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1st Quarter Medical Provider Touchpoint

February 6th & 13th

Sentara Health Plans

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Agenda

1. Medicare STARS Focus – Kelly Pineda, BSN, RN, CPHQ, CSSGB
2. Sentara Chronic Care Management Program Overview – Tammy Forbes, MSN, RN
3. What's New
4. Updates/Follow-up
5. Member Experience
6. Billing Updates/Reminders
7. Important Reminders

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Medicare Stars Focus for Q1 of MY2024

Sentara Health Plans

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Agenda

1. New 2024 Healthy Rewards for Members
2. Health Equity
3. Pharmacy Services – 100-day Fills
4. CAHPS: Background & Best Practices

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2024 Healthy Rewards for SHP Medicare Members

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2024 Healthy Rewards for SHP Medicare Members

Reward Type	Reward Amount	Reward Type	Eligibility* Excludes Savings Members	Quick Notes
Advance Care Planning	$25	Grocery Reward	All members	Captured through provider claim.
Annual Wellness Visit	$50-$100	Grocery Reward	All members	
Bone Density Scan (Osteoporosis)	$25	Standard Reward	Females ages 65+	
Breast Cancer Screening	$50	Standard Reward	All members	
Colorectal Cancer Screening	$25	Standard Reward	All members	At home testing kits are eligible.
Diabetic Management	$40	Standard Reward	Members with diabetes	Must complete three screenings/exams: Diabetic Eye Exam, Diabetic HbA1c Test, Diabetic Kidney Monitoring. At home testing or exam are eligible.
Post Hospital Discharge Visit	$25	Standard Reward	Members w/ hospital in-patient admission. Visit must be completed w/in 30 days.	Follow-up visit can be with PCP or nurse.

Key Notes

- *Sentara Medicare Savings (HMO) members are not eligible for Healthy Rewards.
- *Check additional eligibility notes for each reward.
- Advance Care Planning and Annual Wellness Visit are grocery rewards and can only be used to purchase approved grocery item at approved locations. All other rewards are standard and can be used to purchase nearly anything.
- Rewards cannot be used to buy tobacco or alcohol. Rewards cannot be converted to cash.
- Members can only receive one reward per applicable service per year.
- Rewards take 8-10 weeks to process following the receipt of the claim.
- Services must be completed in 2024 using in-network providers.
- Rewards earned in 2024 expire March 31, 2025

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2024 Annual Wellness Visits (AWV)

Sentara Medicare pays for one AWV in each **calendar year**, no need to wait 365 days

Please ***prioritize*** these visits and get patients scheduled during ***the first half of the year***

2024 AWV Healthy Rewards for Medicare Members	
January - June	$100
July – December	$50

Billing:

- Annual Wellness Visits and Annual Physical Exams **may** be billed in the same visit (with modifier 25)
- Annual Wellness Visits can also be billed with an E&M code as well using the modifier
- AWV billing codes: G0402, G0438, G0439, G0468
  - See description on next slide
- AWV may be done via telehealth visits and should be billed using G0438 or G0439
  - No other G-codes or CPT codes should appear on the claim line for telehealth services delivered in the home
  - Link to 2024 list of codes that can be billed via telehealth: https://www.cms.gov/medicare/coverage/telehealth/list-services

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Annual Wellness Visit Billing Codes

HCPCS	Type of Visit	Description
G0402	Welcome to Medicare/Initial Preventive Physical Examination (IPPE)	Face-to-face visit, services limited to a new beneficiary during the first 12 months of Medicare enrollment
G0438	Initial Annual Wellness Visit (AWV)	Includes a personalized prevention plan of service (PPPS), initial visit; performed after first 12 months of Medicare enrollment
G0439	Subsequent Annual Wellness Visit (AWV)	Includes a personalized prevention plan of service (PPPS), subsequent visit
G0468	Federally qualified health center (FQHC) IPPE or AWV	A FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

