Provider Quality Care Learning Collaborative

April 2, 2025

Sentara® Health Plans

Welcome to Sentara Health Plans

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Medical Director, Value Based Care/
Provider Network

Purpose

1. Provide a platform to build strong relationships with our practice partners.

2. Share resources and best practices to improve health care outcomes, increase HEDIS measure compliance, close care gaps and increase quality scores.

3. Decrease interruptions caused by multiple outreaches to provider offices from the health plan.

You are welcome to post your questions in the chat.

Agenda

A. Welcome
B. Provider Support (time allotment)
C. The Medical Director's Corner (time allotment)
D. Guest Speaker's Topic (20-30 min)
E. Program Updates
    - Vendor Incentives (time allotment)
    - HEDIS & Target Measures (time allotment)
    - HEDIS/Quality (time allotment)
        - Member Incentives (time allotment)
        - Best Practices (time allotment)
F. Q & A
G. Appendix

The Medical Director’s Corner

Dr. Sinha

Agenda

- DSP Documentation Overview
- DSP for Behavioral Health

DSP= Diagnosis, Status, Plan

Content applies to all insurance types, such as, Medicare, Medicaid, Affordable Care Act (ACA) Exchanges

Accurate and detailed documentation and diagnosis coding are critical to:

- Capturing a complete picture of the total clinical health status/burden of the patient

- Deploying the appropriate healthcare resources to the necessary care needs of a population.

The purpose of this presentation is to briefly discuss suggested documentation and coding concepts related to common risk adjustment **Behavioral Health** conditions/diseases.

Risk adjustment quantifies the overall health status/disease burden of an individual or population to predict expected healthcare costs by calculating a risk score using demographics (age, gender) and medical complexity, defined by provider-reported ICD-10-CM diagnosis codes. Risk scores are utilized to deploy the appropriate healthcare resources necessary to provide benefits and services to patients.

3 Components (DSP) of Diagnoses Documentation

Reflect specificity of medical complexity/disease burden in the documentation

D

Diagnosis – Document established definitive diagnoses.

- In a face-to-face visit (in person or telehealth), state the diagnosis to the highest specificity, including complications/manifestations.
- Utilizing linking terms (due to, with, related to, etc.).
- Avoid use of “history of” for active diagnoses
- **Do not code diagnoses if documenting:**
  - History of
  - Probable or possible
  - Rule Out (R/O)
  - Note: Diagnosis codes should only be coded for active or confirmed conditions

S

Status – Document assessed/evaluated status of diagnoses.

Document response to treatment (not a complete list):

- Stable
- Worsening
- Exacerbation
- Recurrence
- Newly diagnosed
- Improving
- Remission
- Response to treatment

Documentation examples:

Provided as references, not as requirements

P

Plan – Document treatment plan for diagnoses.

- Labs ordered to monitor progression
- Medications adjusted for better control
- Plans for future diagnostic tests
- Follow-up visits with primary care provider (PCP) or specialists
- Observe/watch
- Document time invested in counseling or care coordination

Sentara Health Plans

Dementia

Not a complete list

Vascular dementia (result of infarction of brain due to vascular disease) ICD-10-CM codes: F01.5 – F01.C4

Dementia (non-vascular) ICD-10-CM codes: F02.8 – F03.C4

D - Diagnosis

Document and code established definitive diagnoses:

- Vascular versus non-vascular
  - Code specificity:
    - **Severity**: mild, moderate, severe
    - **Associated conditions**: agitation, anxiety, mood/psychotic/behavioral disturbance
- Dementia (non-vascular):
  - Dementia in other diseases classified elsewhere (F02.8 – F02.C4)
    - Also code underlying condition (e.g., Alzheimer's, Parkinson's)
  - Unspecified Dementia (F03.9-F03.C4)

S - Status

Document response to treatment:

- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Decreased sundowning on current medication (*list medication name*)"
- "Patient reports increased memory loss/problem solving"
- "Family noted decreased agitation since dose increase"
- "Recent imaging shows no change "
- "Able to continue routine tasks with little issue"
- "Noncompliant with treatment"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Drug Use Disorder

Not a complete list

Alcohol: ICD-10-CM codes: F10.10 – F10.99

Opioid: ICD-10-CM codes: F11.10 – F11.99

Cannabis: ICD-10-CM codes: F12.10 – F12.99

Cocaine: ICD-10-CM codes: F14.10 – F14.99

Other Stimulant (e.g., amphetamine, caffeine): ICD-10-CM codes: F15.10 – F15.99

Other psychoactive substance (e.g., antidepressant): ICD-10-CM codes: F19.10 – F19.99

D - Diagnosis

Document and code established definitive diagnoses:

- Substance(s) used
- Code specificity t**ype**:
  - Abuse
  - Dependence
  - Use
- Other code specificity:
  - In remission
  - with intoxication
  - with withdrawal
  - with delusions
  - with hallucinations

S - Status

Document response to treatment:

- Time since last use of substance
- Resources being used
- Avoid use of “history of” for active diagnoses

Documentation examples:

- “Patient denies use for three months, stable on current methadone dose, attends weekly group meetings”
- “Relapse episode resulting in hospitalization, patient agreeable to referral to behavioral health specialist”

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Schizophrenia, Delusional, Psychotic Disorders

Not a complete list

Schizophrenia ICD-10-CM codes: F20.0 – F21

Delusional disorders (e.g., paranoia) ICD-10-CM codes: F22

Brief psychotic disorder ICD-10-CM codes: F23

Schizoaffective disorders ICD-10-CM codes: F25.0 – F29

D - Diagnosis

Document and code established definitive diagnoses:

- Schizophrenia **type**:
  - Paranoid (F20.0)
  - Disorganized (F20.1)
  - Catatonic (F20.2)
  - Unspecified (F20.9)
- Schizoaffective disorders:
  - Bipolar type (F25.0)
  - Depressive type (F25.1)

S - Status

Document response to treatment:

- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Patient denies audio/visual symptoms XX (*list symptoms*) for 6 months, normal affect in office"
- "Recent hospitalization for crisis, Rx (*list medications*) changed, patient reports stable since"
- "Consistent with therapy and support group attendance. Good medication compliance"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Mood Affective Disorders

Not a complete list

Bipolar disorder ICD-10-CM codes: F31.0 – F31.9

Depressive/Depression ICD-10-CM codes: F32.0 – F33.9

Post-Partum Depression ICD-10-CM codes: F53.0

Disruptive mood dysregulation disorder ICD-10-CM codes: F34.81

Unspecified mood affective disorder ICD-10-CM codes: F39

D - Diagnosis

Document and code established definitive diagnoses:

- Bipolar specificity:
  - **Type**: manic, hypomanic, depressed, mixed, in remission
  - **Severity**: mild, moderate, severe
- Depression specificity:
  - **Type:** major depressive, depression
  - **Episodic**: single episode, recurrent, partial remission, full remission
  - **Severity**: mild, moderate, severe

S - Status

Document response to treatment:

- Patient Health Questionnaire-9 (**PHQ-9**) results *(depression screening: 5-9= mild, 10-19= moderate, 20+ or suicidal ideation= severe)*
- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Moderate depressive disorder exacerbated with death of husband, denies suicidal ideation/homicidal ideation at this time"
- "Patient acknowledges pressured speech during visit, same day appointment with therapist for consult and possible cognitive behavioral therapy (CBT) made"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Anxiety and Stress-Related Disorders

Not a complete list

Post-traumatic stress disorder (PTSD) ICD-10-CM codes: F43.10 – F43.12

Adjustment disorder ICD-10-CM codes: F43.20 – F43.29

D - Diagnosis

Document and code established definitive diagnoses:

- Code PTSD **type**:
  - Unspecified (F43.10)
  - Acute (F43.11)
  - Chronic (F43.12)
- Code adjustment disorder **type**:
  - With anxiety (F43.22)
  - With mixed anxiety and depressed mood (F43.23)
  - With disturbance of conduct (F43.24)
  - With mixed disturbance of emotions and conduct (F43.25)

S - Status

Document response to treatment:

- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Patient works with specialist for treatment of chronic PTSD, denies concerns at this time"
- "Newly diagnosed, reports stable on medication and therapy, denies hopelessness, crying, feeling anxious, trouble sleeping, concentration concerns"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Eating Disorders

Not a complete list

Anorexia nervosa (F50.00 – F50.029)

Bulimia nervosa (F50.2 – F50.25)

Other eating disorders (F50.8 – F80.89)

*Eating disorder unspecified (F50.9) - (e.g., **atypical** anorexia, bulimia, feeding, or eating disorder)*

D - Diagnosis

Document and code established definitive diagnoses

- Code specificity **type**:
  - Anorexia nervosa
    - Restricting, binge eating/purging
  - Bulimia
    - Mild, moderate, severe, extreme, in remission (full or partial)

S - Status

Document response to treatment:

- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Patient admits to thinking about restricting diet but denies acting on it over last two weeks"
- "Four episodes last week, patient agrees to return to group therapy"
- "BMI increased to 23, will continue treatment plan"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Adult Personality Disorders

Not a complete list

Paranoid ICD-10-CM codes: F60

Borderline ICD-10-CM codes: F60.3

Obsessive-compulsive ICD-10-CM codes: F60.5

D - Diagnosis

Document and code established definitive diagnoses

- Code adult personality disorder specificity **type**:
  - Schizoid, antisocial, histrionic, avoidant, dependent, narcissistic

S - Status

Document response to treatment:

- Document any active neuroses
- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Decrease in compensatory mechanisms since beginning current medication, continuing with behavioral counseling"
- "Management of uncomfortable emotions getting easier with therapy, learning skills to help manage, sees therapist next week"
- "Still with bouts of impulsiveness, less severe than prior to initiation of cognitive behavioral therapy (CBT)"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Attention-Deficit Hyperactivity Disorders (ADHD)

Not a complete list

ICD-10-CM codes: F90.0 – F90.9

Note*:* codes may be reported for patients of any age

D - Diagnosis

Document and code established definitive diagnoses

- Code ADHD **Type**:
  - Predominantly inattentive (F90.0)
  - Predominantly hyperactive (F90.1)
  - Combined (F90.2)
  - Other type (F90.8)
  - Unspecified type (F90.9)

