

Provider Newsletter

Spring 2026



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Sentara Health Plans News

Jiva R12 Release: Provider Affiliations

R12 release to Jiva Production will have an impact on how providers are showing in Jiva upon authorization creation for AvMed commercial and Sentara Health Plans D-SNP and Medicaid lines of business.

Currently, providers are listed in Jiva as a single provider, which is causing inaccuracies with claim payments and linking providers to affiliations incorrectly in QNXT.

To fix the inaccuracies and incorrect linking, there will be multiple affiliations for one provider. All D-SNP/ Medicaid Utilization Management (UM), Sentara Health Plans, and AvMed staff creating or reviewing authorizations, including Sentara Health Plans providers using the Jiva Portal, must select the provider's information that best matches the affiliation by viewing the national provider identifier (NPI) and address/location.

- AvMed providers using Availity will not have visibility into this change, nor be affected by this change.
- Additional provider addresses have been added under each Tax ID, allowing users to more precisely identify and select the correct service location for authorizations.
- After the go-live of R12 release to Jiva Production, you will see these changes occur throughout the week as the provider's information is being uploaded.

Users should review and select the appropriate provider address associated with the Tax ID to ensure accurate authorization placement and reduce errors in processing.

We recognize that change can present both challenges and opportunities. Please know we are dedicated to helping you navigate this transition and ensuring you feel informed and ready. For Jiva escalations or questions, please reach out to JivaSHPIssues@sentara.com.





Medicaid Updates

Welcoming BabySM Program

Welcoming Baby is Sentara Community Plan's incentive-based prenatal and postpartum care program for our members. It includes:

- Pregnant members from conception
- Birth
- Postpartum care for up to 12 months
- Watch Me GrowSM child outreach to babies from birth to 15 months

Contact the Welcoming Baby outreach team

Phone: **1-844-671-2108 (TTY: 711)**
Monday through Friday 8 a.m.–5 p.m.

Email: welcomingbaby@sentara.com

What Do Your Patients Receive From This Program?

- One-on-one supportive services from a certified community health worker (outreach representative), a maternity case manager, and/or behavioral health maternity care coordinator
- Screening and referral to maternity case managers or care coordinators for care planning and goal setting
- Management of high-risk conditions
- Education and community referrals for identified needs
- Family planning, long-acting reversible contraception (LARC), and birth spacing education
- Virtual and in-person **baby showers**
- Access to breast pumps
- Maternal/child education series **classes** (virtual)
- Referrals to parenting, breastfeeding classes, and lactation services
- Virtual and in-person hospital tours
- Timeliness of care incentives



Timeliness of Prenatal and Postpartum Care

Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Members receive reminders, education, and incentives through the Welcoming Baby Program if they have their first prenatal visit within 42 days of enrolling with Sentara Community Plan or within their first trimester. Members will receive the same benefits if they have a timely postpartum provider visit within 7-84 days of giving birth.

OB Registration Program: Early Identification of Pregnancy

- Providers are eligible to receive a \$25 incentive for referring pregnant patients to the Welcoming Baby Program upon identification of pregnancy for Medicaid members.
- Providers must complete the **Welcoming Baby OB Registration Form**, fax it to outreach at **804-799-5117**, and submit a claim using the code G9001.
- Providers can also email the form to **welcomingbaby@sentara.com**.

Early and Periodic Screening, Diagnostic, and Treatment

All of our Sentara Community Plan members, birth to 20 years, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to include annual wellness checkups with their providers, pediatricians, primary care physicians (PCPs), or general practitioners. Children are able to receive comprehensive health screenings and developmental assessments, vision, dental, hearing services, and medically necessary services as identified.

At Sentara Community Plan, the Watch Me Grow infant and child wellness program screens children at birth through 15 months, and other Sentara Community Plan children in the home, for any health needs and ensures access to care. Children identified with additional needs are referred to our internal high risk pediatric case management for further assessment and follow up. Parents are provided with education on timely well-child visits and immunizations to include oral healthcare and vision care.

