SPECIAL NEEDS PROVIDER MANUAL

SUPPLEMENTAL INFORMATION

This supplemental Provider Manual (supplement) is available for providers who participate with Sentara's Special Needs Plans. Sentara offers three special needs plans: Sentara Community Complete (HMO (D-SNP), Sentara Community Complete Select (HMO DSNP), and Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP). Information contained in this supplement details additional information and exceptions that are specific to our D-SNP and C-SNP plans. Unless otherwise indicated in this supplement, information in the Core Provider Manual, the Sentara Medicare Supplemental Manual, and the Sentara Medicaid Program Provider Manual applies to D-SNP and C-SNP, as appropriate. Providers should continue to refer to the Core Provider Manual and supplemental manuals for policies and procedures not addressed in this supplement. Providers should contact provider relations or their assigned network educator for additional questions regarding D-SNP or C-SNP.

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Sentara Community Complete and Community Complete Select D-SNP Overview

Sentara Community Complete and Sentara Community Complete Select are our two Dual-Eligible Special Needs Plans (HMO D-SNP) administered by Sentara Medicare. Our plans provide Medicare Part A, B, and D benefits for members who are also eligible for full or partial Medicaid benefits. Special needs plans allow a monthly enrollment between January and September. The members must apply by the last day of the month for their coverage to begin the first of the next month.

Our Sentara Community Complete (HMO D-SNP) plan limits membership to people who qualify for Medicare A, B, and D and 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)

Our Sentara Community Complete Select (HMO D-SNP) plan limits membership to people who qualify for Medicare A, B, and D and partial Medicaid coverage. Approved populations include the following categories:

- Qualified Medicare Beneficiary (QMB)

Beginning January 1, 2025, full benefit dual eligible Medicaid enrollees that have elected to enroll in a type of Medicare Advantage (MA) Plan called a Dual Eligible Special Needs Plan (DSNP) will be assigned to the same health plan for their Medicaid managed care as they selected for their DSNP.

Full benefit dual eligible enrollees who are in Medicaid managed care and have elected to enroll in a DSNP will have their health plan enrollment aligned. Full benefit dual eligibles who are excluded from Medicaid managed care (such as those who reside in an excluded facility), are enrolled in Medicare Fee-For-Service or a non-DSNP MA plan, and partial benefit duals will not be impacted.

DMAS will move any eligible dually enrolled member with unaligned enrollment (enrolled with one health plan for their DSNP and a different health plan for their Medicaid managed care) to the Medicaid managed care plan that matches their DSNP choice. (The member's Medicaid managed care enrollment is determined by their choice of DSNP, as under Medicare rules, beneficiaries must have coverage choice. Virginia Medicaid, on the other hand, requires that most members enroll in managed care.) No dual that elects to enroll in a DSNP will be allowed to have unaligned enrollment.

There are numerous benefits to an aligned enrollment. For Sentara members, Sentara Medicare will coordinate coverage of both the member's Medicare and Medicaid

benefits through Sentara Health Plans, streamlining administrative processes for providers and meeting the member's need for coordinated, comprehensive care. Sentara Community Complete and Sentara Community Complete Select is available statewide in Virginia.

In addition to standard Medicare coverage, Sentara Medicare D-SNP members also qualify for additional supplemental services. Please refer to the supplemental benefit section for those services.

Sentara Community Complete integrates Medicare and Medicaid benefits through care coordination so members receive a more seamless care experience matched to their specific needs. Providers serving Sentara Community Complete members benefit from the increased coordination of care and benefits by Sentara Medicare. Sentara Community Complete care coordinators perform a health risk assessment (HRA) and develop individualized care plans (ICPs) in collaboration with members, their families, and providers. An interdisciplinary care team (ICT) designed to facilitate easy communication between Sentara Medicare and all providers touching a member's care oversees progress on ICPs.

Providers submit claims directly to Sentara Community Complete. Sentara Medicare coordinates payment to the provider from Medicare and Medicaid. Sentara Community Complete members have Medicare cost-sharing protection under their Medicaid benefits. Providers may not bill members for the balance of any service rendered, nor bill them for services not reimbursed by Sentara Community Complete. Members may have copayment requirements for prescription drugs covered under Medicare Part D.

Sentara Community Complete providers are responsible for adhering to requirements and regulations from this supplemental manual, the Sentara Medicaid Program Provider Manual, the Sentara Medicare Provider Manual, Sentara Medicare Provider Agreement, and state and federal governments.

Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP)

Sentara Medicare Engage Chronic Special Needs Plans (HMO C-SNP) is administered by Sentara Medicare. Our plan provides Medicare Part A, B, and D benefits for members who qualify for membership. This plan is a type of Special Needs Plan that is meant for individuals with certain persistent disabling conditions. They offer the same benefits all Medicare Advantage plans offer; however, they aim to help members manage their chronic conditions.

