ProviderInsight®

Utah Edition
May 2024

Welcome!

Find medical, dental, and pharmacy information as well as program and plan updates for:

- Commercial
- Select Health Medicare
- Select Health Community Care® (Medicaid)
- Federal Employee Health Benefits (FEHB)

Select Health

In this issue:

Select Health News

The Patient Imaging Model Is Changing.

In the past, when a patient needed a CT scan or an MRI, physicians typically would send them to the hospital as that was the only place that offered these services. As technology has improved and as health systems move closer and closer to value-based care models, imaging services have also evolved in ways that are mutually beneficial to both patient and physician.

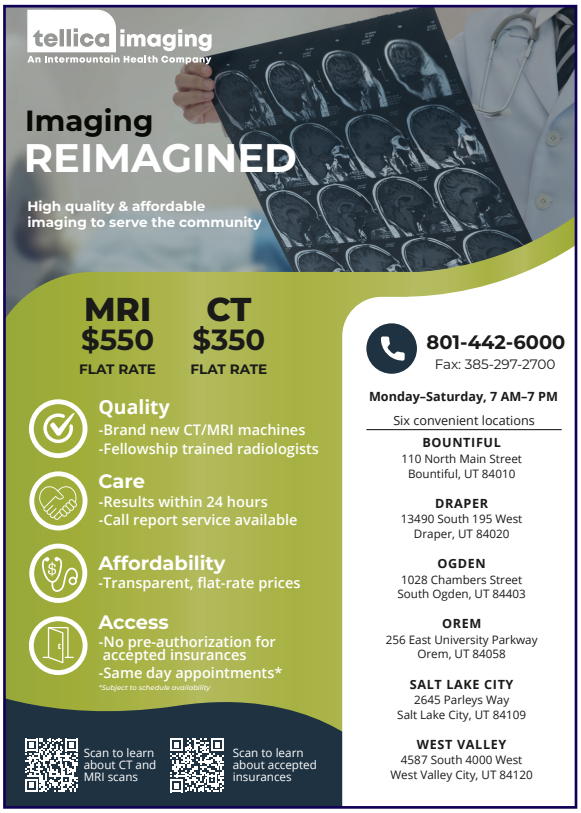
Today, CT scans and MRIs can be efficiently and effectively ordered at non-hospital-based facilities. There are many reasons why this makes sense. For instance, ordering hospital imaging can cost patients and their health plans 5 to 10 times more than the cost of ordering the same imaging though a clinic dedicated solely to providing imaging services. Additionally, the speed at which appointments can be obtained and results delivered is far more advantageous to physicians who want to provide timely care and to the patients who need that care.

tellica imaging
An Intermountain Health Company

Enter Tellica Imaging, a wholly owned, non-profit subsidiary of Intermountain Health. Tellica Imaging has changed the imaging landscape by offering far better service at a fraction of the cost. With 6 clinics in Utah and 1 in Boise, Idaho,* Tellica offers high-quality, cost-effective CT scans and MRIs, to patients in these areas. Benefits for sending patients (ages 12 and over) to Tellica Imaging include:

- **Flat rate, transparent imaging** — $350 for a CT and $550 for an MRI, including contrast needs and the radiologist's interpretation. Fees can be less depending on a patient's plan, and fees are applied towards deductibles and out-of-pocket maximums.
- **Quick turnaround times** — Fast reviews in 30 minutes for STAT, 2 hours for urgent cases, and 1 day for routine exams.
- **Excellent reviews** — Approximately 50,000 scans performed with exceptionally high Google ratings (4.91/5.00 with over 3,500 reviews).
- **Ample, expert staff** — Over 120 fellowship-trained radiologists who read scans (the same providers who read for Intermountain Health).
- **EMR and Visage integration** — When orders are sent through the EMR, they are returned in a seamless fashion. You cannot tell the difference between a Tellica-dictated case and one generated at a hospital site.
- **No preauthorization required** — When using Tellica's service, no wait for preauthorization for in-network insurance.
- **Easy-access locations** — Clinics are located within the community to help address healthcare disparities and make access easy for patients in need.

Learn more about Tellica Imaging.



* Tellica may not be participating in all networks in Idaho.

Select Health Customer Service

In 2023, the **Select Health Member Services** department answered 1.2 million phone calls and 31,000 chats. The **Member Advocates team**, which helps members find the right doctor, made more than 19,000 appointments.

But it's not just the numbers — Select Health is regularly recognized for its customer service and high satisfaction levels. It's all in the name of making insurance accessible and empowering members to understand their health benefits by being in control of their treatments, coverage, and payments.

It starts with excellent training.

Select Health is intentional in how it trains caregivers and aims to empower them with the training and tools to help members.

"Our training is scenario-based, which means caregivers are trained on how to provide service on the phones," said Jenni Crump, director of Member Services. "They're given scenarios for how they can put these skills into action in a caring way. We focus on how we interact with our callers by listening to them, partnering with them, and delivering the best level of service possible."

"When caregivers are empowered, they are able to do their best work and deliver on our mission and the service that sets us apart," said Amanda Atkins, senior manager of Member Services.

CUSTOMER SERVICE MAKES A DIFFERENCE!

The National Council for Quality Healthcare (NCQA) lists Select Health plans as some of the top rated plans in Utah and Idaho.