Maternal/Child Dental Healthcare

Sentara Community Plan members are educated on dental care for before, during, and after pregnancy, and how to care for their baby's teeth, including fluoride varnish. Education is provided through partnership with Cardinal Cares Smiles. Members are encouraged to contact a dental provider through **DentaQuest.com** or by calling **1-888-912-3456**.



Attendance Monitoring and Managed Care Organization Notification for DMAS Licensed Addiction and Recovery Treatment Services Providers

The Virginia Department of Medical Assistance Services (DMAS) requires DMAS licensed Addiction and Recovery Treatment Services (ARTS) providers to monitor member attendance and notify the member's Managed Care Organization (MCO) when members do not meet the minimum service hour requirements outlined in the ARTS Provider Manual for the following American Society of Addiction Medicine (ASAM) levels of care:

- **ASAM Level 2.1** – Intensive Outpatient Program
- **ASAM Level 2.5** – Partial Hospitalization Program
- **ASAM Level 3.1** – Clinically Managed Low-Intensity Residential

Notification is required to support care coordination, assess barriers to engagement, and determine whether clinical reassessment or a change in level of care is indicated.

Providers must continue coordination of care with other treating professionals, involve members in person centered treatment planning, and notify the MCO or Behavioral Health Services Administrator (BHSA) of significant clinical changes or critical incidents, in accordance with DMAS and ARTS requirements.

Required for All ASAM 2.1, 2.5, and 3.1 Extension Requests

All extension requests must clearly include the following:

Attendance and Scheduling

- Number of sessions attended per week
- Type of sessions attended (e.g., group, individual, family, skills)
- Total number of sessions scheduled per week

Weekly Service Hours

- Total clinical hours per week
- Confirmation that minimum ASAM service hour requirements are met
- A clear weekly total when multiple service types are provided

Missed Sessions (if applicable)

- Number of sessions missed
- Reason(s) for missed sessions (e.g., illness, transportation barriers, member refusal)
- Outreach and engagement efforts to address attendance concerns

Attendance information must be documented under **Section 1: Describe how the member is progressing under the current treatment plan.**

Sentara requests that DMAS licensed ARTS providers:

1. Monitor attendance for ASAM Levels 2.1, 2.5, and 3.1
2. Notify the MCO when members fall below required service hours
3. Submit complete attendance documentation with all extension requests

Incomplete or missing attendance information may delay authorization decisions.



Provider Options Following an Adverse Benefit Determination:

Providers should carefully review the **Adverse Benefit Determination (ABD)** letter for specific details about the reason for a denial or partial approval. The ABD outlines whether services were limited due to clinical necessity, timing, or the need for updated information.

If the ABD states that **additional units may be requested after the current authorization period ends**, the provider may submit an **extension request with updated clinical documentation**. In these cases, a **peer-to-peer (P2P) review is not required** to request additional units. A P2P is only needed when the provider is seeking to overturn the current decision or disagrees with the recommendation for the member to transition to another level of care.

Reviewing the ABD first helps ensure providers choose the most appropriate next step and avoid unnecessary delays in care.

