VirginiaPremier™

Provider Newsletter

Spring 2022

PROV_05312022

Table of Contents

Virginia Premier Extends Vaccine Incentive and Offers Booster Incentive to Members

Virginia Premier shares your commitment to encouraging members to get their COVID-19 vaccinations and boosters. In addition to supporting regional vaccination clinics, we are extending the opportunity for members to receive vaccine incentives for becoming fully vaccinated. See details below:

- Members who receive their COVID-19 vaccination and become fully vaccinated are eligible to receive a $50 Walmart gift card through September 30, 2022.
- Members who receive their COVID-19 booster dose are eligible for a $15 Walmart gift card. Please note that this promotion only applies to individuals receiving a booster between April 1, 2022 and September 30, 2022.
- Upon receiving their full vaccination or booster dose, members can obtain their gift card by calling 757-252-7571.

Additional COVID-19 information and resources, including our frequently asked questions document for providers, are available on our **website**.

Resuming Normal Eligibility and Enrollment Operations: Ask Your Patients to Update Their Contact Information

Virginia Department of Medical Assistance Services (DMAS) has assembled a **toolkit** of information and materials to assist Medicaid members as the agency resumes normal eligibility and enrollment operations. Government agencies sometimes refer to this process as "unwinding" the Federal continuous coverage requirements established in response to COVID-19.

While DMAS does not yet know the official date for resuming normal operations, they are preparing Virginians through outreach and communications reminding Medicaid members to ensure their contact information is current if they have moved or updated their mailing address/phone number(s).

Please remind your Medicaid patients to update their contact information so they can maintain their Medicaid coverage and continue receiving high-quality medical care. They should contact their health plan to make updates; Virginia Premier members can call at 1-888-382-0611 (TTY: 711), Monday through Friday, 8 am to 5 pm.

DMAS will continue to send additional resources prior to and during the unwinding period. The member toolkit and other resources for members and stakeholders are available on the Cover Virginia/Cubre Virginia websites, which are listed below. Please share this information with Medicaid members and display appropriate materials in your office(s).

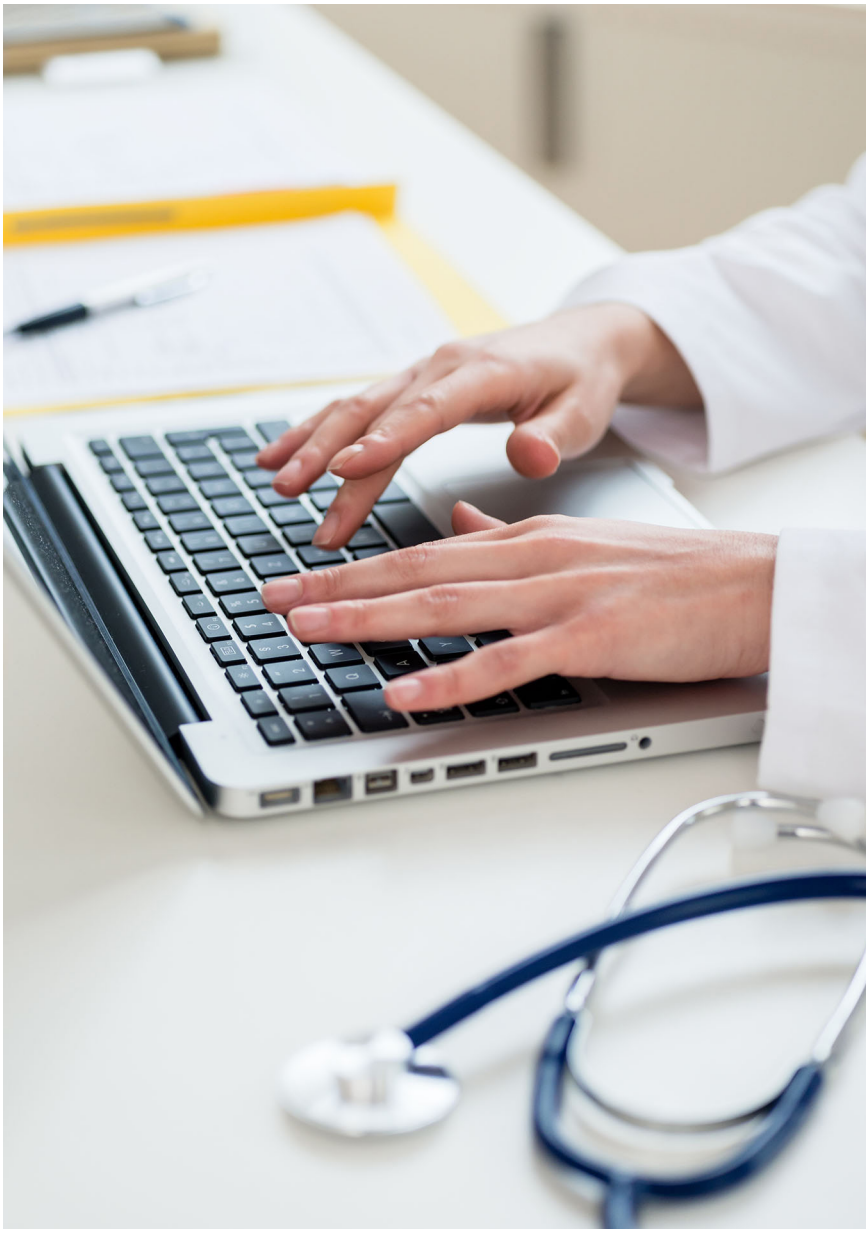
If you have any questions or require additional information regarding DMAS plans for resuming normal Medicaid enrollment operations or outreach efforts and resources, please visit **coverva.org/en**, **cubrevirginia.org/es.**

