

Provider Newsletter - November 2025



2025 CoC & CoC+ Appointment Agenda Program & How To Get Started Guide

Wave 6 of the 2025 program has been released and is in the Provider Portal! We are pleased to continue the 2025 Continuity of Care (CoC) Program. This initiative aims to reward primary care providers (PCPs) for proactively coordinating preventive medicine and thoroughly assessing patients to improve health and clinical quality of care. By participating in this program, you can earn up to \$450 per member based on program-specific requirements. As an additional way to partner with our groups and providers, we have included the following link for the ["Continuity of Care Program: How To Get Started Guide"](#).



2025 Medicare Peak Performance

We are excited to announce the 2025 Medicare Peak Performance Program! The program runs from 8/1/2025 to 12/31/2025 for any eligible patients. Incentives can be earned in addition to the Medicare P4Q Program! Claims and SUDS files are due no later than 1/31/2026. Please reach out to your PQL/QPA for your scorecard and more information.



End of Year Focus: Medicare - Triple Weighted Measures

As we enter the final quarter of the Measurement Year, patients are falling into a critical portion of their Medication Adherence (Statins, RASA, Diabetes), Controlling Blood Pressure (CBP), and Glycemic Status Assessment for Patients with Diabetes (GSD/Diabetes HbA1c <= 9). During this time, we see many patients become noncompliant or unattainable for these measures. To better partner with the assigned groups, your QPA will be providing a list of patients who are still due for these measures before the end of 2025. Please ensure this list reaches all applicable providers. Please discuss possible barriers with your patients and even add messaging about due measures in your EMR as a reminder when discussing current health with your patients. Please reach out to your QPA/PQL with any questions.



End of Year Focus: Medicaid - W30 Patients Needing 1 More Visit

As we enter the final quarter of the Measurement Year, we are sending out lists of patients who have 5 of the 6 needed visits to complete their W30 measure before their 15-month birthday. We are asking that you get these patients in for their final visit before the date. To better partner with the assigned groups, your QPA will be providing a list of patients who are still due for these measures before the end of 2025. Please ensure this list reaches all applicable providers. Please discuss possible barriers with your patients and even add messaging about due measures in your EMR as a reminder when discussing current health with your patients. Please reach out to your QPA/PQL with any questions.



2025 CCIP Outreach

Our Diabetes Chronic Care Improvement Program is set to continue in the coming weeks. All Meridian Complete, Medicare, and Medicaid members with at least one claim-based diagnosis of diabetes in 2022 to 2025 are in the eligible population. This program was effective as of 1/1/2022 and will be conducted over a multi-year cycle. The goal is to engage members with chronic conditions through increased outreach initiatives to improve health outcomes and increase member satisfaction. This will promote effective management of chronic diseases. All applicable



2025 RxEffect Webinar

Starting in August, we will be offering a monthly webinar for RxEffect! Join us for best practices and deep dive into the RxEffect Tool for Medication Adherence! Sign up at the following link for November:

[November 18, 2025 at 12:00pm est](#)



2026 Medicare Formulary Changes

On 1/1/2026, some drugs will no longer be covered on our Medicare Part D Formulary. To assist our providers, we have included the list below of the most commonly prescribed drugs being removed along with the drug's 2026 formulary alternatives:

Product Name	Formulary Alternative
OneTouch	Accu-Chek Guide, True Metrix
Insulin Degludec	Insulin Glargine-yfgn, Insulin Glargine U-300
diclofenac 2% solution	diclofenac 1.5% topical solution
Humira (adalimumab)	Cyltezo (adalimumab-adbm)*, Yuflyma (adalimumab-aaty)*, Tylene (tocilizumab-aazg)*, Steqeyma (ustekinumab-stba)*, Cosentyx*, Otezla*, Rinvoq*, Skyrizi*, Tremfya*
Actemra (tocilizumab)	
Austedo, Austedo XR	tetrabenazine*, Ingrezza*
Trulance	lubiprostone, Linzess
Bydureon BCise	Mounjaro*, Ozempic*, Rybelsus*, Trulicity*
Gammagard Liquid	Gamunex-C*
Xultophy	Soliqua
abiraterone 500mg	abiraterone 250mg tab*, abirtega 250mg tab*
Fasenra	Dupixent*, Xolair*
Vivitrol	acamprostate, disulfuram
Opsumit	ambrisentan*, bosentan*, sildenafil 20mg*, tadalafil 20mg*

** Prior Authorization Required*



HEDIS Data Entry Cut-off Dates

Listed in the table below is the last day quality staff can receive records for each measure. It is preferred that records be submitted prior to the cutoff date listed so there is ample time for the data to be reviewed and entered. These medical records can be faxed to **833-667-1532** or sent to our secure email MIHEDIS@mhplan.com. Please ensure patient's name and DOB are included on documentation.



