report allows you to view each Caregiver’s exception rate.

➢ Reviewing this report to find caregivers with high exceptions helps you to target specific folks who may need additional training or assistance with understanding EVV.
West Virginia Billing Go-Live

- HHAeXchange EVV go-live was March 1, 2021

- As part of EVV compliance, CMS requires proof of visit via electronic means prior to payment
  - Billing Go-Live: October 1, 2021

- Billing through HHAeXchange ensures each claim submitted is backed up with visit evidence for services requiring EVV
  - Visits confirmed manually can also be billed, as long as there is still electronically recorded proof that the visit occurred
Billing through HHAeXchange only applies to EVV required ADW, TBIW, IDDW, and PC services

- CSED agencies will continue billing services for this program directly to Aetna, but your visit data does need to be in HHAeXchange
- ADW, TBIW, IDDW, and PC services that do not require EVV should continue to be billed directly to Gainwell

Important things to remember when billing through HHAeXchange:
- Authorizations are required for billing
- Visits must pass pre-billing in order to be billed
- Caregiver NPI is required on claims generated through HHA
- Billed visits go through standard claim validations in the Billing Review module prior to submission to WV DHHR
- Re-billing is done in the HHAeXchange platform for all submissions (both EDI & HHA users)
Provider Resources

➢ Provider Support Center:
  ➢ Upper right-hand corner of the provider portal, click “Support Center”

➢ Provider Information Center: https://hhaexchange.com/wv/
  ➢ Full FAQ, including Billing specific questions, found here

➢ HHAeXchange Support
  ➢ Phone: 866-983-4627
  ➢ E-mail: wvsupport@hhaexchange.com
Questions?
Agenda

Overview

What is Mountain Health Trust?

Managed Care

Member Enrollment

Provider File

Outreach and Education
As of March 2021, there are approximately 604,060 WV residents covered by Medicaid and WV CHIP.
### Managed Care Terminology

<table>
<thead>
<tr>
<th>Fee For Service</th>
<th>Managed Care</th>
<th>Enrollment Broker</th>
<th>Managed Care Organization</th>
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<td>Members who are <strong>exempt</strong> from managed care are served through a Fee-for-Service delivery system administered by Gainwell Technologies.</td>
<td>Members who are <strong>eligible</strong> for managed care are served through the Mountain Health Trust or WVCHIP programs.</td>
<td>MAXIMUS coordinates and enrolls all eligible managed care members into a managed care organization (MCO).</td>
<td>An MCO is often referred to as a health plan that coordinates the provision of health services through networks and case management.</td>
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What is Mountain Health Trust

Mountain Health Trust is the managed care program for West Virginia. With Mountain Health Trust, a member may choose a:

- Managed care organization (MCO)
- Primary care provider (PCP)

In addition, Mountain Health Trust is not:

- an MCO/Health Plan.
- able to verify Medicaid eligibility.
- able to make exemptions for members.
- able to credential providers.
The Mountain Health Trust is the health services provided to Medicaid members.

West Virginia Children’s Health Insurance Program is the health services provided to WVCHIP members.
Managed Care Eligibility

Medicaid Managed Care Members should provide both their State Medicaid Card and their MCO health plan membership card when receiving healthcare services.

WVCHIP members should provide their MCO health plan membership card when receiving services.

Providers may verify eligibility and enrollment for Fee-For-Service and MCO members via the Gainwell Provider Portal.
Members who are exempt from managed care and are Medicaid Fee-for-Service (Traditional Medicaid) should provide their State Medicaid Card when receiving healthcare services.

Providers may verify Medicaid eligibility and enrollment for Fee-For-Service and MCO members via the Gainwell Provider Portal.
Once DHHR determines eligibility, Members are transferred to Gainwell Technologies.

Gainwell Technologies transfers eligible managed care members to MAXIMUS.

MCOs will provide members with their member identification card.

Members must contact MAXIMUS to enroll in an MCO of their choice.

MAXIMUS mails enrollment packets to all newly eligible managed care members.

MAXIMUS enrolls members into an MCO.
Members must enroll prior to the cutoff date in order to have an effective enrollment date on the 1st day of the next month. Also, when a member enrolls into an MCO, they will need to choose a Primary Care Provider. If the individual does not select a PCP, the MCO will assign them one.

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Eligible members have 30 days to enroll into an MCO of their choice or they will be Auto-assigned to an MCO.

A member enrolls into an MCO of their choice before cutoff date.

Member’s effective coverage date will be the 1st day of the next month.
Eligible members have 30 days to enroll into an MCO of their choice or they will be Auto-assigned to an MCO.