NCQA ratings are based on the quality of care patients receive, how happy patients are with their care, and health plans' efforts to keep improving.

We focus on personalized service.

Member Advocate Jasmine Sosa showed the human side of service when she called more than a dozen providers to help a Medicare member who'd made an appointment with a specialist but hoped to see a doctor sooner. The member said Jasmine's kindness made her feel informed and involved throughout the process.

Every day, Select Health caregivers receive calls and messages about a variety of member issues. Member Advocate Scota Maccarthy recently answered a call from a distressed member who needed help finding an urgent care clinic after falling in their backyard. The member had an idea of where to go, but Scota quickly discovered that the clinic didn't offer urgent care services.

Scota found multiple clinics nearby where the member would be in-network and then offered to stay on the call while the member drove to the care site.

During the call, the member got lost and ended up at the wrong care site. Scota confirmed that the location was in-network, allowing the member to be seen immediately.

"Our members are calling in because they don't know what to do, where to start, who to see, or in some cases what they have to do to be seen," Scota said. "We have all that information right in front of us. From the outside looking in, though, it can be like trying to find one specific noodle in a bowl of spaghetti."

Select Health serves as partners in health — connecting members with the right care at the right time and making healthcare more accessible. These examples of personalized services not only lead to better patient outcomes and experiences — they help reduce costs to the patient, care provider, and Select Health.

Article based on "Select Health Customer Service Bucks Industry Trends" by Michelle Kaiser, *Intermountain Health Caregiver Brief*, March 21, 2024.

Immunization Updates and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on **February 28–29, 2024**, for its regular triennial vaccine meeting.

Figure 1 below summarizes the votes, key guidance, and discussions from these meetings related to COVID-19, chikungunya, diphtheria tetanus DT, influenza, polio, RSV, and meningococcal vaccines.

Learn more by accessing:

- **Related details** (vaccine evidence presented, committee discussion, and votes) for each recommendation summarized in **Figure 1** can be found on the **Select Health Provider Tools** area of our website at ACIP Meeting Updates.
- **Archived meeting minutes and slides** are available on the **ACIP meeting website** (click on "Meeting Materials").
- **COVID vaccine recommendations** are available on the CDC's **Clinical Considerations** website.

Figure 1. Vaccines Guidance Summary

VOTES	
COVID-19	ACIP recommended the administration of an additional dose of 2023–2024 Formula COVID-19 vaccine to persons ages 65 years and older at least four months after the prior dose of 2023–2024 Formula COVID-19 vaccine. Immunocompromised patients should receive an additional dose of 2023–2024 at least two months after the prior dose.
CHIKUNGUNYA VACCINE	ACIP recommends one dose of the live-attenuated chikungunya vaccine (IXCHIQ®: Valneva) for: • Those persons ages 18 years and older at risk of chikungunya when traveling to a region experiencing an outbreak • Laboratory personnel working with live virus • Those persons ages 65 years and older traveling to locations with evidence of Chikungunya virus transmission in the past five years • Adults with plans to stay six months or longer in locations with evidence of virus transmission
DIPHTHERIA TETANUS DT	The Vaccines for Children (VFC) program added Td vaccine for use in children ages less than seven years with a contraindication to the pertussis component of the DTaP vaccine. DT vaccine is no longer available.
REVIEWS AND DISCUSSIONS	
INFLUENZA	Vaccine effectiveness for the 2023–2024 season is comparable to seasons with good strain match in preliminary analyses. ACIP anticipates that most influenza vaccines will be trivalent for the 2024–2025 influenza season due to the removal of the B/Yamagata strain.
H INFLUENZA	For the hexavalent vaccine, ACIP plans to vote in June 2024 on whether Vaxelis® can be used preferentially in American Indian/Alaska Native (AI/AN) infants for *H. influenzae* protection.
POLIO	ACIP discussed whether two fractional IPV doses administered outside of the U.S. could be counted as a dose toward the U.S. Vaccination schedule.

Continued on page 5...

Figure 1. Vaccines Guidance Summary, Continued

RESPIRATORY SYNCYTIAL VIRUS (RSV) — ADULT	ACIP discussed: • Trial results of an mRNA RSV candidate vaccine for persons ages 60 years and older • Post-licensure reports of Guillain Barré Syndrome (GBS) in older recipients • The potential for changing to a universal recommendation for adults ages 60 years and older or for an older cohort • The potential for a risk-based recommendation for adults ages 50–59 years and whether timing vaccination near the respiratory season is preferable.
MENINGOCOCCAL VACCINES	ACIP continued discussion regarding a revised adolescent meningococcal schedule with a planned vote at its February 2025 meeting and reviewed a candidate GSK pentavalent meningococcal ABCWY (MenABCWY) vaccine.
PNEUMOCOCCAL	ACIP reviewed considerations of a Merck pneumococcal conjugate, 21-valent (PCV21) candidate vaccine.

Questions about immunization? Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Immunization Programs, Intermountain Health Canyons Region, at **801-442-3946**.

Nutrition Therapy for Gout

In the United States, an estimated 9.2 million adults are affected by gout with rates more than doubling since the 1960s.[1,2] Nutrition can play a crucial role in the management and prevention of gout, especially when in conjunction with pharmacologic interventions.