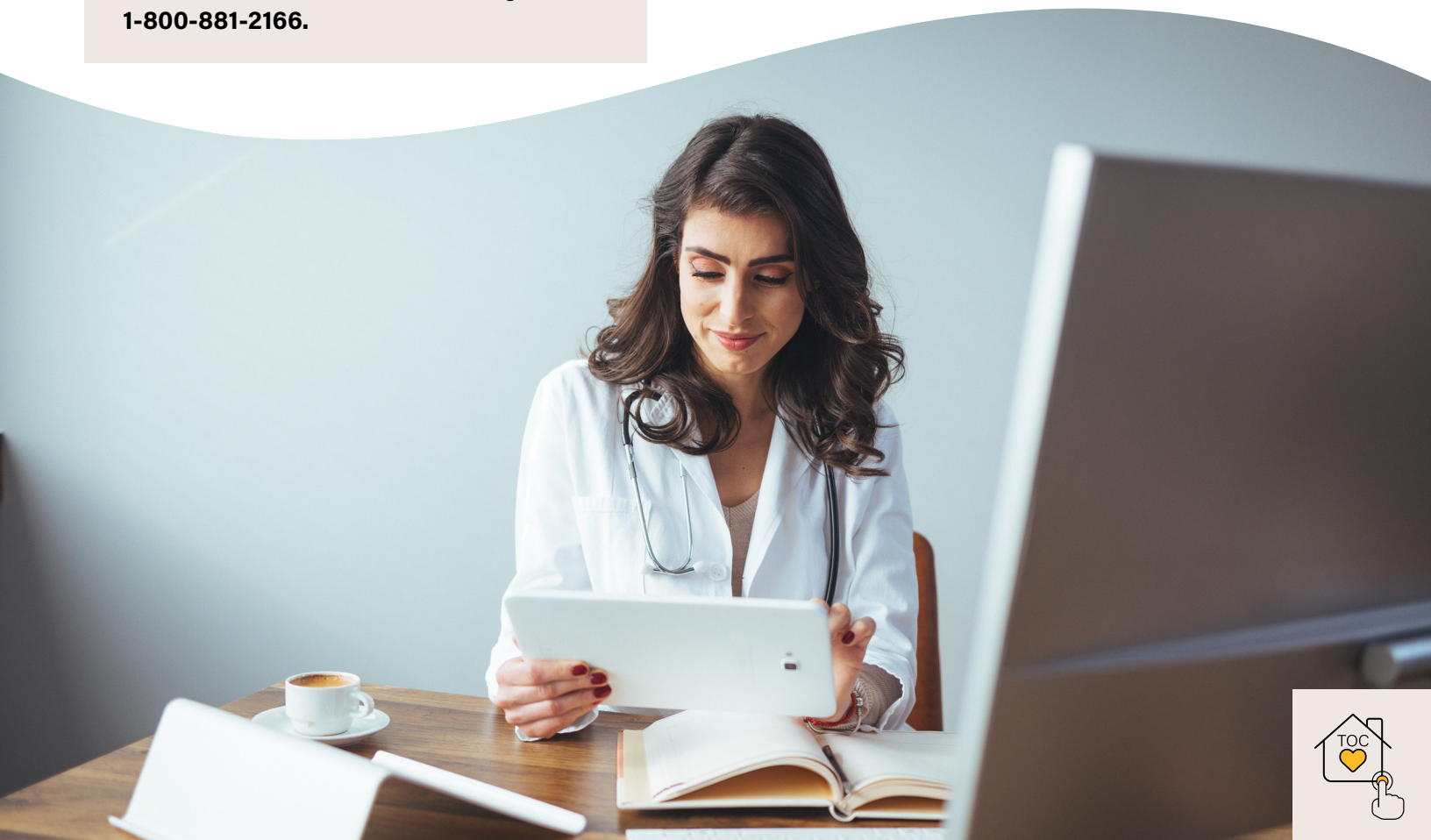
If you have questions related to this notification, please contact Sentara Behavioral Health Utilization Management at **1-800-881-2166**.

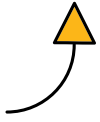
Applied Behavior Analysis Qualifications

In accordance with the DMAS Provider Manual titled Mental Health Services Appendix D: Intensive Community Based Support (Youth), to receive payment for Applied Behavior Analysis (ABA) services, providers must be enrolled with DMAS as:

- PCT 156 or 456 with PS 903
- PCT 020 or 023
- PCT 256 with PS 104
- Licensed by the applicable health regulatory board at the Virginia Department of Health
- Professions (DHP)
- Credentialed with the youth's MCO
- Follow all general Medicaid provider requirements specified in Chapter II of the Provider Manual

Claims submitted for ABA services supplied by providers not meeting these requirements will be denied.