**Cut-off Date**

A member enrolls into an MCO of their choice after cut-off date.

**Effective Coverage Date**

Member’s effective coverage date will be the 1st day of the month after next.

- **30 Days to make a Choice**
- **Cut-off Date for the Month**
- **Member MCO Choice**
Call us at 1-800-449-8466. We are here Monday through Friday from 8:00 a.m. - 6:00 p.m. For hearing impaired (TTY), please call 1-304-344-0015.

Visit our website to find answers to your questions, compare health plan options, search for providers, or enroll in a health plan at mountainhealthtrust.com.

You can mail your completed enrollment form to us at: West Virginia Mountain Health Trust, 231 Capitol Street, Suite 310, Charleston, WV 25301.
MAXIMUS receives a weekly provider file from each MCO that contains all providers currently in their health plan network. The provider file contains: provider name, address, phone number, group or clinic name, provider type, and specialty. The provider file received from each MCO is compiled into a master file that is used on the www.mountainhealthtrust.com website and by our call center agents to validate provider information.

If there is an error in your provider information, you may contact our call center at 1-800-449-8466 and we will forward the correction to the appropriate MCO.
Outreach and Education

Region I – Steve Richardson, OES
StevenPRichardson@Maximus.com
304-844-6148

Region II – Spring Blankenship, OES
MelodieSpringBlankenship@Maximus.com
304-545-6773

Region III – Bonnie Harrell, OES
BonnieHarrell@Maximus.com
304-663-1642
West Virginia BMS

NEMT

Non-Emergency Medical Transportation
Agenda

• What does ModivCare do?
• How to contact ModivCare
• Who can request transportation?
• “Travel (Distance, Trip Limits and Authorization)”
• “Notification, Advance Notice and Same Day Requests”
• Standard Trip Information
• Levels of Service Provided
• Mobility Assessment
• Durable Medical Equipment

• Covered Services
• Return Ride Home
• Service Concerns & Escalation Process
• Facility Liaison
• Exceptions Facility Department
• How to Request Standing Order Services
• TripCare
• Outreach
• Questions
• Contact Information
What does ModivCare do?

- Coordinates requests for non-emergency medical transportation (NEMT) for eligible members
- Schedules & routes NEMT for members based on their medical and mobility needs
- Contracts with, and pays, local transportation companies to perform the non-emergency medical transportation

Hours of operation for routine reservations:
- Monday through Friday, 7am to 6pm (EST)
- Routine reservations will not be accepted on national holidays

Calls for trips for urgent/same-day appointments/facility discharges and Ride Assist: 1-884-549-8354
- 24/7 – 365 days

***Members should never experience a call going to a voicemail***
How to contact ModivCare

Contact Us
• Reservations (Ride Assistance): 844-549-8353
• Facility: 844-889-1941
• Facility Fax: 844-882-5998
• Impaired: (TTY): 844-288-3133
Who Can Request Transportation?

• Member 18 yr. (or under 18 if they are emancipated).
• Parent/Legal Guardian
• Authorized Representative of Member
• Health Plan Representative
• Medical Provider
Travel permitted in the state of West Virginia

- 125 Miles (30 miles outside of WV)
- Unlimited Trips
“Notification, Advance Notice and Same Day Requests”

Notice required for routine (non-urgent) medical appointments:
  o (5) business days

How far in advance can members make reservations?
  o 30 days
  o Members can request standing order transports more than 90 days in advance for the following treatment types:
    ▪ Outpatient therapy services
    ▪ Chemotherapy
    ▪ Dialysis
    ▪ Outpatient behavioral health service

Members/caregivers can request same-day NEMT for urgent trips such as:
  • Hospital discharge requests
  • Life-sustaining treatment
  • Radiation
  • Detox
Mobility Assessment

Callers are asked a series of questions to determine the correct level of service:

- Is the member able to walk safely to the vehicle without assistance?

- Does the member use a walker? If so, what kind of walker?
  - Walker Rollator, 4 wheeled walkers, no wheeled

- If the member uses a wheelchair, can they transfer safely to the vehicle without assistance?