Purines found in certain foods and beverages are metabolized into the byproduct uric acid, which can trigger gout attacks. A low-purine meal pattern with adequate hydration can help reduce serum uric acid levels.

How can an Intermountain registered dietitian nutritionist (RDN) help?

An RDN can work with patients to:

1. Limit purine-rich foods (e.g., organ meat, red meat, beer, and hard liquor)
2. Add nutrient dense low-purine foods (e.g., eggs, cold-water fish, vegetables, fruits)
3. Moderate alcohol intake
4. Encourage hydration with water and limiting fructose containing beverages (e.g., soft drinks, energy drinks, fruit juices, flavored milk)
5. Focus on a balanced meal pattern and engaging in regular physical activity to promote a healthy weight

What nutrition resources can help patients prevent or manage gout?

Intermountain Nutrition Services offers Select Health members access to:

- **Medical Nutrition Therapy (MNT)** – One-on-one nutrition counseling sessions with an RDN. Patients will learn nutrition strategies to prevent gout flare-ups and develop a personalized eating plan.
- **The Way to Wellness Program** – A one-year, Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention program for adults who want to lose weight by addressing healthy lifestyle changes. In-person and distance options are available, and all sessions are facilitated by RDNs.

References:

1) Singh G, Lingala B, Mithal A. Gout and hyperuricaemia in the USA: Prevalence and trends. *Rheumatology (Oxford).* 2019;58(12):2177-2180.
2) Chen-Xu M, Yokose C, Rai SK, Pillinger MH, Choi HK. Contemporary prevalence of gout and hyperuricemia in the United States and decadal trends: The National Health and Nutrition Examination Survey, 2007-2016. *Arthritis Rheumatol.* 2019;71(6):991-999.

Intermountain Health — Committed to Community Investment

Intermountain Health is committed to generating social impact as well as understanding and addressing specific community health needs. Two key parts to this effort are the Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP).

There is collective value in undertaking CHNAs alongside our community stakeholders to address priority needs and measure cross-sector outcomes together.

While CHNAs are federally mandated for hospital service areas, we have undertaken them in Colorado, Idaho, Montana, Nevada, and Utah markets, regardless of a hospital site due to the strategic value and community insight they provide. The most recent CHNAs and CHIPs are publicly available on our **website**.

For 2024, Colorado will conduct five CHNAs for communities from Denver to Grand Junction.

Leveraging new technology

Community Health is also utilizing a new technology called Metopio that synthesizes hundreds of data sources to identify community trends, health disparities, and emerging health issues more precisely.

This data-driven and community informed process identifies priority health needs and drives our Community Health Improvement Plans (CHIPs), which outline our strategies, collaborations, and community investments .

Measuring 2023 community investment progress

In 2023, Intermountain Health invested as follows:

- Community contribution: $34.7 million total
- $43 million committed to social determinants of health investment
  - — 499 housing units constructed or preserved
  - — 252 people supported in improving financial wellness
- $25.2 million worth of diagnostic vouchers provided to uninsured and low-income individuals
  - — 22,754 diagnostic services provided
  - — 58 community organizations distributed vouchers to patients
- $285,000 earned for community causes through iAct, Intermountain's caregiver volunteer program, based on 52,124 caregiver volunteer hours
- 5 CHNAs completed in southern Idaho, southern Nevada*, and 3 regions in Montana

More about Community Investment

CHNA: A systematic process completed every three years that evaluates the health needs and assets in a community. This leads to identifying priority areas that direct community benefit investments.

CHIP: A written implementation strategy describing how the hospital will address the community health needs identified in the CHNA. Intermountain Health and community stakeholders work together to implement interventions designed to improve health outcomes.

Access **CHNA and CHIP reports** by state for area hospitals.

Focusing on key initial investments

Across all areas, Intermountain Health aims to improve mental well-being, improve chronic and avoidable health outcomes, and invest in and address the social determinants of health.

* Intermountain Health has published the first CHNA for southern Nevada. This report details critical health needs among the Las Vegas populations, the socio-economic factors that contribute to those obstacles, and how Intermountain Health can utilize the necessary resources to improve them. **Download the report.**

Continued on page 7...

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In addition, we made initial investments throughout our service area in 2023. For example, Intermountain:

- Provided a low-cost loan to Safenest, a domestic violence service provider in **Las Vegas**, to purchase property that will double their capacity.
- Made a low-cost loan to Elevation Community Land Trust in **Colorado**, to purchase properties that will provide affordable homeownership to people earning less than 80% of the area median income.
- Invested in a housing trust in **Boise** that will provide homeownership opportunities to low-income people.
- Supported the Rocky Mountain Homes Fund, which will provide down-payment assistance to essential professionals **across our service area**.
- Invested in the Perpetual Housing Fund, a **Utah** program that provides renters wealth generation opportunities, and provided loans in Ogden and Park City to support affordable housing construction.

In 2024, we plan on more investments in Colorado and are exploring several potential partnerships to address the lack of access to affordable housing, financial inclusion, and wealth generation opportunities.

Across all areas, Intermountain aims to improve mental well-being, improve chronic and avoidable health outcomes, and invest in and address the social determinants of health.

Article adapted from Intermountain Health's Caring for Our Communities Quarterly Newsletter, published March 5, 2024.

