SEPTEMBER 2024

# the RightCare update

an annual publication for participating providers for RightCare

Scott&White HEALTH PLAN | RIGHTCARE

TEXAS Health and Human Services | TEXAS STAR Your Health Plan ★ Your Choice

RCSWHP10203

# Table of Contents

# Updating Provider Information

A written notice must be sent to RightCare and Texas Medicaid & Healthcare Partnership (TMHP) of any demographic or practice changes such as:

- Tax Identification Number
- Practice address
- Billing address (W-9 required)
- Billing county
- Telephone number
- Fax number
- Email
- Group affiliation
- Specialty
- New physician additions to practice
- Current license (Drug Enforcement Agency, Department of Public Safety, state license, and malpractice insurance) and its expiration date
- Status of board certification
- Status of hospital privileges
- Panel closures (per RightCare's contract must also provide proof, in writing, panel is closed to other MCOs with 7 days advance notice)

A W-9 is required for **all** name and TIN changes.

If you plan to move your office, open a new location or leave your current practice, you should provide written notice at least **90 days** prior to any planned change.

**How to update Provider Information:**
To update your information electronically, please fill out the Provider Information Change Form to make updates and track any provider changes.

**Forward correspondence to:**
RightCare from Scott and White Health Plan
Attn: Provider Relations
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502
Fax: (254) 298-3044

back to TOC

# Tell us your community's biggest health needs.

## This communication contains a community health survey and the policy updates for July.

As a valued provider in our community, Baylor Scott & White Health Plan invites you to take part in a quick, anonymous community health survey.

Your responses will help us better address the needs of your patients and our members, improve our community's health, and influence future program development. This survey should take you less than 10 minutes to complete and will close on **September 15, 2024**.

**Take the survey.**

Thank you for your time and feedback. You are helping to make a better and healthier community.

# Medical Coverage Policy and Prior Authorization Update Notice

The document linked below includes information on new or recently reviewed Medical Coverage Policies as well as notice of upcoming Prior Authorization List changes.

Click to read the notice or copy and paste this URL into your browser and click on Medical Policy and Prior Authorization Update Notices:

https://www.bswhealthplan.com/Providers/Pages/Medical.aspx#medical-coverage-policies-documents

A list of services for which you will no longer need prior authorization for Texas state-regulated plans will be on your Provider Portal and will be updated routinely as necessary.

If you have questions about routine prior authorization requests, please contact us at HPMedicalDirectors@BSWHealth.org. For questions about prior authorization exemptions/gold cards, please contact the **Provider Service Center** at **800.321.7947**. For all other inquiries, please contact your Provider Relations Representative.

back to TOC

# Flu Prevention and Treatment

The Centers for Disease Control and Prevention (CDC) estimates that there have been at least 35 million illnesses, 400,000 hospitalizations, and 25,000 deaths from flu so far this season. Providers can help significantly boost their patients' chances of flu protection by discussing the vaccination before flu season arrives. Pre-planning, emphasizing the vaccine's importance and addressing patient concerns all contribute to higher vaccination rates.

**Prevention:**
The most effective defense against the flu is receiving the flu vaccine. The CDC recommends everyone six months and older get vaccinated—especiallyhigh-risk patients. The CDC guidelines aim to protect vulnerable populations from severe flu complications.

Below are patients who are considered high-risk:

- Pregnant women
- Adults 65 and older
- Patients with chronic medical conditions (asthma/chronic heart disease/diabetes)
- Children younger than five years old

**Treatments:**
For most people with the flu, no medical care is needed, but self-isolation from others is advised. However, if medical treatment becomes necessary, the CDC recommends antiviral medication. These medications are crucial for hospitalized patients, those experiencing severe complications or high-risk individuals. They reduce flu-related complications and shorten the duration of illness.

**Where to get Treatment:**
Appointments can be scheduled through the MyBSWHealth website, the MyBSWHealth app or by calling the contact center at 833.466.3020. Patients can also visit a participating Baylor Scott & White Pharmacy. Find a location near you.

**Stay Informed:**
Want to track the flu this season? Stay informed about flu activity with the CDC's FLUVIEW, a weekly surveillance report on data collected to monitor the flu nationally.

back to TOC

# Behavioral Changes Essential to Achieving and Maintaining a Healthy Weight

In terms of meeting state and national benchmarks, Texas providers rank among the lowest for addressing the Childhood Obesity epidemic. The Health Effectiveness Data and Information Set (HEDIS) measure specific to weight is referred to as Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) and focuses on members between the ages of 3 and 17.

**Billing and Documentation**
Providers are diligently working to address the childhood obesity epidemic, but documentation and billing omissions can prevent these efforts from being reflected in the WCC score results. The score is not about achieving the goal of a healthy weight, but, rather, measuring BMI and providing counseling on nutrition and activity for every patient seen at least once a year.

Claims data is used to determine the ranking, so it is vital to follow proper documentation and billing practices. Use the information in the table below to ensure claims are submitted with the proper information to obtain credit for the WCC measure.