Approved populations must have one of the three qualifying conditions to be eligible:

- Cardiovascular Disease
- Chronic Heart Failure
- Diabetes

Sentara Medicare Engage is offered in our Hampton Roads area. Covered

cities/counties include Accomack, Charles City, Chesapeake City, Franklin City, Gloucester, Hampton City, Isle of Wright, James City, Mathews, Newport News City, Norfolk City, Northampton, Poquoson City, Portsmouth City, Suffolk City, Surry, Sussex, Virginia Beach City, Williamsburg City, and York.

Members submit an attestation with their enrollment application.

Provider Participation Requirements

Medicare Advantage and Medicaid program providers contracted with Sentara Medicare are included in the Sentara Community Complete and Sentara Community Complete Select network unless they have opted out of D-SNP. For further information on credentialing and participation requirements, please refer to the Sentara Medicare Provider Manual or contact a network educator.

In addition to the requirements defined in the Sentara Medicaid Program Provider Manual. Sentara Community Complete and Sentara Community Complete Select providers must agree to the prohibition on billing members for Medicare Part A and B deductibles, premiums, and copayments. Sentara Community Complete and Sentara Community Complete Select members are protected from all cost sharing for Medicare Part A/B and Medicaid services. Members who are not institutionalized or receiving care under a home and community-based services waiver may be responsible for Part D copayments for prescription drugs.

Providers are expected to participate in ICTs and assist members and Sentara Medicare care coordinators in developing and maintaining ICPs.

Model of Care Training

Providers are required to maintain D-SNP and C-SNP Model of Care training on an annual basis. Providers may access the Sentara Medicare Model of Care training here.

This Provider Manual, provider newsletters, and our network educators are also resources for Model of Care training guidelines.

Member Identification and Information

D-SNP members will have two identification cards, one for their Medicare D-SNP coverage and one for their Medicaid coverage. There will be a D-SNP identification card that indicates the D-SNP plan chosen by the member and a Medicaid identification card that indicates the Medicaid plan chosen by the member. Providers should obtain both ID cards and verify benefits for both the Medicare and Medicaid plans for these dual-eligible members.

Providers may identify eligible Sentara Medicare D-SNP members through multiple means, including:

- Sentara Medicare D-SNP member ID card – example provided here
- Sentara Medicare provider portal –sentarahealthplans.com
- Sentara Medicare call center (eligibility) – 1-800-927-6048
- evidence of benefits statements (EOBs)

Eligibility – Sentara Community Complete (HMO D-SNP)

In general, individuals are eligible for Virginia D-SNP if they are eligible for Medicare Part A, B, and D, and are also fully eligible for Medicaid. The three categories of Virginia residents who are eligible for Sentara Community Complete are listed below. However, individuals meeting these criteria who are already enrolled in certain waiver or assistance programs may be excluded from D-SNP.

- **Qualified Medicare Beneficiary Plus (QMB+):** an individual entitled to Medicare whose income is equal to or less than 100 percent of the federal poverty level (FPL) and who is determined eligible for full Medicaid coverage.

- **Special Low-Income Medicare Beneficiary Plus (SLMB+):** an individual entitled to Medicare whose income falls between 100 percent and 120 percent of the FPL and who also meets the financial criteria for full Medicaid coverage.

- **Other Full-Benefit Dual Eligible (FBDE):** an individual entitled to Medicare, who does not meet the income or resource criteria for QMB+ or SLMB+, but who is eligible for full Medicaid coverage either categorically or through optional coverage groups based on medically needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Eligibility – Sentara Community Complete Select (HMO D-SNP)

- **Qualified Medicare Beneficiary without other Medicaid (QMB only):** an individual entitled to Medicare whose income is up to 100 percent of the federal poverty level (FPL) and who is determined eligible for partial Medicaid coverage.

Medicare population categories for which DMAS only pays a limited amount each month toward their cost of care is not eligible for D-SNP plans. Those categories include, but are not limited to, Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), and Qualifying Individuals (QIs).

Eligibility – Sentara Medicare Engage – Heart and Diabetes (HMO C-SNP)

- Qualify for Medicare

- Reside in a city/county that the plan covers
- Has one of these qualifying conditions: Cardiovascular disease, Chronic heart failure, and diabetes

Grace Period

DMAS requires an enrollment grace period for D-SNP members who lose their Medicaid coverage. During this grace period, the member may not be balance billed. Sentara Health Plans Medicaid program provides a three-month grace period for D-SNP member enrollment. If at the end of the three-month grace period Medicaid coverage has not been reinstated, the member will be disenrolled from the D-SNP plan as well.