Quality Provider Program News

Focus on Maternal Mental Health Screening

We honor mothers in May around the globe. Australians present chrysanthemums to their "mums." In Peru, families gather in cemeteries to honor all women in their family, present and past. At the end of rainy season, Ethiopians feast for three days, and men sing while women dance. In America, we celebrate mothers on the second Sunday of May with flowers and gifts. In each culture, celebrating mothers involves personalized action by the community.

How does the healthcare community honor mothers in a personalized and actionable way?

At Select Health, we honor mothers through our Quality Provider Program (QPP) measures focusing on maternal mental health. These quality measures support the Healthcare Effectiveness Data and Information Sets (HEDIS) focused on prenatal and postpartum depression screening. Each of these measures comprise two parts: the screening process and follow-up care. To comply with the measures, we look for electronic evidence that the member:

- Was screened for depression using a validated screening tool once during pregnancy and again in the postpartum period
- Received follow-up care within 30 days for any positive screening result

We invite you to join Select Health in honoring the mothers in our communities by:

- Making maternal mental health screening a priority in your practice
- Establishing a follow-up process for positive screenings
- Standardizing documentation of all screenings and interventions in coded fields
- Sharing your work with payers via electronic means

Why prioritize maternal mental health screening?

Mental health conditions are the most common complication of pregnancy, with 1 in 5 women experiencing issues with depression, anxiety, or substance use in the perinatal period. Of great concern, mental health conditions are the leading cause of maternal mortality in the first year postpartum. Death by suicide and overdose/poisoning related to substance use disorder account for 23% of pregnancy-related deaths. Unfortunately, these preventable complications largely go unrecognized and untreated.

Making screening a priority in your practice brings recognition to the crisis facing mothers and identifies women that may benefit from mental health interventions. **The American College of Obstetricians and Gynecologists (ACOG)** recommends depression screening twice during pregnancy and once in the postpartum period using a standardized and validated screening tool. These tools typically take less than 5 minutes for a patient to complete and help normalize mental health discussions with their provider.

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*Referred to as Quality Provider Plus Program in Idaho, Colorado, and Nevada but may not be available for all regions/networks.

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How can we foster positive screening follow up?

According to the American Psychiatric Association, "Upwards of 75% of pregnant persons affected by mental health symptoms remain untreated" and are often termed "therapeutic orphans."* Ironically, the very focus of obstetric care is left motherless.

How then, can obstetricians adopt mental healthcare and follow-up in their practice? When a positive screening occurs, the goal of follow-up care should address **at least one of the following within 30 days**:

- An outpatient follow-up visit (in person or via telephone, e-visit, or virtual check-in) with a diagnosis of depression or other behavioral health condition
- A depression case management encounter that documents assessment for depression symptoms or a depression/other behavioral health condition diagnosis
- A behavioral health encounter, including assessment, therapy, collaborative care, or medication management
- A dispensed antidepressant medication
- Documentation of additional depression screening on a full-length instrument indicating **either** no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument

Don't let a lack of resources or knowledge inhibit maternal mental health screening and follow-up care. Recognize that the obstetric provider does not have to bear the responsibility of follow-up care alone. As your partner in maternal mental health, the Women's Health QPP provides referral resources, educational opportunities, and workflow solutions to make follow-up care possible. Also consider referring patients with maternal mental health needs to the **Select Health Healthy Beginnings** program for assistance with care management.

What practice management approaches help support screening and follow-up consistency?

Using the electronic medical record (EMR) to standardize documentation. Standardized healthcare documentation via the EMR reduces variability and improves safety, accuracy, quality, and if used properly, gives providers time back in their busy schedule. This is particularly true with standardized mental health screening. For example, missed or misinterpreted information on standardized mental health screening tools can have serious consequences, specifically for questions addressing self-harm. These individuals may require further assistance and/or immediate interventions to stay safe.

Standardized documentation can also give providers time back in their day, providing easily identified, clear, and concise information for warm hand-offs to mental healthcare providers. Documenting screening tools in a coded field also assists with billing efficiency and sharing information for automated quality measurement.

Sharing electronic data. HEDIS maternal mental health measures require Electronic Clinical Data Systems (ECDS) reporting to encourage electronic data sharing between healthcare plans and providers. This exchange of data is mutually beneficial. The healthcare plan can collect data and report to the National Council for Quality Assurance (NCQA) electronically, and providers can receive the highest quality data available to improve care quality.

Our Women's Health QPP (**currently available in Utah**) is designed to support clinics in this effort. When enrolled in the program, we connect you with our data analytics team to set up data transfer and perform audits to ensure accuracy. We also grant access to a provider portal with performance data and a gap-in-care report

...Continued on page 10

...Continued from page 9

that supports follow-up care and identifies outstanding gaps in mental health screenings.

Select Health recognizes the significant effort and resources associated with implementing maternal mental healthcare into practice. Our Women's Health QPP is designed to support clinics adjusting workflows to provide maternal mental healthcare and other important preventative health measures. As such, the program provides clinics with best practice solutions, referral resources, and payment for closing gaps in care.

How can I learn more?

