

Table of Contents:**In This Issue**

- [Healthy Children: Supporting Well-Child Visits in the First 30 Months of Life](#)
- [Women's Health: Improving Postpartum Care for Black Mothers](#)
- [Chronic Conditions: Helping Patients with Diabetes Manage Their Blood Pressure](#)
- [Behavioral Health: Initiation of SUD Treatment](#)
- [Older Adults: Continuous Glucose Monitoring](#)
- [Breast Cancer Screenings for Older Adults](#)

Healthy Children: Supporting Well-Child Visits in the First 30 Months of Life

Regular well-child visits in the first 30 months of life (W30) are essential to promoting healthy growth, development and family engagement in care. These visits provide structured opportunities for developmental surveillance, immunizations, anticipatory guidance and early identification of physical, developmental and social concerns. Consistent participation in early preventive care has been associated with improved health outcomes and reduced emergency department use later in childhood.

Understanding the W30 Healthcare Effectiveness Data and Information Set (HEDIS[®]) Measure

This measure assesses whether young children receive recommended well-child visits during two early life periods:

- First 15 months of life: Completion of six or more well-child visits by 15 months of age
- Ages 15–30 months: Completion of two or more well-child visits between 15 and 30 months of age

Note: Well-child visits must be completed with a primary care provider (PCP).

Leveraging Visits to Support Preventive Care

Although well-child visits are typically scheduled in advance, families may face barriers such as transportation challenges, work schedules or competing responsibilities that can disrupt preventive care schedules. Research shows that missed well-child visits are common and are often driven by practical access barriers rather than caregiver opposition to preventive care.

When clinically appropriate, pediatric practices may help support continuity by:

- Identifying overdue preventive visits during other encounters and assisting families with scheduling upcoming well-child visits as needed
- Reinforcing recommended visit timing and preventative care expectations with caregivers

Engaging families early and consistently can help maintain preventive care schedules during this critical developmental period.

Well Visits for Preventive Health Care

All Ohio Medicaid Managed Care Plans (MCPs) allow a well visit and other visit types (e.g. sick, medication check, sports physical, behavioral health, etc.) on the same day for pediatric patients.

Well Visits can now be scheduled every calendar year for patients of all Ohio Medicaid MCPs:

- Allows members and providers to schedule well visits when it is more convenient.
- Removes the previous barrier of the 365 days+1 policy. All Medicaid members are allowed a well visit once each calendar year.

Points to Keep in Mind:

- If it's the first time a patient will be seen in your office, only one of the two billed visits can be billed as a new patient visit.
 - For example, if a new patient is seen and both a well visit and a sick visit are appropriately received, only one service is a new patient visit. The other is an established visit.
- As long as the provider's documentation supports services for a well visit and another visit type (with no overlapping documentation components), then separate reimbursement is both warranted and supported.
- When billing another visit type on the same day as a well visit, bill the appropriate evaluation and management (E&M) code (i.e., 99201-99215) with modifier 25 and preventive code (i.e., 99381- 99397).

Maintaining continuity and re-establishing preventive care schedules is particularly important during the first 15 months of life, when recommended visit frequency is highest.

The following reminders may help support W30 performance while maintaining clinical appropriateness:

- Reinforce recommended visit timing early and often: Help caregivers understand preventative visit expectations across the first 30 months of life.
- Ensure complete and consistent documentation: Clear documentation of preventive services supports continuity of care and accurate quality reporting.
- Align care with nationally recognized pediatric schedules: The American Academy of Pediatrics Bright Futures periodicity schedule provides a standardized framework for preventive services during early childhood.
- Address access barriers proactively: Transportation challenges are a well-documented reason for missed well-child visits, particularly among Medicaid-enrolled children. Practices are encouraged to remind families about available transportation assistance or scheduling supports when applicable.

Note: Molina Healthcare of Ohio, Inc. members receive an additional transportation benefit of 30 one-way trips per calendar year. To schedule transportation, members may call (866) 642-9279 (TTY 711) at least 48 hours before their visit and up to 30 days in advance, available 24 hours a day, seven days a week.

Additional Resources:

- American Academy of Pediatrics – Bright Futures Periodicity Schedule:
<https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/>

References:

Bohaligah KM, Bohaligah MM, Bohaligah SM. *Preventive strategies for pediatric health in primary healthcare: A systematic review*. *Cureus*. 2025;17(2):e78719.

National Committee for Quality Assurance (NCQA). *HEDIS® Well-Child Visits in the First 30 Months of Life (W30) Technical Specifications*.

Wolf ER, O'Neil J, Pecsok J, et al. *Caregiver and clinician perspectives on missed well-child visits*. *Annals of Family Medicine*. 2020;18(1):30–34.