S - Status

Document response to treatment:

- Stable
- Worsening
- Unable to afford medication
- Medication has not been in stock
- Newly diagnosed
- Improving
- Remission
- Avoid use of “history of” for active diagnoses

Documentation examples:

- “Per mother, teacher notes less impulsive behavior, less easily distracted since starting new dose of medication”

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Behavioral and Emotional Disorders

Not a complete list

ICD-10-CM codes: F91.0 – F98.9

Note*:* Per ICD-10-CM guidelines, codes may be reported for patients of any age. Conditions typically have an onset in childhood or adolescence, but may continue throughout a patient's life or not be diagnosed until adulthood

D - Diagnosis

Document and code established definitive diagnoses

- Code **type**:
  - Oppositional defiant disorder (F91.3)
  - Conduct disorder, unspecified (F91.9)
  - Separation anxiety disorder of childhood (F93.0)
  - Selective mutism (F94.0)
  - Reactive attachment disorder of childhood (F94.1)

S - Status

Document response to treatment:

- Stable
- Worsening
- Unable to afford medication
- Medication has not been in stock
- Newly diagnosed
- Improving
- Remission
- Going to therapy?
- Avoid use of "history of" for active diagnoses

Documentation examples:

- "Less severe bouts of defiance at school seems to not be as easily annoyed per mother, noticing positive changes, not as hurtful toward others"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Suicide Attempt

ICD-10-CM code: (T14.91X_)

D - Diagnosis

Document and code established definitive diagnoses

- Code suicide attempt **type**:
  - Initial encounter (T14.91XA)
  - Subsequent encounter (T14.91XD)
  - Sequela (T14.91XS) – refers to residual or long-term effect

S - Status

Document response to treatment:

- Status of therapy
- Status of medications
- How well patient tolerating treatment

Documentation examples:

- "Patient denies current suicidal ideation, agreeable to continue treatment plan with specialist"

P - Plan

- Each specific evaluated/assessed condition(s) or disease(s) should have a **linked** documented plan
- Medications (changes, discontinue, start, continue with same dose)
  - **Link** medications to the conditions they treat
- Specialist follow-up as appropriate
- Labs or imaging ordered
- Follow-up visit timeline (e.g., follow up in three months)
- Document counseling and/or care coordination provided

Questions?

Medicaid Program Overview

Rosemarie A. Kidd, RN, BSN, MBA/HCM
Manager, Care Coordination Government Services

Lorie Johnson, BSN, RN
Manager, Integrated Care Management Foster Care/Maternity/HR PEDS/HR Infants

Kate Maas, MPH
Manager, Marketing Development & Outreach

Case Management Overview

Rosemarie A Kidd, RN, BSN, MBA/HCM
Manager, Care Coordination Government Services

What is care management?

What does care management look like to you?

What does care management look like to your patients/our members?

We meet members where they are.

Care Management

Care management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options, resources, and services required to meet an individual's physical or behavioral health needs.

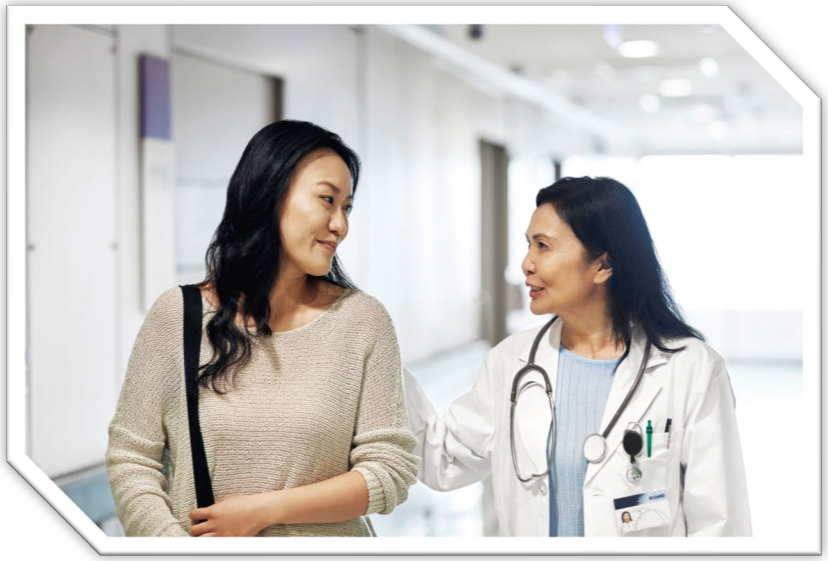
Centering on a member and the member's support system, the care management process is holistic in its approach to the management of the member's situation and that of the member's support system.

The goals of care management are first and foremost focused on improving the member's clinical, functional, emotional, and psychosocial status.

Care managers are responsible for ensuring that they are actively listening to our members to ensure a member-centered plan of care.

Care managers are knowledgeable of resources to assist our patients/members with their individual needs.

Care Management Overview



Sentara Health Plans provides comprehensive care for individuals with complex medical needs through personalized and coordinated management.

Care management seeks to

- Improve quality of care
- Enhance patient outcomes
- Optimize healthcare resources
- Provide personalized, coordinated, and cost-effective care

What do we do to engage members ?

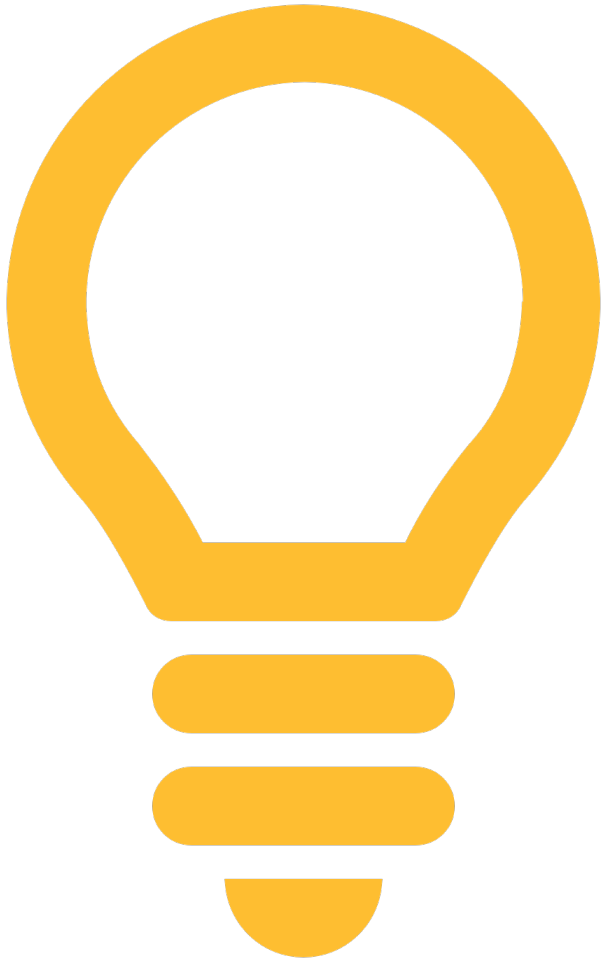
- Engage member – build trust and rapport
- Listen and communicate clearly in laymen’s terms
- Show empathy and compassion
- Encouragement for member to pursue personal health goals
- Advocating for the member – Support system
- Resources – available to member
- Collaboration

Care Management Uses a Health Risk Assessment(HRA)

- Identify needs
- Provides the whole picture
- Helps to stratify and identify members for the appropriate program and level of care
- Health risk assessment (HRA)
- Identify needs
- Provides the whole picture
- Helps to stratify and identify members for the

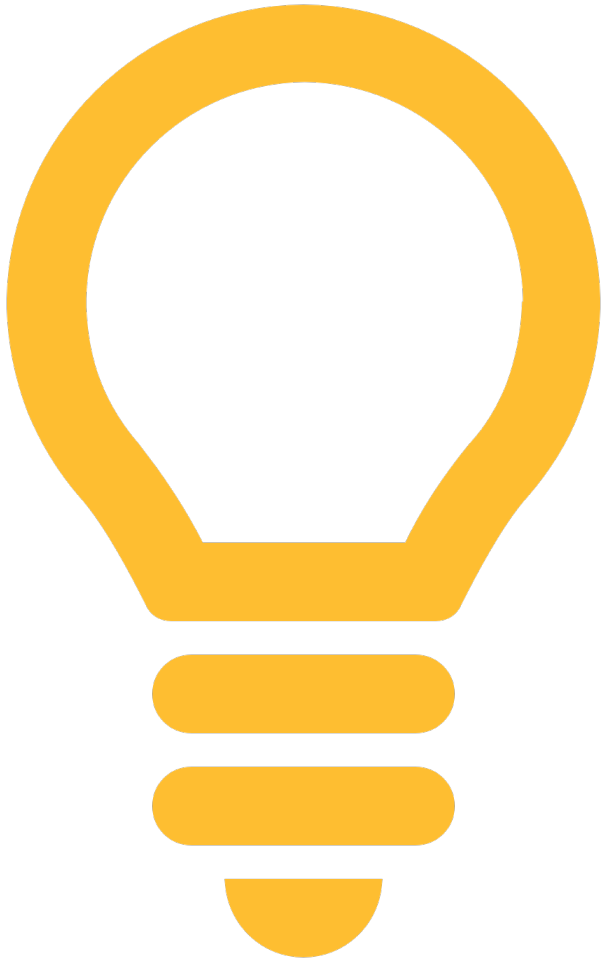
Care Plan

- Care Plans are what we are going to work on with our members.
- The Care Plan is our guide, it is living and changing and should be updated as things change with the member.
- Care Plans should be member-focused.



What is an ICT

- Interdisciplinary Care Team Meeting
- The team, including the member and their caregivers, MDs, social workers from other entities, and anyone who is involved in the plan of care for the member.
- IMPORTANT: The member must be knowledgeable and okay with the people invited to the ICT.



