Fast Facts

HealthPartners

JANUARY 2023

News for Providers from HealthPartners
Provider Relations & Network Management

Administrative

Seeking clinician information

HELP SUPPORT DIVERSITY IN OUR COMMUNITY

We have a great opportunity to continue our partnership with you in serving our increasingly diverse members and community.

We are asking clinicians to voluntarily share information with us about their race, ethnicity and specific cultural competencies to provide personalized care that members request. We will use this information to:

- Assist members requesting specific types of provider attributes from HealthPartners Nurse Navigators and Member Services staff.
- Display your race, ethnicity and cultural competencies in our online provider directory, with your permission.
- Ensure our provider network is representative of the diversity within our communities.

Providing this information is optional, but we hope clinicians in your practices will complete the **Clinician Information for Diversity and Health Equity form** to support our ethnically, racially and culturally diverse communities.

For every form completed, HealthPartners will donate $1 in charitable donations to one of the following organizations to continue the advancement of provider diversity and health equity in our communities.

- **Diverse Medicine Inc.**
- **National Black Nurses Association**
- **National Hispanic Health Foundation**

Please share **THIS LINK** *(healthpartners.com/healthplanequity)* to the form with your clinicians so they can complete and submit it, and support the work of these organizations in increasing diversity in medical fields and supporting health equity in our communities. Thank you again for your partnership.

INSIDE THIS ISSUE

Cultural competency training and office accessibility

HealthPartners and all health plans are required to maintain accurate information in our provider directories including information regarding Cultural Competency Training for providers and whether provider locations are accessible for members with disabilities. Please take a moment to complete the **Questionnaire** included as part of this edition of Fast Facts. Instructions are on the form for returning the information to HealthPartners or send to **providercompliance@healthpartners.com**.

Refund requests for overpaid claims

When HealthPartners identifies an overpayment on a claim, we will send a refund request letter to notify the provider of the overpayment. Providers are expected to respond and/or return the overpayment to HealthPartners within 30 days of the initial refund request letter. If no response and/or refund has been received, a second refund request letter will be generated to the provider.

Effective December 1, 2022, if no response and/or refund has been received after 30 days from the second refund request letter, HealthPartners may recoup the overpayment internally, which may result in a negative Accounts Payable (AP) vendor bank balance. When a provider's HealthPartners AP vendor bank is negative, no additional payment or provider remittance will be generated until the overpayment has been resolved.

If you have any questions, please contact the claims customer service team.

Contacts

GOVERNMENT PROGRAMS (Medicare and Medicaid)	**(952) 883-7699** or toll-free at **(888) 663-6464** Monday through Friday from 8:00 AM to 5:00 PM
COMMERCIAL	**(952) 967-6633** or toll-free at **(866) 429-1474** Monday through Friday from 8:00 AM to 5:00 PM
DENTAL	**(651) 265-1000** or toll-free at **(800) 642-1323** Monday through Friday from 7:00 AM to 5:00 PM

Provider Portal update

AUTHORIZING SECURITY REQUESTS

Beginning mid-January 2023, we are introducing enhanced security for the third party/billing service access to your organization's data on the Provider Portal. As always, third party/billing service requests require approval from your clinic before access is granted, but this new process will begin sending these requests to the Primary Contact, Site Operations or Claims Billing contact for your organization (on file with HealthPartners). As usual, contacts have 30 days to review and approve the email request. If we do not receive a response back with your approval, access will be denied. You may add and update contact information any time using the Provider Data Profiles application.

Learn more about granting access to your third party administrator/billing service:

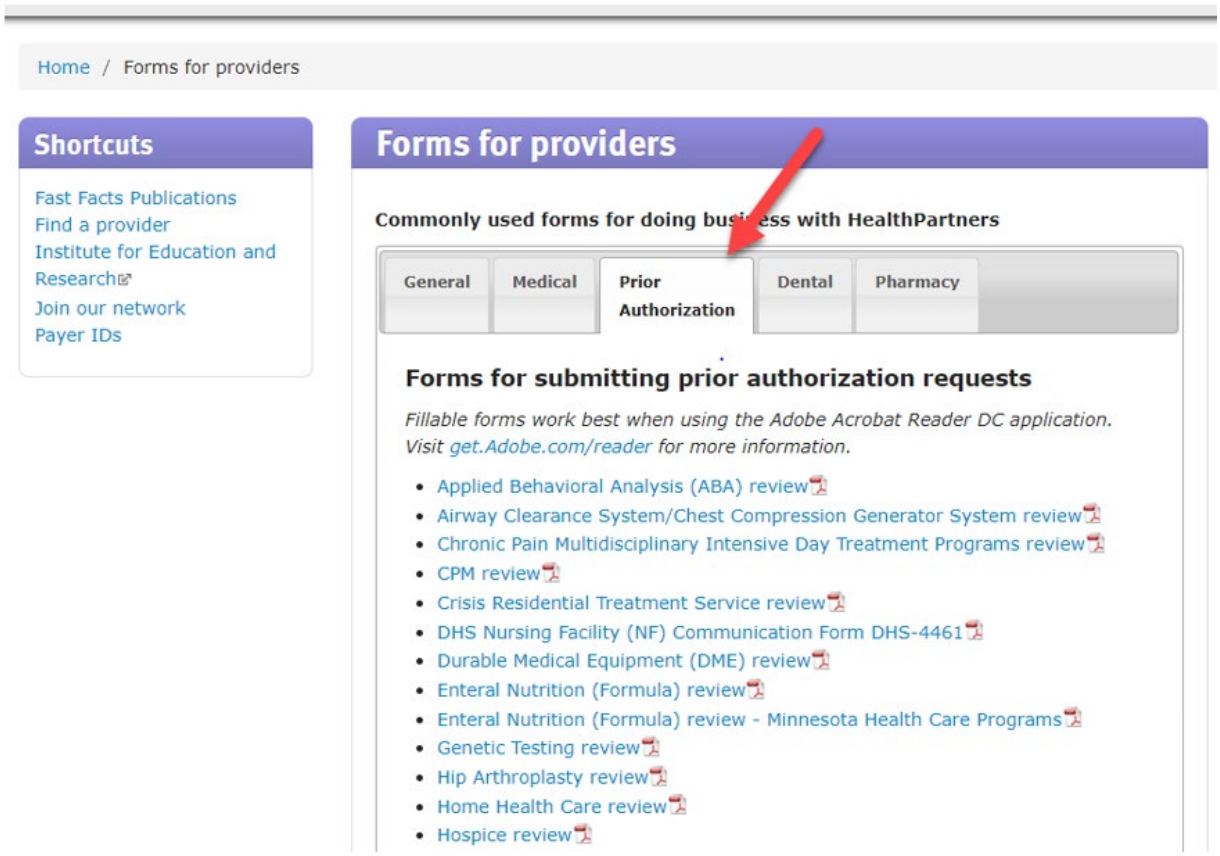
- **Third parties/billing services must register as a billing organization**
- **Third party/billing service registration process**

You may cancel a third party's data access anytime by contacting Provider Web Support at: **providerwebhelp@healthpartners.com** or call **855-699-6694 x2**.

New Prior Authorization tab on Provider Portal

Tabs on HealthPartners Provider Portal, Forms for providers page, have been updated. All prior authorization request forms, for both Medical and Behavioral Health, are now listed alphabetically under a single Prior Authorization tab.

Link to Forms for providers



MinnesotaCare tax change for 1/1/2023

The MinnesotaCare tax has been lowered effective January 1, 2023. The new tax rate is 1.6%. The current MinnesotaCare tax rate in 2022 is 1.8%.

HealthPartners will be applying this new 1.6% MinnesotaCare tax amount starting January 1, 2023.

The 1/1/2023 fee schedules, communicated via market baskets, were calculated using the current MinnesotaCare tax rate of 1.8%. The final 1/1/2023 fee schedules will be calculated using the 1.6% MinnesotaCare tax rate. If you would like a market basket or full fee schedule with the 1.6% tax amount, please reach out to your Service Specialist or Contract Manager.

The tax change is due to a review of the balance in Minnesota's Health Care Access Fund and expected revenue from MinnesotaCare taxes. If certain conditions are met during the fund's annual review, the tax rate must be reduced the following year. For more information, refer to **Minnesota Statute 295.52, subdivision 8**.

HealthPartners will be reviewing this on an annual basis as well and following any other MinnesotaCare tax changes as they are implemented.