Quality Improvement

Dr. Bradley Cotrina: 2026 Dr. Melvin T. Pinn, Jr. Quality Excellence Award Recipient

Sentara Health Plans is excited to announce Dr. Bradley Cotrina as the recipient of the 2026 Dr. Melvin T. Pinn, Jr. Quality Excellence Award (QEA). This prestigious award is presented annually to a physician who demonstrates an exceptional commitment to delivering high-quality care, providing outstanding service to the community, and improving member outcomes.

Dr. Cotrina is a board-certified family medicine physician practicing at Sentara Family Medicine Physicians in Virginia Beach, VA. He earned his medical degree from the West Virginia University School of Medicine in 2019 and completed his residency at Eastern Virginia Medical School in 2023.

Highly regarded by his patients, Dr. Cotrina consistently receives stellar ratings that reflect not only his clinical expertise, but also his compassion and dedication to patient-centered care. Patients frequently describe him as empathetic, attentive, and an excellent listener who takes the time to thoroughly address questions and concerns. His ability to provide clear explanations and thoughtful solutions contributes to a care experience where individuals feel informed, respected, and supported.

Dr. Cotrina was nominated for this honor by members of his staff, who describe him as a "beacon of care and dedication." In their nomination, they highlighted his unwavering commitment to ensuring that every patient feels "seen, heard, and valued." They further recognized his willingness to go above and beyond in service to others, as demonstrated through his dedication to advocacy, mentorship, and excellence in healthcare.

This year marks the twentieth anniversary of the QEA Award which celebrates a legacy of commitment to quality and excellence in care.



Nominations for this distinguished recognition are accepted throughout the calendar year. Submissions may be completed via the **QEA Nomination Form** or by scanning the **QR code**.



Developmental Flyer Provider Education

Developmental screenings must occur during the well-child visit using an age-appropriate standardized developmental screening tool. If the screening is positive, a follow-up plan must be documented on the date of the visit. Please review the "**Standardized Developmental Screening Tool Requirements During Well-child Visits**" resource flyer.

Key takeaways are as follows: Screening Tools must be age-appropriate and standardized, use the correct CPT code coupled with the ICD-10 Code, and adhere to the minimum requirements for age-based administration.

Depression Flyer Provider Education

Depression screening must occur on the date of the encounter (wellness and outpatient visits) or within 14 days prior to the encounter using an age-appropriate standardized depression screening tool. If the screening is positive, a follow-up plan must be documented on the date of the qualifying encounter. Please review the "**Depression Screening and Follow-up Requirements During Adult Wellness Visits and Outpatient Visits**" resource flyer.

Key takeaways are as follows: Screening must be age-appropriate and standardized, document a follow-up plan for positive screens, and use the correct G-codes coupled with LOINC codes.

What Providers Can Do to Reduce Emergency Department Usage

Reducing emergency department (ED) usage involves a combination of strategies aimed at improving access to primary care, enhancing patient education, and optimizing care coordination. Here are some effective approaches:

1. **Extend Hours and Same-Day Appointments:** Providing extended hours and same-day appointments can help patients access primary and specialty care when they need it, reducing the need to visit the ED.
2. **Telehealth Services:** Implementing tele-triage or telehealth services offers patients affordable care and immediate access to healthcare professionals to determine the best level of care.
3. **Patient Education:** Educating patients about managing their conditions and recognizing when to seek primary care versus emergency care can reduce unnecessary ED visits.
4. **Care Coordination:** Implementing care coordination programs, especially for patients with chronic conditions, can ensure patients receive timely and appropriate follow-up care in the most suitable settings.
5. **Community Resources:** Connecting patients with community resources and support services can address social determinants of health, such as housing and transportation which can impact health outcomes and reduce the need for emergency care.