**WCC Quick Reference Guide**
Coding For Credit

Measure demonstrates the percentage of members ages **3 to 17** who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following completed at least **annually**: 1) BMI percentile documentation, 2) counseling for nutrition, 3) counseling for physical activity.

| Description | ICD-10 | CPT | HCPS |
|---|---|---|---|
| BMI Percentile | Z68.51-Z68.54 | | |
| Nutritional Counseling | Z71.3 | | G0447, G0270, G0271, S9449, S9470 |
| Physical Activity Counseling | Z02.5, Z71.82 | 97802-97804 | G0447, S9451 |
| *BMI Percentile – the percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patients BMI number among others of the same gender and age. | | | |
| Telehealth, virtual check-up (modifiers 95 & GT) & other visits even sick visits* | | | |

**Behavioral Change**
Behavioral change occurs within the member and family system. Healthcare providers are instrumental in educating how changes factor into achieving and maintaining a healthy weight for a lifetime. Critical behavioral components that widely contribute to how people approach and maintain weight goals are often overlooked. Members experiencing obesity are also often the targets of bullying, and research shows that this is a major contributor to depression and anxiety.

cont'd next page back to TOC

It is easy to suggest limiting electronic screen time or eating a low sugar diet, but those recommendations do not address the motivation behind the behavior. The tougher challenge is managing eating cues, stress responses and restructuring internal narratives that can operate unconsciously.

A primary care provider can conduct a dietary assessment and provide behavioral counseling and therapy. If additional intervention is needed, the Behavioral Health Department at Baylor Scott & White Health Plan can assist. Our team of licensed clinical social workers engage with our members and/or their families, to help identify a plan of action and connect them to a variety of behavioral health services—including psychotherapy—to continue the support these members will require to truly understand how their thinking impacts their behavior.

back to TOC

# Provider tips: Initiating Naloxone with your patients on chronic opioids

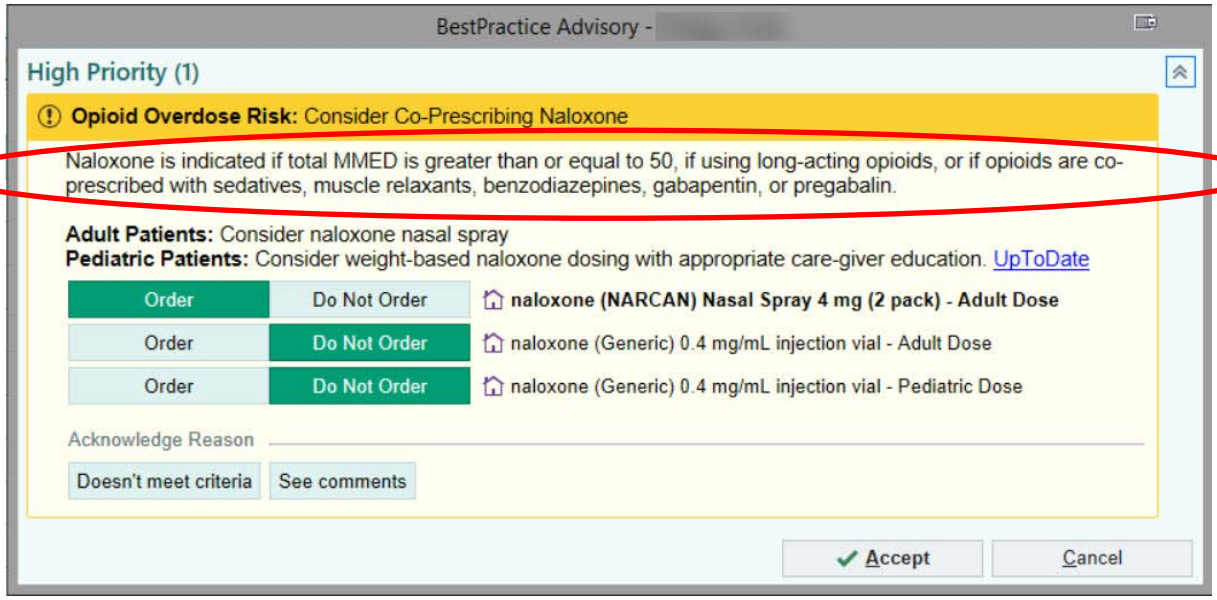
**Prepare in advance:**
Familiarize yourself with covered Naloxone formulations

**Recognize candidates for Naloxone:**
Total MMED ≥50, use of long-acting opioids, or opioids co-prescribed with sedatives, muscle relaxants, benzodiazepines, gabapentin, or pregabalin

**Have a conversation starter ready with non-judgmental and non-blaming language:**
Centers for Disease Control and Prevention (CDC) offers full 1.5 hour CME "Talking About Naloxone"; also available as a focused two-page conversation starter.