If you are interested in how our program can help your clinic implement maternal mental health screenings and follow-up care, please contact either:

- Kari Hardy, RN, Provider Quality Performance Consultant, Kari.Hardy@selecthealth.org
- Chanda Clift, Provider Quality Performance Manager, Chanda.Clift@selecthealth.org

Resources:

- **Maternal Mental Health**
  - — Most common complication of pregnancy
  - — #1 cause of postpartum mortality
  - — Women not receiving mental health treatment
- **Importance of follow-up care**
  - — ACOG recommendations
  - — National Council for Quality Assurance (NCQA) HEDIS Measures, especially:
    - ✓ HEDIS prenatal depression screening
    - ✓ HEDIS postpartum depression screening
- Standardized documentation
- Electronic data sharing

* American Psychiatric Association. *Perinatal Mental and Substance Use Disorders*. **psychiatry.org**. **https://www.psychiatry.org/getmedia/344c26e2-cdf5-47df-a5d7-a2d444fc1923/APA-CDC-Perinatal-Mental-and-Substance-Use-Disorders-Whitepaper.pdf**. Accessed April 24, 2024.

New Maternal Mental Health Resources Released in May

In May, the U.S. Department of Health and Human Services released key documentation relevant to maternal mental health, including:

- **The *National Strategy to Improve Maternal Mental Health Care*, which addresses the urgent public health crisis of maternal mental health and substance use issues.** Recommendations in this strategy were developed by the Task Force on Maternal Mental Health, a subcommittee of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Advisory Committee for Women's Services.
- ***The Task Force on Maternal Mental Health's Report to Congress***, which along with the accompanying national strategy, are part of broader federal efforts to address U.S. women's overall health, and maternal health in particular. This strategy and report are consistent with the ***White House Blueprint for Addressing the Maternal Health Crisis*** and the ***White House Initiative on Women's Health Research.***
- ***Maternal Mental Health State Report Cards*,** released as part of a congressional briefing on the latest national maternal health statistics and federal maternal mental health policy.

Make Your Quality Provider Program Work for YOU!

Your Select Health Quality Provider Program (QPP) engagement needs to fit your practice workflow and bandwidth. We want to help customize your experience with QPP based on the type of user you are. Typically, clinics fall into one of these three types and can change types as the practice expands. Access our online **Resources** area for customized guides for each type of user.

The Basic User

This type of user is typically a single-provider clinic with one person doing quality assurance who pulls a gaps list occasionally to call patients and make appointments to help close gaps for specific measures. Basic users will find customized guidance for:

- Accessing and navigating the QPP dashboard
- Pulling simple gaps lists
- Formatting a gaps list

The Intermediate User

This type of user is a clinic with a few providers at a single location who pull and print gaps lists monthly and may divide up gaps to close (per provider or measure) to share with team members. This clinic likely uses some functions of the Quality Data Correction (QDC) tool. Internmediate users will find customized guidance on:

- Using the data exported form the QPP dashboard
- Accessing and navigating the QDC tool

The Super User

This is typically a multi-provider/multi-location enterprise with a team dedicated to quality assurance. This team uses the dashboard to create "friendly" provider competitions and has a well-defined, follow-up process for high-risk members. They make comprehensive use of the QDC tool for maintaining a member compliance list, case management, and evaluating their hospital census. Super users will find customized guidance for:

- Accessing other reports on the QPP Report Hub (e.g., Hospital Census Report, Case & Disease Management Patient List, etc.)
- Using a visual Member Compliance list to better see gaps required for a particular member

Understanding Value Care Program Differences

Many providers and staff can be confused by the different value care programs we offer, including:

- **The Quality Provider Program (QPP**) — Focuses on enhancing the level of care and patient experience in the transition to a patient-centered medical home (PCMH) model
- **The Quality Transparency Project (QTP)** — Compares provider performance to national standards
- **Castell** — Helps organizations transition to value-based care and manage medical expenses

The following details how to differentiate among these three entities.

The Quality Provider Program (QPP)

This Select Health program is an upside only program designed to support clinics in the transition to a patient-centered medical home (PCMH). PCMH is a team-based healthcare delivery model led by practitioners to deliver comprehensive and continuous medical care for patients.

Participating clinics actively engage in quality improvement projects, with the support and collaboration of QPP representatives, to enhance the level of care, safety, and equity for patients. Additionally, providers strive to meet clinical goal thresholds by closing patient gaps for specific NCQA, STARS, & HEDIS measures; many of which overlap with QTP and Castell.

As part of this model, Select Health provides clinics with robust, dynamic reporting of patients with gaps in care related to quality measures, summaries of success metrics overtime for benchmarking and improvement, a consultant to support in maximizing program benefits, and the opportunity to earn quarterly performance payouts with an annual bonus structure.

Learn more: Visit the QPP Website and watch our **introductory video**.

Quality Transparency Project (QTP)

This Select Health program is designed to compare to local and national averages set by NCQA through the HEDIS audit process. Through the program, providers can see how they compare to their peers when trying to obtain high performance through national standards.

There are four main categories for the QTP: preventive screenings, diabetes screenings, medication adherence, and pediatric monitoring. To obtain an online badge for any of the categories mentioned, providers must have performance **above** national averages for the measurements in each category.

In the future, providers will receive emails with links to their individual reports where they can see more detail about their ratings.

Learn more: Access **Frequently Asked Questions** and a **Quality Transparency Provider Report Example**.

NOTE: Because this program is currently undergoing significant changes, referenced links/content will soon look different.

Castell

This Intermountain Health company provides a comprehensive health platform that helps organizations transition to value-based care, improve patient outcomes, and manage medical expense. **NOTE**: These programs are independent and distinct from Select Health programs.

