APRIL 2024

Provider News

For participating physicians, other health care professionals and facilities

National Healthcare Decisions Day

National Healthcare Decisions Day, observed annually on April 16, aims to inspire, educate and empower all of us to share our preferences for medical treatment should an unexpected illness occur. We encourage you to begin or continue advance care planning (ACP) conversations with all your patients as part of the preventive and treatment services you provide.

We reimburse providers who bill for ACP conversations with members, regardless of age or health status.

ACP conversations may include:

- Designating a medical decision-maker
- Discussing current medical status and prognosis
- Discussing important personal elements that often influence treatment choices (e.g., personal values, social, cultural and spiritual beliefs)
- Reviewing, editing or creating documents, such as an advance directive, durable power of attorney or POLST/MOLST form

Serious Illness Messaging Toolkit

Terms like hospice, palliative care and advance care planning can be confusing to patients. The Serious Illness Messaging Toolkit includes tips for how to talk about serious illness using evidence-based research. The toolkit is available at **seriousillnessmessaging.org/using-the-toolkit**.

Vynca supports members facing serious illness diagnoses

Vynca is a telehealth palliative care provider that focuses on addressing physical, emotional and social impacts of a disease. It's in network for BridgeSpan members. Vynca doesn't replace traditional medical care; its specialists collaborate with a member's established PCP to offer additional care coordination and support tailored for serious illness. Vynca's providers must be licensed in the state in which the member resides.

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Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Subscribe today

Subscribe to receive email notifications when new issues of our publications are available.

Using our website

When you first visit **bridgespanhealth.com**, you will be asked to select an audience type (individual or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you.

Stay up to date

View the What's New section on the home page of our provider website for the latest news and updates.

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Contents

- ■ Critical update
- ♥ Cardiovascular
- ★ Stars Ratings/Quality

We encourage you to read the other articles because they may apply to your specialty.

Click on a title to read the article.

About Provider News

This publication includes important news, as well as notices we are contractually required to communicate to you. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

Provider News includes information for BridgeSpan Health in Idaho, Oregon, Utah and Washington. When information does not apply to all four states, the article will identify the state(s) to which that specific information applies.

Issues are published on the first day of the following months: February, April, June, August, October and December.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via Availity Essentials at **availity.com**.

The Bulletin

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical and reimbursement policies, including changes we are contractually required to communicate to you.

Share your feedback

If you have additional comments about our newsletter or bulletin, please send us an email at **provider_communications@bridgespanhealth.com**.

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Vynca uses telehealth (phone and video), which allows for more accessibility, and they coordinate closely with each member's established care team. Its providers focus on empowering those living with a disease and mitigating ongoing symptoms in the comfort of their own home. Depending on a member's diagnosis, Vynca will coordinate and connect them with a range of palliative care physicians, as well as nursing and social service providers, who know their care plan. Services are available 24 hours a day.

Learn more and access Vynca services by visiting **vyncacare.com** or by calling 1 (888) 227-8884.

Other resources

Visit our provider website for more information and resources: Programs>Medical Management>Personalized Care Support. You'll find links to the following:

- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org**
- Vital Talk: **vitaltalk.org**

Center to Advance Palliative Care (CAPC) membership offer

BridgeSpan is offering one year of online training from CAPC at no cost for participating providers interested in developing their advance care planning and palliative care teams. This national organization is dedicated to increasing the availability of quality, equitable health care for people living with serious illness. CAPC offers more than 500 online courses and tools that can be filtered by topic, practice area or discipline. To learn more and register for this opportunity to earn free continuing education credits, email **DL-PersonalizedCareSupport@bridgespanhealth.com**.

Update your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with the Centers for Medicare & Medicaid Services (CMS) and the Affordable Care Act (ACA).

Our *Provider Directory Attestation Requirements for Providers* policy requires:

- Providers to review for accuracy and submit all updated information about their practice at least every 90 days
- Providers to continue to notify us promptly of changes to directory information
- All participating providers who are eligible to display in directories based on their specialty and current credentialing status to be displayed in our provider directories
- All participating providers to comply with our policies and procedures related to furnishing information necessary to ensure provider directories are up-to-date, accurate and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b); this information includes, but is not limited to, accepting new patients, provider practice location, contact information, specialty, medical group and other institutional affiliations
- Providers to review, update and return roster validation requests

Please follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

As part of your routine review of provider directory information, also review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit NPPES help for more information: **nppes.cms.hhs.gov**.