HEDIS Measure		Cutoff Date
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Adult Immunization Status (AIS-E)	1/31/2026
Advanced Care Planning (ACP)	Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
Breast Cancer Screening (BCS-E)	Blood Pressure Control for Patients with Diabetes (BPD)	
Controlling High Blood Pressure (CBP)	Cervical Cancer Screening (CCS-E)	
Chlamydia Screening in Women (CHL)	Childhood Immunization Status (CIS-E)	
Care for Older Adults (COA)	Colorectal Cancer Screening (COL-E)	
Appropriate Testing for Pharyngitis (CWP)	Eye Exam for Patients with Diabetes (EED)	
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Conditions (FMC)	Follow-Up After Emergency Department Visit for Substance Use (FUA)	
Follow-Up After Hospitalization for Mental Illness (FUH)	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Glycemic Status Assessment for Patients with Diabetes (GSD)	
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Immunizations for Adolescents (IMA)	
Kidney Health Evaluation for Patients with Diabetes (KED)	Lead Screening in Children (LSC)	
Osteoporosis Management in Women Who Had a Fracture (OMW)	Prenatal Depression Screening and Follow-Up (PND-E)	
Prenatal and Postpartum Care (PPC)	Prenatal Immunization Status (PRS-E)	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	
Social Need Screening and Intervention (SNS-E)	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication (SSD)	
Transitions of Care (TRC)	Well-Child Visits in the First 30 Months of Life (W30)	
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)	Child and Adolescent Well-Care Visits (WCV)	
Medication Review (MI5,6)		

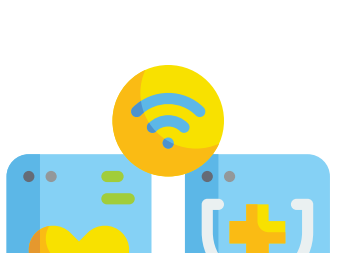
Hybrid Heads Up

It's that time of year again! We are preparing for our 2025 HEDIS hybrid project that will run from January 2026 to April 2026. Your office may be contacted during this timeframe for records with dates of service in 2025 and prior that were not already captured by claims. Please see [this letter](#) for more on what to expect in the upcoming months.



EMR Connectivity

Meridian is participating in a bi-directional data sharing connectivity initiative. Our EMR Payer Platform enhancement is for providers currently participating in EPIC, Healow, Availity, and Athena! Providers can receive Health Plan insights including claims, care gaps, and diagnoses. This can also securely push the appropriate clinical data to the Health Plan to assist in closing Risk Adjustment and HEDIS Care Gaps. Please reach out to your QPA/PQL for more information.



2025 Behavioral Health Measure Changes

The Measurement Year (MY) 2025 changes to the behavioral health measures include:

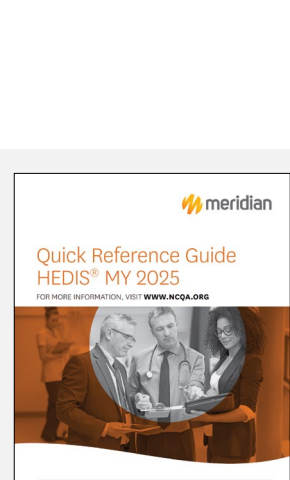
- Antidepressant Medication Management (Retired)
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After Emergency Department Visit for Mental Illness
- Social Need Screening and Intervention

For more detailed information, please follow [this link to the 2025 Behavioral Health Measure Changes Flyer](#).



2025 Quick Reference Guide for HEDIS

Our 2025 Guide for HEDIS measures has arrived! Within this guide, you can navigate through an index of the HEDIS measures that are tracked, find the applicable CPT codes for each measure listed, view information on Administrative Claims, Supplemental Data and Feeds. Be sure to check into the changes for 2025! For more information, [click here](#).



Meridian Portal Access & Self Service Option

Please make sure you have portal access for all staff members. This is where you will find all of your reporting and gain access to your CoC Appointment Agenda's. If you need assistance with access or have any questions, please reach out to your Quality representative.

For those needing access, please register for the portal(s) using the following links:

- [WellCare Portal - https://provider.wellcare.com/](https://provider.wellcare.com/)
- [Centene Portal - https://provider.mimeridian.com](https://provider.mimeridian.com)
- [AmBetter Portal - https://provider.ambettermeridian.com](https://provider.ambettermeridian.com)



Self-Service Options

- Terminations
- Updating credentialing files
- Demographic information changes, etc.
- Now available on our member website: <https://www.mimeridian.com/providers/join-our-network.html>

Measure Spotlight

Glycemic Status Assessment for Patients with Diabetes (GSD)

This measure evaluates the percentage of members 18-75 years of age with Diabetes (Type 1 and Type 2) whose most recent glycemic status was at the following levels during the measurement year:

- HbA1c or glucose management indicator control (<8.0%)
- HbA1c or glucose management indicator poor control (>9.0%)

Tips and Best Practices:

- Member-reported HbA1c results are acceptable if documented in chart with test date and value. Ensure your EMR has appropriate fields to house this data for all visit types
- Discuss the importance of HbA1c/blood glucose control in patients with diabetes and long-term effects of elevated HbA1c/blood
- Offer referrals to Diabetes Education, Endocrinologist, and/or Dietician
- Offer lab testing on-site or support lab scheduling at accessible in-network facility during patient visit and have referrals easily accessible or standing orders
- For patients taking diabetes medication, encourage adherence by providing 90-day prescriptions. Your patient may be eligible for prescription delivery by mail through Express Scripts

Blood Pressure Control for Patients with Diabetes (BPD)

This measure evaluates the percentage of members 18-75 years of age with Diabetes (Type 1 and Type 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year:

- Take member's blood pressure at each outpatient visit
- Indicate in the medical record all recorded blood pressure measurements, blood pressure results taken by the patient at home and reviewed via telehealth, or member-reported blood pressure readings

Tips and Best Practices:

- If BP result is >140/90 mmHg, recheck the BP at the end of the visit and document the second reading
- Ensure you are coding from the chart above for both systolic and diastolic values
- Member-reported blood pressure readings and blood pressure readings collected via telehealth are acceptable if documented in chart with date and value. Ensure your EMR has appropriate fields to house this data for all visit types
- Your patient may be eligible for automatic home blood pressure monitor through their standard over-the-counter benefits when supplied through in-network durable medical equipment provider