- If the member requires a wheelchair-equipped vehicle, please be prepared to provide the following information:
  - The type of wheelchair (manual or electric)
  - The weight of the wheelchair
Types of Transportation and Level of Service

• **Types of Transportation**
  - Gas Mileage Reimbursement
  - Mass Transit
  - Commercial drivers
  - Independent drivers

• **Level of service**
  - Ambulatory
  - Wheelchair
Durable Medical Equipment

A member is required to provide their own:
• Wheelchair
• Child safety/booster seats
• Any other durable medical equipment

Additional Passengers
• Member and one additional passenger (escort/guardian/attendant) are allowed on a space available.
• Attendant must be required by the healthcare provider.
• Attendant must be requested at time of the reservation.
• One escort is allowed to accompany members who are blind, deaf, mentally challenged, or under 18 years of age.
• Transportation of an escort will not have an associated expense.
• A legal guardian with multiple children is allowed to ride. Must provide own car safety seat.
Return Ride Home

Member return home options:

• Schedule a set pickup time for the return home from the medical facility
• Schedule the return home as a “Will Call” and the return time is left open until the member calls us to advise they are ready to go home
  
  o If scheduled as a “Will Call” Provider has up to 1 hours from the time of the call to pick up Member.
Service Concerns & Escalation Process

• ModivCare’s Ride Assist Number: 844-549-8354
  o The Customer Service Representative (CSR) will attempt to resolve the issue in real-time whenever possible.
  o If the driver is running late, they will notify ModivCare and we will work with the member and Healthcare Facility to see if member can still be seen at a later time.
  o The CSR will document any complaint for further research and resolution.

• Contact the appropriate insurance plan from the list ModivCare distributes to facilities as soon as there is a transportation issue with member i.e. late drop off, late pick up, no show, safety issues, etc.

• Inform ModivCare or encourage the member to inform ModivCare if member arrives through other means of transportation, (i.e. family member, public transportation) and still needs the B-leg. (B-leg automatically cancelled if A-leg is not used).

• Keep ModivCare up to date on member, i.e. several missed appointments, member no longer attends facility, etc.

• Refrain from contacting transportation provider/driver directly. ModivCare strongly advises members and facility personnel against direct contact with the transportation provider/driver as this will delay ModivCare procedures and diminish the amount of information for us to investigate and assist in identifying/resolving transportation issues.
Facility/ Provider Liaison

ModivCare Facility/Provider Liaison:

• Acts as a focal point for issues, questions, or concerns that facilities and members may have.
• Coordinates with the proper company personnel/department to provide timely and accurate answers for the customers.
• Assists with complaints/issues and follows up within a reasonable time frame.
• Updates facilities and members on ModivCare processes.
• Provides facilities with information about available features such as TripCare, as well as assists in solving specific member issues with involved facility staff.
• Prompts the Facility Social Worker or responsible parties to obtain complete member addresses and accurately updates ModivCare database.
• Provides outreach via in-person meetings, WebEx, conference calls as needed or requested by facility.
Exceptions Facility Department

Modivcare Exceptions Facility Department:

- Assists facilities (i.e. nursing homes, dialysis, etc. with standing orders) in arranging and coordinating their clients’/members’ transportation needs via fax or email.
- Coordinates and schedules transportation requests for dialysis clients received by fax or email.
- Screens requests for appropriate level of care needed and service covered per insurance contracts.
- Provides consistent and timely communication with all facilities and members regarding transportation issues.
- Provides superior customer service as evidenced by handling all facility-related phone calls.
- Maintains and updates addresses, phone numbers, and fax numbers as needed.
- Coordinates recertifications and attendance reports in a timely fashion and communicates all information with the health care plan.
How to Request Standing Order Services

• Email to wvexceptions@modivcare.com
• Fax to (855)882-5998
• Request online at TripCare https://tripcare.logisticare.com
• Please allow 3 business days for standing orders and standing order changes to take effect (weekends and holidays not included)
TripCare is a one stop solution for managing patient transportation our website portal offers the following:

- User friendly website
- Manage and enter your patient’s transportation needs.
- Eliminates the use of calling in for most trips.
- Manage and see Trip Requests, Recertifications, Attendance and Reservation Details including transportation provider assignment.
- Provides resources such as state by state forms and feedback options.

The TripCare Site processes healthcare facilities NEMT requests online. This eliminates the need to call in or fax these requests.
Outreach

For further inquiries related to outreach:

• Standing orders
• TripCare: request access, training etc.
• In-service visit
• Please contact your Outreach Coordinator or Facility Liaison for further information. (Please see last slide)
<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Liaison</td>
<td>Scott Coleman</td>
<td>304-550-6389</td>
<td><a href="mailto:scott.coleman@modivcare.com">scott.coleman@modivcare.com</a></td>
</tr>
<tr>
<td>Exceptions/Facilities Manager</td>
<td>Tiara Woods</td>
<td>681-215-5110</td>
<td><a href="mailto:tiara.woods@modivcare.com">tiara.woods@modivcare.com</a></td>
</tr>
<tr>
<td>Sr. Director- Client Services</td>
<td>Joshua McGill</td>
<td>304-993-2171</td>
<td><a href="mailto:josh.mcgill@modivcare.com">josh.mcgill@modivcare.com</a></td>
</tr>
</tbody>
</table>