We have expanded our provider directory information to help our members connect with providers they feel best meet their health care needs and individual preferences. Update your demographics and indicate if your office offers LGBTQ+-affirming care, culturally-specific services, expanded language access and disability competent care by following the instructions on your provider website: Contact Us>Update Your Information. To learn more about providing culturally competent and linguistically appropriate services, view *An Implementation Checklist for the National CLAS Standards* (available in English and Spanish). Links to these checklists are included in our Cultural Competency Toolkit, available on the homepage of our provider website.

Reimbursement schedule tips

Participating providers can view reimbursement schedules and other pricing documents after signing in to Availity Essentials.

- From Availity Essentials, navigate to Claims & Payments>Fee Schedule Listing.
  - You must have the Provider Fee Schedules role assigned to you to access the application. Your Availity administrator can assign that role for you.
  - Your Availity administrator can also add additional tax IDs to your account to allow you to access fees for other providers within your clinic or organization.
- Reimbursement schedules are available for medical, dental and durable medical equipment (DME) providers with standard provider agreements.
  - Alcohol and drug treatment services reimbursement schedules can be found in Payer Spaces. **Related**: See *Reminder: ADTS reimbursement changes* on page 9.
  - Users will only be able to access the reimbursement schedule for which they are contracted.
- Non-standard (negotiated) schedules are not available.

To access the reimbursement schedule, select a payer and enter your:

- Organization
- Tax ID
- National Provider Identifier (NPI) (Type 1)
- Date of service

You can either enter specific CPT or HCPCS codes or download the entire reimbursement schedule.

- You can enter up to 100 individual procedure codes on the Enter Codes tab. The field searches for text as you type, so you can enter the procedure code or any word from the description. Non-facility and facility fees are returned in search results.
- The Code Range tab will return up to 500 codes, including all available modifiers.
- If you are unable to download the schedule, enter a previous month's date of service.
- The date of service entered should be after your network participation effective date (after your agreement is in effect).

View more tips on Availity Essentials: Help & Training>Find Help>Fee Schedules and Help & Training>Get Trained>Fee Schedules - Training Demo.

Join us for a webinar to improve patient experience

We recognize that access to care and its impacts on patient experience are a challenge across the health care industry. We have partnered with Press Ganey Consulting to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. 1.0-hour continuing education (CE) will be available.

Redefining Access to Improve Patient Experience

The webinar will cover the following topics:

- Redefining access to improve quality and experience
- Providing access throughout the patient journey
- Setting expectations to support access to care for both PCP and specialty care
- Specific interventions that promote access beyond traditional face-to-face appointments
- Applying tactics that can be implemented starting your next day at the office

Join us for a 60-minute webinar on one of the following dates:

- April 5, 2024, noon (PT)
  - **Register**
- June 7, 2024, noon (PT)
  - **Register**
- August 2, 2024, noon (PT)
  - **Register**

We are excited to offer this opportunity and hope you can join.

Pre-authorization updates

Procedure/medical policy	Added codes effective April 1, 2024
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- Q4121
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 0444U
Noninvasive Prenatal Testing to Determine Fetal Aneuploidies, Microdeletions, Single-Gene Disorders, and Twin Zygosity (Genetic Testing #44)	- 81243
Small Bowel, Small Bowel/Liver, and Multivisceral Transplant (Transplant #09)	- 44135, 44136, 47135, 48554, S2053, S2054, S2152
Transurethral Water Vapor Thermal Therapy and Transurethral Water Jet Ablation (Aquablation) of the Prostate (Surgery #210)	- 0421T, C2596
Procedure/medical policy	**Adding codes effective July 1, 2024**
Cardiology	- 93650, 93653, 93654, 93656, 93228, 93229, 33285, C1764, E0616, K0606

Our complete *Pre-authorization List* is available in the Pre-authorization section of our provider website. Please review the list for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Essentials Electronic Authorization application.