Sentara Medicare Member Services

Sentara Health Plans member services (1-800-927-6048 and the free TTY phone line 1-800-828-1140 or 711) are available to Sentara Health Plans members from October 1 through March 31, 7 days a week, from 8 a.m. to 8 p.m. or April 1 through September 30, Monday through Friday, from 8 a.m. to 8 p.m. These numbers are published in member materials to assist members in contacting Sentara Medicare with questions regarding their benefits, eligibility, claims, behavioral health services, or any other question/information related to their health plan benefit coverage. The Sentara Community Complete member website is found here.

Care Management

All Sentara Community Complete members receive assistance coordinating their care from a Sentara Medicare care coordinator. Care coordinators conduct comprehensive health risk assessments (HRAs) with 100% of Sentara Community Complete members to stratify them into levels of care, identify areas for intervention and monitoring, and understand the member's existing supports.

Sentara Medicare Levels of Care

Health risk assessments are repeated periodically to ensure the member receives the appropriate level of care coordination as their condition and circumstances evolve. However, the care coordinator may adjust the member's level of care at any time on the advice of the ICT.

Individualized Care Plans/Health Risk Assessment

The health risk assessment forms the basis for the member's ICP. Care coordinators develop ICPs with members and providers to reflect the members' health needs, barriers, treatment plans, and goals. ICPs include:

- member's goals

- treatment and education needs
- type and frequency of services to be provided
- potential barriers and mitigation plans
- measurable objectives for meeting goals
- estimated timetable for achieving the goals and objectives

ICPs are available to providers involved in the member's care on the Sentara Medicare provider portal. Providers may access the ICP, add comments, and send notifications to the care coordinator directly through the portal.

Interdisciplinary Care Team

The member's interdisciplinary care team may include the member, the member's authorized representative, the care coordinator, the member's primary care provider, specialists, and other providers supporting the member. The goal of the ICT is to ensure clear communication channels between providers, coordinate care, and overcome any barriers preventing the member from achieving their health goals.

As care coordination, ICPs, and ICTs are an integral part of Sentara Community Complete, providers are expected to participate in ICTs for their assigned members. Providers may contact their network educator for further information on care management services for Sentara Community Complete members.

Prior Authorization

Prior authorization is required for:

- advanced diagnostic radiology services, including, but not limited to MRI, MRA, CT, CTA, and PET scans
- ambulatory surgery centers
- cardiac rehabilitation services (Medicare covered)
- chiropractic care (Medicare covered)
- durable medical equipment/supplies/prosthetics – single items over $500
- elective ambulance transport
- electroconvulsive therapy
- home health services
- inpatient hospitalization (including mental healthcare)
- intensive outpatient program
- insulin pumps
- Medicare-covered Part B injectable drugs
- mental health specialty services
- outpatient rehabilitation services
- outpatient substance abuse
- outpatient surgery
- observation services (Medicare covered)
- partial hospitalization
- psychiatric services
- pulmonary rehabilitation services (Medicare covered)

- skilled nursing facility
- therapeutic radiology services
- X-rays

Pharmacy

The Sentara Community Complete formulary is available on the provider website.

Mail-order pharmacy services are available for a minimum of a 63-day supply and a maximum of a 90-day supply. Order forms are available from the Sentara Community Complete website above. Prescriptions are generally received within 14 days.

Benefits

Sentara Community Complete members receive all benefits covered by original Medicare plus additional supplemental benefits. General benefit information and the complete evidence of coverage (EOC) for Sentara Community Complete is available on the Sentara Community Complete website at provider website. Specific Sentara Community Complete benefit information is available to providers by calling provider relations during Sentara Community Complete business hours.

Service Types Typically Covered by Medicare and Medicaid

MEDICARE TYPICALLY COVERS	MEDICAID TYPICALLY COVERS
• inpatient hospital care (medical and psychiatric)	• Medicare copayments
• outpatient care (medical and psychiatric)	• hospital and SNF (when Medicare benefits are exhausted)
• physician and specialist services	• long-term nursing facility care (custodial)

MEDICARE TYPICALLY COVERS	MEDICAID TYPICALLY COVERS
• X-ray, lab, and diagnostic tests	• home and community-based waiver services like personal care and respite care, environmental modifications, and assistive technology services
• skilled nursing facility (SNF) care	
• home health care	
• hospice care (covered by FFS Medicare)	• community behavioral health and substance use disorder services

• prescription drugs	• Medicare noncovered services, like OTC drugs, some DME and supplies, etc.
• durable medical equipment	

Extra Benefits

Sentara Medicare offers additional supplemental benefits that are not covered by fee-for-service Medicare. For specific benefits for each plan, please check with the member's EOC located on the website.