LexisNexis Outreach: Update Your Practice Information

Maintaining current practice information helps our members select in-network providers, choose health plans, and access care. By keeping your information up to date, it's also easy to comply with your Virginia Premier provider participation agreement and the requirements set by the Centers for Medicare & Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS). Virginia Premier partners with LexisNexis to offer our providers VerifyHCP®, a clinician directory verification portal.

Each quarter, LexisNexis reaches out to our providers via email, fax, and phone to verify practice information. To ensure a timely response from all providers, we have designed the process to be easy. You will need to register for the Verify Health Care Portal and log in to confirm that all details are correct. If you registered for the portal previously, use your existing credentials to log in.

For help, contact LexisNexis Risk Solutions Tech Support at **healthcare.custhelp.com/app/ask**. Thank you for assisting us with this process and for your timely response. We appreciate our ongoing partnership and your efforts to improve health every day for your patients.



Changes Impact How You Search for Members

We want to alert you to changes to how you search for members in the online portal during the authorization request process. Previously, you would search for members by selecting the Medicare or Medicaid drop-down box and entering the member's corresponding number.

Effective May 1,2022, you now select Alternate ID when searching for a member using a Medicaid number. State ID must be selected when searching for a member using the Medicare number. If you have any questions, please email **contactmyrep@virginiapremier.com**. As always, we appreciate your partnership and look forward to continuing to work together.

PRSS Portal Update: Enrollment Outreach Begins Soon for MCO Providers

In April 2022, the Virginia Department of Medical Assistance Services (DMAS) launched a new portal to manage provider enrollment – the Provider Services Solution (PRSS). Medicaid providers will use the PRSS portal, located on the Medicaid Enterprise System (MES) website, to complete enrollment and maintenance processes. This platform will be more efficient and make it easier for you to access the information you need as a Medicaid provider. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act. Those network providers that are currently enrolled as FFS in Medicaid do not have to re-enroll in PRSS.

Starting this month and continuing until early 2023, Virginia Premier will begin outreach to its providers with instructions on initiating enrollment through the new PRSS enrollment wizard. You do not need to take any action until you hear from Virginia Premier, DMAS, or another MCO with which you are a participating provider. Only one enrollment application is necessary in PRSS, even if you participate with more than one as the enrollment process allows for selection of one or more MCO plans. Once approved, providers will need to create a PRSS portal online account in order to revalidate their enrollment, make changes to personal or business information, and check member eligibility. You may be asked to provide evidence of your submission.

Provider Education and Training Courses
You can get ready to use the new PRSS portal by using training resources on the **MES website**. DMAS offers a variety of live and pre-recorded training opportunities to help prepare providers to receive the maximum benefits from the PRSS portal. Please encourage your staff to register for virtual instructor-led courses to make sure your organization is ready to use the new portal. Please visit the MES website for a **comprehensive listing of current courses**.

