Sentara®
Health Plans

Provider Newsletter

Spring 2024

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Sentara®
Health Plans

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New Name, Same Trusted Coverage

As part of Sentara Health's commitment to providing exceptional healthcare, Optima Health and Virginia Premier consolidated under a new name—Sentara Health Plans. This consolidation marked a pivotal moment in our journey toward improving healthcare accessibility and quality.

Our goal is to ensure that your patients and our members get the care that they need. There have been instances where health plan members have been turned away or providers have not accepted insurance due to unfamiliarity with our name change. We want to re-educate all providers and staff at Sentara medical offices and facilities to be aware of this recent change.

We ask that you please update your accepted insurance lists and all informational materials to reflect our new name, Sentara Health Plans. This ensures a smooth transition and uninterrupted access to our comprehensive healthcare services. Our goal is to increase education and knowledge of the name change to Sentara Health Plans and mitigate member confusion and frustration.

If you need informational materials for your medical office, such as flyers, FAQs, window clings, tabletop signage, and other promotional materials, to provide awareness to members, please contact your network educator or physician liaison.

At Sentara Health Plans, our core mission of "We Improve Health Every Day" remains steadfast. Thank you for your partnership.

Welcoming Baby Program

The Welcoming Baby Program is Sentara Community Plan's incentive-based maternal healthcare program. Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Through the Welcoming Baby Program, members receive reminders, education, and incentives if they receive their first prenatal visit within 42 days of enrolling with Sentara Community Plan (or within their first trimester). Members receive reminders and education and are eligible for an incentive if they receive their timely postpartum provider visit within 7–84 days of giving birth.

What does the program include?

- Pregnant members from conception
- Birth
- Postpartum care up to 12 months
- Watch Me Grow outreach to 15 months postpartum

What do your patients receive from this program?

- One-on-one supportive services from a certified community health worker (outreach representative) and maternity case manager
- Screening and referral to maternity case managers/ care coordinators for care planning and goal setting
- Education - community referrals for identified needs
- Family planning - LARC and birth spacing education
- Baby showers (virtual and in-person)
- Access to breast pumps
- Maternal/child education series classes
- Referrals to parenting and breastfeeding classes and lactation services
- Hospital tours (virtually and in person)
- Timeliness of Care Incentives

Contact the Welcoming Baby Outreach Team:
Monday–Friday, 8 a.m.–5 p.m.

Phone: **1-844-671-2108 (TTY: 711)**

Email: **welcomingbaby@sentara.com**

OB Registration Program:

- Providers are eligible to receive a $25 incentive for referring pregnant patients to Sentara Community Plan's Welcoming Baby Program upon identification of pregnancy.
- All providers should fill out a **Welcoming Baby OB Registration Form**, fax it to outreach at **1-804-799-5117**, and submit a claim using the code G9001.

Sentara® Health Plans

DMAS Updates

- Quality Management Review
- Rate Increases for Acute and MLTSS Populations

Quality Management Review

Introduction
Quality Management Review (QMR) is the process by which the Department of Medical Assistance Services (DMAS) and/or Sentara Health Plans assess and evaluate waiver services and their providers. The purpose of the QMR is to ensure the provider's overall compliance with the administration of home and community-based waiver services in the Commonwealth of Virginia. QMRs are not to be confused with Utilization Reviews and are not a financial audit. The QMR process includes a review of waiver services along with ensuring those services are being provided in accordance with DMAS regulations, policies, and procedures as outlined in the Commonwealth Coordinated Care Plus Waiver Provider Manual. The ultimate goal of the QMR is to ensure the health, safety, and welfare of the individuals receiving waiver services. Areas of review include but are not limited to provider qualifications, individual eligibility criteria, individualized personal needs, quality of care, and adequate record keeping.