**Educate on Naloxone administration and provide additional resources as needed.**

**Utilize clinical decision support tools in electronic medical record (i.e., Naloxone Best Practice Advisory or BPA):**
BPA identifies candidates and assists with ordering Naloxone

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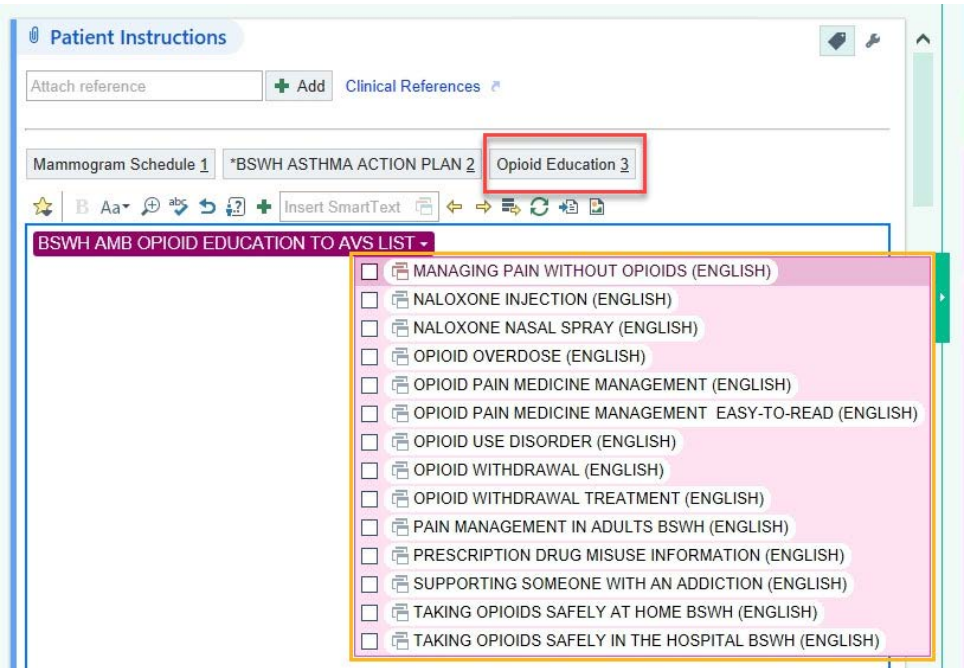
back to TOC

## Add Epic patient education to the After Visit Summary (AVS)

- When a provider prescribes an opioid or naloxone, the Patient Instructions page (already required) shows specific patient education to add to the AVS as shown.
- When Epic shows the patient language preference is information in Spanish or Vietnamese, the list will automatically show patient education in their preferred language (not shown).




Resources:
CDC "Talking About Naloxone" CME available.
Introduction to Naloxone for People Taking Prescribed Opioids - YouTube (YouTube video by the Veterans Health Administration)
Overdose Prevention Resources - National Harm Reduction Coalition
PrescribeToPrevent – Prescribe Naloxone, Save a Life (prescribetoprevent.org)
What is Naloxone? - SAMHSA

back to TOC

# Formulary Information and Pharmaceutical Management Procedures

RightCare's Pharmacy Benefit Manager (PBM) is Navitus Health Solutions. Navitus administers prescription benefits for RightCare Medicaid STAR members. RightCare members can access prescriptions through any pharmacy contracted with Navitus Health Solutions. STAR members are eligible to receive an unlimited number of prescriptions per month and may receive a one-month supply.

**Formulary**

- RightCare uses the state-mandated Medicaid STAR formulary.
- View and obtain updates from the Texas Medicaid Formulary Drug Search.
- The Texas Medicaid formulary includes legend, over-the-counter drugs, generic equivalents, interchangeable products, certain supplies, and select vitamin and mineral products.

**Preferred Drug List (PDL)**

- RightCare uses the state-mandated PDL.
- View and obtain updates for the Texas Preferred Drug List.
- Most drugs are identified as "preferred" or "non-preferred." Drugs identified on the PDL as "preferred" are available without prior authorization unless there is a **clinical** prior authorization associated with the drug. Some drugs are subject to both non-preferred and clinical prior authorizations.

Pharmaceutical management procedures are used by the Texas Drug Utilization Board to help manage the drug formulary/PDL. To provide the most clinically safe and cost-effective therapy options, restrictions may be applied to certain drugs on the formulary/PDL. The Medicaid formulary/PDL identifies pharmaceutical management procedures, including, but not limited to, prior authorization, quantity limits, step therapy, and covered generic substitution.

**Obtaining Prior Authorization**

Navitus processes pharmacy prior authorizations for RightCare STAR.

Prior authorizations are available through:

- **Phone Requests:** Prescribers can also call Navitus Customer Care at 877.908.6023 (prescriber option) and speak with the Prior Authorization department.
- **Written Requests:** Prescribers can access prior authorization forms online. Completed forms can be faxed 24/7 to Navitus at 855.668.8553 (toll free).
    - Using drug-specific PA forms from the Navitus website may assist your team with submitting the complete clinical information requested and avoiding denials.
- **Electronic Automation:** This is performed at the Point of Sale (POS). Upon submitting the prescription claims for payment, Navitus's electronic system will review the member's medical and pharmacy historical claims to determine whether criteria have been met.
    - Where criteria have been met, claims will adjudicate and no further action is needed.
    - Where criteria have not been met, claims will reject with a POS message, notifying the pharmacists a prior authorization is required. Pharmacist (or personnel) is instructed to notify the prescriber of this information.

Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The provider will be notified of the outcome by fax or verbally if an approval can be established during a phone request.

**Exception to Coverage Request:** When a medication is not on the RightCare formulary, you can request a PA exception by completing the request form and submitting it to the Navitus PA team for review. View or download PA forms.

For more information regarding medical policies and prior authorizations for medical drugs and services, please refer to the SWHP Provider Reference Guide.

If you have any questions or wish to obtain a printed copy of the formularies or pharmaceutical management procedures, please contact RightCare at 855.897.4448.

back to TOC

# Changes to Provider Enrollment Revalidation Requirements

The ACA requires providers submit a revalidation application at the end of their enrollment period. Most providers have an enrollment period of five years, but some providers have shorter enrollment periods (e.g., one year, two years). Providers can find the effective dates of their enrollment period within the Provider Enrollment and Management System (PEMS) and on their Provider Welcome letter.

**Effective May 31, 2024, the provider enrollment revalidation timespan has been extended from 120 days to 180 days.** Providers can now revalidate their enrollment in the Provider Enrollment and Management System (PEMS) up to 180 days before their revalidation due date.

Due to this change, updates have been made to the timeline of revalidation notifications sent to providers. Providers will now receive a 180-day notification to inform them revalidation is open. Additional reminders will be sent at 120, 90 and 45 days before the revalidation due date.

If a provider does not complete the revalidation process by their deadline, they will be disenrolled from all Texas state healthcare programs. Claims and prior authorization requests will also be denied. Remember, separate enrollment is required for **ALL** programs including Texas Health Steps and Texas Vaccines for Children (TVFC).

Providers can find more information and begin their revalidations in PEMS through the Texas Medicaid & Healthcare Partnership (TMHP) website under "Determine Your Application Type."

**Provider Requirements**
Revalidating providers may need to provide fingerprints, submit additional documentation or complete other screening requirements.

Providers may view and confirm their revalidation date and enrollment information in PEMS. To reduce application time, providers are encouraged to have the following information available:

- First and last name
- Organization name
- Social Security number
- Date of birth
- Employer's Tax Identification Number and legal name
- Licenses or certifications, if applicable
- Identification for the provider and any person who meets the definition of owner, creditor, principal, subcontractor or managing employee
- Documentation related to disclosures, if needed
- Additional documentation required for program participation

cont'd next page back to TOC

Providers revalidating an existing enrollment should continue to submit claims to meet their timely filing requirements.

Certain revalidating providers must pay an application fee. Refer to State of Texas Provider Types Required to Pay an Application Fee to determine which institutional providers must pay the provider enrollment application fee.

Providers can also refer to the current Texas Medicaid Provider Procedures Manual, Vol. 1, "Provider Enrollment and Responsibilities," for more information.

To learn more about revalidation and the end of the COVID-19 public health emergency (PHE), providers can refer to the article posted on TMHP.com.

For more information, call the TMHP Contact Center at 800.925.9126.

back to TOC

# OIG Lock-In Program helps fight prescription drug abuse

The Texas healthcare community plays a critical role in stemming the tide of prescription misuse through participation in the Texas Prescription Monitoring Program (PMP) and the Medicaid Lock-In Program (MLIP). The PMP equips pharmacists and prescribers with information to help prevent the overprescribing and potential misuse of controlled substances.

The law requires prescribers to check a patient's PMP history before prescribing opioids, benzodiazepines, barbiturates and carisoprodol. The Texas Medical Board notes exceptions for patients with cancer or in hospice care. According to the Texas State Board of Pharmacy, pharmacies must report **all** dispensed controlled substances (Schedule II, III, IV and V) to the PMP within **one** business day of filling the prescription.

The PMP and the MLIP are resources for medical professionals to identify patients who may need help with substance-use issues. Patient prescription histories, collected into a database and monitored by the PMP can identify patients receiving multiple prescriptions from multiple doctors and point to evidence of potential doctor-shopping or a misuse of prescription drugs.

Through the MLIP, the Texas Health and Human Services Office of Inspector General (OIG) reviews referrals and data to determine if a person who receives Medicaid benefits meets the criteria for lock-in to a single designated pharmacy and/or prescriber.

The patient data reviewed includes diagnoses, acute care services and prescription drug history. Lock-in determinations are based on several factors, including:

- The number of overlapping or duplicative controlled substance prescriptions
- Using multiple unaffiliated pharmacies and prescribers
- The number of emergency room visits resulting in opioid prescriptions
- Treatment that exceeds the daily therapeutic morphine equivalent dose

An average of 2,398 Medicaid clients were part of the Lock-In Program in fiscal year 2020, resulting in approximately $2.9 million in cost savings to Texas taxpayers. The OIG calculates estimated cost savings by comparing each member's pharmacy, hospital and emergency room claims before and after lock-in.