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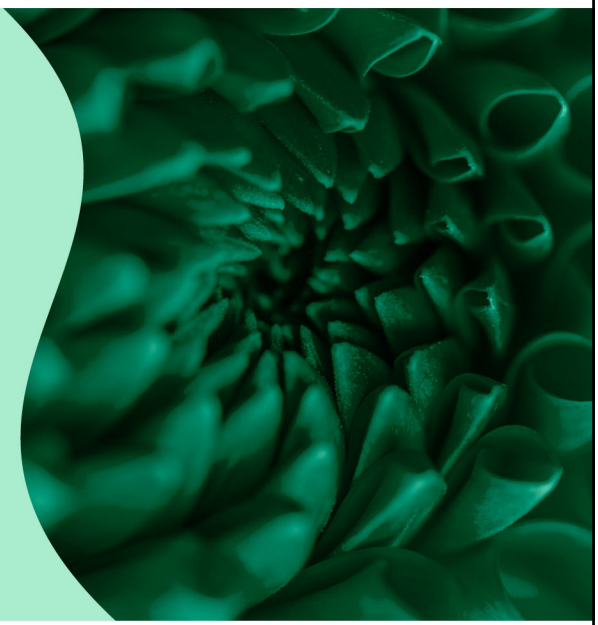
Health Equity



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Health Equity

The CMS Final Rule, published in Spring of 2023, finalized the Health Equity Index Reward to incentivize Medicare Advantage and Part D plans to focus on improving care for members with Social Risk Factors such as low income and disability status.

Individuals with low income or disability may be facing:

- Limited Education
- Food Insecurity
- Lack of Social Support
- Lack of Digital Access
- Lack of Transportation
- Functional Limitations

Data from 2022 shows that Sentara Medicare has some opportunities for improvement. The following measures were found to have disparities:

- Monitoring physical activity
- Getting appointments and care quickly
- Rating of healthcare quality

Patient-Centered Practices for Improving the Care of Individuals with **Social Risk Factors**:

Incorporate reminders and recall systems to flag at-risk participants. Consider a biopsychosocial approach and trigger more holistic care.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2688060/

Treat patients with dignity and respect and create safe spaces for disclosure. Be open to different cultural backgrounds and avoid stereotyping.
https://www.ahrq.gov/health-literacy/improve/precautions/tool10.html

Take a few extra minutes per consultation to address complex health and social needs. Increasing consultation time by 2 – 3 minutes can improve patient enablement.
https://pubmed.ncbi.nlm.nih.gov/18252071/

Maintain a locally relevant and user-friendly internet directory of community resources so that practitioners and office staff can better support patients.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080219/

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Health Equity: Provider-related Medicare Stars Measures

The following measures had disparities identified between members with low-income and disabilities and those without.

Monitoring physical activity

- Health Outcomes Survey (HOS) measure
- Questions:
  - Did you talk with a doctor or other health provider about your level of exercise or physical activity?
  - Did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

Getting appointments and care quickly

- CAHPS Survey measure
- Questions:
  - In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
  - In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Rating of healthcare quality

- CAHPS Survey measure
- Question:
  - Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

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Health Equity: Provider-related Medicare Stars Measures

How our partner providers can help balance the disparities and provide equitable care:

Assess patients for social factors that place patients at higher risk medically:

- Low income
- Disabilities

Be aware of and recommend Sentara Medicare's extra benefits to members with risk factors:

- Groceries
- Over-the-counter items
- Transportation
- Papa Pals (companionship)

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Pharmacy Services – 90 & 100 Day Prescription Supply

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90 & 100 Day Prescription Supply

Sentara Medicare offers a 90-day supply of many prescription medications used to treat chronic conditions

Benefits:
- Convenience for prescribers and patients
- Consistency in managing healthcare needs
- Improved medication adherence
- Cost savings for patients

These benefits are amplified with the new 100-day fill option available for Tier 1 maintenance medications!

Tips:
1. Screen your patients for financial burdens that may decrease medication adherence.
2. Use 90- or 100-day fills to reduce practice refill burden and improve patient adherence and cost savings.
3. Refer patients who require more intensive support to Sentara Medicare for assistance.