Cardiology program to include additional services

We are expanding our cardiology program to review additional outpatient cardiovascular tests, procedures and certain cardiac devices. The program will require pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) for the following types of cardiac services delivered on or after July 1, 2024:

- Ambulatory cardiac rhythm monitoring
- Cardiac ablation
- Wearable cardioverter defibrillator

About the program

Carelon administers the program, which reviews outpatient cardiovascular tests, procedures and implantable cardiac devices. **Note**: Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

Providers will be able to contact Carelon to request pre-authorization for these additional services in June 2024. Read the June 2024 issue of this newsletter for more details.

- **Online**: The Carelon ProviderPortal is available 24/7 and processes requests in real-time using clinical criteria, **providerportal.com**.
- **By phone**: Call Carelon at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim may be denied as provider responsibility or pended for post-service review, depending on the line of business.

Learn more

- Program details are available on our provider website: Programs>Medical Management>Cardiology.
- **Related**: See *Pre-authorization updates* for a complete list of affected codes on page 5.

The Bulletin recap

We publish updates to medical and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: Library>Bulletins.

Medical policy updates

We provided 90-day notice in the February 2024 issue of *The Bulletin* about changes to the *Biomarkers for Cardiovascular Disease* (Laboratory #78) medical policy, which are effective May 1, 2024.

We provided 90-day notice in the March 2024 issue of *The Bulletin* about the new *Folate Testing* (Laboratory #79) medical policy, which is effective June 1, 2024.

The *Medical Policy Manual* includes a list of recent updates and archived policies and is available on our provider website: Library>Policies & Guidelines.

Reimbursement policy updates

We provided 90-day notice in the March 2024 issue of *The Bulletin* about changes to the *Maternity Care* (Medicine #107) reimbursement policy, which are effective June 1, 2024.

View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

Ambulance bundled services reimbursement

We are expanding our ambulance bundled services editing to our primary editor, Lyric, effective for dates of service on or after March 1, 2024.

In the December 2022 issue of this newsletter, we announced this editing change and stated that reimbursable ambulance services would be limited to the base fee for transportation and mileage. Services including, but not limited to, oxygen, medications, additional attendants, supplies, electrocardiograms (EKGs) and night differentials will be denied when billed as part of an ambulance transportation service.

Beginning in July 2024, we will apply a clinical edit to review these claims.

BridgeSpan EquaPathRx™ program implementation update

In the December 2023 issue of this newsletter, we provided an update on our plans for BridgeSpan EquaPathRx in 2024. We have additional program updates to share with you below.

We continue to work with providers to contract with the Prime IntegratedRx™ - Medical network to become a designated provider for this program. Until further notice, all BridgeSpan network providers are temporarily eligible to provide medications included in the BridgeSpan EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. **Members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based the member's benefits and your existing contract terms with us.**

Notes:

- Medications included in this program must be pre-authorized according to our medication policies, including the *Provider-Administered Specialty Drugs* (dru764) policy.
- Claims should be submitted directly to BridgeSpan; there is no need to split claims and submit medication claims separately to Prime for this program.

Prime Therapeutics contracting and credentialing

Please complete the credentialing and contracting process with Prime for the IntegratedRx - Medical Network as soon as possible so we can finalize the contracting setup and next steps in our systems.

To start IntegratedRx - Medical network credentialing, please visit Prime's credentialing website: **pharmacy.primetherapeutics.com/content/primetherapeutics/en/provider-credentialing.html**.

If you need further assistance, you can reach out to your Prime contact to complete the process. If you do not have a Prime contact established, please email Prime Provider Relations at **providerrelations@primetherapeutics.com**.

If you do not contract with Prime, we will work closely with you and our members to ensure they continue to have uninterrupted access to their treatment.

Find more information about BridgeSpan EquaPathRx on our provider website: Programs>Medical Management> Pharmacy.

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our provider website: Programs>Pharmacy. **Note**: Policies are available online on the effective date of the addition or change.

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com**.

Expert feedback: We routinely assess our medication policies based on updated medical literature, national treatment guidelines, practicing provider feedback and pharmaceutical market changes. If you'd like to provide feedback or be added to our distribution list, please email us at **BridgeSpanRxMedicationPolicy@bridgespanhealth.com** and indicate your specialty.