*Please do not give this contact information directly to members.*
Open Discussion & Next Steps
Thank You
WV Children with Serious Emotional Disorder Waiver

CSEDW Fall Provider Workshops

Jennifer Eva, Senior Project Manager

2021
WV Children with Serious Emotional Disorder Waiver (CSEDW) Program Overview

Training Objectives
1. Define Serious Emotional Disorder (SED).
2. The Primary Goals.
3. CSEDW Eligibility Criteria.
4. CSEDW Services.
5. Becoming a CSEDW Provider.
6. Aetna’s Responsibilities on the CSEDW Program.
What is Serious Emotional Disorder?

- Children from age 3 up to the child’s 21st birthday.
- Children with a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the Diagnostic and Statistical Manual of Mental Health Disorders (DSM Criteria).
- Results in functional impairment substantially interfering with or limiting role of functioning in family, school and/or community activities.
Primary Goals

• Provide support for children with Serious Emotional Disorder in the child’s home and community.

• Prevent Psychiatric Residential Treatment Facility or Residential Treatment placement.
CSEDW Eligibility Criteria

- Must meet medical eligibility;
- Must meet financial eligibility by being enrolled in WV Medicaid;
- Must be between the ages of 3 and 21;
- Must be a resident of West Virginia, and be able to provide proof of residency upon application; and
- Must have chosen Home and Community Based Services over services in an institutional setting.
CSEDW Services
CSEDW Services

• **T1016-HA: Wraparound Facilitation**
  • $24.40 per 15-minute unit
  • 874 units per service plan

• **H2033-HA: Independent Living/Skills Building**
  • $17.00 per 15-minute unit
  • 160 units per week in combination with T2021-HA and T2019-HA

• **T2021-HA: Job Development**
  • $8.47 per 15-minute unit
  • 168 units per week in combination with H2033-HA and T2019-HA
CSEDW Services

• T2019-HA: Supported Employment, Individual
  • $8.52 per 15-minute unit
  • 160 units per week in combination with H2033-HA and T2019-HA

• H0004-HA-HO: In-Home Family Therapy
  • $52.43 per 15-minute unit
  • 8 units per day or 56 units per week

• H0004-HA: In-Home Family Support
  • $28.76 per 15-minute unit
  • 8 units per day or 56 units per week
CSEDW Services

• T1005-HA: Respite, In-Home
  • $8.52 per 15-minute unit
  • 24 days per year in combination with T1005-HA-HE

• H2017-HA: Mobile Response
  • $34.00 per 15-minute unit
  • 56 units per week

• A0160-HA: Non-Medical Transportation
  • 0.54 per mile
  • 800 miles per month within WV or within 30 miles of the WV border
CSEDW Services

• **H0038-HA: Peer Parent Support**
  • $17.00 per 15-minute unit
  • 8 units per week

• **G0176-HA: Specialized Therapy**
  • $1.00 per unit up to $1,000 per service plan year in combination with Assistive Equipment

• **T2035-HA: Assistive Equipment**
  • $1.00 per unit up to $1,000 per service plan year in combination with Specialized Therapy.
CSEDW Services

• **T2038-HA: Community Transition**
  • $1.00 per unit up to $3,000 for a one-time transition for an individual coming out of a Residential or Psychiatric Residential Facility into Independent Living

• **T1005-HA-HE: Respite, Out-of-Home**
  • $8.52 per 15-minute unit
  • 24 days per year in combination with T1005-HA
Becoming a CSEDW Provider
How to Become a CSEDW Provider

- All agencies who provide CSEDW services must be a Licensed Behavioral Health Center (LBHC).

- If an agency wants to pursue LBHC designation, they will need to contact the WV Healthcare Authority at 304-558-7000 to start this process.

- In addition, all agencies who provide CSEDW services must have a signed contract with Aetna as a CSEDW provider.