If you need addition information, please contact your Service Specialist or Contract Manager.

Medical Policy updates – 01/01/2023

MEDICAL, BEHAVIORAL HEALTH, DURABLE MEDICAL EQUIPMENT (DME) & MEDICAL DENTAL COVERAGE POLICY

Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at **healthpartners.com** *(path: Provider/Coverage Criteria).* Upon request, a paper version of revised and new policies can be mailed to clinic groups whose staff does not have Internet access. Providers may speak with a HealthPartners Medical Director if they have a question about a utilization management decision.

Coverage Policies	Comments / Changes
Genetic testing: aortopathies and connective tissue disorders	• Effective immediately: ○ Multigene panels that address multiple connective tissue disorders (Marfan syndrome, Loeys-Dietz syndrome, Familial Thoracic Aortic Aneurysm and Dissection, vascular Ehlers-Danlos syndrome) are covered when criteria for one of those four syndromes are met. • See online policy for details.

Genetic testing: epilepsy, neurodegenerative, and neuromuscular disorders	• Effective immediately, the criteria for the following genetic tests have been revised:
	  ○ A portion of the criteria for epilepsy multigene panels has been revised to allow for a broader range of clinical circumstances.
	  ○ A portion of the criteria for Genetic testing of HTT repeat analysis to establish a diagnosis or for predictive testing of Huntington's disease have been revised to allow for a broader range of clinical circumstances.
	  ○ Criteria for PMP22 Sequencing and/or Deletion/Duplication analysis or multigene panel analysis to establish a genetic diagnosis of an inherited peripheral neuropathy are revised to allow for a broader range of clinical circumstances or close relative with diagnosis.
	• See published policy online for details.

Genetic testing: hematologic disorders (non-cancerous)	• Effective immediately: ○ Policy criteria are revised to allow Factor V Leiden (F5) and Prothrombin (F2) Variant Analysis for Inherited Thrombophilia when member has a first-degree relative known to be homozygous for factor V Leiden or factor II 97G>A. • See published policy online for details

Coverage Policies	Comments / Changes

Genetic testing: cardiac disorders	• Effective immediately:
	  ○ Criteria for Comprehensive cardiomyopathy panels expanded to allow coverage when a member has a first degree family member with sudden unexplained death (SUD) at any age, when other criteria are met.
	  ○ The Allomap post heart transplant gene expression panel for rejection risk is eligible for coverage when criteria are met.
	  ○ Post heart transplant gene expression panels other than Allomap are considered investigational and therefore not eligible for coverage.
	  ○ Peripheral blood measurement of donor-derived cell-free DNA in the management of patients after heart transplantation is considered investigational and therefore not eligible for coverage.
	• See published policy online for details.

Genetic testing: oncology - algorithmic testing	• Effective immediately:
	  ○ Prostate cancer treatment and prognostic algorithmic tests, Decipher and Prolaris, are considered medically necessary for low, favorable intermediate, unfavorable intermediate- and high-risk prostate cancer when other criteria are met.
	  ○ The Decipher assay to inform adjuvant counseling for risk stratification is considered medically necessary when the member meets the following:
	  ▪ Adverse features are found post-radical prostatectomy, including but not limited to PSA resistance/recurrence.
	• See published policy online for details.

Wheelchairs – mobility assistive equipment (MAE) – Minnesota Health Care Programs	• Effective immediately, policy revised as follows to reflect DHS provider manual language:
	  ○ Criteria for all Covered Mobility Assistive Devices (MAEs)
	  ▪ #5: In-home trial criteria simplified. An in-home trial must demonstrate that the mobility device fits and can be used in all necessary areas of the home.
	  ▪ #6: Back-up chair for members with powered mobility criteria revised. Requests will be reviewed individually to determine medical necessity. It must be clearly stated that the request is for a back-up chair.
	  ○ Coverage Criteria – Manual MAEs
	  ▪ #1.D. High strength, lightweight wheelchairs (K0004) criteria revised.
	  ▪ Member must meet one of the following:
	  • The member self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair.
	  • The member requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