Vendors

Hearing
Routine hearing aids and fittings are offered through NationsHearing.

Chiropractic
Must use our vendor American Specialty Health.

Routine chiropractic care is offered. This covers therapeutic manipulation and adjustment.

Dental (preventive and comprehensive dental)
Must use our vendor DentaQuest (DentalMax).

This includes preventive services such as two oral exams, two prophylaxis (cleaning), two fluoride treatments, and two dental x-rays, in addition to an allocation for comprehensive dental which includes such thing as restoration, extractions, and dentures.

Eye exams and eyewear
Must use our vendor Community Eye Care (CEC).

One routine eye exam per year and an allowance for eyewear (combined total for contacts, lenses, and frames) is permitted.

Over the Counter
Must use our vendor, Nations Benefits.

Over the counter medications and medical supplies are covered up to $400 every three months.

- $300 combined allowance per year for eyeglasses (lenses and frames) and contacts
- 1 routine eye examination per year $0

Routine podiatry care
Preventive treatments a year, i.e., cutting or removal of corns, warts, calluses, and nail

care, are included.

Fitness Benefit
Must use our vendor SilverSneakers.

Sentara Medicare offers fitness benefits for gym or fitness classes designed for the elderly. Participation is available through a gym or online.

Personal Emergency Response System (PERS)
Sentara Medicare offers a PERS to members who qualify. Members can call for help in an emergency at the push of a button.

Transportation
Must use vendor Motivcare.

Sentara Medicare offers transportation to medical appointments and in some cases to non-medical locations such as the grocery store and church. Please see member's EOC for coverage.

Bathroom Safety Supplies
Must use vendor Nations Benefits.

Eligible members may obtain up to two bathroom safety devices in a calendar year.

Grocery Allowance
Must use vendor Nations Benefits.

Sentara Medicare offers a monthly grocery benefit to members who qualify.

Meals
Must use vendor Nations Benefits.

Eligible members can receive post-discharge meals after a stay at an inpatient facility such as an inpatient hospital or skilled nursing facility.

In-Home Support Services - Papa Pals
Sentara Medicare offers 90/hours a month of companionship for members who qualify. Papa Pals can assist with things like grocery shopping, medication pick up, technical guidance, and light house help.

MDLIVE program
Video and phone appointments for routine medical conditions with board-certified internal medicine, family medicine, or emergency medicine physicians 24 hours a day/7days a week/ 365 days a year are included.

Worldwide emergency/urgent care
A $50,000 max plan benefit coverage for emergency or urgent care treatment worldwide

is included.

Benefit Limitations – Diabetic Test strips and CGMs

Diabetic test strips, monitors, cartridges for insulin pumps, etc., should be obtained from participating retail pharmacies.

Preferred continuous glucose monitors are Dexcom and Freestyle Libre. Prior authorization would be needed for other manufacturers.

Preferred test strips are vendors are LifeScan (one touch), and Abbott (Freestyle & Precision). Prior authorization would be needed if other brands are needed, or if they exceed 120/strips month.

Claims

Providers submit claims directly to Sentara Community Complete. Sentara Health Plans will coordinate the claim processing for primary and secondary and no claim submission for secondary claim is required. If the member has Medicare fee-for-service, CMS will submit the crossover claim directly to Sentara for processing and no secondary claim is required.

Sentara Community Complete (Medicare) is primary on all Medicare-covered services. Sentara Health Plans' Medicaid program is secondary but primary on non-Medicare covered services.

D-SNP members are protected from all balance billing. In Virginia, D-SNPs are "zero cost share" plans. Providers may not seek payments for cost sharing from SCC members for healthcare services. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Sentara Community Complete during the enrollment grace period or for the difference between what has been paid and the billed charges.

Skilled nursing facility claims must be submitted with the appropriate resource utilization group (RUG) code and assessment identifier.

Provider Appeals

A document with detailed information on how to make a complaint, request a coverage decision, or file an appeal about covered Medicare medical care and services or covered prescription drugs is available on the Sentara Community Complete website located here. This document includes specific timelines and contact information.

Members may make a complaint, request a coverage decision, or file an appeal for Part C medical care or services or Part D prescription drugs, or appoint an authorized representative. Physicians may act as an authorized representative if requested by the member.

Members should call Sentara Community Complete member services for assistance or contact Medicare, as indicated in the document above. Medicare requests should be made within 60 days of occurrence. A pre-service expedited (fast) decision process is available when required by the member's condition.

If the complaint, coverage decision, or appeal is about Medicaid program benefits, members should follow the process for their Medicaid plan. Medicaid plans require complaints to be filed within 180 days of the concern or issue.