- A provider agency MUST meet both criteria in order to provide CSEDW services.
Aetna’s Responsibilities on the CSEDW Program
Aetna’s Responsibilities

- Execution of Provider Contracts and ensuring statewide provider capacity;
- Care Coordination;
- Distribution of the Member Handbook and a Provider Reference Guide;
- Prior authorization and utilization management of CSEDW services;
- Review of the Plan of Care (POC) prior to service authorization;
- Ensures the development and execution of the POC;
- Ensures the POC includes a Crisis Plan;
Aetna’s Responsibilities

• Care Manager collaboration with the CSEDW Wraparound Facilitator and Child and Family team;

• Provides Child and Family team assistance and securing of services;

• Claims processing and reporting;

• Quality assurance and quality improvement activities;

• Grievances and appeals; and

• Review of hospitalization and death data.
Incident Management

- Tracking and reporting of all incidents;
- Provide information and resources to all members;
- Receive provider’s report of critical incidents as soon as possible;
- Monitor provider’s critical incident investigations; and
- For suspected abuse and/or neglect, verify the provider has made a report to Adult Protective Services (APS) or Child Protective Services (CPS).
CSEDW Contacts: BMS Program Manager

Rachel Goff
Program Manager 1
Bureau for Medical Services
350 Capitol Street  Room 251
Charleston, WV 25301-3706
Phone: 304.352.4211
Fax: 304.558.1542
Rachel.a.goff@wv.gov
CSEDW Contacts: Aetna

➢ Jennifer Eva, Aetna CSEDW Project Manager

304-533-8300 or evaj@aetna.com

➢ Kayla Sustakoski, Aetna Clinical Manager

959-299-9678 or sustakoskik@aetna.com
Claim Submission – CMS 1500 Form

- EDI payer ID
  128WV

- Claims mailing address
  Aetna Better Health of West Virginia
  Attn: Claims Department
  P.O. Box 67450
  Phoenix, AZ 85082-7450

Claims can also be submitted through Emdeon WebConnect (https://office.emdeon.com/vendorfiles/AetnaWV.html) or through the Availity portal (https://www.availity.com/provider-portal-registration)

Emdeon and Availity each provide provider support for their products

- Emdeon Webconnect 1-800-527-8133, option 2
- Availity 1-800-282-4548
CMS 1500 Claim Form
Claim Timely Filing

• Initial claims - Timely filing requirement
  - 365 days from date of service or date of discharge for inpatient claims for Mountain Health Trust (TANF, ACA & SSI), Mountain Health Promise (Foster and Adoptive Care) and WV Health Bridge
  - 180 days from date of service or date of discharge for inpatient claims for WV CHIP

• Corrected Claims Filing requirement
  - 120 days from the date of the initial remittance advice to submit corrected claims or request an adjustment
Prior Authorization

• Required from the first unit for codes T2021, T2019, T1005, H2033, G0176, T2035 and T2038

• You can request prior authorization
  ✓ By phone: 1-844-835-4930
  ✓ By Fax: 1-866-366-7008
  ✓ Through the Availity Provider Portal
Peer to Peer Process

- For denied prior authorization, the request for a peer-to-peer review must be received within five (5) business days of the date the denial of coverage determination fax was sent, prior to services being rendered, and prior to the receipt of a claim or request for an appeal.

- For services that have already begun or have been completed, the request is handled in accordance with the Aetna Better Health provider appeal process.
Claim Resubmissions and Corrected Claims

- Resubmitted claims may be sent electronically

- Label all corrected claims as "Corrected Claim" on the claim form
  - Submit all claim lines, not just the line being corrected

- Send paper claims for adjustment with attached documentation to:
  Aetna Better Health of West Virginia
  P.O. Box 67450
  Phoenix, AZ 85082-7450
Denied Claims Process

• Determine reason for denial from remittance advice
• Timely filing or no prior authorization denials follow the Appeals process
• Claims editing for mutually exclusive, inclusive or non-covered services follow the Reconsideration process
• Incorrect rate paid or provider non-participating follow the Disputes process
Appeals

The provider appeal process is a formal mechanism that allows the Provider the right to appeal the health plan’s decision.

Appeal submissions

- Provider appeals must be received within 90 days of the action taken by Aetna Better Health of West Virginia, giving rise to the appeal.
- The appeal letter should clearly note you are filing an “Appeal”.
- All documents to support the appeal should be provided, such as a copy of the claim, remittance advice, medical review sheet, medical records, and correspondence.
- Claims editing denials are NOT subject to appeal.
Appeals

- Submission via fax, mail or through the Availity Provider Portal
  - Fax: 1-888-388-1752
  - Mail: Aetna Better Health of West Virginia
    Attn: Provider Appeals
    500 Virginia St E
    Ste 400
    Charleston, WV 25301

- Decision response within 30 calendar days

- The appeal decision is the final decision
Reconsiderations

• Can be submitted for claim editing denials such as duplicate, inclusive or mutually exclusive services

• Medical records are required for review

• Submit via the secure provider portal, or mail to the claims address with a copy of the CMS 1500 form
Claim Disputes

• Can be submitted for incorrect rate paid or services denied for prior authorization when prior authorization was on file

• Can be emailed or faxed
  ✓ Fax: 1-866-810-8476
  ✓ Email: ABH_WV_ProviderRelations@aetna.com
Cynthia Harper – WVU, CAMC, Cabell Huntington, Marshall Health
304-348-2932
HarperC1@aetna.com

Outside West Virginia will be handled by the representative based on the West Virginia border counties.