American Academy of Pediatrics. *Bright Futures: Recommendations for Preventive Pediatric Health Care*.

Centers for Medicare & Medicaid Services (CMS). *Well-Child Care in Medicaid and CHIP*.

<https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement/well-child-care>

Women's Health: Improving Postpartum Care for Black Mothers

Postpartum care is a critical period for new mothers. Studies show that Black women continue to face unique and preventable challenges rooted in systemic racism, implicit bias and gaps in culturally responsive care. According to the Centers for Disease Control and Prevention (CDC), Black women are three times more likely to die from pregnancy-related complications than white women, with most of the maternal deaths being preventable.

Key Strategies to Improve Outcomes:

- **Diversify the Healthcare Workforce:** A workforce that reflects the communities it serves strengthens trust, communication and quality of care. Diverse teams promote cultural humility, shared learning and more equitable postpartum care experiences.
- **Improve Cultural Competence and Empathy:** Disparate maternal health outcomes are driven by systemic and structural factors, not biological differences. Ongoing training helps providers recognize implicit bias, validate patient concerns and deliver respectful, patient-centered postpartum care.
- **Strengthen Postpartum Monitoring and Support:** Postpartum care extends beyond the traditional six-week visit. Early and continuous follow-up improves identification of warning signs and reduces the risk of severe maternal outcomes.

Moving Forward

The postpartum period presents a critical opportunity to reduce maternal health disparities. By diversifying care teams, strengthening cultural competence and providing proactive, respectful postpartum support, providers can significantly improve outcomes for Black mothers and their families.

References:

1. Centers for Disease Control and Prevention (CDC). Maternal Mortality Rates in the United States. <https://www.cdc.gov/nchs/data/hestat/hestat113.htm>

Chronic Conditions: Helping Patients with Diabetes Manage Their Blood Pressure

The Blood Pressure Control for Patients with Diabetes (BPD) HEDIS® measure assesses the percentage of members aged 18-75 with type 1 or 2 diabetes who achieved adequate blood pressure control (<140/90 mmHg) during the measurement year. For members with diabetes, blood pressure control is especially critical, as hypertension significantly increases the risk of cardiovascular disease, kidney disease and stroke.

Best Practices to Improve Blood Pressure Control in Patients with Diabetes:

1. **Measure Accurately, Document Clearly**
 - Use proper technique (seated, rested, correct cuff size).
 - Record both systolic and diastolic values at the most recent visit.
 - If blood pressure is elevated, recheck at the end of the visit and document the lowest systolic and lowest diastolic readings from the combined measurements.
 - Utilize Current Procedural Terminology (CPT) II codes to report blood pressure values when applicable – these codes help ensure clinical actions are captured for quality measurement, reduce reliance on chart abstraction and support accurate HEDIS® reporting even when lab or vital sign data may not flow cleanly through claims.
2. **Align Treatment with Diabetes-Specific Risk**
 - While BPD uses <140/90 mmHg, many clinical guidelines recommend <130/90 mmHg for patients with diabetes when safely achievable.
 - Individualize targets based on age, comorbidities and hypotension risk.
3. **Optimize Medication Management**
 - Consider ACE (Angiotensin-Converting Enzyme) inhibitors or ARBs (Angiotensin II Receptor Blockers) as first-line therapy when appropriate.
 - Assess adherence regularly and simplify regimens when possible.
 - Avoid therapeutic inertia – adjust therapy when BP remains uncontrolled.
4. **Reinforce Lifestyle Interventions**
 - Encourage DASH (Dietary Approaches to Stop Hypertension)-style eating patterns, sodium reduction and regular physical activity.
 - Promote weight management and tobacco cessation.

- Use brief counseling and referrals to nutrition or lifestyle programs when available.

5. Support Self-Monitoring and Follow-Up

- Encourage home blood pressure monitoring and submit Durable Medical Equipment (DME) referrals for a home blood pressure monitor when appropriate to support member access and adherence.
- Provide patient education on proper home monitoring technique.
- Schedule timely follow-up visits or outreach after elevated readings.
- Leverage care teams (nurses, pharmacists, community health workers) for ongoing support.

Behavioral Health: Initiation of Substance Use Disorder (SUD) Treatment

HEDIS® Measure: Initiation and Engagement of Substance Use Disorder (SUD) Treatment (IET) – Initiation Phase

The Initiation phase of the IET measure evaluates whether members with a new SUD diagnosis or qualifying SUD-related encounter receive a timely follow-up service within 14 days. Early follow-up supports treatment engagement, continuity of care and improved outcomes.

Molina remains committed to collaboration with providers by supporting workflow alignment across care settings, clarifying qualifying services, facilitating care transitions and sharing quality insights to address barriers to timely initiation of SUD treatment for our shared members/patients.