New U.S. Food & Drug Administration- (FDA-) approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication, pivotal trial criteria and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Effective June 1, 2024	Description
Revised policy	
Medications for Phenylketonuria (PKU), dru551	- Adding that Javygtor will require step therapy through the more cost-effective generic sapropterin

Effective July 1, 2024	Description
Revised policies	
Oxlumo, lumasiran, dru668	- Adding requirement for minimum eGFR (≥ 30 mL/min) and baseline urinary oxalate excretion level (≥ 0.7mmol/1.73m2)
Drugs for chronic inflammatory diseases, dru444	- Removing Amjevita (adalimumab-atto) as a preferred product - Preferred adalimumab products will include Humira and Hadlima (adalimumab-bwwd)

Behavioral health corner

About behavioral health corner

This section highlights the articles that affect behavioral health providers. We also recommend you use the search function (**Ctrl + F**) on your computer to search for keywords that concern your practice.

Additionally, the following recurring articles often have policy updates that may affect your practice:

- Update your directory information
- *Administrative Manual* updates
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Reminder: ADTS reimbursement changes

To align with current market rates, we are revising reimbursement for alcohol and drug treatment services (ADTS) for providers with our standard *Participating Ancillary Provider Agreements* effective May 1, 2024.

Updated reimbursement rates will be available on Availity Essentials. **Related**: See *Reimbursement schedule tips* on page 4.

Social determinants of health impact health outcomes

We strive to close health equity gaps to ensure simpler, better, more affordable health care for those we serve—from all backgrounds and walks of life. This includes collecting and tracking social determinants of health (SDoH) information about our members to understand barriers and support equitable access to quality health care and health education.

SDoH have a major impact on people's health, well-being and quality of life. Examples of SDoH include:

- Polluted air and water
- Language and literacy skills
- Racism, discrimination and violence
- Education, job opportunities and income
- Safe housing, transportation and neighborhoods
- Access to nutritious foods and physical activity opportunities

The SDoH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health.

Provider resources

- CMS, 2024 ICD-10-CM updates: **cms.gov/medicare/icd-10/2024-icd-10-cm**
- CMS *ICD-10-CM Official Guidelines for Coding and Reporting*: **cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf**
- ICD10data.com: **icd10data.com/ICD10CM/Codes/Z00-Z99**

Member resources

- **Community resources**: Individuals can find support to address social needs (e.g., food insecurity, housing instability, transportation access and more) by visiting **211.org** or **findhelp.org**.
- **BridgeSpan Customer Service**: Members can call the number on the back of their member ID card for help with SDoH resources, finding a PCP, understanding their benefits and more.

Connect patients to the right care at the right time

We are committed to providing our members access to high-quality care at the lowest price. We continue to educate our members about their care options to ensure that they are receiving the care they need in a setting that's clinically appropriate and most cost-effective.

An emergency department (ED) visit can cost up to 10 times the rate of an urgent care center or PCP visit and often includes a long wait time. Studies have shown that:

- More than 30% of ED visits are avoidable.
- More than 70% of ED visits are by patients who are receiving their first treatment for a condition at the ED.

To help your patients save time and money, we encourage you to remind them about their care options before they need sudden medical care.

Convenient care options

- In-person care
  - Share your office hours with your patients, especially if you offer extended hours.
  - If your patient does not have a PCP, encourage them to use the Find a Doctor tool on our website or call Customer Service at the phone number on the back of their member ID card for help finding an in-network provider.
- Virtual care
  - If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your directory information on our provider website: Contact Us> Update Your Information.
  - Our members have access to in-network telehealth vendors and behavioral health providers.
- Nurse line
  - For questions about common health issues and whether a patient should see a doctor, most members can contact BridgeSpan Advice24.
- Same day in-home care (available in the Portland, Oregon, and Seattle, Olympia, Spokane and Tacoma, Washington, areas)
  - With DispatchHealth, members can receive urgent care, hospital-level care and post-hospital care in the comfort of their home to avoid a trip to an urgent care clinic or ED. They are available 7 days a week, including holidays, from 8 a.m. to 10 p.m. Services vary by location. Learn more at **dispatchhealth.com**.
- Urgent care
  - Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms. Many urgent care clinics are conveniently located and more accessible than EDs, allowing members to save time and money.
- ED care
  - Remind patients to go to the ED if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.
  - To help our members have a better understanding of their care options, our care advocates contact members who had three or more ED visits in a six-month period or one or more avoidable ED visits to provide information about alternative treatment options.

