Sentara® Health Plans

Model of Care Provider Guide

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Purpose of the Guide

The Model of Care Provider Guide (MCPG) is designed for general information purposes only, and providers should always refer to the **Sentara Health Plans Provider Manuals** and the provider agreement for the most detailed and up-to-date requirements.

Provider Training Requirements

Providers are required to review the MCPG within 30 days of their initial orientation date as a newly contracted provider and by January 31 each subsequent year. **Attestation is required and will be recorded by the provider's (practice/facility) name, tax identification number, and email address.** Out-of-network providers must review the MCPG when they sign the requisite Single Case Agreement. The MCPG and attestation can be located **here**, and the attestation must be executed by the provider and verified by Sentara Health Plans prior to Sentara Health Plans signing and returning the agreement.

Special Needs Plan and Model of Care Overview

The Model of Care (MOC) is an approach to identifying targeted populations for outreach, care management, and disease management, expectations for member engagement, assessment, care planning, interdisciplinary team meetings, and other interventions to improve member outcomes and experience.

A Special Needs Plan (SNP), a Medicare Advantage (MA) coordinated care plan (CCP), is specifically designed to provide targeted care and limit enrollment to special needs members. A special needs individual could be:

- An institutionalized individual
- Dual eligible for Medicare and Medicaid
- An individual with a severe or disabling chronic condition, as specified by the Centers for Medicare & Medicaid Services (CMS)

A SNP may be any type of MA CCP, including either a local or regionally preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO POS) plan. Sentara Health Plans offers HMO plans.

There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual-eligible SNP (D-SNP)
- Institutional SNP (I-SNP)

Sentara Health Plans offers C-SNP and D-SNP plans.

Importance of the SNP Model of Care (MOC)

SNP MOCs are designed to optimize the health and well-being of members, particularly our aging, vulnerable, and chronically ill members, by:

- Identifying care needs through a comprehensive initial health risk assessment and annual reassessment
- Creating and updating an individualized care plan (ICP) with goals and measurable outcomes based on the member's needs identified in the health risk assessment
- Addressing the member's healthcare needs with the member in their current state of health
- Building an interdisciplinary care team (ICT) with goals and measurable outcomes to:
  - Ensure the member's providers are involved in care decisions
  - Manage utilization of services effectively
  - Improve member access to affordable medical, mental health, and social services

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Sentara Health Plans MOC Plans

Sentara Health Plans' MOC plans are designed to ensure that the provision and coordination of specialized services meet the needs of the SNP-eligible members. Our SNP plans include:

- Fully Integrated Dual Eligible (FIDE) SNP: Sentara Community Complete (HMO D-SNP)
- Partial D-SNP: Sentara Community Complete Select (HMO D-SNP)
- C-SNP: Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP)
- C-SNP: Sentara Medicare Engage – Lung (HMO C-SNP)

Dual-eligible Special Needs Plans (D-SNP)

These plans are for members who are eligible for both Medicare and Medicaid.

Applicable Integrated Plan (AIP) FIDE SNP

An AIP is a plan that requires exclusive enrollment under one organization's MA plan and its Medicaid plan. Under this plan, members are exclusively aligned to have our Sentara Community Complete D-SNP plan and our Cardinal Care Medicaid plan.

Sentara Community Complete (HMO D-SNP)

Members enrolled in Sentara Community Complete are both Medicare and full-benefit Medicaid eligible, also called dual-eligible. Members will have access to a care coordinator and our high-quality network of doctors, specialty providers, and healthcare facilities. To be eligible for Sentara Community Complete, a member must reside in the plan's service area, qualify for Medicare Parts A, B, and D, and have full Medicaid coverage. Approved populations include the following categories:

- Qualified Medicare Beneficiary Plus (QMB+)
- Special Low-income Medicare Beneficiary Plus (SLMB+)
- Other Full-benefit Dual Eligible (FBDE)

Since January 1, 2025, full benefit dual-eligible Medicaid members who elected to enroll in a D-SNP have been assigned to the same health plan for their Medicaid managed care as they selected for their D-SNP. There is also alignment when an individual becomes eligible for Medicaid and is also eligible to enroll in a D-SNP. If an individual becomes eligible for and enrolls in a Medicaid plan, the member will be aligned with the same health plan's D-SNP if they are also eligible for Medicare.

Partial D-SNP

Sentara Community Complete Select (HMO D-SNP)

Some members are not fully dual eligible but may still qualify for extra help. Sentara Community Complete Select is designed to meet the needs of people who are not eligible for full-benefit Medicaid. This partial D-SNP offers a care coordinator and access to our high-quality network of doctors, specialty providers, and healthcare facilities. To be eligible for Sentara Community Complete Select, a member must reside in the plan's service area, qualify for Medicare Parts A, B, and D, and partial Medicaid coverage, have income and resources less than a certain amount, and qualify for the following Medicare Savings Program (MSP):

- Qualified Medicare Beneficiary (QMB)

Chronic Condition Special Needs Plans (C-SNP)

C-SNPs are specialized plans for people who have certain qualifying chronic conditions determined by the health plan.