QMR Overview
The QMR team will conduct a desk review. The analysts will request member and employee records for review. It is an expectation that the provider knows and fulfills all applicable state and federal requirements related to the services that he/she is authorized to provide per the Medicaid participation agreement. The QMR team will assess and evaluate the overall performance of the provider through the record review process. At the conclusion of the review, an exit summary will be conducted. If the QMR team determines the provider has deficiencies, these deficiencies will be noted during the on-site exit summary.

A formal letter will be sent to the provider within 30 days of the on-site review. This letter will include greater detail related to the findings of the on-site review and will provide manual citations to explain the deficiencies identified. This letter may include deficiencies not addressed in the exit summary. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance,

and/or referral to the Division of Program Integrity. Along with the formal letter, there may be a Corrective Action Plan (CAP) document attached. The provider is given 30 days to address in writing the areas identified within the letter. Please refer to Chapter VI pages 3–8 of the Commonwealth Coordinated Care Plus Waiver Provider Manual for more information regarding the QMR process.

What is a Technical Assistance (TA)?
TA refers to deficiencies found during the QMR that do not rise to the level of requiring a CAP but are recommendations for best practice. TA means compliance is present but there is room for improvement in order to meet best practices. TAs do not require any corrective action be taken on the part of the provider.

What is a Corrective Action Plan (CAP)?
A CAP requires action on behalf of the provider to correct the deficiency cited. A CAP is a plan of action developed to address findings and observations that have been identified by the QMR team during the QMR site review. The CAP gives the Medicaid provider the opportunity to analyze their program and identify the root causes of the identified findings and observations, to develop a corrective action to address the findings, and to ensure future compliance with the Virginia Medicaid Provider Manual.

Preparing Your CAP
The first step in preparing your CAP is to review the specific findings/observations noted in the findings letter and determine the root cause of the deficiency and the applicable Medicaid Manual sections. Your CAP should not contain arguments or dispute the specific audit findings. Your CAP should always include the following information:

- Copy and identify the specific review finding/ observation that is being addressed.
- Explain the specific plan of correction for each finding/observation identified in the findings letter.
- Identify the person(s) responsible for implementing and/or completing specific plan of correction for each finding/observation identified.
- Identify a target date for implementation and completion of the specific plan of correction for each finding/observation identified.

Examples of specific plans for corrective action include:

- Developing/implementing policy and enforcement through monthly internal audits
- Developing training manuals and conducting staff training sessions
- Establishing scheduled monitoring

Submitting Your CAP
Once you have completed a specific plan of correction, identified the responsible person(s), and identified your target dates for each finding/observation designated in the report, you should submit your corrective action plan as instructed in the letter. The provider will be given 30 days to respond to the CAP letter.

Expectations
Upon receipt of the corrective action plan, the QMR team will review the submitted CAP and determine whether the specific plan for each finding/observation meets the requirements for approval. The QMR analyst will provide a letter of acceptance or denial to the provider based upon the submitted CAP.

QMR analyst may deny a submitted CAP if it:

- Fails to address the specific findings/observations
- Fails to provide a specific plan for corrective action for each deficiency
- Contains argument or refutation of findings/observations
- Fails to identify the person(s) responsible for implementation
- Fails to identify target dates, including implementation and completion dates

The QMR team can accept the CAP or can request further revisions as needed. Once the CAP is accepted by the QMR team, the provider will receive a letter of acceptance. In the letter of acceptance, the provider is also notified of the follow-up QMR, or CAP validation review. This review will be a desk review and is performed after the provider has had time to implement their Corrective Action Plan(s). The purpose of this follow-up visit is to ensure the provider has implemented the CAP and is now in compliance with DMAS requirements. Any follow-up review must show adequate corrections of the deficiencies and follow through of the Corrective Action Plan(s) submitted to the QMR Team.

Source: Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapters II, IV, and VI.