Castell consolidates and manages risk-based contracts with payers, offering a single, simplified model to help primary care practices keep costs more affordable, measure quality performance, and ensure appropriate utilization. To support clinics, Castell offers patient outreach, coding education, home visits, and an enhanced data platform. **Learn more**.

Pharmacy News

Diabetes Formulary Changes in 2024

Changes are coming to our prescription drug coverage for members with diabetes. Several medications will no longer be covered; however, many existing and new alternatives will still be covered.

Commercial

For Commercial formularies, we will remove Jardiance (empagliflozin) and combinations, and Tradjenta (linagliptin) and combinations from formulary effective **October 1, 2024** (effective **January 1, 2025**, for Colorado, Nevada, and FEHB). This change will be effective for all current users of these drugs and combinations as well as future users of SGTL2 (sodium-glucose cotransporter 2) inhibitors and DPP4 (dipeptidyl peptidase IV) inhibitors.

We will notify providers and members multiple times before October 1, as this will be a significant change. Brenzavvy (bexagliflozin) and Qtern (dapagliflozin/saxagliptin) will be added as preferred products. There will be no changes to insulin coverage. Please see **Figure 2** for a summary of changes.

Medicaid

For Medicaid formularies, generic dapagliflozin and Brenzavvy (bexagliflozin) will be added as preferred SGLT2 inhibitors. Admelog (insulin lispro) will be a non-preferred insulin effective **July 1, 2024**, for new insulin patients and current patients will be grandfathered until **December 31, 2024**.

This change allows us to add Novolog, insulin aspart, Humalog, and insulin lispro to the **Medicaid** formulary without any prior authorization or step therapy requirements effective **July 1, 2024**. Please see **Figure 3** for a summary of changes.

Medicare

For Medicare formularies, the only change to formulary effective **July 1, 2024**, is the addition of Humalog. The SGLT2/DPP4 coverage will not change for Medicare members. Please see **Figure 4** for a summary of changes.

Figure 2. Commercial Formulary Changes

	Current Preferred Therapies	Preferred Therapies (Effective 10/1/24)
SGLT2 inhibitors	• **Farxiga** (dapagliflozin) • **Jardiance** (empagliflozin) • **Xigduo** (dapagliflozin/metformin) • **Synjardy** (empagliflozin/metformin)	• **Farxiga** (dapagliflozin) • **Xigduo** (dapagliflozin/metformin) • **Brenzavvy** (bexagliflozin)
DPP4 inhibitors	• **Tradjenta** (linagliptin) • **Jentadueto** (linagliptin/metformin) • aloglitpin • alogliptin/metformin	• alogliptin • alogliptin/metformin • saxagliptin • saxagliptin/metformin
SGLT2/ DPP4 inhibitors	• **Glyxambi** (empagliflozin/linagliptin) • **Trijardy** (empagliflozin/linagliptin/metformin)	**Qtern** (dapagliflozin/saxagliptin)

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Figure 3. Medicaid Formulary Changes

	Current Preferred Therapies	Preferred Therapies (Effective 7/1/24)
SGLT2 inhibitors	• **Steglatro (ertugliflozin)** • **Segluromet (ertugliflozin/metformin)**	• **Brenzavvy** (bexagliflozin) • **Steglatro** (ertugliflozin) • **Segluromet** (ertugliflozin/metformin) • dapagliflozin • dapagliflozin/metformin
DPP4 inhibitors:	• aloglitpin • alogliptin/metformin	• alogliptin • alogliptin/metformin • saxagliptin • saxagliptin/metformin
Short Acting Insulins	**Admelog** (insulin lispro)	• Insulin aspart • **Novolog** (insulin aspart) • Insulin lispro • **Humalog** (insulin lispro)

Figure 4. Medicare Formulary Changes

	Current Preferred Therapies	Preferred Therapies (Effective 7/1/24)
Short Acting Insulins	• Insulin aspart • **Novolog** (insulin aspart) • Insulin lispro	• Insulin aspart • **Novolog** (insulin aspart) • Insulin lispro • **Humalog** (insulin lispro)

Updated Pharmacy Provider Reference Manual Available

Access the updated **Pharmacy Provider Reference Manual** for 2024.

Select Health Medicare News

Select Health Medicare Health Outcomes Survey (HOS)

Q: What is the Health Outcomes Survey (HOS)?

A: The HOS is sent to a random sampling of patients who have a Medicare Advantage plan. It is related to patient-provider relationships and asks questions related to physical and mental health, bladder issues, physical activity, fall risk and prevention, and other topics.

Q: Why does HOS matter?

A: HOS data helps the Centers for Medicare and Medicaid Services (CMS) monitor health plan performance based on patient health outcomes. It also affects Star Quality Ratings that help Medicare beneficiaries choose a health plan.

Q: When is the HOS sent?

A: Each year a random sample of Medicare Advantage members are surveyed by a CMS-approved vendor. A baseline HOS is sent in July and respondents who are still a plan member two years later get a follow-up HOS in September.

Q: How can providers affect HOS outcomes?

A: You can positively impact HOS results by starting important conversations during office visits (see **Figure 5** below and on the next page). Use every office visit to ask patients about physical activity, depression, bladder issues, and falls. Discuss preventions, recommendations, and treatments. Create recall about conversation by following up with patients after a visit. Member perception of care and recall are key to impacting HOS results.