Sentara Health Plans offers two types of C-SNPs. They are listed below with their respective covered chronic conditions.

1. Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP)
    a. Diabetes mellitus
    b. Chronic heart failure
    c. Cardiovascular disease
2. Sentara Medicare Engage – Lung (HMO C-SNP)
    a. Asthma
    b. Chronic bronchitis
    c. Emphysema
    d. Pulmonary fibrosis
    e. Pulmonary hypertension

C-SNP Enrollment – **Time Sensitive**

Member enrollment into C-SNP is **extremely time sensitive**. CMS allows thirty days to complete the verification process. If enrollment and verification are not completed within this time frame, the member cannot be enrolled in the C-SNP plan.

Part of the enrollment process includes provider attestation that the chronic condition exists for eligible members. It is critical that providers verify the member has been diagnosed with one or more of the qualifying chronic conditions on the same day the request is received to support enrollment in the C-SNP plan.

Workflow

Day 1

Sentara Health Plans contacts the provider's office to confirm the fax number, explains the reason for provider verification, and faxes the pre-enrollment qualification assessment tool (PQAT) form to the provider of record. (Members or their brokers may also contact the provider to have the PQAT completed and sent back to Sentara Health Plans.)

Day 2

If the PQAT form has not been returned by the provider, Sentara Health Plans will start the follow-up process with the office.

Days following

Sentara Health Plans will follow up with the provider's office two additional times, and if the PQAT is not received by the end of the enrolling month, Sentara Health Plans is required to send a notification informing the member that they cannot remain enrolled in the C-SNP.

Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented, suboptimal care coordination that can increase acute or emergency utilization.

By returning the PQAT timely, we can begin the care coordination and management process with these members.

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Care Management Model

The care management model includes four levels of increasing intensity: care coordination for those with minimal needs and three levels of care management intensity to include low, moderate, and high.

Care Coordination:	**Care Management:**
Population of Focus: Individuals identified as not being in a priority population or otherwise requiring care management. **Key Activities:** Initial screening; assessing and coordinating access to needed services (e.g., making referrals); identifying individuals who require care management, as needed; lower staffing requiring; responsive to requests for assistance. If the care coordinator determines that a full HRA and ICP are warranted, the member would transition to care management at the appropriate intensity level.	**Populations of Focus:** Priority populations according to the Department of Medical Assistance Services (DMAS) and MCOs. **Key Activities:** Developing comprehensive and centralized care plan, managing physical/behavioral/Rx needs, making timely and necessary referrals, monitoring SDOH needs, implementing and leading interdisciplinary care team, etc. **Low intensity** → **Moderate intensity** → **High intensity** Timelines, contact frequency, and staffing ratios increase based on level of intensity assigned.

Supporting Levels of Care and Administrative Transitions:

- Supports transitions between clinical settings and the community, such as hospital discharges, nursing facility transitions, foster care transitions, etc.
- Minimizes disruptions during transitions between managed care organizations (MCOs)/fee-for-service/Medicaid eligibility, or due to provider contract termination.

Case Management

Clinical case managers assist with members' healthcare needs:

- All SNP members are enrolled in case management. Members have the option of declining participation in case management, but will remain assigned to a case manager.
- An individualized care plan (ICP) is developed for each member.
- Members are stratified according to their risk profile to trigger focus on the most vulnerable.

The MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the SNP-eligible members. Our overall goals are as follows:

1. Address the member's healthcare needs as well as the nonmedical needs that impact access to health care.
2. Improve access to affordable care by making sure our benefits are affordable.
3. Improve coordination of care at both the plan and care levels. Integration of both Medicare and Medicaid ensures the right care for the right member at the right time through the right provider.
4. Support all transitions of care, including facility to facility as well as life transitions.
5. Ensure our members are protected and receive early intervention.
6. Facilitate appropriate utilization of services by ensuring the right care for the right member at the right time through the right provider.
7. Take the steps necessary to ensure access to benefits and services.
8. Utilize the provider network to support the specialized needs of our members by having the right providers engaged with our members' care and supporting our provider network when needed.

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SNP coordination goals include ensuring:

- Members are informed of the benefits offered by both programs.
- Members are provided with information on how to maintain Medicaid eligibility.
- Members have access to staff who know about programs and community resources.
- Members are informed of their rights to pursue appeals and grievances through both programs.
- Members are provided with information on how to access providers that accept Medicare and Medicaid.
- The plan provides clear communication regarding claims and cost sharing from both programs.

Individualized Care Plan

CMS requires all SNPs to develop and implement an individualized care plan for each member enrolled in a SNP.