If you suspect any misuse of prescriptions, the OIG would like to hear from you. Referrals may come from pharmacists, prescribers, medical providers, managed care organizations, state agencies, law enforcement officials or members of the general public. Candidates for new or continued lock-in may be referred by calling the OIG's fraud hotline at 800.436.6184 or by clicking "Report Fraud" on the OIG's website.

back to TOC

# Requests to Provide Records for Annual Independent Review

Federal regulations require the Health and Human Services Commission (HHSC) contract with an independent External Quality Review Organization (EQRO) to validate quality measures. The EQRO analyzes and evaluates the quality, timeliness and access to healthcare services provided by managed care organization and their contractors to Medicaid beneficiaries. This annual process ensures accountability and drives quality improvement in Medicaid and CHIP managed care programs.

The Institute for Child Health Policy at the University of Florida has been the EQRO for Texas Medicaid and CHIP since 2002.

The EQRO collects data from Managed Care Organizations (MCO), including encounter data and other information. The EQRO may also request health record data directly from the provider to validate the accuracy and completeness of the information and verify the adherence of clinical guidelines, appropriateness of services and other quality indicators.

Under the terms of your provider contract, you are required to provide requested documents to the EQRO in its role as an independent verification and validation contractor, acting on behalf of HHSC.

Contracted providers are permitted to share health record information—in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA)—as they, and the EQRO, qualify as a business associate of HHSC. Beneficiaries also give their consent for this activity as part of their Medicaid/CHIP enrollment.

The EQRO mails record requests to the address it has on file for each provider. If the request is sent to a group practice address, please forward the health information request to the group practice site where the patient was seen. If a provider does not send the health information by the deadline, the enrollee's case will be deemed non-compliant when the compliance rate is determined.

Any questions should be directed to the EQRO.

Toll Free: (866) 265-1254
Fax: (352) 294-8516

Address: Institute for Child Health Policy / Texas EQRO
PO Box 100147
2197 Mowry Road
Gainesville, FL 32610-0147

back to TOC

# Announcement Approach for Increasing HPV Vaccination

Take these steps to more effectively recommend HPV vaccination. They will save you time and improve patient satisfaction.

## 1 ANNOUNCE

Start with a presumptive announcement that assumes parents are ready to vaccinate. This is an effective way to recommend adolescent vaccines, including HPV vaccine.[1]

if a parent is hesitant

## 2 CONNECT & COUNSEL

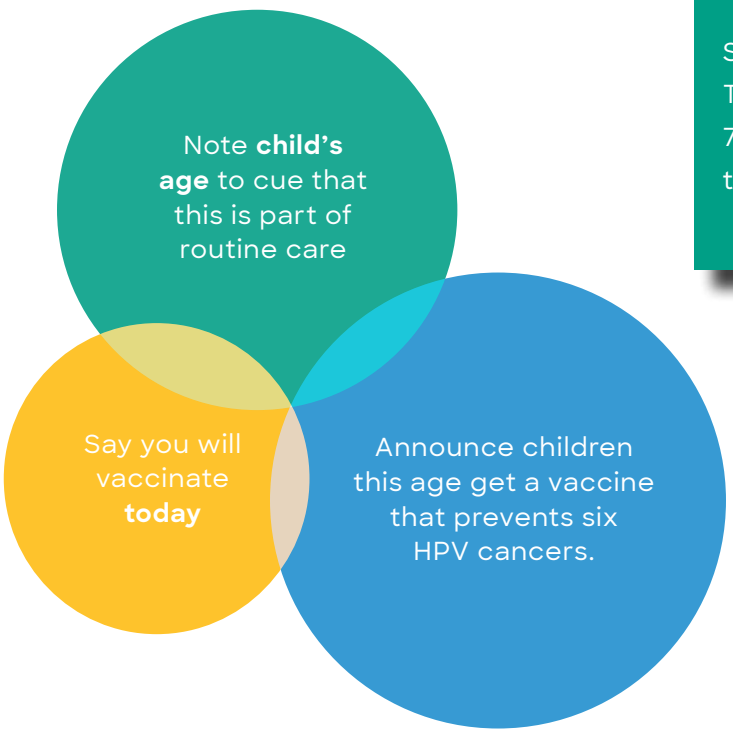
Connect with parents by asking for their main concern about the HPV vaccine. Counsel parents by using a research-tested message to address their concern.[2] Then clearly recommend getting the HPV vaccine today.

If a parent declines

## 3 TRY AGAIN

Say you'll bring up HPV vaccine at the next visit. Then make a note in the child's chart. Almost 70% of parents who initially decline later agree to an HPV vaccine, or plan to soon.

KEY ELEMENTS OF AN ANNOUNCEMENT:




ANNOUNCEMENT EXAMPLE

"Marcus is now 9, so today he'll get a vaccine that prevents six HPV cancers."