Departments Providing Care Management Services

- Cardinal Care Management
- Welcoming Baby
- Addiction Recovery Treatment Services and Behavioral Health (ARTS/BH)
- Transitions of Care (Medical and Behavioral Health)
- Chronic Disease Management

Care Management Supports Members in Keyways:

Helping	avoid unnecessary emergency department visits, hospital admissions, and readmissions that could have been prevented
Assisting	with the acquisition of durable medical equipment (DME)
Connecting	members with local resources to address social determinants of health
Offering	help with pharmacy-related issues, such as delays in prior authorizations, formulary questions, incorrect prescriptions, or medication renewal delays
Facilitating	connections with specialty providers
Prioritizing	appointments for those experiencing worsening health conditions
Providing	condition-specific interventions and educational resources
Helping	members understand their benefits more clearly

Partnership Post-Discharge aka Transitions of Care

Sentara Health Plans

Service Impacts

- Medical Admissions
- ARTS/BH Inpatient Hospitalizations

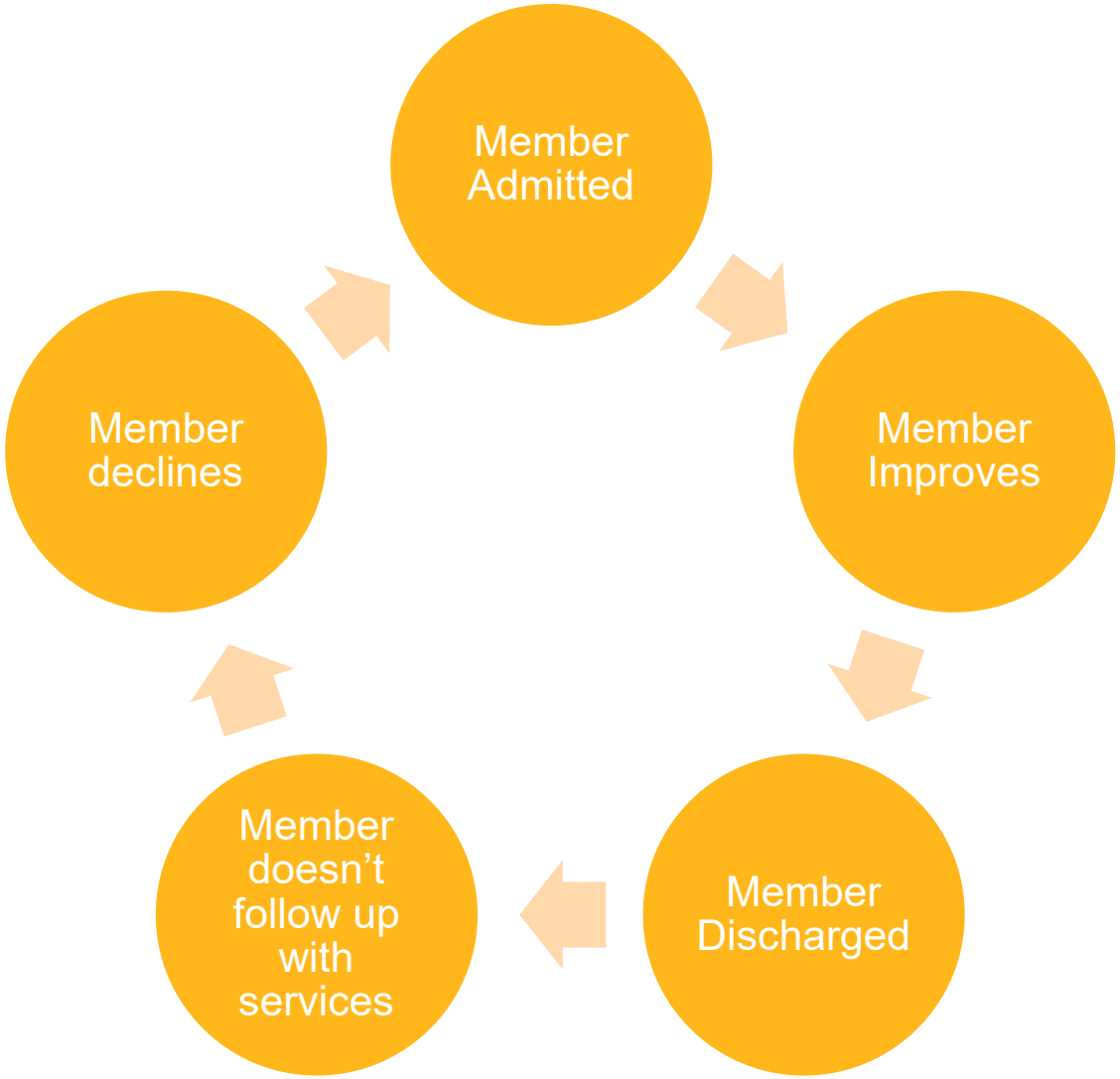
Aftercare Resources

- Therapy
- Medication management
- Community-based services
- Housing referrals
- Food
- Peer support
- Transportation

We Assist Our Members Post-discharge By:

- Completing health risk assessments
- Creating individualized care plans
- Providing education on disease states and wellness
- Evaluating the need for durable medical equipment (DME)
- Assistance with referrals and resources
- Assisting closing gaps in care
- Participating in interdisciplinary care planning

An Unfortunate Cycle



Collaboration Can Break the Cycle

- Provider or delegate participation in Interdisciplinary Care Team (ICT) meetings
- Referrals to Sentara Health Plans' chronic disease management (team for chronic disease support
- Collaboration with Sentara Community Center/Sentara Mobile Clinics to assist members with post-discharge follow-up visits if the PCP is unable to get members in due to a full schedule*
- Behavioral Health/ARTS transition care coordinators are available to participate in treatment team meetings with facility staff.
- Behavioral Health/ARTS transition care coordinators are available for consultation on available resources in the community.

*Services offered by Sentara Health Plans in collaboration with the member's PCP to fill in gaps in care.

Case Management Programs

Lorie Johnson, BSN, RN
Manager, Integrated Care Management Foster Care/Maternity/HR PEDS/HR Infants

Complex Case Management

Focus on High-Risk Members

This program focuses on high-risk individuals facing conditions like COPD, CHF, diabetes, and asthma. With personalized assessment and care planning, registered nurses provide continuous support to enhance patients' health outcomes.

Maternal & Infant Care

Welcoming Baby

Supporting mothers and their infants, this program provides essential resources including prenatal and postpartum care, substance use treatments, and access to community services to ensure healthy outcomes for both baby and mother.

NICU Program

Care managers guide families through their baby's condition, coordinate care, and ensure follow-up with specialists. Partnering with Progeny, they assess the baby's health, family needs, and home setup to create a personalized care plan, supporting a smooth transition home and healthy development.

High Risk Pediatrics

Supports high-risk pediatric members, including those in foster care or receiving EPSDT services. Care managers coordinate with providers, schools, and social services to ensure preventive care, address social needs, support development, and help caregivers navigate complex systems for better long-term outcomes.

Long Term Care Programs

Long Term Services & Supports

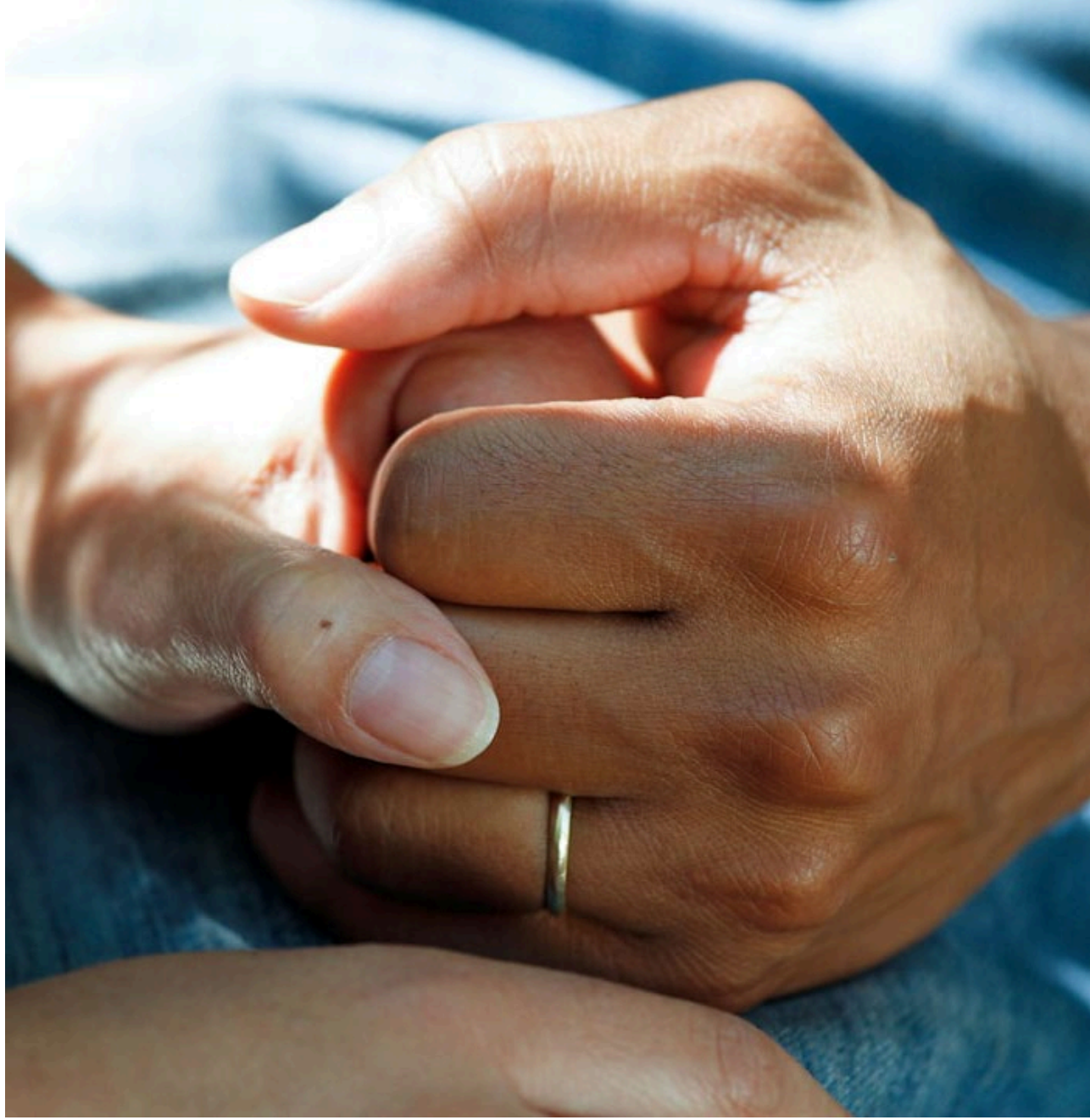
Supports LTSS members with PDN, ventilator care, and personal care services. Case managers promote independence, coordinate care, connect to resources, monitor health, track service effectiveness, and support care transitions to improve quality of life.