NEW! for 2024: 100-day supply fills for Tier 1 maintenance medications

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CAHPS: Tips for Success

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CAHPS: Tips for Success

Why is patient experience important?
- Patient retention
- Improved health outcomes

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Highlights:
- Required by CMS
- Begins in March, annually
- Evaluates members' experience and satisfaction with the health plan, providers, and their care
- Collects data directly from plan members

CAHPS Fast Facts:
- Results from CAHPS are used toward the health plan's overall Medicare Stars rating.
- The questions cover important aspects of the patient's experience with access and quality of care from their providers.
- Using results from CAHPS can allow health plans and providers to work together to improve patient experience and health outcomes.

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Tips to Improve Patient Experience

Getting Appointments and Care Quickly
- Develop new patient onboarding processes to ensure high-risk patients are seen quickly.
- Encourage patients to use telehealth appointments and explain how it can help them manage their care.

Getting Needed Care
- Educate patients on other ways to access care, such as nurse advice lines, after hours call service, secure email, or telehealth.
- Offer to help schedule specialist appointments or tell patients what to do if the next available appointment time is longer than their level of care requires.

Care Coordination
- Promote patient portals or mobile apps that give patients access to manage their care.
- Be clear and specific with patients about how they will receive their test results.

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Thank you

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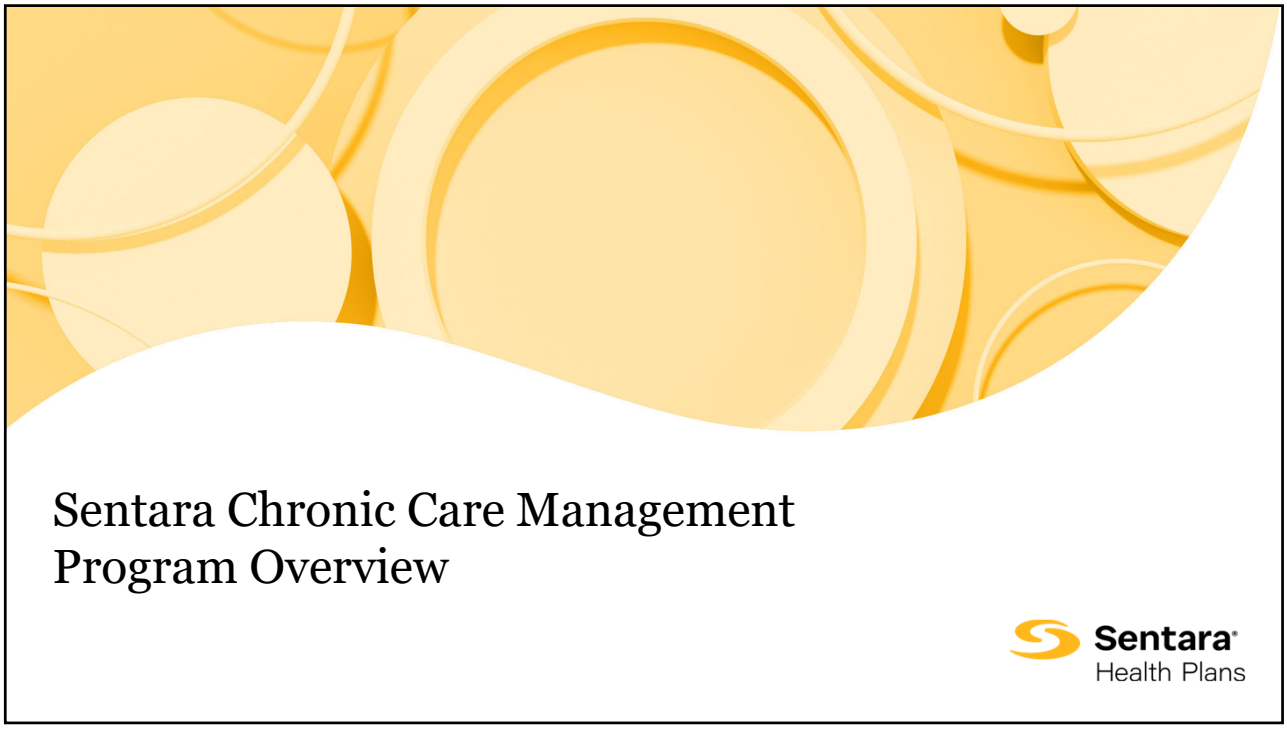