Q: What actions does Select Health take?

A: First, Select Health administers an HOS like survey to our Select Health Medicare members. This year there will be live outreach to members who report a fall or report being afraid of falling. We will also be sending letters and emails to these members as added reminders of what they can do to prevent a fall. Second, Select Health will be developing some support materials for our providers to have when patients voice concerns about physical activity, depression, bladder issues or falls.

Figure 5. Suggested Actions to Improve HOS Results

HOS Measure	Sample HOS Questions	Potential Provider Actions
Improving and Maintaining Mental Health and Physical Health	• In the past 12 months, did you talk with your provider about your mental health? For example, did your provider ask if you're feeling depressed, having trouble sleeping, taking any medications, or seeing another provider to help you maintain your well-being? • In general, would you say your health is: excellent, very good, good, fair, poor • Does your health limit you in these activities: pushing a vacuum cleaner, playing golf, or climbing stairs.	• Discuss physical and mental health. • Ask patient if they've felt down or depressed. • Refer patient to a mental health provider as appropriate. • Offer activities to improve mental health such as walks, socializing, crossword puzzles, going to a senior center, etc. • Ask patients what factors (such as pain) may be limiting their ability to complete daily activities. • Refer to a specialist as appropriate.
Monitoring Physical Activity	• In the past 12 months, did you talk with your provider about your level of exercise or physical activity? For example, did your provider ask if you exercise regularly? • Has your provider advised you to start, increase or maintain your level of exercise or physical activity? For example, did your provider advise you to start taking the stairs, increase walking every day, or to maintain your current exercise program?	• Talk about the importance of exercise and physical activity. • Discuss how to start, increase, or maintain activity. • Refer patients with limited mobility or walking/balance issues to physical therapy to learn safe and effective exercises.

...Continued on page 16

...Continued from page 15

HOS Measure	Sample HOS Questions	Potential Provider Actions
Improving Bladder Control	• Have you talked with your provider about urine leakage? • There are many ways to control leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a provider about any of these approaches?	• Ask if bladder control is a problem and discuss when it has been a problem and other symptoms that may be accompanying it. • Discuss treatments for bladder control issues that may arise as patient ages, such as behavioral therapy, exercises, medications, medical devices, or surgery.
Reducing Fall Risk	• In the past 12 months, did you talk with your provider about falling or problems with balance or walking? • Has your provider done anything to help prevent falls or treat problems with balance or walking? Some things they might advise are to use a cane or walker.	• Discuss balance problems, falls, difficulty walking, and other fall risks. • Suggest cane or walker. • Check blood pressure with patient standing, sitting, and reclining.

Update to Statin Exclusion Coding

NEW: PQA has removed the ICD-10 code of **T46.6X5A** from the eligible rhabdomyolysis myopathy exclusions. Please refer to the updated table below for appropriate statin exclusions. As a reminder, exclusion coding must be submitted in a claim EACH year for the patient to be removed from statin measures. Charting a statin intolerance in the EMR does not remove a member from the statin measures. Use the list of required codes in **Figure 6** below; note that a statin allergy does not count without coding for one of these listed exclusions below.

Figure 6. Overview of Qualifying Statin Exclusions to be Coded

For Diabetes Patients ONLY	For Cardiovascular Patients ONLY
• Prediabetes (R73.03, R73.09 codes) • PCOS (E28.2 codes)	• IVF • Myalgia (M79 codes) • Palliative Care

For BOTH Diabetes and Cardiovascular Patients			
• Cirrhosis	• Hospice Care	• Myopathy (G72 codes)	• Pregnancy
• Dialysis	• Lactation	• Myositis (M60 codes)	• Rhabdomyolysis (M62 codes)

Questions? Contact either Kirstin Johnson, Select Health Quality Consultant RN (for cardiovascular statin measure) at **801-442-8224** or **kirstin.johnson@selecthealth.org** OR LeeAnn Madrid (for diabetes statin measure) with the Select Health pharmacy team at **leann.madrid@selecthealth.org**.

Select Health Community Care® (Medicaid) News

Adult Medicaid Preventive Exams

Preventive services are covered under Utah Medicaid at no charge to members, including:

- Routine physical examinations and immunizations
- Educational methods and materials for promoting wellness
- Disease prevention and management

One comprehensive preventive health examination is covered per calendar year. The initial code **99385** or **99386** may be billed once for an annual examination. In subsequent years, code **99395** or **99396** should be billed.

Evaluation and Management Care

Evaluation and management care for preventive services include counseling, anticipatory guidance, and/or risk factor reduction interventions.

Except for immunization codes, no special programs or codes are covered.

Language Services Available

Select Health contracts with language interpreters to help you provide the best care for our Community Care members who speak little or no English as well as for those who use sign language.

Select Health will pay for interpretation services for Community Care members when the service is:

- Provided by a contracted interpreting agency (see **Figure 7** below)
- A covered service by Medicaid and Select Health
- Related to follow-up phone calls for communicating lab/radiology results, scheduling appointments, or managing medication changes

The provider will be responsible for interpretation service costs when:

- Using a non-contracted interpreter instead of a vendor listed in **Figure 7**.
- The member is ineligible at the time of service
- Costs accrue from a provider's office changing or canceling an appointment

NOTE: Only members who have Community Care as secondary coverage will be covered for interpretive services under Medicare Advantage or Commercial plans.