Resources for providers and members

- View the Care Options Toolkit on the homepage of our provider website. It includes:
  - Information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
  - A member FAQ with information about virtual, in-person (including urgent care centers) and emergency care.
- Members can view their care options on the member website.
  - Members can sign in to their **bridgespanhealth.com** account and select Find Care to see their care options. They can also contact the phone number on the back of their member ID card.

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Cultural Competency Toolkit updates

We've collected tools and resources to help your practice provide care that meets every patient's unique social, cultural and linguistic needs.

We recently added the following resources to our Cultural Competency Toolkit to help support your practice:

- **American Hospital Association's Disparities Toolkit**: This toolkit includes resources for systematically collecting race, ethnicity and primary language data from patients.
  - **aha.org/hretdisparities/toolkit**
- **Rural Health Literacy Toolkit**: This toolkit compiles evidence-based and promising models and resources to support organizations implementing programs to improve health literacy in rural communities across the U.S.
  - **ruralhealthinfo.org/toolkits/health-literacy**
- **TeamSTEPPS**: This site includes resources and tools to address language and cultural barriers and improve patient safety. In addition, they offer a guide for hospitals treating patients with limited English proficiency.
  - **ahrq.gov/health-literacy/professional-training/lepguide/app-e.html**
  - **ahrq.gov/sites/default/files/publications/files/lepguide.pdf**
- **U.S. Department of Health and Human Services (HHS)**: The HHS website outlines which entities must comply with non-discrimination laws and how to help those entities implement and maintain compliance. HHS has also created the *Implementation Checklist for the National CLAS Standards* in English and Spanish.
  - **hhs.gov/civil-rights/for-providers/index.html**
  - **thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf**
  - **thinkculturalhealth.hhs.gov/assets/pdfs/ListaDeVerificacionParaLaImplementacionDeLosEstandaresNacionalesCLAS.pdf**

Our Cultural Competency Toolkit is available on the homepage of our provider website.

Improving members' experience with medications

Many factors influence members' experience with obtaining medications and adhering to their treatment plan. We are increasing the support and assistance we offer for members to improve their health outcomes and experience.

Reasons your patient may not be taking medications you prescribed

Sometimes members are prescribed medications they cannot obtain for various reasons (e.g., cost, nonformulary, pre-authorization or step therapy requirements or medications excluded from coverage). These barriers can lead to untreated or poorly controlled conditions and impact the quality of care the patient feels they received.

Look for the **Medications and member experience with medications** category in the Quality Improvement Toolkit, available on the homepage of our provider website. The toolkit includes best practices and action items, along with a variety of flyers you can share with your patients.

Cancer screenings and prevention

According to the Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in the U.S. Leading risk factors for preventable cancers are driven by lifestyle, including smoking, getting too much ultraviolet (UV) radiation from the sun or tanning beds, being overweight or having obesity, and drinking too much alcohol.

While cancer affects people of all ages, races, ethnicities and sexes, it does not affect them equally. Differences in genetics, hormones, environmental exposures and other factors can lead to differences in risk among different groups of people. For most cancers, though, increasing age is the most important risk factor.

Between 30-50% of cancer cases are preventable. We cover a variety of preventive services, including cancer screenings, at no cost (no copay and no deductible) to our members. Preventive screening services can help detect the following cancers in early stages, when treatment is more likely to be successful.

Screening coverage for commercial members

- Breast cancer prevention counseling (for those at high risk) and screening mammogram (ages 40+ or at high risk)
- Cervical cancer screening (Pap smear test) (ages 21+)
- Colorectal cancer screening (ages 45+)
- Lung cancer (ages 50-80 with history of smoking)
- Skin cancer counseling (ages 6 months-24 years for those with fair skin type)

Preventive vs. diagnostic care

When scheduling appointments, please remind your patients that during the preventive care visit, if diagnostic care is needed to treat a new symptom or an existing problem, cost share (e.g., copay, coinsurance or deductible) amounts may apply for these additional services.

Earn incentives for preventive care visits

By opting in to participate in our Quality Incentive Program, you can earn incentives for completing breast cancer screenings, cervical cancer screenings and colorectal cancer screenings for your BridgeSpan patients.

Learn more on our provider website: Programs> Quality Incentive Program.

View our preventive care list

View the complete list of preventive services that we cover in English and Spanish, listed for members of all ages, pregnant members and children: **bridgespanhealth.com/member/use/preventive-care-list**.