- The clinical case manager will work with the member or the member's caregiver in developing and implementing the member's ICP.
- The ICP is based on the member's health risk assessment (HRA) and any identified opportunities for intervention.
- The ICP is prioritized to consider the member's preferences and their desired level of engagement.
- The ICP is updated and revised to reflect any change in the member's medical and psychosocial status, including the evaluation of identified goals and whether they have been met.
- The ICP is communicated for coordination of care and when there is a transition to a new care setting, such as a hospital or an SNF.
- The ICP is also provided to the PCP and the member's caregiver.

Interdisciplinary Care Team

CMS requires that all SNPs use an interdisciplinary care team (ICT) in the care management of each individual enrolled in the SNP. This team is made up of physicians, clinicians, and any other healthcare practitioners involved in the member's care.

The ICT contributes to improving the member's health status. The initial meeting of the ICT occurs after the ICP has been developed. The team continues meeting regularly as needed to manage the medical, cognitive, psychosocial, and functional needs of the member.

Members can be faced with significant challenges when moving from one setting to another. The management of transition is focused on supporting our members with their treatment plan as they move from one setting to another to prevent readmissions or delays in care needs.

ICT Members:

- Member/caregiver
- SNP medical director
- SNP clinical director
- Case managers
- Network practitioners

Optional ICT Members:

- Specialty providers
- Pharmacist
- Behavioral health specialists
- Social worker
- Nurse practitioner
- Palliative care
- Home care
- Dietitian/nutritionist

Personnel Involved in Coordinating Care Transitions:

- Utilization clinical review staff
- Case manager
- Transition case manager/additional support staff
- Hospital case manager/discharge planner
- Dedicated medical director

Specialized Intensive Care Management

Specialized care managers provide expert and dedicated oversight, continually assessing the member's status and service needs, including:

- Comprehensive, whole-person assessments and care plans developed with input from the member, family, and care team.
- Close monitoring to ensure timely care and services, including nursing, durable medical equipment, enteral nutrition, and supplies.
- Reporting of quality-of-care concerns to clinical leadership and provider concerns to network management.
    - Proactively ensuring members are not at risk of failing to receive the care and services needed due to denied service authorizations for any reason, including due to a provider or an MCO error.
    - Care managers are being stretched too thin to provide proactive and effective monitoring.
    - Lapse in Medicaid coverage, which could result in a lapse in care/adverse medical event.
    - Provider issues, including a lack of specialized providers and poor quality of service.
    - Lack of coordination with other insurance.

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Health Risk Assessment (HRA)

- A comprehensive initial assessment is completed within 90 days of enrollment.
- An annual reassessment of the individual's medical, physical, cognitive, psychosocial and functional, and mental health needs is also conducted.
- Members will be advised of their right to an advanced directive and a durable power of attorney. Additional information will be sent to members regarding these topics if requested.

Medicaid provides flexibility for MCOs to use telephone or video conferencing to administer the MMHS and HRA and develop the ICP. The MCO is, however, required to conduct:

- An HRA in-person for members in high-intensity care management
- The initial HRA and level of care assessments in-person for members in nursing facilities and Cardinal Care members

Vendors

Sentara Health Plans has contracted vendors to provide health care and/or care management services. Here are some examples:

Vendor	Service
NationsBenefits®	Over-the-counter (OTC), Hearing, Grocery Allowance, Meals
Express Scripts	Pharmacy Benefit Manager (PBM)
SilverSneakers®	Fitness Membership
PAPA Pals	In-home Companion Care
Modivcare	Transportation Services
DentaQuest	Dental - FIDE SNP
Delta Dental	Dental - All other plans
Vision	Community Eye Care (CEC)

Quality Improvement and Performance

Sentara Health Plans evaluates quality performance through the Quality Improvement Committee's (QIC) oversight and annual performance evaluation:

- The QIC comprises our medical director and various departmental directors who conduct a comprehensive and effective internal quality performance review. The QIC director works with the departments to collect, analyze, and report on data for evaluation of the MOC. Different reports are generated based on the specific needs and initiatives, as requested by the committee to meet MOC standards and other improvement initiatives.
- Sentara Health Plans evaluates effectiveness annually at a minimum to identify results from performance indicators, including lessons learned and challenges for the support of ongoing program improvements.
- Evaluation results are provided to key stakeholders annually at a minimum. This evaluation allows the plan to analyze and assess how well the plan manages the SNP population.

Provider Training Requirement
After reviewing this resource in full, please complete the MOC Provider Education Attestation at the **link** on this page.

Helpful Resources

Explore these resources on the **DMAS website**:

- DMAS Provider Manuals
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplement B
- MES Provider Portal
- Commonwealth of Virginia Referral Directory by City/County

Sentara Health Plans Quick Reference Resources

Explore Sentara Health Plans' provider support resources on our **website**.

- Sentara Health Plans Provider Manual
- Avoiding Common Claim Submission Errors
- Submit an Authorization
- Provider Portal Authorization Tips
- Sentara Community Plan Claims and Billing Quick Reference

E-booklets

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider Desk Reference
- Doing Business With Sentara Health Plans

Slide Presentations

- Transitioning to Cardinal Care