Figure 7. Contracted Language Interpreters (based on location where member receives care)

Interpreter Service	Intermountain Health Facilities	Non-Intermountain Health Facilities (Affiliate Providers)
American Sign Language		
American Sign Language (ASL)	ASL Communication: **801-699-9609** / **800-908-3386**	
Limited English Proficiency (LEP)		
Onsite In-Person Visits (Patient and interpreter are both in the office.)	InSync Interpreters: **801-838-8100** LanguageMed: **801-750-4661**	InSync Interpreters: **801-838-8100** LanguageMed: **801-750-4661** CommGap: **801-944-4049** / **888-338-5538**
Telephonic In-Person Visit (Patient is in the office, and interpreter is on the phone.)	InSync Interpreters: **801-838-8100** LanguageMed: **801-750-4661** CommGap: **801-944-4049** / **888-338-5538**	
Telephonic Follow-up (Patient and interpreter are both on the phone.)	Select Health Member Services: **855-442-3234** (for help with communicating lab or radiology results, appointment scheduling, medication changes, etc.)	

Practice Management Resources

Automate Select Health Preauthorization Requests: Switch to CareAffiliate®

CareAffiliate is our online preauthorization tool that enables you to submit preauthorization requests and supporting documentation online rather than through fax or email. This electronic functionality improves security and the speed at which requests are reviewed.

As the industry moves to online preauthorization, there will come a time when faxing requests is no longer a viable option for payers and providers.

Why should I use CareAffiliate?

Compared to faxed and emailed requests, using the CareAffiliate tool offers many benefits, such as:

- Reduced response time
- 24/7 preauthorization status information
- No risk of faxed information being lost, sent to the wrong number, or other errors
- Reduced follow-up calls and decision delays due to missing information
- Automatic review and preauthorization decisions for many procedures

How do I access CareAffiliate?

To request access for both CareAffiliate and the Provider Benefit tool, follow these **online instructions**.

Where can I learn more?

Learn more by reading the CareAffiliate **Frequently Asked Questions** or by visiting our **online training area**, where we now feature short training videos and live training appointments.

Recent Updates

April 24, 2024: Eye procedures have been updated to reflect current criteria for the Medicare plan.

April 3, 2024: Eye procedures have been updated to reflect current criteria. (Commercial, CHIP and Medicaid)

March 13, 2024: Hyperbaric Oxygen Therapy request type has been updated to improve user experience.

Remember:

- Exclude: Procedure codes that do not require review should not be included on requests.
- Try the following steps to resolve common issues, such as being unable to access a provider or receiving a 401 error:
  - Clear your browsing data. **Ctrl+Delete** keyboard shortcut can be used for most browsers.
  - Instead of selecting the requesting or servicing provider from the type-ahead drop-down list, do a new search by using the magnifying glass icon and entering the NPI.
- **Intermountain Providers and Facilities:** To maintain a timely review process, please include the date, title, and location of iCentra-based clinical documentation in the Notes section.
- **Pharmacy Preauthorization?** Submit pharmacy preauthorization requests through **PromptPA**.

Questions? Email us at careaffiliate@selecthealth.org.

Navigate! How can we help you today?

Start with Select Health online self-service solutions. Access our provider website (selecthealth.org/providers) for the quickest way to get your questions answered. Direct links are in purple type.

Do you need to:	Go to:
Find member ID card information?	https://selecthealth.org/providers/claims/id-guides
Access non-covered codes/ preauthorization requirements?	https://selecthealth.org/providers/resources/tools
Request preauthorization?	https://selecthealth.org/providers/preauthorization
Appeal a claim?	https://files.selecthealth.cloud/api/public/content/98df6ab82e-9942948035b36ebba71ddc?v=0c2ef5c1
Find pharmacy resources?	https://selecthealth.org/providers/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/resources/policies
Learn about our secure provider tools (Provider Benefit Tool, CareAffiliate®)?	For the Provider Benefit Tool (check eligibility and claims status): https://selecthealth.org/providers/claims/provider-benefit-tool For CareAffiliate (submit and track online preauthorization requests): https://selecthealth.org/providers/preauthorization/careaffiliate/ca-training

Contact us when you can't find answers online. We're here to help Monday through Friday. Phone and email requests are answered in the order they are received.

When you need to:	Access:
Verify member benefits or get help with claims payment issues and information	The Provider Benefit Tool or Member Services: **800-538-5038**
Resolve issues with provider setup or directory listing	Provider Development: **800-538-5054**; provider.development@selecthealth.org
Get help with access to tools on our secure Provider Portal and online tools (Provider Benefit Tool, CareAffiliate)	Provider Web Services: providerwebservices@selecthealth.org
Resolve claims appeals/preauth issues	Compliance and Appeals: **844-208-9012**
Manage Electronic Funds Transfer (EFT)	EDI Department: **800-538-5099** (fax: **801-442-0372**); edi@selecthealth.org
Change passwords, reactivate accounts, resolve issues with 2-Step Authentication (PingID)	Account Help Desk: **801-442-7979, Option 2**
Request fee schedules (contracted providers only)	Provider Development: SHFeeScheduleRequests@selecthealth.org

Select Health