Rate Increases for Acute and MLTSS Populations

As of January 1, 2024, DMAS required rate increases became effective and went into production at Sentara Health Plans for the Acute and the Managed Long-Term Services and Supports (MLTSS) populations. Visit the links below to view the list of impacted billing codes:

- **Early Intervention Services Increase**
- **Mental Health Partial Hospitalization and Intensive Outpatient Increases (H0035 and S9480)**
- **Community-Based Behavioral Health Services Increase**
- **Personal Care Services Increase**
- **Complex Rehabilitative Technology Coverage for Nursing Facility Members**

Sentara® Health Plans

Quality Improvement

- Managed Behavioral Health and Health Equity Full Accreditation Awarded
- Low Back Pain
- The Value of Z Codes
- Creating a Community Resource Guide
- Medicare: Medication Adherence
- Medicare: Extra Help Program
- Medicare Health Outcomes Survey
- Quality Management Review
- 2023 Quality Improvement
- Activities and Programs
- Provider Satisfaction and Access Surveys

Managed Behavioral Health and Health Equity Full Accreditation Awarded

Sentara Health Plans is pleased to announce that the National Committee for Quality Assurance (NCQA) has awarded us full accreditation, the highest possible approval level, for Managed Behavioral Health Accreditation (MBHO) and Health Equity Accreditation (HEA).

Earning the Health Equity Accreditation shows that we have implemented a proven and actionable framework for improving and advancing health equity.

Obtaining the Managed Behavioral Health Accreditation demonstrates our commitment to following evidence-based practices to provide high-quality care, adequate network access, and consumer protections for our membership.

Low Back Pain

The HEDIS® measure "Use of Imaging Studies for Low Back Pain" assesses whether imaging studies (plain X-ray, MRI, CT scan) are overused in the evaluation of members 18–75 years of age who present with low back pain within 28 days from the day of diagnosis. Clinical guidelines for treating patients with acute low back pain strongly recommend against the use of imaging in the absence of "red flag" conditions, such as a history of cancer, osteoporosis, and IV drug use. Evidence shows that unnecessary or routine imaging of the lower spine before six weeks does not improve outcomes but rather increases healthcare costs.

For more information on Sentara Health Plans Clinical Practice Guidelines on Acute and Chronic Low Back Pain, visit **sentarahealthplans.com**.

The Value of Z Codes

Adoption of Z codes has been slow since their inception in 2016, but data that paints a whole picture of a patient's life is vital to improving equity in healthcare delivery.

What?
Z codes are the ICD-10-CM diagnosis codes used to document Social Determinants of Health (SDOH).

Who?
Any member of a patient's care team can document Z codes.

When?
SDOH data can be collected during medical visits, Health Risk Assessments, intake with case management, or appointments with community health workers or other professionals.

Where?
Z codes should be recorded in a patient's paper or electronic health record in the diagnosis list, patient history, or provider notes.

How?
SDOH information can be collected via patient interview or with screening tools such as:

- **The Accountable Health Communities Health-Related Social Needs Screening Tool**
- **Social Needs Screening Tool**
- **Identifying and Addressing Social Needs in Primary Care Settings**

Why?
Social Determinants of Health (SDOH) account for up to 55% of health outcomes**. Collection of this data has wide ranging implications from a variety of perspectives—patient, practice, population health, quality improvement, and community. Each of a patient's care partners, from primary care provider (PCP) to health plan, can use analysis of Z code data to strengthen patient support on many levels.

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment

Z59 – Problems related to housing and economic

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstances

Z65 – Problems related to other psychosocial circumstances

Creating a Community Resource Guide

Screening for SDOH does not mean actively addressing all the needs that are found. Providers must look to the surrounding community and its support agencies to bridge those gaps. One effective way to harness the power of community resources is to create a Community Resource Guide for your practice.