Coverage Policies	Comments / Changes
Continued: *Wheelchairs – mobility assistive equipment (MAE) – Minnesota Health Care Programs*	○ Coverage Criteria – Power MAEs ▪ #2.A.vi. Added: Member is able to bring the POV (power operated vehicle) into the home for use and storage or, if homeless, has demonstrated a plan to safely charge and store the POV. ○ Throughout policy, where there are multiple criteria to be met for a specific type of mobility device (e.g., Group 3 Power Wheelchair), clarified whether the member must meet one or all of the criteria listed. ○ Wheelchair Options and Accessories ▪ Removed list of standard/non-standard accessories. ▪ #3.D. Seat elevation feature (E2300). Added: Documentation must specify where uneven transfers will be needed in the member's home, or where in the home safe transfers cannot be made using a patient lift or standing transfer. ○ Wheelchairs in long-term care facilities ▪ Criteria simplified. Wheelchair purchases and rentals are not included in the ICF/DD per diem. ▪ Standard wheelchairs (HCPCS code: K0001) are included in the nursing facility per diem. All other wheelchairs (including tilt-in-space) are billable outside of the nursing facility per diem if they are necessary for the continuous care and exclusive use by a member. The member must also meet any of the policy criteria for their requested chair. ○ Indications that are not covered ▪ #7: Added that Adult power mobility devices (power wheelchairs or power operated vehicles) not reviewed by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor or reviewed by the PDAC contractor and found not to meet the definition of a specific power mobility device are not covered. • Prior authorization continues to be required for purchase of a manual wheelchair, rental or purchase of a scooter or power wheelchair; and for specified wheelchair options. Please refer to published policy for details.
Proton beam radiation therapy	• Effective 12/1/2022 policy has been revised as follows: ○ Additional covered indications include: ▪ Advanced and/or unresectable head and neck cancers; ▪ Cancers of the maxillary sinus or paranasal/ethmoid sinuses. ○ Requests for proton beam radiation therapy for diagnoses other than those specifically listed as covered will be reviewed by a medical director and considered for coverage when documentation clearly outlines the benefit of PBRT over standard radiation techniques for the member's clinical circumstances.

Coverage Policies	Comments / Changes
Autism – early intensive developmental and behavioral intervention (EIDBI) – Minnesota Health Care Programs	• Effective immediately, policy revised to reflect DHS EIDBI benefit policy manual language. ○ Added that EIDBI services that are provided by an individual who has a relationship that violates ethical guidelines for dual relationship or would result in a conflict of interest, as defined by the modality or licensure, are not covered.
Sex therapy, sexual dysfunctions and paraphilic disorders	• Effective immediately: Policy has been retired. This service is a non-covered benefit/contract exclusion.
Residential – children's treatment services	• Effective immediately: ○ Significant revisions have been made via removal of listed coverage indications in order to reflect review is determined by MCG coverage criteria only. • See online policy for details.
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies (Commercial and MHCP)	• Effective immediately: ○ JAK2 Variant Analysis in solid tumors or hematologic malignancies is medically necessary when the member is suspected to have a myeloproliferative neoplasm, the member has acute lymphoblastic leukemia, or the member is suspected to have a myelodysplastic syndrome. • See published policy online for details.
Genetic testing: immune, autoimmune and rheumatoid disorders	• Effective immediately: ○ Policy criteria are revised to allow for the use of HLA Typing to confirm or establish the diagnosis of ankylosing spondylitis or another spondyloarthropathy when a member has clinical or radiographic features of ankylosing spondylitis or another spondyloarthropathy, and HLA-B27 results are needed to establish a diagnosis of ankylosing spondylitis or another spondyloarthropathy. • See published policy online for details.
Genetic testing: metabolic, endocrine and mitochondrial disorders	• Effective immediately: ○ Mitochondrial genome sequencing, deletion/duplication and/or nuclear genes analysis to establish or confirm a diagnosis of a primary mitochondrial disorder is medically necessary when the member has non-specific clinical features suggestive of a primary mitochondrial disorder and has at least two clinical findings listed out in the policy criteria section. Revisions to the list were made regarding the listed indication, "diabetes mellitus and deafness." Deafness has been moved to a separate indication in the list. • See published policy online for details.