Training Schedule and Registration
You must register to participate in live webinars. Webinar participants must use a computer with internet access and a telephone line to dial in. Registered participants will have the chance to engage with the trainer and ask specific questions. As you review training options, PLEASE be sure to register for the following three courses:

- **PRSS-111 Provider Enrollment Application:** This training course explains the provider enrollment process, identifies the different enrollment types and offers guidance on the documentation that providers need to prepare before enrolling. The training also includes an overview of what the provider enrollment application looks like and how to submit a provider enrollment application.
- **PRSS-118 Introduction to Provider and MCO Portal Delegate Management:** The goal of this virtual training is to offer instructions on this important process for providers, authorized administrators of providers, and delegates of providers. In PRSS, a provider's primary account holder and/or delegate administrators must register their delegates and assign them permission to access the provider portal to complete enrollments and other tasks.
- **PRSS-120- Introduction to the Provider Portal:** The goal of this virtual training is to introduce the provider portal registration process and the functions, features, and basic navigation within the provider portal.

There is also an optional working session available (PRSS-111-WS Working Session: Provider Enrollment Support) that provides real-time support from our trainer as you work through one or more provider enrollment applications.

To register for any training, please visit the **MES Provider Training Registration page** to choose a date and time that works best for you. Please help us spread the word about this upcoming training opportunity. If you have questions related to training, please contact **DMAS_VA_MESregistrations@briljent.com**.

Partnership with DarioHealth Supports Members with Type 2 Diabetes

Virginia Premier is pleased to announce a new partnership to offer additional support to members with type 2 diabetes. **DarioHealth** helps members with chronic conditions, such as diabetes, to manage their health. This program provides a comprehensive digital solution for diabetes via a smartphone app. Participants receive personalized experiences that drive behavioral changes to improve their health through evidence-based interventions, specialized coaching, and more.

In the coming weeks, Virginia Premier will reach out to members who qualify for this program. As a provider, you do not need to take any action. This program will complement the care our members receive and may contribute to improvements in health outcomes. See the details below to learn more.

Is there a cost to use Dario?

Dario is covered by Virginia Premier at no cost to eligible members. In other words, there are no copays or cost-sharing applied to the Dario program for members.

How do members find out about Dario?

Virginia Premier Medicaid and Advantage Elite (HMO D-SNP) members over 18 with type 2 diabetes are identified by claims data and this information is shared with Dario. They will receive an email or letter offering them the program with a phone number and website to enroll. We encourage members to enroll. Eligible members may be invited to enroll based on their individual needs; enrollment experiences may vary by eligible member.

What members are eligible to participate in Dario?

Virginia Premier Medicaid and Advantage Elite members, who meet the criteria, are eligible.

How do members qualify for Dario?

Members qualify if they:

- are covered by a Virginia Premier Medicaid or Advantage Elite plan,
- are at least 18 years of age,
- have been diagnosed with type 2 diabetes, and
- own a smartphone to use the app.

Members may not qualify if they are pregnant or have:

- Liver failure
- End-stage renal disease
- Had an organ transplant or bone marrow transplant
- Cystic fibrosis
- Other exclusionary conditions

If you have questions about Dario, please reach out to Dario Member Services at 1-833-914-3798 (TTY: 711).

Connecting Your Patients With Support After a Hospital Visit

The Virginia Premier Transition Team plays a key role in reducing the number of readmissions among our members. We can help support members with an inpatient stay of three nights or more. Our goal is to assist members with follow-up appointments to providers and specialists, transportation, compliance, and understanding their medications. The team also assists members with self-management, sick day plans, equipment, and community resources to prevent further readmissions.

The Transition Care Coordinator (TCC) participates in discharge planning and coordinating activities to ensure a safe transition with appropriate referrals and resources in place. We also support members as they transition from nursing facilities back into the community. The Transition Team works alongside social workers to ensure that this transition is safe and appropriate. The TCCs are led by Kaprisha McGill and Stacey Troublefield and the team is composed of 23 regionally based TCCs.