To create a Community Resource Guide, you'll need to gather information from across the care spectrum, including the following areas:

Care management contacts at your patients' health plans

- Hospital social workers and discharge planners
- Local Department of Social Services
- Area Agency on Aging
- Focused online search
- 2-1-1

Local contact information for the following:

- Primary and specialty providers
- Behavioral health providers
- Substance use disorder providers
- Dental providers
- Adult day programs
- Housing and rent assistance
- Financial assistance
- Food assistance
- Transportation assistance
- Aging, disability, personal care services
- Legal assistance
- Volunteer and faith-based services

Sharing written and verbal resource information or taking a "warm transfer" approach to seeking out help for social risk factors is one way to invest in the long-term health of our most vulnerable patients.

Medicare: Medication Adherence

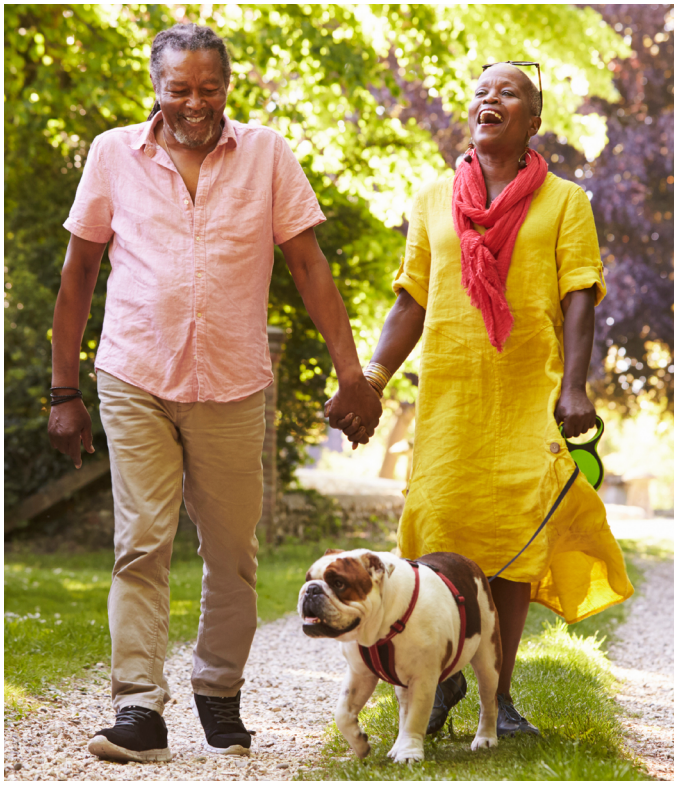
Effective two-way communication is critical for medication adherence; in fact, it doubles the odds of your patients taking their medications properly. Try to understand your patients' barriers and address them honestly to build trust.

The Over the Counter (OTC) benefit from Sentara Medicare offers a range of tools and resources to support medication adherence. Members have access to a variety of nonprescription drugs, supplies, and healthcare products at no additional cost to help them manage their health effectively, including items such as pill boxes, pill crushers, medication bottle openers, and more.

Here are some best practice tips for improving medication adherence:

- **Educate:** Provide clear and comprehensive education to patients about the importance of medication adherence, potential risks of nonadherence, and strategies to overcome barriers.
- **Assess:** Regularly assess medication adherence levels through open discussions and validated assessment tools to identify any challenges or gaps.
- **Support:** Offer personalized support and encouragement, including reminders, follow-up calls, and access to resources such as pill organizers or medication management smartphone apps.
- **Technology:** Embrace modern technology and communication methods, such as telehealth consultations, text message reminders, or virtual support groups to engage patients.

Thank you for your continued partnership in improving medication adherence and delivering quality care to our members.



Medicare: Extra Help Program

In 2024, even more people qualify for "Extra Help," a Medicare program that can pay Part D premiums, deductibles, coinsurance, and other costs.

This year, everyone who qualifies will pay:

- $0 Medicare drug plan premium
- $0 plan deductible
- A reduced amount for generic and brand-name drugs

To apply:

- Call Social Security at **1-800-772-1213** or **1-800-325-0778** (TTY)
- Visit Social Security online at **ssa.gov/medicare/part-d-extra-help**
- Be sure to ask patients if they've applied for Extra Help. For more information, visit **medicare.gov/basics/costs/help/drug-costs**.