1. Brewer, et al., 2017, Pediatrics. 2. Shah, et al., 2019, Pediatrics. 3. Kornides, et al., 2018, Academic Pediatrics.

hpvIQ.org

back to TOC

# Research-tested Messages to Address HPV Vaccine

1,200 parents told us these were the best messages to use when addressing their concerns.[2]

**AGE**
"Kids respond more strongly to the HPV vaccine when they are younger. This may give better protection against some cancers."

**REQUIREMENTS**
"School requirements don't always keep up with medical science. The HPV vaccine is an important vaccine that can prevent many cancers."

**SEX**
"This really isn't about sex. The HPV vaccine is about preventing cancer."

**BOYS**
"HPV infections don't care if you're a boy or girl. The virus can cause cancer and many other diseases."

**SAFETY**
"This vaccine is one of the most studied medications on the market. The HPV vaccine is safe, just like the other vaccines given at this age."

**GUIDELINES**
"Experts at the CDC agree that kids can start HPV vaccine by age 9 to prevent six cancers."

**EFFECTIVE**
"Over 36,000 Americans get cancer from HPV every year. Most could be prevented with the HPV vaccine."

2. Shah, et al., 2019, Pediatrics. Messages adapted to reflect current clinical practice.

hpvIQ.org

Developed with funding from the CDC (U01IP001073-03-04) and NCI (P01CA250989).

back to TOC

# Accessibility of Services Requirements

To ensure members receive care in a timely manner, Primary Care Providers (PCPs), specialty providers and behavioral health providers must maintain the following appointment availability and after-hours access standards.

### Appointment and Access Standards

| Level of Service/Appointment Type | Standard |
|---|---|
| **Newborn** | |
| Newborn Care (less than six months of age) | 14 calendar days |
| **Primary** | |
| Urgent Primary Care | 24 hours a day |
| Routine Primary Care | Commercial and Medicaid: 14 calendar days<br>Medicare: 30 calendar days |
| **Specialty** | |
| Urgent Specialty Care | 24 hours a day |
| Routine Specialty Care | Commercial and Medicaid: 21 calendar days<br>Medicare: 30 calendar days |
| **OB/GYN** | |
| High-Risk Prenatal Care<br>New Member of 3rd Trimester Care | Five calendar days or immediately if an emergency |
| Routine Prenatal Care | 14 calendar days |
| **Preventive Care** | |
| Preventive Care Child (6 months of age through 20 years of age) | 60 calendar days |
| Preventive Care Adult (21 years of age and older) | Commercial and Medicaid: 90 calendar days<br>Medicare: 30 calendar days |
| **Behavioral Health** | |
| Care for a Non-Life-Threatening Emergency | Within 6 Hours or Directs Member to the ED or Behavioral Health Crisis Unit |
| Urgent Behavioral Health Care | 24 hours |
| Initial Behavioral Health Care | Within 10 business days |
| Routine Follow-up Behavioral Health Care | 14 calendar days |

* Standards are applicable to Commercial/Exchange, Medicaid & Medicare.

back to TOC

# After-hours Accessibility Requirements for Practitioners

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for member contact after normal business hours.

## ACCEPTABLE

| | |
|---|---|
| **Phone answered by an answering service** | Person who answers the phone can contact the PCP, and all calls must be returned within 30 minutes. *Note: An answering machine recording that directs members to leave a message, even if it is indicated that the call will be returned, would **not** be an appropriate example of an answering service.* |
| **Phone answered by a recording** | Recording directs member to call another number to reach the PCP or another provider designated by the PCP. Someone **must** be available to answer the call at the second number (e.g., the recording directs the member to dial 123.456.7890 to reach the PCP after-hours). |
| **Phone transferred to another location (e.g. nearest emergency room, after-hours answering service)** | The person answering the call must be able to contact the PCP to return the call within 30 minutes. |
| **After-hours message available in English and Spanish** | To accommodate non-English speaking members, after-hours messaging must be provided in both English and Spanish or provide options such as directing member to dial 1 for English and 2 for Spanish. |

## NOT ACCEPTABLE

| | |
|---|---|
| **Answering only during office hours** | Examples: Calls not picked up by an answering machine recording that directs the member on how to reach the PCP, calls not answered by or transferred to an after-hours answering service, calls not transferred to another location. |
| **Recording telling member to leave a message** | The answering machine recording should not direct the member to leave a message, even if it is indicated that the call will be returned. However, the recording can direct the member to call another number to reach their PCP. Someone must be available to answer the phone at the second number. |
| **Other unacceptable practices** | • Recording directing the member to go to the emergency room for needed services<br>• Returning after-hours calls outside of a 30-minute time frame<br>• Failing to provide after-hours messaging in both English and Spanish |

* Standards for after-hours accessibility may be applicable to PCPs in the following areas: General Practice, Family Practice, Internal Medicine; Pediatrics. APRNs & PAs (where the APRN or PA is working under the supervision of a physician specializing in one of the above areas who also qualifies as a PCP).