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Program Definition

Chronic disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Program Conditions
1. Diabetes
2. Asthma
3. Chronic Obstructive Pulmonary Disease (COPD)
4. Cancer
5. Cardiovascular conditions (Heart Failure, Hypertension, and Coronary Artery Disease)

Program Goals

- Engage enrollees and care partners in the enrollee's care.
- Increase utilization of preventive services.
- Improve health outcomes by utilizing objective and measurable methods.
- Facilitate the scientific approach to improving health care services through the use of goals, specific interventions, reference populations, analysis plans, and quantifiable, measurable outcomes.
- Close the gaps on disparate access, utilization, or outcomes.
- Implement best practices informed by ongoing program evaluation.
- Provision of education and outreach interventions to engage enrollees and caregivers as partners in care.

Thank you

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What's New

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Welcome to Sentara Health Plans

Sentara Health Plans became a unified brand fully integrating with Virginia Premier Health Plan and Optima Health Plans on January 1, 2024. New name. Same trusted health plan.

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Availity Essentials Update – Effective January 1, 2024

Sentara Health Plans partnership with Availity Essentials began on January 1, 2024. To ensure Sentara Health Plans provides the best user experience, some Availity Essential features will be implemented throughout the year. Current features are listed below for Availity, and our legacy portals for Optima Health Plans and Virginia Premier Health Plans.

Availity Essentials access:

- Claims Submission
- Payer Space
  - Access helpful resources and views our newsletters and important updates/announcements.
  - Connect to the legacy portals for Optima Health and Virginia Premier to conduct transactions not yet available in Availity Essentials. Features available:
    - **Optima Health Portal access**: claims status, eligibility & benefits, claims submission, remittance viewer member ID card views, authorizations and claims corrections.
    - **Virginia Premier Portal access**: claims status and reconsiderations for Medicare and Medicaid lines of business.

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Payspan
Remit Consolidation 1/1/2024

payspan

Effective 1/1/2024 consolidated remits are listed in Payspan for all LOBs that are processed on the QNXT claim payment platform. This update includes the consolidation of negative balances.

- Legacy VPHP users will be required to utilize their **new** Payspan log-in.
- OHP users will access their current Payspan log-in

Pharmacists as Providers

On January 1, 2024, phase one of the Pharmacists as Providers initiative was implemented. This initiative allows pharmacists to bill Sentara Health Plans via the medical benefit utilizing the Evaluation & Management (E&M) codes to receive payment for consultations for allowed services.

The initiative applies to Medicaid and fully insured individual group commercial lines of business. For Medicaid, pharmacists must meet PRSS enrollment requirements as well as enrolling with Sentara Health Plans.

For commercial, pharmacists must enroll and credential with Sentara Health Plans like any other provider.

Pharmacists can find additional information on the contracting, credentialing, and billing processes by visiting the Sentara Health Plans provider website.

Pharmacists are responsible for adhering to the State Board of Pharmacy protocols for allowed services.

Brain Injury Case Management Services Effective January 1, 2024

Brain Injury Services Case Management is designed to provide service coordination and person-centered planning with members who have sustained a traumatic brain injury. Brain Injury Case Management Services are defined in the provider manual supplement posted in the MES Provider Manual Library. Please refer to the DMAS link for more information about the services. Brain Injury Services | DMAS - Department of Medical Assistance Services (virginia.gov)

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Update to Legally Responsible Individuals Implementation Delayed to March 1, 2024

The bulletin in the following link is to provide an update to the Medicaid Bulletin dated September 29, 2023, regarding the permanent provision of payment to legally responsible individuals for personal care services.

Update to Legally Responsible Individuals: Implementation Delayed to March 1, 2024 | MES (virginia.gov)

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Managed Care Plans to Assist Enrollees in Completing Medicaid Renewal Process Effective Through February 28, 2024

CMS approved a request from DMAS to allow managed care organizations (MCOs) to assist enrollees in completing the Medicaid renewal process, including completing certain arts of the renewal forms, to help reduce the number of procedural terminations during the state's Return to Normal Operations Period. This flexibility is in effect immediately and will be in effect through February 28, 2024.