Nursing Facility Program

Collaborate with providers and families to create personalized care plans, monitor health, prevent hospital visits, and support care transitions. Connect members to behavioral health, therapy, and community resources to enhance well-being.

Transition of Care

Supports members transitioning from inpatient or nursing facilities by coordinating discharge plans, ensuring medications and follow-up care, providing education, and addressing social needs. Care managers connect members to home health, behavioral health, and community resources to support recovery and prevent readmission.



Maternal/Child Services

Kate Maas, MPH
Manager, Marketing Development & Outreach

Welcoming Baby Maternity Program

One-on-one supportive services from a certified community health worker, maternity case manager, behavioral health care coordinator, ARTS/SUD Pregnant and parenting care coordinator, and peer support.

Screening and referral for internal program support and external resources

Education, community referrals for identified needs

Care planning with identified goals

Consistent outreach and follow-up with members

Doula engagement

WIC, breastfeeding, family planning, LARC, and birth spacing education

Regional and statewide Baby Showers

Maternal/child education virtual series

Referrals to parenting, breastfeeding classes, and lactation services

Postpartum care services and support

SUD/behavioral health screening and coordination for maternal mental health and ARTS

OB Provider Registration Program, early identification of pregnancy from providers

Timeliness of Care Incentives for prenatal and postpartum care

Program Components

Welcoming Baby

One-on-one supportive services from a certified community health worker (outreach representative) – non-clinical team

Screening and referral to maternity case manager/care coordinators-clinical

Education, community referrals for identified needs

WIC, Family planning, LARC, and birth spacing education

Baby showers (virtual and in-person)

Maternal/child education series (classes)

Referrals to parenting, breastfeeding classes, and lactation services

OB Provider Registration Program

Timeliness of Care Incentives

Watch Me Grow

Birth-21 EPSDT Program, timely PCP visits and education

Birth-15-month interval outreach for well child visits and immunizations

Health check at birth and up to 15 months, and to all other identified health plan members in the home

Parenting resources and education as requested

Other

Home visit requests and care management requests as needed

MMHS screenings as needed

Mobile clinic participation (Petersburg & regionally) as needed

WIC and OB Provider engagement

Community event participation

Engagement and referrals to behavioral health care coordination

Program Points and Gift Card Incentives

Initial:
Timely first prenatal visit
Enrollment into Welcoming Baby Program

Postpartum:
Timely postpartum visit

Completion:
40-99 points for Gift Bag
100+ points for Gift Bag and
(for baby) for completing the program

*Disclaimer: “Members may qualify” for incentives. This is determined by the care team if the member meets the qualifications.

Activity	Points
First “timely” prenatal doctor visit, gift card earned	10
Joining the Welcoming Baby program and initial screening, work with a community health worker, gift card earned	10
First Welcoming Baby visit or phone call	10
Additional Welcoming Baby visits or calls	5
OB doctor visit or call	10
Prenatal classes (hospital, community, baby shower, breastfeeding, other)	50
Additional education books, tv, videos (safe sleep, etc.)	20
WIC enrollment	10
Choosing a pediatrician (doctor specializing in children’s health)	10
Postpartum screening, gift card earned	10
6-week “timely” postpartum visit, gift card earned	10

Safe Sleep Program

- Education provided and a “mini-quiz” for members and caregivers and staff to take to stay current on safe sleep practices

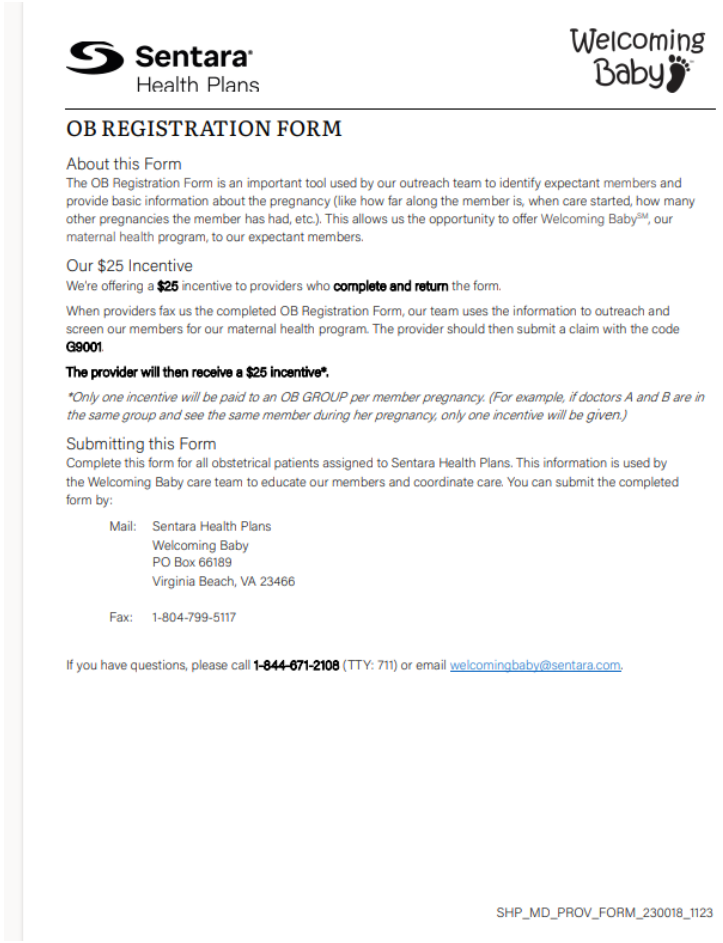
- Partnership with Cribs for Kids
- https://cribsforkids.org/
- https://safesleepacademy.org/safe-sleep-training/

- Provide safe sleep kits and car seat kits to members as needed by the outreach team referral process
  - Offered in Spanish and English
  - Community referrals as needed

Provider Incentive

OB Registration Program Providers are eligible to receive a $25 incentive for referring pregnant patients to the Welcoming Baby member outreach team upon identification of pregnancy.

All providers need to do is fill out an OB Registration Form and fax it to Outreach at: 804-799-5117, and submit a claim using the code G9001.



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Welcoming Baby

OB REGISTRATION FORM

About this Form

The OB Registration Form is an important tool used by our outreach team to identify expectant members and provide basic information about the pregnancy (like how far along the member is, when care started, how many other pregnancies the member has had, etc.). This allows us the opportunity to offer Welcoming Baby℠, our maternal health program, to our expectant members.

Our $25 Incentive

We're offering a **$25** incentive to providers who **complete and return** the form.

When providers fax us the completed OB Registration Form, our team uses the information to outreach and screen our members for our maternal health program. The provider should then submit a claim with the code **G9001**.

The provider will then receive a $25 incentive*.

**Only one incentive will be paid to an OB GROUP per member pregnancy. (For example, if doctors A and B are in the same group and see the same member during her pregnancy, only one incentive will be given.)*

Submitting this Form

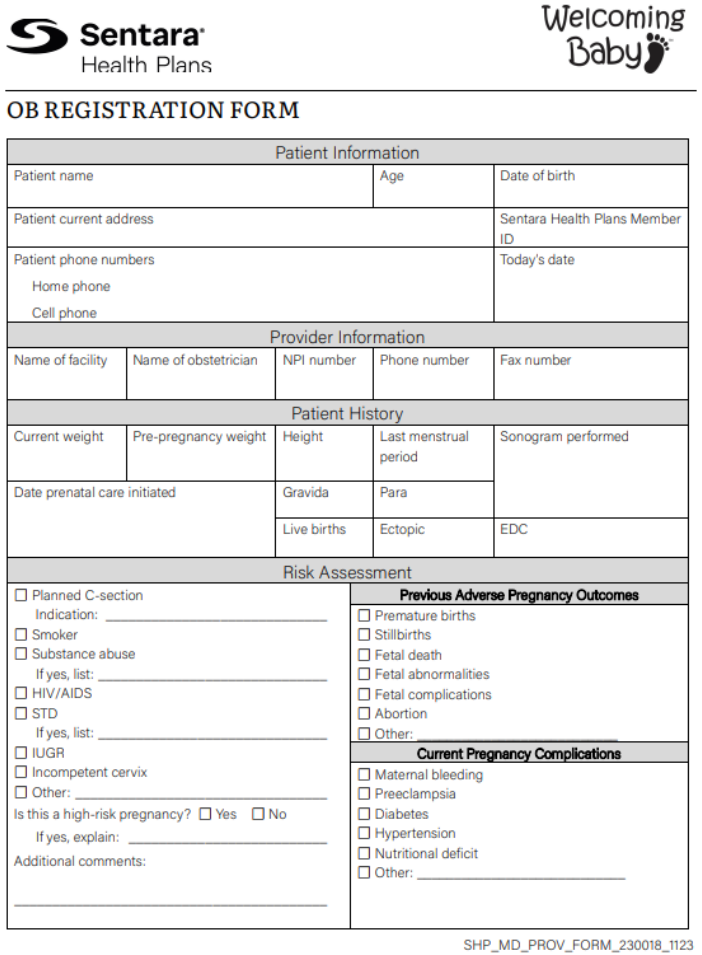
Complete this form for all obstetrical patients assigned to Sentara Health Plans. This information is used by the Welcoming Baby care team to educate our members and coordinate care. You can submit the completed form by:

Mail: Sentara Health Plans
Welcoming Baby
PO Box 66189
Virginia Beach, VA 23466

Fax: 1-804-799-5117

If you have questions, please call **1-844-671-2108** (TTY: 711) or email welcomingbaby@sentara.com.