Providers Can Support By:

- Acting Quickly after qualifying encounters, ensuring follow-up services occur within 14 days, using qualifying services as outlined in IET TIP Sheets (available upon request from Molina).
- Submitting Accurate Documentation and coding, strengthening care transitions and engaging members early in the treatment journey.

Supporting initiatives that promote earlier engagement in treatment and better outcomes for members with SUD, improves the overall quality of care, access and continuity of care.

Older Adults: Continuous Glucose Monitoring

Continuous glucose monitoring (CGM) is transforming diabetes care for older adults. Evidence demonstrates that CGM use is associated with improved A1c, fewer hypoglycemic events and enhanced quality of life—particularly for older adults using insulin.

The 2025 Standards of Care in Diabetes¹ recommend CGM for older adults with type 1 diabetes to help reduce hypoglycemia risk, with growing evidence supporting its use in type 2 diabetes as well. CGM also offers added safety for members with cognitive or physical limitations by enabling caregivers to remotely monitor glucose readings and receive alerts when values fall outside target ranges.

Education and ongoing support are essential for successful CGM use. Manufacturers offer training resources and mobile applications to assist both members and caregivers with proper use and ongoing engagement.

Providers play a critical role in CGM use among older adults by identifying appropriate candidates, supporting access and education, and using CGM data to guide care, engage caregivers when needed, and improve safety, self-management, and glycemic outcomes.

Molina supports CGM as an effective component of diabetes management. Prior authorization is not required for Ohio Medicaid members obtaining CGMs through a participating pharmacy or DME providers.

Providers interested in CGM samples, in-office training or additional support are encouraged to contact their Dexcom and/or Abbott representative or visit freestylelibre.us or dexcom.com.

¹American Diabetes Association Professional Practice Committee. *Older Adults: Standards of Care in Diabetes—2025. Diabetes Care.* January 1, 2025; 48 (Suppl 1): S266–S282. <https://doi.org/10.2337/dc25-S013>

Breast Cancer Screening for Older Adults

Breast cancer screening plays a key role in early detection and improved outcomes. Under the HEDIS® Breast Cancer Screening (BCS) measure, Molina tracks screening rates for women ages 40–74 who receive a mammogram within the recommended time frame.

The American Cancer Society (ACS) reports that breast cancer death rates have been decreasing steadily since 1989. The overall rate of decline is 44% through 2022. Early detection through screening, increased awareness, and advanced treatments are key factors in reducing breast cancer death rates.

While most groups issuing breast cancer screening guidelines recommend women continue to be screened until the age of 74, there is little evidence regarding the efficacy of screening women who are 75 and older. Hence, some of the groups that issue the screening guidelines offer no recommendation for older women in this age range; however, they do suggest that if screening is offered, patients should understand the uncertainty about the balance of benefits and harms.

Offering a different perspective, the ACS recommends that screening continue if a patient has good overall health and a life expectancy of 10 years or longer. Similarly, the American College of Radiology suggests that screening recommendations for women who are over 74 years of age should be tailored to individual circumstances, such as life expectancy, comorbidities and the intention to seek (and ability to tolerate) treatment if cancer is detected.

Even though there are varying recommendations for breast cancer screening in women beyond the age of 74, clinicians can fully engage and support older women in the breast cancer screening process by using shared decision making and health decision aids as they have these important discussions.

Please see coding tips for Breast Cancer Screening below.

Breast Cancer Screening (BCS-E)

Description	Code
Mammography	CPT: 77061-77063, 77065-77067
Measure Common Exclusions	
Description	Code
Absence of Left Breast	International Classification of Diseases (ICD)-10: Z90.12
Absence of Right Breast	ICD-10: Z90.11
Bilateral Mastectomy	ICD-10: OHTV0ZZ
History of Bilateral Mastectomy	ICD-10: Z90.13
Unilateral Mastectomy	CPT: 19180, 19200, 19220, 19240, 19303-19307
Unilateral Mastectomy Left	ICD-10: OHTU0ZZ
Unilateral Mastectomy Right	ICD-10: OHTT0ZZ

Online Reference:

1. American Cancer Society. Breast Cancer Facts & Figures. <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/2024/breast-cancer-facts-and-figures-2024.pdf>
2. Schrager S, Ovsepyan V, Burnside E. (2020). Breast Cancer Screening in Older Women: The Importance of Shared Decision Making. *J Am Board Fam Med*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7822071/>

Questions and Quick Links

Provider Services: (855) 322-4079 Mon. – Fri.
Medicaid 7 a.m. to 8 p.m., MyCare Ohio 8 a.m. to 6 p.m.,
Medicare and Marketplace 8 a.m. to 5 p.m.

Email: OHProviderRelations@MolinaHealthcare.com

Provider Website: MolinaHealthcare.com/OhioProviders.