Medicare Health Outcomes Survey (HOS)

What is the Health Outcomes Survey?
HOS is a member experience survey that collects clinically meaningful health status data directly from Medicare Advantage patients. The results are used to support planning for quality health improvements, monitor health plan performance, and improve patient health outcomes.

How can providers help?
Providers can help impact how patients assess their health status when asked questions on the survey about specific topics. The survey asks patients about their health status and if they've discussed this topic with their provider.

HOS Measure	How Providers Can Help	Featured Sentara Medicare Plan Benefits*

Overall	• Provide discussion starters during office visits to make it easier to bring sensitive topics up.
	  • Provide an office visit checklist with HOS-related topics to patients at check-in at each office visit to guide discussion.
	  • Hang posters in the exam room with HOS topics highlighted that encourage patients to ask questions.
	  • Check in with patients and offer tips to manage medication side effects.
		• **SilverSneakers** offers online and in-person classes with options for every fitness level, including chair yoga and balance and fall-prevention classes.
		• **Over-the-Counter (OTC) allowance** can help with incontinence products, blood pressure cuffs, and more.
		• **Bathroom safety supplies** help eligible patients access items such as a raised toilet seat or shower safety bench.*
		• **Transportation to medical appointments** can make it easier for patients to get to appointments.
		• **Vision and hearing** services offer coverage and allowances.

Monitoring Physical Activity	• Discuss how to start, increase, or maintain activity, and schedule a check-in appointment to discuss progress on this plan.	
Improving Bladder Control	• Discuss treatments and quality of life options for bladder control issues that may arise from aging, side effects from medications, or health conditions.	
Reducing Fall Risk	• Check blood pressure with patient standing, sitting, and reclining. • Suggest vision or hearing tests. • Ask about medication side effects that could cause dizziness or other symptoms that could increase risk.	

**Patients enrolled in Sentara Medicare can call member services using the number on their ID card to learn more about these extra benefits and eligibility. Benefits vary by plan. Bathroom safety supplies may be available to members with chronic conditions that meet certain criteria.*

2023 Quality Improvement (QI) Activities and Programs

Sentara Health Plans' mission is to inspire healthy living within the communities we serve with a focus on those in need. We do this through innovation, strategic partnerships, industry-leading healthcare, and the power of integration. The Sentara Health Plans Quality Improvement Program has an ongoing commitment to promote excellence in healthcare to all members, enhance personal wellness, continuously improve member experiences and outcomes, and provide access to care in a safe and culturally sensitive manner.

The Sentara Health Plans QI Program core strategy is aligned with the IHI Quintuple Aim.

We have designed our Quality Strategy to continually improve the delivery of quality healthcare to all our members. This Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care and the quality, satisfaction, and timeliness of services.

Our Quality Team would like to acknowledge our providers and their commitment to providing safe, high-quality, and empathetic care to our members.

Source: "The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity." Institute for Healthcare Improvement, ihi.org/resources/publications/quintuple-aim-health-care-improvement-new-imperative-advance-health-equity.

Provider Satisfaction and Access Surveys

Starting in May, our contracted survey vendor, Press Ganey, will perform several surveys of participating providers that will assist Sentara Health Plans in identifying and prioritizing service improvements, allocating resources, and meeting the National Committee for Quality Assurance (NCQA) and government regulatory requirements.

Appointment Access and After-hours Survey
This required survey determines how well providers meet our appointment access standards and after-hours coverage requirements. Press Ganey will perform the appointment access survey during office hours and the after-hours coverage survey by phone for a random sample of providers. Current appointment standards are listed in the Sentara Health Plans provider manuals, and after-hours coverage requires that a person or recording be in place to immediately direct patients for emergency care. If a person is directing patients for emergency care, they must provide the patient an opportunity to indicate that it is an emergency prior to placing the call on hold. The call cannot be placed on hold without giving the patient an opportunity to speak.