Update your clinic contact information: BSWHealthPlan.com/Provider

back to TOC

# Cultural Competency and Language Assistance Services

Our mission at Baylor Scott & White Health Plan is to create an environment embracing the differences that make us better together, and promote the well-being of all individuals, families and communities regardless of race/ethnicity, gender or sexual orientation.

To accomplish this, BSWHP developed the Cultural Competency Plan to eliminate health disparities and improve cultural and linguistic services for our multi-cultural population. The Cultural Competency Plan framework follows the Culturally and Linguistically Appropriate Services (CLAS) national standards by providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

## Reduce Disparities

Baylor Scott & White Health Plan works with providers and community partners to collect and analyze race, ethnicity, language, gender identity and/or sexual orientation data from our members. In addition, the Health Plan monitors HEDIS measures. The collection and monitoring of this data are used to:

- Develop quality improvement programs and interventions to improve CLAS
- Reduce or eliminate health disparities
- Develop cultural and linguistic tools and services for members.

Baylor Scott & White Health cooperates fully with all required regulatory reporting and external audits, including audits by the Texas Department of Insurance, HCQIA, HHSC, CMS and their contractors. By cooperating with this reporting, Baylor Scott & White Health Plan makes quality outcome measures available to CMS and HHSC that will be used in plan ratings and enable beneficiaries to compare health plan performance and select between them.

## Language Assistance

Baylor Scott & White Health Plan understands that meeting the language needs and basic health literacy of our members begins with access to services and clear, easy-to-use materials. We offer language assistance at no cost to members with limited English proficiency and for members with other communication needs.

Language assistance resources are accessed by contacting the Customer Service Department. Representatives speak English and Spanish and can connect callers with an interpreter for other languages. The Health Plan also provides access to TTY services and American Sign Language interpreters.

## RightCare Customer Service

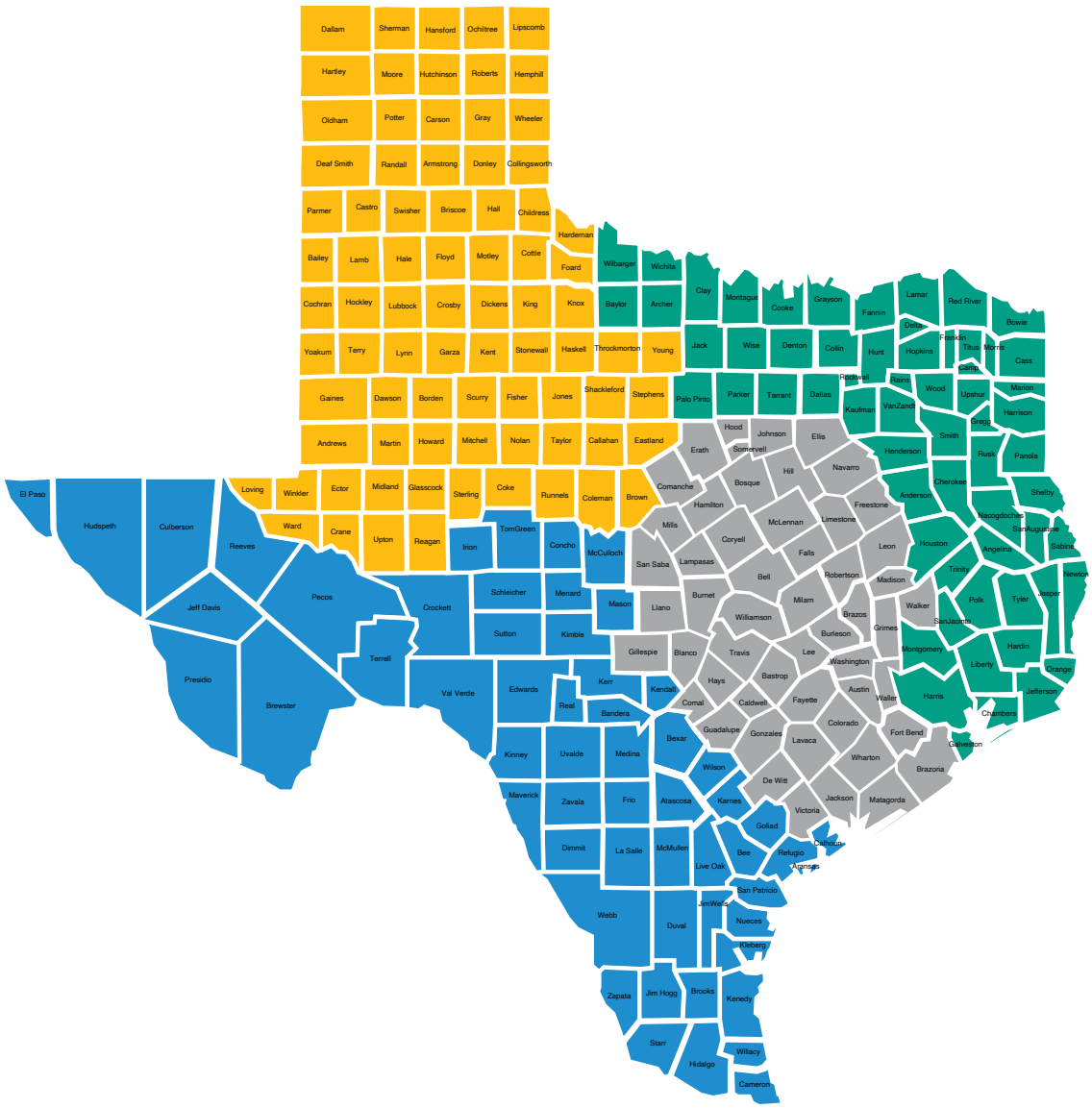
STAR 855.897.4448 (TTY 711)