Coverage Policies	Comments / Changes
Wheelchairs – mobility assistive equipment (MAE)	• Effective 3/1/2022 policy has been revised as follows: ○ A wheelchair-mounted assistive robotic arm (K0108) is considered not medically necessary. There is insufficient reliable evidence in the form of high quality peer-reviewed medical literature to establish the safety and efficacy of this device or its effect on health care outcomes. ○ Mobility assistive equipment that does not meet the definition of durable medical equipment (DME) is not covered. ▪ DME is equipment which: • can withstand repeated use; • is primarily and customarily used to serve a medical purpose; • generally is not useful to a person in the absence of illness or injury; and • is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.

Contact the Medical Policy Intake line at **952-883-5724** for specific patient inquiries.

Drug Formulary updates

MEDICARE DRUG FORMULARY

CONTRACT YEAR 2023 CHANGES TO PART D COVERAGE OF VACCINES AND INSULIN RELATED TO INFLATION REDUCTION ACT

On August 16th, the Inflation Reduction Act of 2022 (IRA) was signed into law. The bill, among other things, will affect the cost sharing for vaccines and covered insulin products starting 1/1/2023.

Part D Vaccines

Effective January 1, 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) will be available to our members at no cost sharing and no deductible will apply.

Part D Covered Insulin Products

Effective January 18, 2023, covered insulin products will be available to our members at $35 for a one-month supply and no deductible will apply. Additionally, cost sharing will be rolled up based on the days' supply prescribed, e.g., two-month supply will not exceed $70 and three-month supply will not exceed $105. Members who have filled insulin products between January 1, 2023, and January 18, 2023, will be reimbursed for overpayments within one month of the original claim.

PHARMACY MEDICAL POLICIES

COMMERCIAL UPDATES

Coverage Policies	Comments / Changes
Betibeglogene (Zynteglo)	New medical policy for gene therapy for beta thalassemia.
Elivaldogene (Skysona)	New medical policy for gene therapy for cerebral adrenoleukodystrophy.
Ocular VEGF medications	Adding ranibizumab (Cimerli), a new biosimilar medication.
Spesolimab (Spevigo)	New medical policy for generalized pustular psoriasis.
hATTR Medications (Onpattro and Amvuttra)	Amvuttra added to Onpattro policy, outlining coverage for rare disease hATTR, covered at parity with Onpattro.

Pharmacy medical policies can be found in the **Medical Coverage Policy search page**, searchable by drug name or billing codes. Policies will be searchable on or before the effective date. *(healthpartners.com/public/coverage-criteria)*

For additional information, please contact **healthpartnersclinicalpharmacy@healthpartners.com.**

HealthPartners APC Methodology changes effective 4/1/2023

Effective April 1, 2023, HealthPartners (HPI) will change our APC Outlier and Capping at Billed Methodologies to more closely align with the Centers for Medicare and Medicaid Services (CMS). These changes will apply to facilities that are currently reimbursed using HealthPartners APC Methodology (excluding claims for members in Medicare Advantage, Federal Annuitants and Retiree National Choice products, which already follow the CMS methodology). Details regarding the changes are outlined below:

PRIOR TO THIS CHANGE:

- HPI's outlier methodology applied to eligible billed charges for all services including those paid according to the outpatient (OP) hospital fee schedule (FS).
- The only lines excluded from the outlier methodology were those paid at a default discount, denied lines or those paid via a carveout FS.
- The HPI outlier is calculated at the claim level.
- HealthPartners caps payment at the lesser of the allowed amount or eligible billed charges at the claim level.

AFTER THIS CHANGE:

- The outlier applies to eligible charges for lines with a Payment Status Indicator (PSI) of P, S, T, V, J1, J2, U, R and N.
- Denied lines, claim-level carveout services, and all other services with PSIs that aren't listed above will be excluded from the outlier methodology.
- The outlier will be calculated at the line level.
- CMS completes an outlier reconciliation once the cost report is finalized and will adjust outlier payments if the finalized Cost-to-Charge Ratio (CCR) is different by plus or minus ten percentage points of the original CCR used during claim payment.
    - HPI will not implement this portion of the CMS methodology.
- Carveouts will only be administered at the claim level.
    - A claim-level carveout means the entire claim is carved out of APC packaging, so the APC groupings will not apply.