Provider Satisfaction Survey
A random sample of provider offices will receive mail, email, and/or a phone call from our vendor, Press Ganey, asking them to participate in our Provider Satisfaction Survey. This survey asks providers to rate the services Sentara Health Plans offers to our providers and is an excellent vehicle to anonymously provide feedback and make suggestions for operational areas within the health plan.

Sentara® Health Plans

Authorizations, Medical Polices, and Billing

- Billing Guidance for Speech Provider Codes 92507 and 92508
- Medicaid Prior Authorization Updates: Effective July 1, 2024
- Authorization Updates: Effective July 1, 2024

Billing Guidance for Speech Provider Codes 92507 and 92508

CPT Codes 92507 and 92508 are not timed codes. When using these codes, providers should bill each code as one unit, regardless of the time spent in a treatment session with a member.

Medicaid Prior Authorization Updates: Effective July 1, 2024

Authorization requirements for 81380 will be updated to reflect Authorization Required effective July 1, 2024.

Procedure	Name	Authorization Requirement	Effective Date
0469T	RTA POLARIZE SCAN OC SCR W/ONSITE AUTO RSLT BI	NC	October 1, 2023
0743T	B1 STR & FX RSK VRT FX ASSMT	NC	October 1, 2023
0749T	B1 STR&FX RSK ASSMT DXR-BMD	NC	October 1, 2023
0750T	B1 STR&FX RSK ASMT DXRBMD1VW	NC	October 1, 2023
81380	HLA CLASS I TYPING HIGH RESOLUTION ONE LOCUS EA	Y	July 1, 2024

Note: Code changes and deleted codes are also updated on **sentarahealthplans.com**

Authorization Updates: Effective July 1, 2024

In keeping with the Centers for Medicare & Medicaid Services (CMS) final rule 4201F, Sentara Health Plans will be archiving applicable Medicare policies in favor of utilizing the NCD/LCD when appropriate. **Visit our website to view the most recent authorization updates.**

Sentara Health Plans has a new medical policy weblink available to access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical polices. You can access this at **sentarahealthplans.com/providers/clinical-reference/medical-policies**.

Sentara® Health Plans

Pharmacy

- Pharmacy Formulary Updates

Pharmacy Formulary Updates

The Sentara Health Plans Pharmacy and Therapeutics Committee (P&T) meets at least bimonthly to provide strategic clinical direction on formulary management and clinical programs. Clinical recommendations made by the committee may result in drug formulary placement updates. These updates help ensure that the most clinically appropriate, cost-effective formulary drugs remain accessible and that contractual obligations are maintained.

Formulary updates for our commercial, exchange, FAMIS, Medicaid, and Medicare lines of business can be found on our website.

Once at the 'Formularies and Drug Lists' page, choose the appropriate line of business. The 'Quarterly Pharmacy Changes' document(s) are updated quarterly. Updates are posted a minimum of 60 days prior to implementation.

Sentara® Health Plans

Important Updates and Reminders

- Register for Our Upcoming Webinars
- Visit Us Online

Register for Our Upcoming Webinars

Mark your calendars to join our upcoming quarterly educational sessions. **Visit our website** to learn more and register. Presentations from previous sessions are also available.

Medical Provider Touchpoint

- May 8, 2024 - 10 a.m.
- May 15, 2024 - 1 p.m.

Let's Talk Behavioral Health

- May 14, 2024 - 1 p.m.

Claims Brush-up Clinics

- June 12, 2024 - 1 p.m.

Visit Us Online

Sentara Health Plans is easy to find on your socials. Feel free to visit, follow, and like:

Facebook:
facebook.com/sentarahealthplans

Instagram:
instagram.com/sentarahealthplans

LinkedIn:
linkedin.com/showcase/sentara-health-plans