SHP_MD_PROV_FORM_230018_1123



Sentara Health Plans

Welcoming Baby

OB REGISTRATION FORM

Patient Information				
Patient name			Age	Date of birth
Patient current address				Sentara Health Plans Member ID
Patient phone numbers Home phone Cell phone				Today's date
Provider Information				
Name of facility	Name of obstetrician	NPI number	Phone number	Fax number
Patient History				
Current weight	Pre-pregnancy weight	Height	Last menstrual period	Sonogram performed
Date prenatal care initiated		Gravida	Para	
		Live births	Ectopic	EDC

Risk Assessment

- ☐ Planned C-section
  Indication: _____
- ☐ Smoker
- ☐ Substance abuse
  If yes, list: _____
- ☐ HIV/AIDS
- ☐ STD
  If yes, list: _____
- ☐ IUGR
- ☐ Incompetent cervix
- ☐ Other: _____

Is this a high-risk pregnancy? ☐ Yes ☐ No

If yes, explain: _____

Additional comments: _____

Previous Adverse Pregnancy Outcomes

- ☐ Premature births
- ☐ Stillbirths
- ☐ Fetal death
- ☐ Fetal abnormalities
- ☐ Fetal complications
- ☐ Abortion
- ☐ Other: _____

Current Pregnancy Complications

- ☐ Maternal bleeding
- ☐ Preeclampsia
- ☐ Diabetes
- ☐ Hypertension
- ☐ Nutritional deficit
- ☐ Other: _____

SHP_MD_PROV_FORM_230018_1123

Aeroflow Breastpumps

Preferred Pump Provider Program

Free breast pumps to members

Pump and lactation education

Member referrals

Contact:

1-844-867-9890 (TTY: 711)

aeroflowbreastpumps.com

MCH Outreach Events

Baby Shower Program

- Regional baby showers
- Offered in person and virtually
- Education, gifts, games, raffles & community presenters
- Hospital tours
- Baby shower locations and registration
- Baby Showers | Sentara Health Plans

Maternal Child Health Education Series

- Virtual, online classes are available to all
- Education and resources highlighted on various health topics
- Mental health, postpartum support, bereavement and loss, parenting education, and fatherhood support
- MCH class topics and registration
- Maternal and Child Health | Sentara Health Plans

Maternal/Child Health Program

- **Certified Community Health Worker**
- Adjunct Support
- Non-clinical
- Unlicensed
- High functioning

Liaison for health plan, internal care management and membership

Direct member contact:

- Phone: 1-844-671-2108
- Email: welcomingbaby@sentara.com
- Fax: 804-799-5117

Certified Community Health Workers

- Member Outreach Team
  - Certified Community Health Workers
    - Live in the service area
    - Supply culturally competent interventions
      - Telephonic & Face-to-face
    - Address Health-Related Social Needs
      - Conduct Risk Screenings
    - Link members directly to services
    - Link members directly to CM/BH
    - Advocate for individuals and communities
    - Actively identify gaps
    - Build Relationships
    - Health education based on established standards of care

Vendor Initiatives

Lucas White, PMP, CSM

Project Management Manager, Clinical Shared Services

Active Vendors supporting Member Health

Retina Labs

Brief Description of Services:
Supports members with in-home screening for diabetic retinopathy and in-home bone density screening after a fracture.

Of Note:
Ship to member test kits for A1c, Kidney Function and Fecal immunochemical tests will be provided by our Sentara Lab partner, **Quest Diagnostics,** soon. These were previously provided by Retina Labs

Performance Metrics:
Care Gap Closure

Dario

Brief Description of Services:
Provides members who have a cell phone a smart app compatible glucose monitor and multiple tools within the app to help them successfully manage diabetes.

Of Note:
Inclusion criteria recently been modified to provide services to all Members with a Type II Diabetes diagnosis, subject to defined exclusions.

Members are no longer disenrolling at the end of 12 months if they have an A1C value below 7.9.

Performance Indicators:
Members Eligible/Members Enrolled

Onduo

Brief Description of Services:
Onduo is like Dario but supports our commercial members.

Of Note:
Diabetes management support like Dario, but for opted-in Commercial plan Members. Onduo provides in-app consultations with vendor employed physicians and submits claims for their services.

Performance Metrics:
Care Gap Closure, Member Engagement

Active Vendor cont.

Ovia

Brief Description of Services:
Provides members with education and coaching on fertility, pregnancy, and parenting-related topics.

Performance Metrics:
Reduction in NICU stays; improvement of prenatal and postnatal rates

Pfizer/Televox

Brief Description of Services:
Free postcard vaccine reminder campaign

Performance Metrics:
Vaccination compliance rates

Koda

Brief Description of Services:
Provides advanced care planning through digital and 1:1 platforms.

Performance Metrics:
Reduced cost of care

Vendors in the pipeline for 2025

HealthMap

Brief Description of Services:
Lowers medical cost by developing disease-specific, vendor-led programs for members with Chronic Kidney Disease and End Stage Renal Disease.
When this goes live it will assist members with tools and education to better manage their condition.

Performance Metrics:
Cost of Care, Member Outcomes, Medication Adherence

Upfront

Brief Description of Services:
Utilize AI and Behavioral Nudging to support better health for members and patients through person-centered communications

Performance Metrics:
HEDIS, Stars, PWP

HEDIS & Target Measures

Sandra L. Spencer, MSN, RN
Team Coordinator, Quality Improvement HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures, developed and maintained by the National Committee for Quality Assurance (NCQA), designed to ensure that consumers have the information they need to reliably compare the performance of managed health care plans (MCO). HEDIS measures are derived from a number of health issues including cancer, heart disease, obesity, and diabetes. Some other measures are related to prenatal care, well child visits, and immunizations.

HEDIS Hybrid Measure Issues and Actions for Compliancy

Measure	Issues Impacting Compliance	Actions to take
All Measures	• Medical records do not have a **name** and **DOB or MRN** on every page, so oftentimes unable to verify that the medical record belongs to the same member • Hand-written documentation in medical records is often difficult to interpret	• Need name and DOB or MRN clearly documented on every page • Switch from hand-written documentation to an electronic (typed) version
BPD/CBP • Blood Pressure-Diabetes • Controlling High BP	• Lack of documentation for BP re-takes when BP elevated • Lack of documentation of BP value or "average" value during a telehealth or telephone visit	• Recheck BP if > 140 and/or >90, document original and retake • During telehealth visits document BP taken by member with a digital device or average BP (no ranges)
CIS • Childhood Immunization Status	• Immunizations given after second birthday • Missing documentation of complete series of immunizations given	• Keep an eye on when the second birthday will occur and coordinate the visits so that all vaccines will occur by two years of age • Inquire where immunization occurred if not within your records
COA • Care of Older Adults	• Functional status assessment not including enough ADLs/IADLs • Medication Review- Not including the second code for a medication list	• Need to document at least five ADLs and/or four IADLs • Need 2 codes to close this gap. One for the medication review and one for the actual medication list
EED • Eye Exam - Diabetes	• No documentation of details on last diabetic eye exam	• Need documentation of retinal/dilated eye exam by an eye care professional (who the professional was), the date and the results
PPC • Prenatal/Postpartum Care	• Lack of pregnancy diagnosis for confirmation of pregnancy visit with PCP	• Need positive pregnancy test, as well as diagnosis of pregnancy
TRC • Transitions of Care	• No documentation of when provider is notified of member's hospital admission and/or when provider receives member's DC summary • Follow up after inpatient admission- lack of documentation stating admission or inpatient stay along with hospitalization dates	• Need documentation of the date when the provider is notified of the member's inpatient admission and when the DC summary is received, along with the provider's signature or initials, within two days after the admission and discharge dates • Include documentation that references visit for "hospital follow-up", "admission", "inpatient stay", along with dates of admission

What's' New for HEDIS 2025

New Measure:

Blood Pressure Control for Patients with Hypertension (BPC-E)

The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was <140/90 mm Hg during the measurement period.

Intent:

This new measure has a component that captures members with hypertension who may not have been included in the denominator for Controlling Blood Pressure (CBP).

- BPC-E is an administrative measure vs CBP, which is a hybrid measure (includes medical record review)
- The denominator includes a pharmacy data method with a hypertension diagnosis

Revised/Retired Measures:

Eye Exam for Patients With Diabetes:

NCQA retired the Hybrid Method; this measure is now reported using the **Administrative Method only**.

Care of the Older Adults (COA)

NCQA has retired the **Pain Assessment** indicator from the COA measure

HEDIS Administrative Measures

Child and Adolescent Well-Care Visits (WCV)

Youth 3-21 years of age during the measurement year (2025)

Looking for comprehensive well visit with either a PCP or 0B/GYN during the measurement year

NCQA Recommended Codes : 99381-99385, 99391-99395; 99461

Use Of Imaging Studies For Low Back Pain (LBP)

Members ages 18-75 with primary diagnosis of low back pain who did not have an imaging study (plain Xray, MRI, CTI within 28 days of the diagnosis.

The measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain. The purpose of this measure is to assess whether imaging studies are overused to evaluate patients with low back pain.

NCQA Recommended Codes: M47.26-M47.28, M47.816-H47.818, M47.896-M47.898, M48.061-M48.07, H48.08, H51.16-M51.17, M51.26, M51.27-M51.36, M51.37, M51.86. M51.87, M53.2X6-M53.2X8, M53.88, M54.16-M54.9, M99.03-M99.84, S33.100A-S33.9XXA, S39.002A-S39.92XS

Kidney Health Evaluation for Patients With Diabetes (KED)

Commercial/ Medicaid/ Medicare- members 18-85 years of age with Diabetes (type 1 and type 2) who received a kidney health evaluation as defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) performed in the measurement year(2025)

NCQA Recommended Codes: (eGFR) 80047-80048, 80050, 80053, 80059 or 82565; (uACR) 82043, 82570) 82043, 82570

Osteoporosis Management in Women Who Had a Fracture (OMW)

Women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

NCQA Recommended Codes: (Bone Mineral Bone Density Tests) 76977-77078, 77080, 77081, 77085-77086: (Osteoporosis Medications) HCPCS: J0897,J1740, J3110, J3111, J3489

Breast Cancer Screening (BCS-E)

Percentage of women 50-74 who had a mammogram to screen for breast cancer on or between October 1 two years prior to and December 31 of the measurement year.