TCCs assist members in managing social determinant of health (SDOH) needs and connecting members to resources available in their communities directly following discharge. In addition, the team reviews patient utilization management and safety (PUMS), Pediatric Antipsychotic Care Coordination Program Process (PACCP A-typical) programs, newborn delivery notifications, and Adult/Child Protective Services reporting follow ups, assists with transitions to community/facilities, and are the referring agents to the internal Virginia Premier Housing Specialist.

Together, the TCCs ensure that our members are provided with the quality service, resources, and support they need to transition successfully and live healthy.

How can I best work with Virginia Premier on discharge planning for a member?

- For successful discharge planning to occur, it is imperative that providers engage in active care coordination with Virginia Premier and be intentional in involving members in discharge planning throughout their admission. Remember, discharge planning begins at the admission to the service.
- Collaborate with the member's care coordinator for assistance linking to other services when needs are identified or barriers are present. As noted above, our care coordinators will work directly with providers and members coordinating services, unmet needs, and transitions of care.

View and share this flyer to learn more about the services available to your patients.

Medicare Stars: Focus Measures for Star Year 2024 (MY 2022)

As we continue to close gaps throughout the measure year, we want to emphasize the importance of timely and accurate billing as it impacts gap closure initiatives and has a direct impact on the overall Medicare Stars Rating. Accurate documentation through claims reduces the chart retrieval process during hybrid season for the health plan and gives back time to provider practices to focus on patient care versus chart retrieval.

Below are a few measures Virginia Premier Medicare is focusing on in the beginning of the new measure year. Helpful tips, documentation requirements, and codes for claim submission are listed below to help practices capture all the information they need to successfully close gaps.

Controlling Blood Pressure

What is the measure? The percentage of patients with a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Patients are identified by event and diagnosis.

Controlling Blood Pressure

Key Points:

- Patients of Virginia Premier Medicare have an OTC benefit allowance they can utilize to purchase a digital/remote blood pressure cuff.
  - Encourage patients to get a BP cuff that takes readings higher on the arm for better accuracy; wrist cuffs are not recommended
  - Consider communicating to patients the positive effects of monitoring blood pressure frequently.
  - Utilize digital/remote blood pressure cuffs during Telehealth visits to help capture data for this measure.
- Talk with patients about what a lower goal is for a healthy BP reading.
- Controlled blood pressure is <140 systolic and <90 diastolic.
- Be sure to record the BP in the medical record.
- Be aware that the new guidelines allow self-reported blood pressures to be documented in the EMR during telehealth visits as long as the blood pressure was taken with a digital machine in the home.
- Don't round up or down when recording the BP. If the initial BP was elevated, take it a second time after a few minutes rest.

Documentation Requirements:

- If a BP is listed on a vital flow sheet, it must have date of service listed as well.
- If your office uses manual blood pressure cuffs, don't round up the BP reading.
- Patient self-reported BP should be documented during the telehealth visit with a note saying the blood pressure was obtained with a digital cuff in the home.
- The use of CPT Category II codes helps Virginia Premier Medicare identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.
  - *Please note, CPT II codes are for reporting purposes only and are not separately reimbursable. If you receive a claim denial, your reporting code will still be included in the quality measure.*

CPT Category II Codes for Filing Claims:

- 3077F: BP >= 140
- 3074F: Systolic < 140
- 3080F: Diastolic >=90
- 3079F: Diastolic 80-90
- 3078F: Diastolic < 80
- Remote Blood Pressure Monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457,99473, 99474

Changes to Diabetes Care - Kidney Disease Monitoring

What is the measure? The measure evaluates adults with diabetes (type 1 and type 2) who have received an annual kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Comprehensive Diabetes Care - Kidney Health Evaluation for Adults with Diabetes	

Key Points:
• Replaced the medical attention for nephropathy measure.
• Patients with diabetes (type 1 and type 2) are eligible for this measure.
Best Practices:
• Consider prescribing ACE/ARB inhibitors for diabetic patients as appropriate.
• Use the appropriate CPT II code to report that the patient is on treatment for nephropathy.
• For point-of-care nephropathy testing, document the date of the in-office test with the result.
• Submit the CPT code for the test performed and CPT II codes to report nephropathy result value.
	Documentation Requirements:
	• Patients who had a quantitative urine albumin test and a urine creatinine test within four days during the measure year meet the criteria.
	The above tests must have service dates documented within four days (or fewer) of each other.
	• **Exclusions**: Patients with ESRD, on dialysis, or receiving hospice or palliative care are exempt from this measure.
	CPT Category II Codes for Filing Claims:
	• Estimated glomerular filtration rate (eGFR):
	  • 80047 – Basic metabolic panel (Calcium, ionized)
	  • 80048 – Basic metabolic panel (Calcium, total)
	  • 80050 – General health panel 80053 – Comprehensive metabolic panel
	  • 80069 – Renal function panel
	  • 82565 – Blood creatinine level
	• Urine albumin-creatinine ratio (uACR):
	  • 82043 – Urine microalbumin
	  • 82570 – Urine creatinine