back to TOC

# Provider Relations

## Representative Territory Map

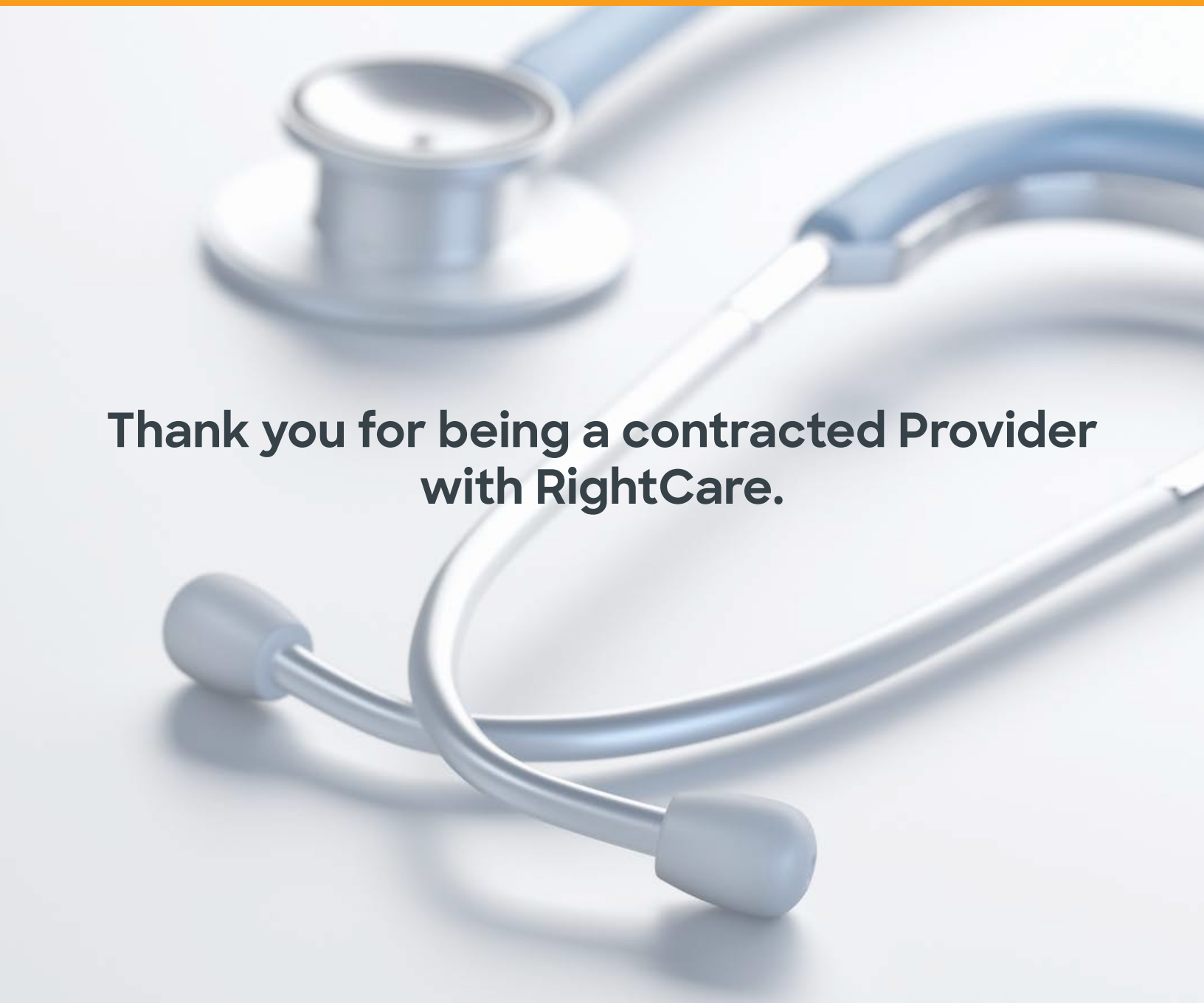
Provider Relations Representatives can be contacted via the regional email addresses below.




### Contact a Provider Relations Representative

- Region 1 HPRegion1@BSWHealth.org
- Region 2 HPRegion2@BSWHealth.org
- Region 3 HPRegion3@BSWHealth.org
- Region 4 HPRegion4@BSWHealth.org

back to TOC



# Thank you for being a contracted Provider with RightCare.

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH
RIGHTCARE