- HealthPartners will also follow CMS methodology for capping the payment at billed charges.
  - For Claim-Level Carveouts (CLCO) that are not considered part of the APC package:
    - Cap lesser of billed at the claim level.
    - Outlier will NOT apply.
  - If APC pricing applies, then PSIs of P, S, T, V, J1, J2, U, R and N are considered part of the APC package:
    - The total of all these lines will cap at billed charges.
    - These lines will also be subject to the outlier provision.
  - For claims with pricing formula of flat rate per diem that are not packaged into an APC (e.g., per visit), group the lines by service type and pricing formula:
    - Cap lines in each group at the billed charges for that group.
    - Outlier will NOT apply.
  - For all other services where the PSIs are not part of an APC package (e.g., Payable Medical Injectable Site of Care [MISOC] codes, OP Hospital FS):
    - Capping of billed charges will be at the line level.
    - Outlier will NOT apply.
- HealthPartners will reimburse PSI G and K using the Hospital Relative Value Unit (RVU) schedule (since they are not part of the APC package), rather than our current methodology of imputing an APC weight and paying off the APC schedule.
- Behavioral Health will now be priced according to APC's/OP Hospital Fee schedule.
  - Behavioral Health is not currently subject to outlier. However, once these services are reimbursed according to APCs, they will be subject to outlier.

WHAT IS STAYING THE SAME?

- HealthPartners will continue to use the same OPPS APC methodology/logic for OP Hospital, Critical Access Hospitals and ASCs (except for the items mentioned above).
- Phase 1/Phase 2 rate calculations will remain in place.

If your contract is impacted by any of the changes implemented on 4/1/2023, your HPI Contract Manager will work with you to model the changes to budget neutrality.

Government Programs

HealthPartners MSHO Model of Care 2023

REMINDER – TRAINING REQUIREMENT FOR PROVIDERS

The Minnesota Senior Health Options (MSHO) Model of Care provides a description of the management, procedures and operational systems that HealthPartners has in place to provide the access to services, coordination of care and structure needed to best provide services and care to our MSHO population. The training provides a general understanding of how a member would access the benefits provided through the MSHO Model of Care.

Annual training on the Model of Care is a Centers for Medicare and Medicaid Services (CMS) requirement for Special Needs Plans. The Model of Care contains the following components:

1. Description of the MSHO population
2. Care coordination
3. MSHO provider network
4. MSHO Quality Measurement & Performance Improvement

The HealthPartners 2023 MSHO Model of Care Training can be accessed on the Provider Portal at **2023 MSHO Model of Care**.

Medicare and Medicaid QMB program

BILLING MEMBERS ELIGIBLE FOR BOTH PROGRAMS IS PROHIBITED

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from HealthPartners members enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program that exempts individuals from Medicare cost-sharing liability. These same laws may also apply to other dual-eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. Low Income Subsidy copayments still apply for Part D benefits.

Providers that are enrolled in Medicare have access to Medicare's HIPAA Eligibility Transaction System (HETS), which will identify QMB status. **Link to the HETS website**

Providers are responsible for identifying the QMB status of HealthPartners Medicare members and for following QMB billing requirements. When a claim is processed by HealthPartners for a Medicare member enrolled in the QMB program, the provider remittance advice statement includes remarks alerting the provider of a member's QMB status.

For more information on the QMB program and requirements, visit the **QMB Program**.

For more information on QMB plans, visit **MedLearn Matters Article re QMB**.

HealthPartners Minnesota Senior Health Options (MSHO) 2023 Cost Sharing and Supplemental Benefits

The MSHO plan provides comprehensive coverage for seniors covered by Medicare and Medical Assistance. We want to call your attention to two significant updates for 2023.

$0 COST SHARING

As a reminder, MSHO members don't pay a monthly premium, have no deductibles and pay $0 for covered services when they go to an in-network provider. New for 2023, all HealthPartners MSHO members have a $0 copay for all covered prescription drugs. HealthPartners is the only MSHO plan with $0 drug costs.