By implementing these strategies, healthcare providers can improve primary care access and ensure patients are receiving the right care at the right time, ultimately reducing the strain on emergency departments.

Source:

National Committee for Quality Assurance (NCQA). "Emergency Department Utilization (EDU)." NCQA, [ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/emergency-department-utilization-edu/](https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/emergency-department-utilization-edu/).



Improving Asthma Medication Management: Asthma Medication Ratio

The Asthma Medication Ratio (AMR) was a HEDIS® measure that evaluated whether members ages 5–64 with persistent asthma received appropriate long term controller therapy relative to their use of rescue medications. An AMR below 0.50 may indicate poor asthma control and increased risk for exacerbations.

Why It Matters:

Patients who rely more heavily on rescue inhalers than controller medications are at a higher risk for asthma exacerbations, emergency department visits, and hospitalizations. Consistent use of controller therapy helps prevent symptoms and improve overall asthma control.

How Providers Can Improve Asthma Outcomes:

- Prescribe controller therapy when clinically appropriate
- Reinforce daily use of controller medications at every visit
- Explain the difference between controller and rescue inhalers
- Review inhaler technique to ensure proper use
- Monitor refill history and discuss adherence or missed doses
- Identify frequent rescue inhaler use and adjust treatment as needed
- Address barriers such as cost, access, or medication side effects
- Provide or update Asthma Action Plans
- Ensure accurate diagnosis and coding

AMR Measure Update:

The National Committee for Quality Assurance (NCQA) retired the AMR measure beginning with Measurement Year 2026. While reporting has ended, current performance periods continue to reflect prior results, and these evidence-based care practices remain essential for improving asthma outcomes and reducing avoidable acute care utilization.

Thank you for your continued commitment to providing high-quality care for patients with asthma.

Sources:

1. Sentara Health Plans. "Clinical Guidelines." Sentara Health Plans, sentarahealthplans.com/en/providers/clinical-reference/clinical-guidelines.
2. National Committee for Quality Assurance (NCQA). "Asthma Medication Ratio (AMR)." NCQA, ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/asthma-medication-ratio-amr/.
3. National Committee for Quality Assurance (NCQA). "HEDIS MY 2026: What's New, What's Changed, What's Retired." NCQA, 3 May 2024, ncqa.org/blog/hedis-my-2026-whats-new-whats-changed-whats-retired/.

Case Management

At Sentara Health Plans, we work as your partners in care. Our case management team reinforces the plan of care you establish and helps ensure your patients receive what they need at the right time and in the right setting. Everything we do aligns with and supports your clinical direction.

We help monitor complex health needs, close care gaps, and keep patients engaged between visits with your practice. We also guide members, so they know how to make the most of their appointments by helping them understand what to prepare, what to ask, and how to follow through on your recommendations.

Through early identification of high-risk situations, we work to reduce avoidable hospitalizations and help resolve barriers that can interfere with progress. We connect patients with resources, provide education, and offer ongoing support that complements the care you deliver.

Clear and consistent communication is central to an effective partnership. Identifying the assigned case manager, establishing defined communication channels, and sharing timely updates through a designated liaison all strengthen coordination and support improved outcomes.

We look forward to continuing to work alongside you, reinforcing your care plan, supporting your patients, and partnering to improve health together.



Provider Availability: Access and After-Hours Standards

Access to care is recognized as a key component of quality care. As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis, in accordance with Sentara Health Plans' standards for provider accessibility. This includes, if applicable, call coverage or other backup, or providers can arrange an in-network provider to cover patients in the provider's absence.

Providers must plan to refer members seeking care after regular business hours to an appropriate provider. Providers may direct the member to go to an emergency department for potentially emergent conditions, and this may be done via a recorded message.