- Lisa Sentich 304-234-3486
  SentichL@aetna.com
- Richard Day 304-348-2931
  DayR1@aetna.com
- Aimee Davis 304-348-2011
  DavisA2@aetna.com
- Layla Sawyers 304-348-2013
  SawyersL@aetna.com
Thank you
• Effective July 1, 2021 (August 1 for FQHC/RHC providers), THP has implemented a Social Determinants of Health Program (SDOH) that rewards providers for submitting Z-code diagnoses as part of their claims submission.

• Providers submitting a covered Evaluation and Management (E/M) code, along with a qualifying Z-code diagnosis (Z55-Z65), shall receive an enhanced reimbursement on their claim.

• This information will be used by THP to help build our members’ care plans and conduct more targeted intervention to help find resources for them in their communities.
Early Periodic Screening, Diagnostic Treatment (EPSDT)

- Exams at a minimum must include, but are not limited to the following:
  - Comprehensive health & developmental history (both physical & mental health development)
  - Unclothed physical exam
  - Lab tests (with blood lead screening appropriate for age & risk factors)

- Vision testing
- Appropriate immunizations
- Hearing testing
- Dental services
- Behavioral health screening
- Health education (including anticipatory guidance)

Please note: Providers should utilize the EP modifier when billing for EPSDT services. Example of CPT Codes: 96110 & 96127
Practice management consultants will be educating providers to capture:

- Annual dental visit
- Breast cancer screening
- Cervical cancer screening
- Controlling high blood pressure

- Comprehensive diabetes care
- Blood sugar control
- Diabetic eye exam
- Kidney disease monitoring
WV Children’s Health Insurance Program

- Effective January 1, 2022, all behavioral health providers rendering services to WVCHIP shall be required to be credentialed with THP at the individual level. This will mirror the process that is required for the provider enrollment component completed by Gainwell.

- After January 1, claims submitted with a rendering provider that has not completed credentialing will be denied.

- If you are unsure if you or a provider within your organization is credentialed at the individual practitioner level, your Practice Management Consultant can assist with reviewing to help prevent any payment denials.
Examples of activities which are NOT appropriate for Targeted Case Management billing include the following:

- Quality and completeness reviews of member records
- Preparation of urine drug samples to be sent to the lab
- Reviews of UDS results in Medication Assisted Treatment programs
- Billing that duplicates TCM billing by another staff person in the same time frame performing different TCM activities
- Billing by different case managers on the same member (exceptions can be made for unusual circumstances)
- Preparation of group therapy workbooks
- Calls from front desk staff as appointment reminders
Dual-Eligible Special Needs Population (D-SNP)

- **D-SNP is a THP Medicare Advantage plan**
  - Members have SecureCare HMO primary
  - WV or OH State Medicaid Secondary
  - **Member has $0 responsibility**

- **Annual training is required by Centers for Medicare and Medicaid (CMS) for providers serving the D-NSP population**
- **Training materials and attestation are currently available at:**
  healthplan.org. Click “For Providers,” “Medicare & Medicaid” “Dual Eligible Special Needs Plan (D-SNP).” Information regarding the D-SNP program and the attestation can be found there or by contacting your practice management consultant.
Cultural Competency Requirement

• CMS requires ALL providers complete cultural competency training
• THP tracks network providers to ensure compliance and it is noted in THP’s provider directories
• Click “Secure Login” on THP’s website to access training materials and an attestation form under Resource Library
• Attestation from another MCO or proof of attendance at a seminar is acceptable
Encounter Data Validation (EDV)

- Qlarant, the External Quality Review Organization for WV Medicaid, has been contracted to complete Encounter Data Validation (EDV) for accuracy and completeness.

- To complete this exercise, Qlarant will be contacting providers directly for medical records to help with their review.

- Providers should submit all requested information to Qlarant to assist.
Appeal Process

If a member believes his or her benefits were unfairly denied, reduced, delayed or stopped, the member has the right to file an appeal with The Health Plan. The member also have the right to appeal any adverse decision.