SUPPLEMENTAL BENEFITS

HealthPartners also offers supplemental benefits to MSHO members. These benefits may change each year. Members can contact Member Services with questions about these and other benefits. The Supplemental Benefits for 2023 are as follows:

CARE & SUPPORT

- A tablet with education and wellness tools for members with diabetes, heart disease, cognitive impairment or depression*
- RideCare transportation to/from SilverSneakers* health club, health and weight management classes, Alcoholics Anonymous or Narcotics Anonymous meetings
- Foot care visits
- Independent Living Skills*
- Home delivered meals
- Unlimited visits to Virtuwell®, a 24/7 online medical clinic
- An animatronic cat or dog that gives companionship and joy; lowers anxiety and loneliness*

SAFETY & PREVENTION

- Motion sensor night lights (2)
- Pedaler
- In-home bathroom safety devices and installation
- Personal Emergency Response System (PERS)
- First aid kit

DENTAL & VISION

- Adult fluoride
- Periodic exams
- Additional coverage for root canals on molars
- Crowns coverage
- An electric toothbrush and three toothbrush heads
- Eyeglasses coatings

HEALTHY LIVING

- Weight management program
- FarmboxRx fresh produce boxes with nutrition education (delivered up to two times each month)*
- SilverSneakers® fitness program
- Healthy aging and cooking classes
- Wearable activity tracker
- Pocket hearing amplifier

FOR MEMBERS WITH A COGNITIVE IMPAIRMENT DIAGNOSIS, LIKE DEMENTIA OR ALZHEIMER'S

- Caregiver support including coaching and counseling through family caregiver services, short-term respite care, psychotherapy and transportation to these services*

*Available to members with specific diagnoses who meet eligibility criteria.

Enroll with Minnesota Health Care Programs (MHCP) now

HealthPartners contracted providers must be screened and enrolled with the Minnesota Department of Human Services (DHS) in order to be eligible for reimbursement for services provided to Families and Children, Minnesota Senior Health Plus (MSC+), Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) members. This enrollment requirement is part of the 21st Century Cures Act (Cures Act).

Providers and groups who are currently contracted with DHS for FFS or their delegate should register with the Minnesota Provider Screening and Enrollment (MPSE) portal to enroll providers online. The portal also allows providers to manage enrollment records and submit enrollment-related information. The MPSE portal page can be found at the **MPSE Portal**.

In the near future, providers who are only contracted with managed care organizations for services provided to state public programs patients will also be required to enroll directly through the MPSE online portal. Stay tuned for updates!

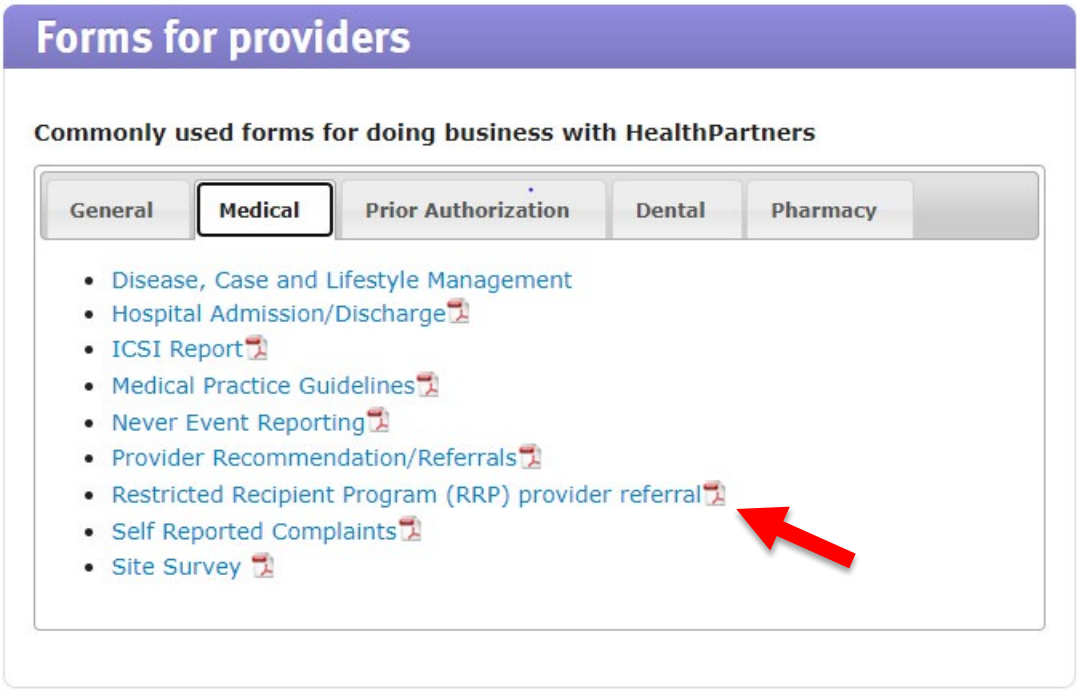
If your providers are not enrolled with DHS yet, visit this page to learn more about enrollment on the DHS website: **MHCP Enrollment**.