The purpose of this measure is to evaluate primary screening through mammography. Do not count biopsies, breast ultrasounds or MRIs for this measure.

NCQA Recommended Codes: 77061-77063, 77065-77067

HEDIS/Quality

Jacquie Chamberland, M.Ed., RN
Quality Improvement Coordinator HEDIS

EMR Access

Do you struggle with HEDIS season?

Our HEDIS team can pull the records for you by granting us EMR access.

How You Can Assist in Closing Gaps in Care

- What is the best process for retrieving records to close gaps in care for HEDIS 2025?
  - EMR Access
  - Email/Fax
  - Portal
- **Using NCQA Recommended Billing Codes**
- **Make appointments available for members who may be calling you**
- Members will be incentivized for closing gaps in care
- HEDIS Fax number to send medical records: 1-844-518-0706

Questions?

- Please call a member of the HEDIS team at 757-252-7571.

Sentara® Health Plans

Quality Team Contacts

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Quality HEDIS Team Coordinator

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axhudson@sentara.com

Member Incentives

Sentara Health Plans Medicaid Member Incentives 2025

Please contact Asha Tillery,

QHC Team Coordinator, with any questions.

Email: axhudson@sentara.com

Phone: 804-613-6547

Sentara Health Plan MEDICAID Incentives	Reward Amount	Qualifying Members
Breast Cancer Screening	$15	Women 40-74 years of age
Cervical Cancer Screening	$15	Females 21- 64 years of age
Child and Adolescent Well Care	$15	Children turning 3 through 21 in the measurement year
Childhood Immunizations	$15	Children turning 2 in the measurement year
Chlamydia Screening in Women	$10	Females 16-24 years of age
Colorectal Cancer Screening	$15	Members 45-75 years of age
Comprehensive Diabetes: ▪ Eye Exam- Retinal or Dilated ▪ Kidney Health Evaluation ▪ Hemoglobin A1C Control ▪ BP Control	 $15 $10 $15 $10	Members 18-75 years of age with diabetes (Type 1 and Type 2)
Controlling High Blood Pressure	$10	Members 18-85 years of age with Diagnosis of Hypertension
Flu Vaccination	$10	Members 18-64 years of age
Immunizations for Adolescents	$15	Children turning 13 in the measurement year
Lead Screening	$10	Children turning 2 in the measurement year
Prenatal and Postpartum Care ▪ Initial Assessment ▪ Physician Visit ▪ Postpartum Visit ▪ Postpartum Assessment	 $15 $20 $15 $15	Pregnant Members who deliver a live birth between October 8, 2024, and October 7, 2025
Weight Assessment and Counseling for Nutrition and Physical Activity	$10	Children turning 3 through 17 in the measurement year
Well Care First 30 Months	$15	Children turning 30 months in the measurement year

2025 Medicare Healthy Rewards Program

Preventive screening, exam, or vaccine	Reward	Who is eligible?
Annual wellness visit	$100	All members
Combined with annual physical exam* NEW	+$20	
Breast cancer screening	$20	All members
Colorectal cancer screening	$20	All members
COVID-19 vaccine NEW	$10	All members
Diabetic A1c test	$15	All members with diabetes
Diabetic eye exam	$20	All members with diabetes
Diabetic kidney test	$10	All members with diabetes
Falls risk assessment NEW	$15	All members
Flu vaccine NEW	$10	All members
In-home assessment	$25	All members
RSV vaccine NEW	$10	All members

*The Annual Physical Exam must be completed at the same appointment as the Annual Wellness Visit to earn the additional $20.

- *One per calendar year*
- *Receipt is 8-10 weeks after we receive the claim*
- *May not be converted to cash or to buy tobacco, alcohol, firearms*
- *2025 rewards funds are available for members to spend until March 31, 2026*

Pink Promise

Sentara Individual & Family Health Plans members who receive a breast cancer screening mammogram in 2025 can also earn a **$25 wellness reward.**

Eligibility:

1. Female
2. Sentara Individual & Family Health Plans member
3. 40-74 years old
4. Receive a breast cancer screening mammogram between January 1, 2025 and December 31, 2025

Busy schedule? Visit a Sentara mobile mammography van in your neighborhood. No physician's referral required.

2025 Mammograraphy Van Schedule

Sentara mobile mammography vans do not require a physician's referral. Simply provide your primary care physician's contact information.

Mammography Van Schedule

April 7, 2025- Rockingham Health Center, 13737 Spotswood Trail, Elkton, VA 22827

April 8, 2025- Love the Tree of Life Clinic, 2016 25th Street, Newport News, VA 23607

April 8, 2025- Bridgewater Health Center, 100 Health Center Drive, Bridgewater, VA 22812

April 11, 2025- Plaza Annex, 641 Carriage Hill Road, Virginia Beach, VA 23452

April 14, 2025- Sentara RMH Timber Way, 13892 Timber Way, Broadway, VA 22815

April 18, 2025- Hampton Roads Community Health, 4575 Shore Drive, Norfolk, VA 23518

April 21, 2025- Rockingham Health Center, 13737 Spotswood Trail, Elkton, VA 22827

April 26, 2025- That Life Fitness, 1305 W Ehringhaus Street, Elizabeth City, NC 27909

Best Practices

Care Gap Closure Best Practices

1. Use appropriate documentation and correct coding
2. Maintain appointment availability for patients with recent emergency department visits
3. Amplify multiple HEDIS measures by educating on the importance of effective and consistent healthcare
4. Provide personalized messages for appointment reminders and follow-up appointments
5. Encourage follow-up visits via telehealth when appropriate to the principal diagnosis
6. Submit claims and encounter data timely

Provider Support

Ebony Franklin
Network Relations Manager

How Can Sentara Health Plans Help You?

1. Sharing Care Gap Reports frequently
2. Financial Incentives available for members
3. Scheduling Member Appointments
4. Providing Educational Resources and Documents
5. Support Visits

Support Visits

- Outreach will be made to coordinate a site visit or virtual visit within the coming months
- An opportunity to review your individual Care Gap Report
- Review EMR access options
- Medical record review
- Identify and address questions/barriers

To request a support visit sooner, please contact me at emfrankl@sentara.com.

Sentara Health Plans

Resources

Care Gap Closure Resources **Value-Based Care | Providers | Sentara Health Plans**

Annual Wellness visit and Annual Routine Physical Exam

Comprehensive Care Gap Documentation Guide 2025

Provider News. Provider News | Providers | Sentara Health Plans | Sentara Health Plans ***most recent provider alerts and Newsletter***

Sentara Mobile Care Get the Sentara Health Plans Mobile App | Members | Sentara Health Plans *for members to get access to their health plan information*

Provider Tool Kit Provider Toolkit | Providers | Sentara Health Plans

Provider Manuals Provider Manuals and Directories | Providers | Sentara Health Plans

Medical Policies Medical Policies | Providers | Sentara Health Plans | Sentara Health Plans

Prior Authorization Tool to review if authorization is required Search PAL List: Sentara Health Plans

Jiva Tutorial / Demo **JIVA Resources | Providers | Sentara Health Plans | Sentara Health Plans**

Billing and Claims Billing and Claims | Providers | Sentara Health Plans

Upcoming Provider Education Opportunities - 2025

Register for our Upcoming Webinars

- **Provider Quality Care Learning Collaborative: 12 - 1 p.m.**
  - April 2
  - May 7
- **Let's Talk Behavioral Health: 1 - 2 p.m.**
  - May 13
  - August 12
- **Sentara Health Plans Spotlight: 10 - 11 a.m.**
  - September 23
- **Claims Brush Up Clinics: 1 - 2 p.m.**
  - June 18

Provider Newsletter Schedule

Edition
Winter (January)
Spring (April)
Summer (July)
Fall (October)

Past issues are available on the provider webpages sentarahealthplans.com/providers/updates.