• To file an appeal, call The Health Plan at 1.888.613.8385.
• To file an appeal in writing, fax it to The Health Plan at 1.888.450.6025, or mail it to 1110 Main Street Wheeling, WV 26003.

If the member calls and gives his or her appeal over the phone, The Health Plan will acknowledge the appeal in a letter.

Members must file an appeal within 60 calendar days from the date on the notice of action from The Health Plan. Members are entitled to one level of appeal, prior to requesting a State Fair Hearing.

The Health Plan will issue a decision on the member’s appeal within 30 days.
### Provider accessibility standards for PCPs include

- PCPs available 24/7 with appropriate call coverage and after-hours answering service for urgent/emergent conditions.

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine (other than preventive) care (exemptions permitted when PCP capacity is temporarily limited)</td>
<td>Within 21 calendar days</td>
</tr>
<tr>
<td>Adult urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Pediatric urgent care</td>
<td>Seen same day</td>
</tr>
</tbody>
</table>
## Provider accessibility standards for PCPs

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent cases</td>
<td>Seen immediately, refer to an emergency facility or call 911</td>
</tr>
<tr>
<td>Physical exams</td>
<td>Within 180 calendar days</td>
</tr>
<tr>
<td>Preventive/EPSDT</td>
<td>Scheduled per EPSDT guidelines and the EPSDT Periodicity Schedule within 30 days</td>
</tr>
<tr>
<td>In office wait time</td>
<td>Within one hour of appointment time</td>
</tr>
</tbody>
</table>
## Access to Care - Specialist

<table>
<thead>
<tr>
<th>Provider accessibility standards for Specialists</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New or established patients</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>In office wait time</td>
<td>Within one hour of appointment time</td>
</tr>
</tbody>
</table>
## Access to Care - Prenatal

<table>
<thead>
<tr>
<th>Provider accessibility standards for Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial prenatal visit</strong></td>
</tr>
<tr>
<td><strong>First and second trimester visits</strong></td>
</tr>
<tr>
<td><strong>Third trimester visit</strong></td>
</tr>
<tr>
<td><strong>High risk pregnancy</strong></td>
</tr>
</tbody>
</table>
Overpayments

As a reminder, providers are required to follow the guidelines within the provider manual. The provider manual is located on our website at https://www.healthplan.org/providers/resources/provider-manual

- The Health Plan is responsible for the recovery of all overpayments, including those due to fraud, waste, and abuse.
- Providers are required to return the full amount of the overpayment within 60 calendar days of identification.
- THP may recover the overpayments up to 24 months from the date of service.
  - This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.
Front End Editing Modification

The Health Plan is making modifications to our front-end editing known as EDIFECs for electronic, paper claims, and denials for incomplete billing

Example: admission dates missing

To ensure your practice does not receive denials, follow the Gainwell companion guide as we are setting up additional edits on the front end that will reject claims

Paper claims will begin going through the EDIFECs logic as well.

We encourage you to make sure your system is set up to follow Gainwell guidelines.
The Health Plan is pleased to announce an enhancement to our provider portal.

This will give providers a heightened view in the following areas:

• Prior Authorizations
• Member Rosters
• Quality Measures/Care Gaps
• Document Upload
• Admission, Discharge, Transfer Info. (Medicaid Members Only)
• Case Management
• Care Coordination
The Health Plan is pleased to announce an enhancement to our provider portal.

This will give providers a heightened view in the following areas:

- Inpatient admission notifications with document upload for level of care assessment and concurrent review
- Status updates on inpatient admissions
- Ability to communicate with UM staff within an authorization request
Provider Portal Registration

Register at myplan.healthplan.org

- View announcements and educational presentations
- View claim status
- Submit professional claims online
- Verify member eligibility
- Print payment vouchers
- Request prior authorizations
- View prior authorization status
Provider Information

To ensure you are correctly listed in THP’s directories, visit findadoc.healthplan.org

- Go to “Find a Provider”
- Click “Search Online” button
- Enter last name
- Select “All” providers and submit
- Double click on appropriate underlined name
- Click new button “Verify/Update Practice Info”
- Option to “Confirm No Changes” or update erroneous information
  - You will need the provider’s tax ID and NPI numbers
  - Submitted directly to provider support department to update THP system
Provider Communication

THP primarily communicates via email blast

• Core Communication – a brief communication sent every 2 weeks that highlights trends or issues we are identifying within our provider community

• THP ProviderFocus – a quarterly newsletter sent via email

You may register to receive these communications at providersupport@healthplan.org