Follow-up After ED Visit with Multiple Chronic Conditions

What is the measure? The percentage of emergency department (ED) visits between January 1 and December 24 of the measurement year for patients who have multiple high-risk chronic conditions and who had a follow-up service within seven days of the ED visit (eight days total).

Follow-Up After ED Visit with Multiple High Risk Chronic Conditions (within 7 days)	

Best Practices:
• Schedule post-ED follow-up visit three to five days after discharge.
• Assist patients as they navigate the health system to lessen the impact of barriers.
  • Recommend that patients utilize their transportation benefit to get to their follow-up appointment.
• Encourage patients to have regular office visits with primary care provider to monitor and manage chronic disease conditions.
• Develop a daily process to schedule patients who have been discharged from the ED or an inpatient stay.
	Documentation Requirements:
	Eligible Population (Denominator):
	• A patient had an ED visit within the timeframe of January 1 – December 24.
	• The patient had two or more of the below Chronic Conditions documented prior to the ED visit:
	  • COPD, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, stroke, transient ischemic attack
	If a patient has more than one ED visit within an eight-day period, include only the first eligible visit.
	Numerator:
	• A follow-up service within seven days after the ED visit (eight total days). Visits that have occurred on the date of the ED Visit qualify.

HOS Season is Approaching

What is HOS? The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care. All managed care organizations with Medicare contracts must participate. This survey is distributed annually to a cohort of patients and involves a two-part survey – the baseline and follow up two years later.

Why Does HOS Matter? The goal of the Medicare HOS is to gather clinically meaningful health status data to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health.

The two-part survey is meant to measure whether a patient's health has improved in specific areas over time. This data is helpful to monitor health plan performance based on patient-reported outcomes and affects the Medicare Star rating.

Timeline: HOS survey timing has changed due to COVID impacts and now occurs from late July through early November. When published as measure results, the HOS scores affect the rating for the year following the survey.

Outlined below are measures included in the HOS survey. These measures are considered HEDIS® (Healthcare Effectiveness Data and Information Set) effectiveness of care measures. Providers can help impact HOS results by starting important conversations during office visits to help create recall and encourage action.

HOS Measure	Actions You Can Take

1. Overall	• Provide discussion starters for members during office visits
	  • Provide an office visit checklist with HOS related questions to patients at check-in during each office visit to guide discussion.
	  • Hang posters in the exam room with HOS topics highlighted.
	• Due to the sensitive nature of some of the HOS topics, members may be reluctant to bring them up. These checklists and posters can help open and encourage dialog between the patient and provider.

2. Monitoring Physical Activity in Older Adults	• Discuss how to start, increase, or maintain activity. • Refer patients with limited mobility or walking/balance issues to physical therapy to learn safe and effective exercises.
3. Improving Bladder Control	• Discuss treatments for bladder control issues that may arise as a patient ages, such as behavioral therapy, exercises, medications, medical devices, or surgery.
4. Reducing Fall Risk	• Discuss balance problems, falls, difficulty walking and other fall risks. • Suggest using a cane or walker. • Check blood pressure with patient standing, sitting, and reclining. • Suggest vision and hearing tests.

Virginia Premier Launching Doula Benefit for Pregnant Members

In 2022, Virginia Premier will begin offering a doula benefit for members covered by Medicaid plans (Medallion and Commonwealth Coordinated Care Plus). Adding doula services can help address many of the drivers of poor maternal and child health outcomes.

Based in the community, doulas offer a broad set of nonclinical, pregnancy-related services centered on continuous support throughout pregnancy and into the postpartum period. Emotional, physical, and informational support includes childbirth education, lactation support, and referrals for health or social services.