Prior Authorization Changes for Medicare Part B

Starting March 1, 2024, Sentara Medicare will implement changes to prior authorization requirements for drugs billed through medical claims. Providers should refer to the website for the most up-to-date authorization requirements. Prescription Drug Authorizations | Providers | Sentara Health Plans | Sentara Health Plans

Please see the December 21, 2023 Provider Alert which lists the impacted medical drugs that will require authorizations starting **March 1, 2024**.

DMAS Service Manual Updates

DMAS

- Nursing Facility Manual – Chapters 7, 9, 10 and 11
- Psychiatric Services Manual – Chapter 6
- Durable Medical Equipment and Supplies Provider Manual – Chapter IV
- Pharmacy Manual – Chapter 4 and a New Supplement to the Pharmacy and Practitioners Manual.
- All Manuals for Virginia Medicaid and FAMIS Programs and Managed Care Programs – Chapter 2 of all manuals have been updated.

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Updates/Follow-up

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Delegated and Non-delegated Update Requests

Available now for delegated groups you can submit provider updates via web submission under Update Your Information. **Please note:** This will be required effective 3/1/2024.

Non-delegated providers will continue to submit the new practitioner onboarding and updates via the Provider Update Date Form link on the website. Legacy Virginia Premier requests unless it's related to an update effective prior to 12/31/2023 will no longer be accepted via the Provider Update Form. There will need to be a notation in the request submission that this is effective prior to 12/31/2023 or the assumption will be that all requests/updates are for Sentara Health Plans.

Verifying Member Eligibility with Sentara Health Plans – Medicaid & Medicare

Changes were made to member ID numbers and how they appear on the respective ID cards for both the Medicaid and Medicare product lines for Sentara Health Plans. A Provider Alert was sent out January 10, 2024

Medicaid
- The Medicaid ID number is required for real-time eligibility transactions (i.e., through clearinghouses, provider portals, etc.).

Medicare
- The Medicare ID number (including the asterisk *01) is required for real-time eligibility transactions (i.e., through clearinghouses, provider portals, etc.).
- All Medicare member ID numbers lead with "900" (new for former Virginia Premier members).

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Verifying Eligibility with DMAS

Effective January 1, 2024, when determining eligibility via the DMAS provider portal, Sentara Health Plans members will be identified under **Sentara Community Plans**.
For dates of service before January 1, 2024, members will be identified under Optima Health or Optima (formerly Virginia Premier).

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Member Experience

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Tobacco Cessation Referral Process

- Tobacco Referral Process
  - ❖ EPIC Tip Sheet found here: [Provider Toolkit | Providers | Sentara Health Plans]

Provider submits tobacco cessation referral in Epic → Sentara Health Plans— Health and Preventive Services routes referral to Quit Services → QuitNow reaches out to patient within 24 hours of receiving referral → After contacting patient OR after several attempts, Quit Services sends back an outcome report → Sentara Health Plans — Health and Preventive Services documents outcome in the patient's chart in Epic for provider to review

- QUITNow Services

Free 24/7 individualized coaching for ages 13+ via phone, online chat, or text	**18-20 years old:** 5 counseling calls and 12 weeks NRT	Pregnancy and Postpartum: 7 counseling calls and 12 weeks NRT	Behavioral Health: 7 counseling calls and 12 weeks NRT	Youth support: Access to online dashboard and chat option. No NRT

- For questions, contact tobaccocessation@sentara.com

Sentara Health Plans

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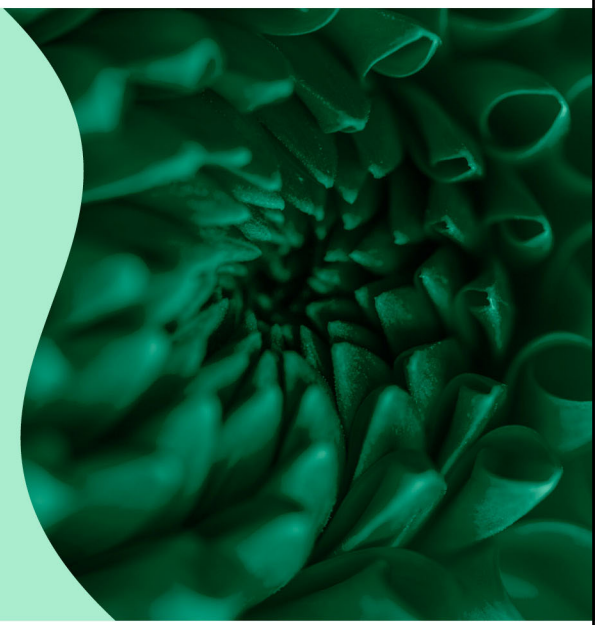
Billing Updates/Reminders