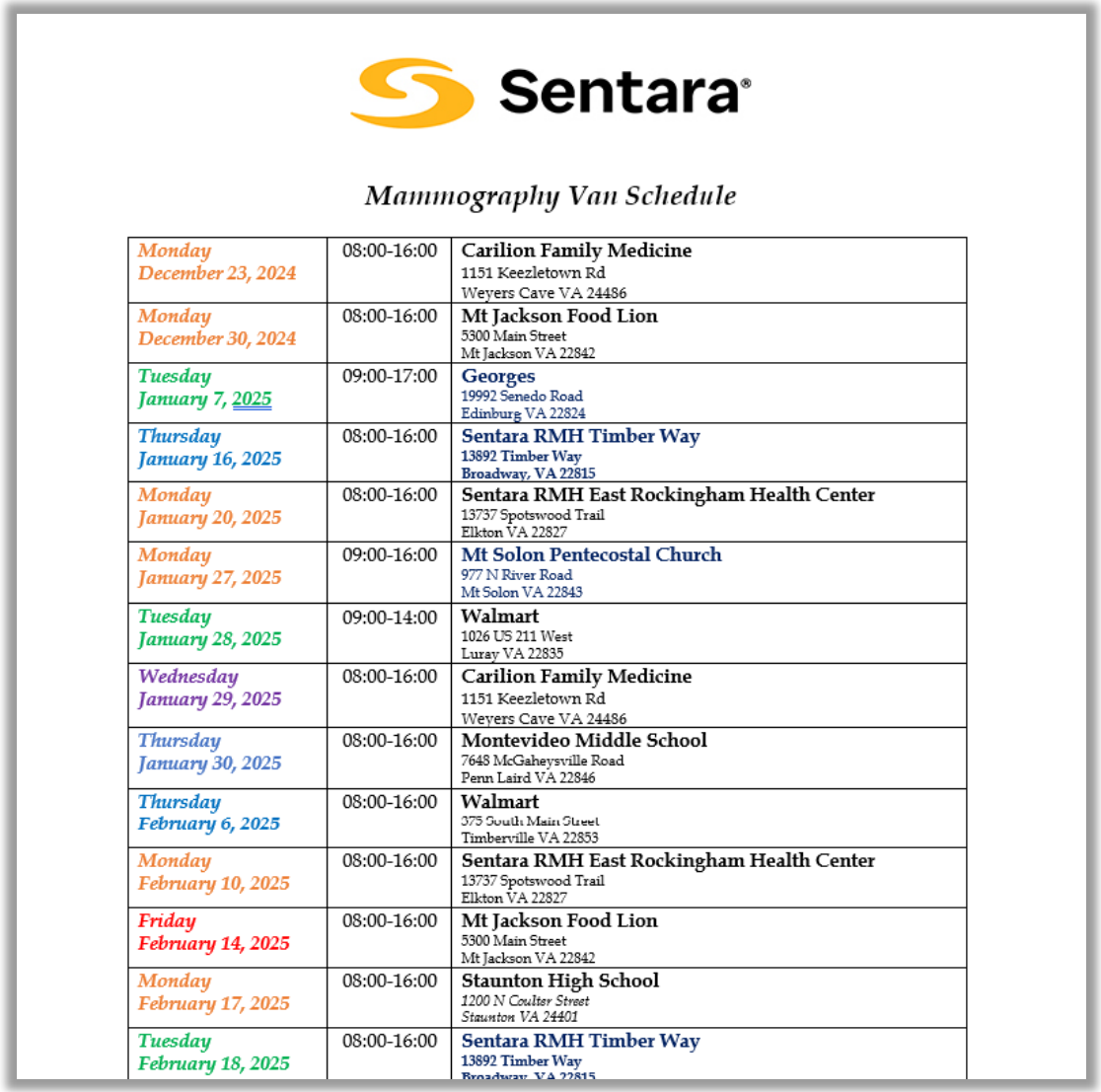
Register for Upcoming Webinars as well as view previous webinars here: sentarahealthplans.com/providers/webinars.

Questions?

Sentara Health Plans

Appendix

Mobile Mammography Van Schedule 2025



Sentara

Mammography Van Schedule

Monday *December 23, 2024*	08:00-16:00	**Carilion Family Medicine** 1151 Keezletown Rd Weyers Cave VA 24486
Monday *December 30, 2024*	08:00-16:00	**Mt Jackson Food Lion** 5300 Main Street Mt Jackson VA 22842
Tuesday *January 7, 2025*	09:00-17:00	**Georges** 19992 Senedo Road Edinburg VA 22824
Thursday *January 16, 2025*	08:00-16:00	**Sentara RMH Timber Way** 13892 Timber Way Broadway, VA 22815
Monday *January 20, 2025*	08:00-16:00	**Sentara RMH East Rockingham Health Center** 13737 Spotswood Trail Elkton VA 22827
Monday *January 27, 2025*	09:00-16:00	**Mt Solon Pentecostal Church** 977 N River Road Mt Solon VA 22843
Tuesday *January 28, 2025*	09:00-14:00	**Walmart** 1026 US 211 West Luray VA 22835
Wednesday *January 29, 2025*	08:00-16:00	**Carilion Family Medicine** 1151 Keezletown Rd Weyers Cave VA 24486
Thursday *January 30, 2025*	08:00-16:00	**Montevideo Middle School** 7648 McGaheysville Road Penn Laird VA 22846
Thursday *February 6, 2025*	08:00-16:00	**Walmart** 375 South Main Street Timberville VA 22853
Monday *February 10, 2025*	08:00-16:00	**Sentara RMH East Rockingham Health Center** 13737 Spotswood Trail Elkton VA 22827
Friday *February 14, 2025*	08:00-16:00	**Mt Jackson Food Lion** 5300 Main Street Mt Jackson VA 22842
Monday *February 17, 2025*	08:00-16:00	**Staunton High School** *1200 N Coalter Street* *Staunton VA 24401*
Tuesday *February 18, 2025*	08:00-16:00	**Sentara RMH Timber Way** 13892 Timber Way Broadway, VA 22815

sentarahealthplans.com/en/providers/value-based-care

Programs for Members

Sentara Mobile Care

Sentara Mobile Mammography Van Schedule

Sentara Health Plans Phone Numbers

Resources	
Care Management	DL_SHP_MCM_MGR@sentara.com 757-552-8360 or toll-free 1-888-512-3171 Available Monday through Friday, 8:00 a.m. – 5 p.m.
Behavioral Health	757-552-7174 or 1-800-946-1168
Welcoming Baby	Monday-Friday, 8 a.m.-5 p.m. Phone: 1-844-671-2108 (TTY: 711) Email: welcomingbaby@senatar.com
24/7 Nurse Advice Line	Medicaid: 833-933-0487 Calling the 24/7 Nurse Advice Line puts the member in contact with a professional nurse who can assess your medical situation, advise you as to where to seek care, and if possible, suggest self-care options until you can see your primary care provider (PCP). In any life-threatening emergency situation, always go to the closest emergency room or call 911.
Behavioral Health Crisis Line	Toll-free. Available 24 hours a day, 7 days a week. 1-833-686-1595 (TTY: 711)
Member Services	757-552-7401 or toll-free at 1-877-552-7401 Available Monday through Friday, 8:00 a.m. – 5 p.m. members@sentara.com

Sentara Health Plans Vendor Partnerships

Resources	
DentaQuest (Dental Care)	Contact a DentaQuest representative at **1-888-912-3456** to find a dentist and learn more about the new dental benefit for adults enrolled in Medicaid.
VSP (Vision)	Members age 21 and up get one eye exam and $100 for frames each year. Must use an in-network provider. Contact: **1-844-453-3378 (TTY: 711)** or online.
Assurance Wireless (Cell Phones)	Approved member households can get a free smartphone. The plan includes: • a free smartphone with unlimited texts, 350 minutes, and free calls to SHP • free unlimited wireless, texts, minutes, and hotspot (one per household) Contact: Assurance Wireless at **1-888-321-5880** or online
Omada (Diabetes Prevention)	Members most at risk for developing diabetes are invited into a special program. It features health coaching and a weight management program. Watch this video to see how the program works. Not a FAMIS or managed long term services and supports added benefit. Contact: Member Services at **1-800-881-2166 (TTY: 711) to be connected with Health and Prevention.**
Transportation (Modivcare)	Members call to schedule pick up for "will call" return trips: • **Members call 1-877-892-3986** • M-F 6 a.m.- 6 p.m. • Closed Saturdays, Sundays and national holidays

Medicare Only Measures

Measure	Age/Measure Eligibility Requirements	Documentation Needed
COL-E – Colorectal Cancer Screening (**Admin measure starting 2025)** ★ CMS Stars Measure	Members 45-75 years of age during the measurement year (2025)	Date of one of the following colorectal cancer screenings was performed: • FOBT during the measurement year (2025) • FIT-DNA (2023 through 2025) • Flexible sigmoidoscopy (2021 through 2025) • CT colonography (2021 through 2025) • Colonoscopy (2016 through 2025)
COA - Care for Older Adults ★ CMS Stars Measure	Members 66 years of age or older during the measurement year (2025)	Evidence of **all** three of the following from a visit during 2025: • **Medication Review** Presence of a medication list and indication that the list was reviewed by a prescribing practitioner • **Functional Status Assessment** Notation that ADLs (minimum of four IADLs or five ADLs) were assessed • **Pain Assessment** Notation of at least one pain assessment, ie: numeric pain scale, or pain assessment in Review of Systems
TRC - Transitions of Care ★ CMS Stars Measure	Members 18 years of age and older who had an inpatient discharge on or between January 1 and December 1 of the measurement year (2025)	**Any** medical record that is accessible to either the member's PCP or ongoing care provider • **Notification of Inpatient Admission** Notice must include date of receipt plus acknowledgement on the day of admission through 2 days following admission • **Receipt of Discharge Summary** Evidence of a discharge summary or form, including date of receipt plus acknowledgement on day of discharge through 2 days after discharge • **Patient Engagement** Evidence of a patient engagement within 30 days after discharge (outpatient visit, including office visits, home visits, telephone visit or telehealth visit) • **Medication Reconciliation** Documentation that discharge medications were reconciled with most recent medication list in the outpatient medical record

Childhood Measures

Measure	Age Requirements	Documentation Needed
CIS - Childhood Immunization Status	Children by two years of age	• 4 DTaP • 3 IPV • 3 HIB • 3 Hep B • 4 PCV • 1 MMR • 1 Hep A • 1 VZV • 2 flu • 2-3 RV
LSC – Lead Screening	Children by two years of age	• At least one lead capillary (finger stick) or venous (venous puncture) blood test • Clear evidence of the date the test was performed • The actual result or finding
IMA – Immunizations for Adolescents	Adolescents 9 - 13 years of age 10 - 13 years of age 11 - 13 years of age	• 2 HPV at least 146 days apart • 1 Tdap • 1 Meningococcal
WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Child & Adolescents 3 - 17 years of age	Ht/Wt/BMI% Counseling for nutrition and physical activity

Adult Measures

Measure	Age/Measure Eligibility Requirements	Documentation Needed
CBP – Controlling High Blood Pressure ★ CMS Stars Measure	Adults 18- 85 years of age with 2 diagnoses of HTN	• Last blood pressure of the year (2025) from office visits/telephone/e-visits/virtual check-ins • Both systolic and diastolic readings must be < 140/90
Diabetes ★ CMS Stars Measure	Adults 18-75 years of age with the diagnosis of type 1 or type 2 diabetes	
• BPD – Blood Pressure Control for Patients With Diabetes		• Last blood pressure of the year (2025) from office visits/telephone/e-visits/virtual check-ins • Both systolic and diastolic readings must be < 140/90
• EED – Eye Exams for Patients With Diabetes		• A retinal or dilated diabetic eye exam by an eye care professional, the date and the results (2024 – 2025)
• GSD – Glycemic Status Assessment for Patients With Diabetes *(formerly HBD)*		• Date and result of the most recent A1c lab of the year (2025).
CCS – Cervical Cancer Screening	Women 24- 64 who had either a pap smear/pap + hrHPV co-testing/hrHPV testing	• Cytology results of pap smear (2022-2025) • Cytology results pap/hrHPV co-testing (2021-2025) • Cervical hrHPV testing (2021-2025)
PPC – Prenatal and Postpartum Care	Live births on or between October 8, 2024, and October 7, 2025	• References to pregnancy or being pregnant • Basic OB exam • Office visit + screening labs or US