Member reminders for colorectal cancer, breast cancer and cervical cancer

Eligible members may receive opt-in texts asking whether they would like to receive preventive screening reminders. If the member agrees, they receive a text message emphasizing the importance of the screening and letting them know they might be due and should make an appointment The member can respond to the text to request help scheduling their appointment. The member's request triggers a call from a BridgeSpan care advocate to help the member find a provider or schedule an appointment.

Best practices and member flyers

Our Quality Improvement Toolkit, available on the homepage of our provider website, includes best practices and resources you can share with your patients that address the importance of breast, cervical and colorectal cancer screenings.

Tobacco cessation resources

Tobacco is the leading cause of preventable disease, disability and death in the U.S. Cigarette smoking is linked to diseases of nearly all organs of the body, particularly cardiovascular, metabolic and pulmonary diseases.

We measure the rate at which our members are advised to quit smoking. Currently, our score for this measure is lower than national benchmarks, indicating that this is an area of opportunity for us. Providers play a key role in helping patients decrease tobacco use by introducing and encouraging tobacco cessation tools and resources.

Integrating treatment into the routine clinical workflow and engaging the entire health care team in treatment delivery can make a difference. Here are some suggestions:

- Advise patients to quit.
    - Talk to patients at every visit about their tobacco use. Even brief advice can influence a patient's decision to quit using tobacco.
    - Advise patients that quitting is one of the most important things they can do to improve their health and prognosis.
    - Remind patients that it is never too late to quit using tobacco. Quitting is beneficial at any age.
    - Provide patients support, regardless of their readiness to quit.
- Offer a combination of counseling and medications for treatment.
- Refer patients to additional support (e.g., cessation resources and programs in your health system and community).
- Follow up.
    - Assess your patients' progress over time and provide additional support. It may take several attempts for them to quit using tobacco.
    - Try new strategies (e.g., new medications the patient hasn't tried, medication combinations or new approaches to handling triggers).
    - Provide ongoing support to encourage members to quit.

Resources

Healthwise Knowledgebase flyers

Our Quality Improvement Toolkit, available on the homepage of our provider website, includes Healthwise Knowledgebase flyers in English and Spanish for you to share with your patients. Select Tobacco cessation from the dropdown list.

CDC website

The CDC also has information about tobacco use, including resources to help people quit using tobacco: **cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm**.

Quality Incentive Program (QIP) reminders

QIP payout

Payout for the 2023 program year will be mailed by June 30, 2024.

2024 program year

QRS measures

As a reminder, changes were made to the Quality Ratings System (QRS) measures for the 2024 program. View the updated measures and incentives in the program overview on our provider website: Programs>Quality Incentive Program

New program information and features in the CGMA

We continue to work to improve your user experience in the Care Gap Management Application (CGMA). The following updates have been made for 2024:

- **You will need to opt in** to the 2024 program through the CGMA.
- You can now access **2024 QIP program year gaps and performance data** in the CGMA.
- A new **Gap Status Report** is available. This report is a self-serve option for providers who require a report documenting the status of all gaps, not just open gaps. To run the report, select **Reports** from the main menu in the top right-hand corner, select **Gap Status Report**, and then **Generate Report**.
- **Scorecards have been redesigned** to include structured supplemental data submission (SDS). SDS information is now available on providers' scorecards.
- The **Member Level Gap Report has been redesigned** to include the ability to download multiple reports. The report now includes:
  - Gaps listed by type
  - Gap submission status
  - Appropriate data fields for gaps by gap type
  - Gaps listed in the same order as they appear on the Member Level Gap Screen
- **Reports highlighting risk adjustment care gaps** are now available. Risk adjustment gaps are available as a separate monthly downloadable report in CGMA. This report enhances your overall understanding of each member to ensure all health conditions are being addressed during their visit. **Note**: Risk adjustment care gaps are accessible to offer additional insights to a patient's health and wellbeing. We do not currently offer an incentive for closing risk adjustment care gaps.

Learn more

Do you want to have access to CGMA for yourself or a colleague? Email us at **QIPQuestions@bridgespanhealth.com** to get connected or to learn more about QIP. You can also learn more about the program on our provider website: Programs>Quality Incentive Program.

Resources for you

Use our Self-Service Tool, available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.

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