• Contact Customer Service at 1.877.847.7901 to request paper copies

• View the latest edition and past newsletter editions on our website at healthplan.org
Contact Information

THP Customer Service
1.888.613.8385 – MHT Products
1.800.624.6961 – All Other LOB’s

THP Provider Portal
myplan.healthplan.org

THP Corporate Website
healthplan.org

Prior Authorization
1.740.695.5297 (Fax)
2021 FALL WORKSHOP

UniCare Health Plan of West Virginia, Inc. (UniCare)
Joining the UniCare network

- Enroll your NPI with Gainwell Technologies prior to reaching out to UniCare.
- All new network contracts for UniCare require a current W9.
- Send a completed Provider Application Form with updated Council for Affordable Quality Healthcare (CAQH) information when adding a new provider to UniCare.
- Your effective date will be the credentialing approval date and cannot be backdated with UniCare.
Electronic funds transfer (EFT) updates

• As of November 1, 2021, EnrollSafe at enrollsafe.payeehub.org will replace CAQH EnrollHub for providers to enroll or make changes to their EFT:
  o Current EFT providers will be automatically transferred, and no action needed unless they need to make changes.
• CAQH EnrollHub will be phased out by January 2022.
Dental benefits

• Medicaid:
  o Children dental:
    ▪ Includes preventive and restorative services up to the age of 21.
    ▪ Orthodontic services require a prior authorization up to the age of 21.
  o Adult dental:
    ▪ Includes preventive and restorative services 21 and over:
      • These services have a $1,000 per calendar year maximum benefit.

• UniCare’s dental vendor is Skygen®.* For additional benefit information, please contact Skygen at 877-408-0917.
Dental benefits (cont.)

- WVCHIP:
  - Children dental up to the age of 19 includes preventive and restorative services.
  - Premium members have $150 out-of-pocket maximum per family per benefit year. Copayments are per visit.
  - Orthodontic treatment requires a prior authorization and is payable only once in the member’s lifetime.

- UniCare’s dental vendor is Skygen®. For additional benefit information, please contact Skygen at 877-408-0917.
Chiropractic services

• Chiropractic services are covered under Medicaid and WVCHIP:
  o Medicaid:
    ▪ Adult — 20 visits per calendar year*
    ▪ Children — 20 visits per calendar year*
  o WVCHIP:
    ▪ Children — 20 visits per calendar year*
      • Ages 16 and under require prior authorization after initial visit.
• Claim submission:
  o Claims do not require a referring provider.

Prior authorization is required after visit limit — Physician Certification for Chiropractic Services form must be included with prior authorization request:
Member cards

Note: The member’s plan will be designated on the front of the card.
Billing updates and reminders

• Timely filing limit:
  o Original claim submission — 180 days from date of service
  o Corrected claim submission — 180 days from the original *Explanation of Benefits (EOB)* date

• All eligibility should be verified on Availity* and/or Gainwell portals prior to care being rendered.

• Member balance billing reminder:
  o Providers may not balance bill our members, meaning that members cannot be charged for covered services above the amount that UniCare pays to the provider. Medicaid providers may bill a member only when specific conditions have been met. These conditions can be found at the two links provided below:
    ▪  [https://provider.unicare.com](https://provider.unicare.com) > Resources > Provider Manuals, Policies & Guidelines
Availity reminders

Availity offers multiple features to help decrease your need to reach out to our Customer Care Center:

• Claim status
• Eligibility
• Corrected claims
• Direct data entry (DDE) on claims
• Remittance advice
• Provider Online Reporting — pull your member panel for your primary care providers (PCPs)
• Prior Authorization Lookup Tool
• Provider chat
Cultural competency training

- Cultural Competency and Patient Engagement Training includes:
  - Enhanced content regarding culture including language and the impact on healthcare.
  - A cultural competency continuum that can help providers assess their level of cultural competency.
  - Guidance on working effectively with interpreters.
  - Comprehensive content on serving patients with disabilities.
Cultural competency training (cont.)

• **Caring for Diverse Populations Toolkit** includes:
  o Comprehensive information on working with diverse patients and effectively supporting culture, language, and disabilities in healthcare delivery.
  o Tools and resources to help mitigate barriers including materials that can be printed and made available for patients in your office.
  o Guidance on regulations and standards for cultural and linguistic services.

• In addition, providers can access [https://mydiversepatients.com](https://mydiversepatients.com) for easy and free access to tools and resources that are accessible from any smartphone, tablet, or desktop. Providers will find continuing medical education courses.
Thank you