Sentara Health Plans

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ATTN: OB/GYN Providers – Doula Balance Billing

DMAS has notified us that they are continuing to receive complaints that some providers are charging members for completion of the Doula Recommendation and Verification of Pregnancy forms required to access doula care. This is considered balance billing. Please be reminded that it is **not permissible to balance bill Medicaid members for covered services**. Providers must reimburse members who have been charged for the completion of the Doula Recommendation and Verification of Pregnancy form, a covered Medicaid service. If you have any questions regarding this notice, please contact your Network Educator at contactmyrep@sentara.com.

Primary COB for Dual eligible Members (DSNP)

When submitting claims for members with both Medicare and Medicaid always file Medicare as primary. Doing so will avoid processing delays. Claims must include the member's Medicare ID number. Following this process allows our team to process these claims in a timely manner. Going forward with claims DOS 5/1/2023 forward if the claim is not filed with the Medicare number first it will be denied D95 stating the provider needs to resubmit with Medicare number.

Important Reminders

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Provider Training

Required Annually
Model of Care

Encouraged
Cultural Competency Training
Trauma Informed Care Training
Fraud Waste and Abuse

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Provider Changes and Updates – 60 days notice

60 days notice is required for all changes.

Submit the following changes by completing the **Provider Update Form** located at Update Your Information | Providers | Sentara Health Plans | Sentara Health Plans

- ✓**Panel Status/Accepting new patients**
- ✓**Contact information (address, phone, email, etc. – for all locations)**
- ✓**Provider relocation or joining additional practice**
- ✓**Tax ID change (need a new/current W-9)**
- ✓**Name change**
- ✓**Practitioner leaving practice/deceased**

Directly Notify your contract manager of the following:

- ✓**Tax ID change (need a new/current W-9)**
- ✓**Name change**

Sentara

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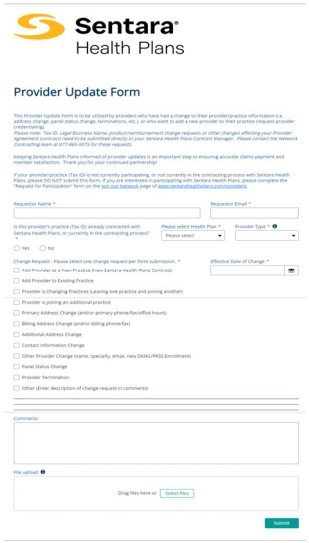
Online Provider Update Form and Applications

We are finding when providers are submitting the online Provider Update Form and Applications, they are not being filled out completely. We are finding that notes are being made in the comments instead of completing the entire form. Please remember to fill out the forms completely, which will assist us in a quicker turnaround time for the applications and the updates can be processed in a timely manner.



Sentara Health Plans

Proprietary and Confidential

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PRSS Enrollment

All Medicaid managed care network providers must enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act.

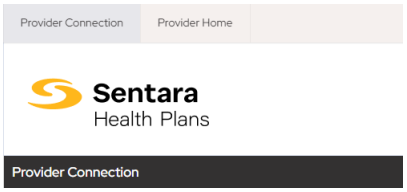
Main points:

- From **virginia.hppcloud.com/,** go to “Menu,” then “Provider Enrollment,” and select either “New Enrollment” or “Enrollment Status.”
- Only one enrollment application is necessary in PRSS, even if you participate with more than one managed care organization (MCO).
- In order to be a Medicaid provider in an MCO’s network, providers must first enroll through PRSS and then contact the MCO(s) you wish to participate in to ensure each MCO’s requirements are satisfied