Benefits include up to eight prenatal and postpartum visits and support during labor and delivery. Doula support will be offered in addition to existing benefits, including OB/GYN and hospital labor and delivery services. The effective date for this benefit will be released to members and providers at a later date. For more information, please email **networkdevelopment@virginiapremier.**

New Fax Line Dedicated to Service Authorization Requests with a New Waiver

To facilitate a more efficient process, Virginia Premier has established a new fax line dedicated solely to receiving all service authorization requests that also require a new waiver.

This line is currently in operation, and as of May 1, 2022, we ask that providers use this dedicated line when submitting these requests. Submitting your request to any other fax line may cause a significant delay in processing your request.

Please do not submit any other requests to this dedicated line, as this may cause a significant delay in processing service authorization requests that do NOT require a new waiver.

New waiver service authorization request fax lines:

- 804-793-0579
- 1-833-977-4190

If you encounter any connectivity issues, please notify us via email, **vpepcarecoordinationfax@virginiapremier.com**. Thank you for your cooperation as we work together to make this a better process.

Medical Record Documentation Standards

Virginia Premier reminds providers to adhere to the following guidelines for maintaining medical records:

- A current active problem list must be maintained for each member. It should be legible and updated as appropriate. Significant illnesses and chronic medical conditions must be documented on the problem list. If there are no significant problems identified, there must be some indication in the progress notes stating that this is a well child/adult.
- Allergies and adverse reactions must be prominently displayed. If the member has no known allergies (NKA) or history of adverse reactions, this is appropriately noted in the record. A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.
- Past medical history (for patients seen three or more times) must be easily identified and includes family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.
- Prescribed medications, including dosages and dates of initial or refill prescriptions, are recorded.
- Each page of the medical record contains patient name or identification (ID) number. All entries are dated.
- Working diagnoses and treatment plans are consistent with medical findings. Appropriate plans of action/treatment are consistent with diagnosis.
- All requested consults must have return reports from the requesting consultant or documentation of a follow-up phone call must be noted by the primary care physician (PCP) in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consults filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically need to show representation of PCP review.
- Continuity and coordination of care between PCP and specialty physicians/provider sites (hospitals, home health, skilled nursing facilities, and free-standing surgical centers) must be evidenced when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance care planning/advance directives have been discussed. If the patient does have an advance directive it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must be following Health Insurance Portability and Accountability Act (HIPAA) privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 and older. Referrals to a behavioral health specialist should be documented as appropriate.
- Records should indicate preventive screening services are offered in accordance with Optima Health Preventive Health Guidelines. This should be documented in the progress notes for adults 21 and older.

Critical Incident Reporting: Resources and Training Available

As a reminder, providers must report Critical Incidents to Virginia Premier within 24 hours of learning about the event. Incidents can be reported using the following:

- Email: **criticalincident@virginiapremier.com**
- Critical Incident Fax Line: 804-200-1962
- Call Virginia Premier: 1-877-719-7358, option 2, 4

A critical incident is defined as any actual — or alleged — event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or wellbeing of a member.

Critical incidents include, but are not limited to, the following: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation and death of a member.

Use the following resources to learn more or report an incident:

- **Training**
- **One-Pager**
- **Reporting Form**

Monitoring for Over- and Under-Utilization Improves Member Outcomes

Virginia Premier carefully monitors the over- and under-utilization of services provided to our members to ensure appropriate, cost-effective care. Over-utilization is monitored by analyzing trends among key performance indicators that demonstrate effective utilization of resources.

Using licensed health care staff and board-certified physicians, Virginia Premier can ensure that decisions reflect a member-centric philosophy that incorporates evidence-based practice. While monitoring over-utilization is important, under-utilization can be equally hazardous to both members' overall health and total health care costs. When members do not receive the care they need, when they need it, they may relapse and require a higher level of service to treat their condition.

Virginia Premier monitors both routine and preventive services for utilization trends and will follow up with members when utilization is noted to be low.

VirginiaPremier™

Call us at 1-800-727-7536 (TTY: 711)
or visit us online at VirginiaPremier.com.

Hours of Operations
Monday – Friday; 8 am – 6 pm

Information in this newsletter - such as plan benefits for members, offerings to providers and other details - is subject to change.