HEDIS Hybrid Measure Issues and Actions for Compliancy

Measure	Issues Impacting Compliance	Actions to take
ALL MEASURES	• Medical records do not have a **name** and **DOB or MRN** on every page, so oftentimes unable to verify that the medical record belongs to the same member • Hand-written documentation in medical records is often difficult to interpret	• Need name and DOB or MRN clearly documented on every page • Switch from hand-written documentation to an electronic (typed) version
BPD/CBP	• Lack of documentation for BP re-takes when BP elevated • Lack of documentation of BP value or "average" value during a telehealth or telephone visit	• Recheck BP if > 140 and/or >90, document original and retake • During telehealth visits document BP taken by member with a digital device or average BP (no ranges)
CIS	• Immunizations given after seconnd birthday • Missing documentation of complete series of immunizations given	• Keep an eye on when the seconnd birthday will occur and coordinate the visits so that all vaccines will occur by two years of age • Inquire where immunization occurred if not within your records
COA	• Lack of documentation of a pain assessment • Functional status assessment not including enough ADLs/IADLs	• Include a pain scale (especially with the vital signs is helpful) • Need to document at least five ADLs and/or four IADLs
EED	• No documentation of details on last diabetic eye exam	• Need documentation of retinal/dilated eye exam by an eye care professional (who the professional was), the date and the results
PPC	• Lack of pregnancy diagnosis for confirmation of pregnancy visit	• Need positive pregnancy test, as well as diagnosis of pregnancy
TRC	• No documentation of when provider is notified of member's hospital admission and/or when provider receives member's DC summary • Follow up after inpatient admission- lack of documentation stating admission or inpatient stay along with hospitalization dates	• Need documentation of the date when provider is notified of member's inpatient admission and when DC summary is received along with provider signature or initials • Include documentation that references visit for "hospital follow-up", "admission", "inpatient stay" along with dates of admission

Breast Cancer Screening (BCS)

- For women ages 50-74 who had a mammogram to screen for breast cancer on or between October 1 two years prior to and December 31 of the measurement year.
- The purpose of this measure is to evaluate primary screening through mammography.
- Do not count biopsies, breast ultrasounds or MRIs for this measure.

Child and Adolescent Well-Care Visits (WCV)

HEDIS Administrative Measure

For members aged 3-21 years of age during the measurement year (2025).

- Looking for a comprehensive well visit with either a PCP or OB/GYN during the measurement year.

Childhood Immunization Measure

MEASURE	SCREENING, TEST, OR CARE NEEDED
***Childhood Immunization** Children who turn 2 years old during the measurement year (2024) Vaccines must be completed **on or before the second birthday.** **CPT Codes:** Dtap: 90697, 90698, 90700, 90723 IPV: 90697, 90698, 90713, 90723 HiB: 90644, 90647, 90648, 90697, 90698, 90748 Pneumococcal Conjugate: 90670, 90671 Rotavirus (2 dose): 90681 Rotavirus (3 dose): 90680 VZV: 90710, 90716 MMR: 90707; 90710 Hepatitis A: 90633 Hepatitis B: 90697, 90723, 90740, 90744, 90747, 90748 Influenza: 90655, 90657, 90661, 90673, 90674, 90685,90686, 90687, 90688, 90689, 90765 LAIV: 90660, 90672	• **4 DTaP** or anaphylaxis or encephalitis due to diphtheria, tetanus, or pertussis vaccine (do not count any before 42 days of age) • **3 IPV** or anaphylaxis due to the IPV vaccine (do not count any before 42 days of age) • **1 MMR**; history of measles, mumps, and rubella; or anaphylaxis due to the MMR vaccine (do not count any before 42 days of age) • **3 HiB** or anaphylaxis due to HiB vaccine (do not count any before 42 days of age) • **3 hepatitis B**, anaphylaxis due to hepatitis B vaccine, positive serology, or history of hepatitis B • **1 VZV**, anaphylaxis due to the VZV vaccine, positive serology, or documented history of chicken pox disease • **4 pneumococcal conjugates** or anaphylaxis due to the pneumococcal conjugate vaccine (do not count any before 42 days of age) • **1 hepatitis A**, anaphylaxis due to the hepatitis A vaccine, or documented hepatitis A illness • **2 or 3 rotavirus vaccines** – depends on the vaccine administered or documented anaphylaxis due to the rotavirus vaccine (do not count any before 42 days of age) • **2 influenza** with different dates of service or anaphylaxis due to the influenza vaccine – One of the two vaccinations can be a live attenuated influenza vaccine (LAIV) if administered on the child's second birthday (do not count any given prior to 6 months of age). **Exclusions:** • members in hospice or using hospice services anytime during the measurement year. • members who had a contraindication to a childhood vaccine on or before their second birthday. • members who died anytime during the measurement year. **Parental refusal is *not* an exclusion.** Documentation of "immunizations are up-to-date" is **not** acceptable. Documentation of an immunization (such as the first hep B) received "at delivery "or "in the hospital" may be counted. For documented history of illness, a seropositive test result, or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the the member's second birthday.

2024-2025 Medicare Benefit Changes (High Level)

Plan	Benefits Changes
Hampton Roads Value H2563-017 (001/002) **Southside 001/Peninsula 002**	**MOOP:** Changed from $3,000 to $3,500 **Comprehensive Dental:** Changed from $3,000 Max to $2,500 and copay changed from $25 to $35 **Over-the-Counter (OTC):** Changed from $100 to $130 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $10 to $15 **Food and Produce (SSBCI) :** No Changes – stays $90 monthly allowance **Routine Chiropractic:** Removed Benefit
Hampton Roads Prime H2563-005 (001/002) **(Southside 001 and Peninsula 002)**	**MOOP:** Changed from $5,500 to $3,500 **Comprehensive Dental:** Changed from $3,500 Max to $3,000 and copay changed from $75 to $50 **Over-the-Counter (OTC):** No changes – stays at $100 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $25 to $20 **Food and Produce (SSBCI):** N/A **Routine Chiropractic:** No change – stays $10 (18 visits/year) **Premiums: (001):** Changed from $63 to $75 **Premiums (002):** Changed from $53 to $65
Engage – Diabetes and Heart (C-SNP) H2563-018	**MOOP:** Changed from $3,400 to $3,500 **Comprehensive Dental:** Changed from $3,000 Max to $2,500 and copay changed from $25 to $35 **Over-the-Counter (OTC):** Changed from $100 to $130 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $10 to $15 **Food and Produce (SSBCI):** Changed from $115 to $100 monthly allowance **Routine Chiropractic:** No Change – stays $10 (18 visits/year)

Sentara Health Plans

2024-2025 Medicare Benefit Changes (High Level)

Plan	Benefits Changes
Roanoke/Alleghany/ Value **(Members that were in this plan initially)** **H2563-016**	**MOOP:** Changed from $3,700 to $3,900 **Comprehensive Dental:** $2,500 max (no change) and copay changed from $25 to $35 **Over-the-counter (OTC):** Changed from $100 to $156 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $10 to $15 **Food and Produce (SSBCI):** Changed from $100 to $90 monthly allowance **Routine Chiropractic:** No Change
Northern Virginia Value **H2563-008**	**MOOP:** Changed from $3,500 to $4,300 **Comprehensive Dental:** Copay changed from $25 to $35 **Over-the-counter (OTC):** Changed from $100 to $181 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $10 to $15 **Food and Produce (SSBCI):** Changed from $100 to $50 monthly allowance **Routine Chiropractic:** No changes
Central/Halifax Value **H2563-009**	**MOOP:** Changed from $3,300 to $3,400 **Comprehensive Dental:** Copay changed from $25 to $35 **Over-the-Counter (OTC):** Changed from $100 to $139 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $10 to $15 **Food and Produce (SSBCI):** No change **Routine Chiro:** Changed from $0 (12 visits/year) to $15 (12 visits/year)

Sentara Health Plans

2024-2025 Medicare Benefit Changes (High Level)

Plan	Benefits Changes
Salute **H2563-014**	**MOOP:** Changed from $3,400 to $3,550 **Comprehensive Dental:** Changed from $2,000 Max to $1,500 and copay no change at $50 **Over-the-counter (OTC):** Changed from $125 to $75 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from $25 to $35 **Food and Produce (SSBCI):** Changed from $75 to $90 monthly allowance **Routine Chiro:** No changes at $20 (18 visits/year)
FIDE D-SNP **H4499**	**MOOP:** Changed from $8,850 to $9,250 **Comprehensive Dental:** No changes **Over-the-counter (OTC):** Changed from $500 to $200 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from Max $55 to Max $45 **Food and Produce (SSBCI):** Changed from $100 to $350 monthly allowance **Routine Chiropractic:** No changes
Partial D-SNP **H2563-020**	**MOOP:** Changed from $8,850 to $9,250 **Comprehensive Dental:** No changes **Over-the-counter (OTC):** Changed from $400 to $150 quarterly allowance **In Home Support Services:** Changed from 90 hours to 40 hours **Urgently Needed Services:** Changed from Max $55 to Max $45 **Food and Produce (SSBCI):** Changed from $100 to $200 monthly allowance **Routine Chiropractic:** No changes

Dario Health Program

Partnership Overview

The collaboration with Dario Health offers a tailored program for eligible Medicaid members with type 2 diabetes, focusing on fostering healthy habits and lifestyle changes. Members utilize the Dario app for personalized coaching on nutrition, stress management, and physical activity to enhance diabetes care.

Ponos Care Services

Chronic Condition Focus

Ponos Care is a value-based care provider delivering in-home pain and symptom management for conditions like RA and Crohn's. They focus on culturally sensitive care and risk assessments to diminish healthcare disparities and enhance access to essential treatments.