Provider Connection – Requesting Access for New Providers

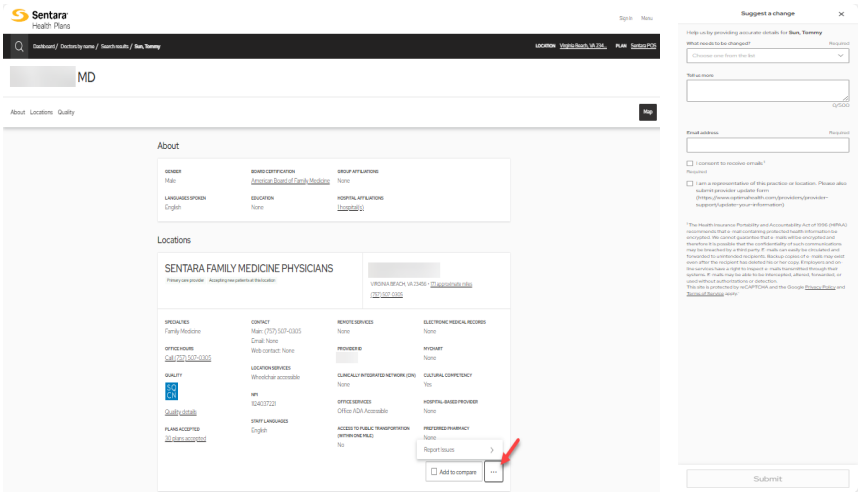
Before Provider Connection access can be granted to new providers the completion of loading provider information must be done to have the accounts available to link to the user’s portal profile.

Providers are sent an auto email completion message notifying of credential approval, when they are loaded, and that they can submit a provider connection portal request. Submitting requests prior to notification causes high volumes of requests and delays.



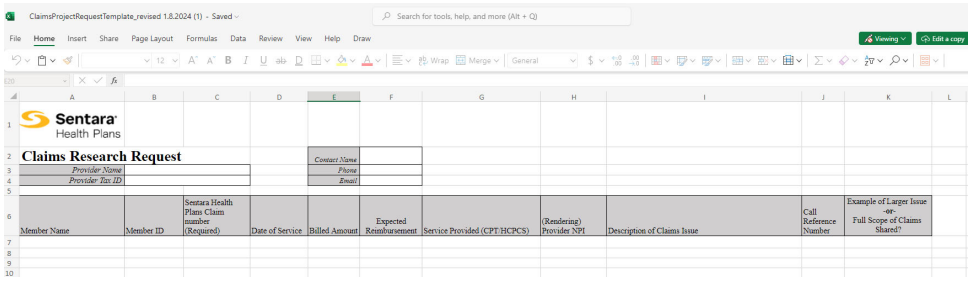
Ensure Your Online Provider Directory Information is Accurate

Please take a moment to view and verify the accuracy of your profile as unverified provider information cannot be included in our online directory.



Claims Project Request Template

Please Note: When completing the claims project template, **the claim number MUST** be included. The inclusion of the claim number ensures that the claims project team can work more efficiently to complete your request.



Report Critical Incidents

A critical incident is defined as any actual, or alleged, event or situation that creates significant risk of substantial or serious harm to the member's physical or mental health and safety or well-being of a member/patient.

Immediately report alleged abuse, neglect or exploitation related critical incidents to appropriate protective services agency: Contact:

- Adult Protective Services (APS): (888) 832-3858
- Child Protective Services (CPS): (800) 552-7096

Within **24 hours**, Email: **criticalincidents@sentara.com**; OR fax Critical Incident Report form to Fax: (833) 229-8932 located at Critical Incident Form_11092021 (sitecorecontenthub.cloud) **OR** Call Sentara Health Plans: (757) 252-8400

Register for Our Upcoming Webinars

Medical Provider Touchpoint

February 6th – 10 AM **February 13th – 1 PM**
May 8th – 10 AM **May 15th – 1 PM**

Let's Talk Behavioral Health

February 14th – 1 PM
May 14th – 1 PM

Claims Brush-up Clinics (POP UP Trainings)

March 13th – 1 PM
June 12th – 1 PM

Question and Answers

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Provider Survey

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Thank you for Partnering with Sentara Health Plans

Contact Us

CONTACTMYREP@sentara.com

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