HealthPartners Restricted Recipient Program

FOR MN PROVIDERS ONLY

HealthPartners Restricted Recipient program (RRP) has been developed to support the health and safety of patients who have demonstrated unsafe or inappropriate use of the health care system.

The goals of RRP are to promote patient safety, decrease use of inappropriate services, improve care coordination and empower members' self-management.



These goals focus on ensuring patient safety by reducing the risk of overdose and reducing the use of emergency rooms for non-emergency conditions and over treatment.

Case managers help patients understand appropriate use of the emergency room and can facilitate a care plan in the emergency room of the patient's assigned hospital. The member is assigned a primary care provider (PCP) responsible for directing all the medical care the patient receives. The PCP completes a referral for any additional providers and faxes the form to the case manager.

Providers can simply click on the link below and select Medical to access the form, where they can enter a referral to a specialty or other provider for members enrolled in the RRP.

HealthPartners Restricted Recipient Program Link

If you have questions regarding the content of this newsletter, please contact the person indicated in the article or call your HealthPartners Service Specialist. If you don't have his/her phone number, please call **952-883-5589** or toll-free at **888-638-6648**. This newsletter is available online at **healthpartners.com/fastfacts**.

Fast Facts Editor: Mary Jones

HealthPartners

Last updated: March 2022

Provider Directory Cultural Competency and ADA Accessibility Questionnaire

Purpose:

Managed Care Federal Regulations require providers to confirm their cultural competency training and office accessibility for people with disabilities.

Instructions:

Please complete this form for each office location and submit the completed form to **compliance@healthpartners.com** or fax the form back to **952-853-8708**.

If you have any questions regarding completing this form, call **844-732-3537**.

Clinic/Facility Name_____

Office Location Address_____

City_____State_____Zip Code_____

NPI Number(s)_____

Clinic/Facility/Sole Practitioner Website URL_____

Clinic/Facility/Sole Practitioner Phone Number (including area code)_____

Is your office accepting new patients? Yes ☐ No ☐

Cultural Competency:

Cultural and linguistic competence is the ability of managed care organizations and the providers within their network to provide care to recipients with diverse values, beliefs and behaviors, and to tailor the delivery of care to meet recipients' social, cultural and linguistic needs. The ultimate goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion or socioeconomic status.

Has office staff completed cultural competency training in the past 12 months?

Yes ☐ Type of training _____

Month/Year completed _____

No ☐

Cultural Capabilities:

Cultural capabilities include cultural awareness, cultural safety and cultural competence offered by health care providers to better adapt and serve members' backgrounds, values, and beliefs to meet social, cultural, and language needs.

Do any staff in your office possess the following cultural capabilities (select all that apply)?

Cultural Awareness ☐

Please Describe _____

Cultural Safety ☐

Please Describe_____

Cultural Competence ☐ (check box if you answered Yes to Cultural Competency Training)

Please Describe_____

Accessibility:

Home Health, Home and Community Based Services (HCBS), Nursing Homes, Personal Care Assistance (PCA), and Transportation providers do not need to complete this section.

The Americans with Disabilities Act (ADA) requires public accommodations to take steps to ensure that persons with disabilities have equal access to their goods and services. For example, the ADA requires public accommodations to make reasonable changes in their policies, practices and procedures; to provide communication aids and services; and to remove physical barriers to access when it is readily achievable to do so. Visit **www.ada.gov.**

Is your office, including parking, entry ways, and other relevant space, accessible for people with disabilities? Yes ☐ No ☐

Are your office exam rooms accessible for people with disabilities? Yes ☐ No ☐

Does your office have equipment accessible for people with disabilities? Yes ☐ No ☐

Please provide a contact name and phone number in case there are questions regarding your responses to this questionnaire:

_____ _____

Print Name Phone Number

_____ _____

Signature Date