After-Hours Availability Standards

After-Hours Standards (Live answer or automated system)	Standards (Appropriate responses)
Emergency Instructions Provided	Caller is directed to hang up and dial 911 or go to the nearest emergency room for life-threatening emergencies.
Process to Reach Physician	<ul style="list-style-type: none"> ▪ Directly connects or forwards caller to the physician/on-call physician or appropriate medical professional. ▪ Caller can select an option on their telephone to be directly connected to the physician/on-call physician or appropriate medical professional. ▪ Pages the medical professional; call returned within 30 minutes to the physician/on-call physician or appropriate medical professional. ▪ Answering machines allows caller to leave message; call returned within 30 minutes by the physician/on-call physician or appropriate medical professional. ▪ Call forwarding automatically—call is automatically forwarded to the physician/on-call physician or medical professional.



Appointment Standards

Appointment access standards for Medicaid program:

Service Type	Sentara Health Plans Medicaid Standards
Emergency Services, Including Crisis Services (medical and behavioral health)	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. Follow up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Non-Life-Threatening Behavioral Health Emergency	Within 6 hours or directed to emergency care.
Urgent (non-emergency) Appointments (medical and behavioral health)	Within 24 hours of the member's request.
Regular and Routine Primary Care Services	Regular and routine primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester	Within 7 calendar days of request.
Maternity Care – Second Trimester	Within 7 calendar days of request.
Maternity Care – Third Trimester	Within 3 business days of request.
Maternity Care – High-risk Pregnancy	Within 3 business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Behavioral Health Services (initial and follow-up routine)	Must be made available as expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met.
LTSS	Must be made available as expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met.

Appointment access standards for commercial/exchange (HMO/POS/PPO) plans:

Service Type	Sentara Health Plans Commercial/Exchange Standards
Emergency Services, Including Crisis Services (medical and behavioral health)	Must be made available immediately upon the member's request.
Non-life-threatening Behavioral Health Emergency	Within 6 hours or directed to emergency care.
Urgent Care Appointments (medical and behavioral health)	Must be made within 24 hours of the member's request.
Regular and Routine Services	Must be made within 14 business days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester	Must be made within 7 calendar days of request.
Maternity Care – Second Trimester	Must be made within 7 calendar days of request.
Maternity Care – Third Trimester	Must be made within 3 business days of requests.
Maternity Care – High-Risk Pregnancy	Must be made within 3 business days of high-risk identification, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Routine Behavioral Health Initial and Follow-Up Visits	Within 10 business days.

Appointment access standards for Medicare Dual-Eligible Special Needs (D-SNP) program:

Service Type	Sentara Health Plans D-SNP Standards
Urgently Needed Services or Emergency	Must be made immediately.
Services That Are Not Emergency or Urgently Needed, but the Member Requires Medical Attention	Must be made within 7 business days.
Routine and Preventive Care	Must be made within 30 business days.





Authorizations, Medical Policies, and Billing

Authorization, Medical, and Clinical Policy Updates

Access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical policies on the Sentara Health Plans [medical policy webpage](#).

Visit our [website](#) to view the most recent authorization updates.

Authorization Clarification – Service Facilitation of Consumer Directed Services

Sentara will increase the number of routine visits (99509) that are permissible for a member, without prior authorization within a rolling year (within the prior 365 days). Effective July 1, 2026, the limit for routine visits will increase from four to six. Routine visits beyond the sixth within a rolling year will require authorization.



Pharmacy

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 before implementation.





Important Updates and Reminders

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.

Provider Quality Care Learning Collaborative

June 3 at 12 p.m.

New Provider Orientation

June 4 at 7 a.m.

Lunch & Learn: Provider Website Tour

June 11 at 12 p.m.

Claims Brush-up

June 17 at 1 p.m.

Appeals, Reconsiderations, and Contestment Processes

July 8 at 1 p.m.

Let's Talk Behavioral Health

August 11 at 1 p.m.

Stay Connected!

Follow Sentara Health Plans on social media for updates that support your patients and practice.

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