Provider 2018 Fall/Winter Newsletter

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From the Medical Director

Medical Director Article for Fall Provider Newsletter October 2018

The season has changed and Virginia Premier is pleased that each of you has contributed to the Virginia Premier success stories during this year. As always, Virginia Premier Health Plan, Inc. would like to thank you for everything you do to help us provide excellent healthcare and quality services to our members and your patients.

Clinical Practice Guidelines

Each 12-24 months Virginia Premier reviews and updates all of its Clinical Practice Guidelines. The guidelines are reviewed and updated by the physicians on the Virginia Premier committees. The guidelines are all evidenced based with references. The guidelines are posted on the website at www.virginiapremier.com and distributed to the providers in printed form if requested. Also if requested the clinical practice guidelines can be faxed or e-mailed.

Virginia Premier recently updated its Pain and Opioid guidelines to comply with recent changes by the CDC. The behavioral health guideline for ADHD, diabetes and depression are updated each year as treatment modalities for these conditions tend to change frequently.

Providers in the network are made aware of the clinical practice guidelines throughout the year. Each provider can also call 1-800-727-7536 (Option 2, then 6) and ask for the provider network department and receive a copy of the clinical practice guidelines.

Virginia Premier guidelines cover acute and chronic care, medical, preventive, and behavioral conditions.

Presently there are 14 Clinical Practice Guidelines.

Pharmacy Updates

Virginia Premier updates its Pharmacy information monthly. The Formulary changes are made to the website for each line of business, including programs for Medicaid and Medicare. Virginia Premier Pharmacy Benefits Manager (PBM) is EnvisionRx and they are available 24 hours a day for questions. Javier Menendez, Vice President for Pharmacy has expanded the staff in the Pharmacy Department and now it is prepared for all lines of business. The website www.virginiapremier.com has the Formulary and it is user friendly for providers and members.

There are many articles in this newsletter. Please read them and remember if you have any questions, please call 1-800-727-7536 (Option 2, then 6).

Enjoy the Fall Season!
Warm regards,

Melvin T. Pinn, Jr. MD, MPH, FAAFP

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Advance Directives (Patient Self-Determination)

A **living will** is a written document that specifies what medical treatment the patient wants in the event they are unable to communicate their wishes.

A **durable power of attorney for health care** is a written document indicating that the member has chosen someone to make health care decisions on their behalf in the event they are unable to communicate their wishes.

Virginia Premier expects practitioners and/or providers to actively engage our members in discussions related to their expressed advance directive wishes and document the details of those discussions in the member's medical records. Virginia Premier will provide information to members about any changes in state law related to advance directives as soon as possible but no later than ninety (90) days after the effective date of the change. Information about advance directives will be provided to members through our Member Handbook.

Additional information on Advance Directives is posted at www.virginiaadvancedirectives.org/. This information can be used to education members, practitioners, and providers.

Utilization Management (UM) and Incentives

Virginia Premier is prohibited from providing incentives for denying, limiting, or discontinuing medical services for its members inclusive of practitioners and Virginia Premier staff. Utilization Management (UM) decisions are based on appropriateness of care, service, and existence of coverage. UM decision-makers do not receive money or other gifts to influence decisions that result in under usage nor are doctors or other individuals rewarded for denying service or care. Additional information pertaining to Virginia Premier utilization management procedures can be accessed at www.virginiapremier.com.

Utilization Management (UM) Criteria

To ensure Virginia Premier renders the most appropriate UM decisions, we use clinically and evidence-based criteria and consider the individual circumstances when determining the medical appropriateness of requests for authorization. If you receive notification of an adverse decision, which includes a determination to deny, modify, or reduce services for which you requested authorization, you may request the clinical guideline or criteria that was applied to make the decision by calling the Medical Management department at 1-888-251-3063.

Notice to CMHRS and ARTS Providers

Regarding Beacon Authorizations Prior to 08/01/2018:

This notice is being sent to Community Mental Health and Rehabilitation Services (CMHRS) & Addiction and Recovery and Treatment Services (ARTS) providers who received an authorization number prior to August 1, 2018 from Beacon Health Options.

Due to recent changes with our claims system, when billing for services that were approved with a Beacon authorization number prior to **August 1, 2018**, please **do not** include the authorization number on the claim. If you use the Beacon authorization number on the claim, your claim will be denied.

Effective August 1, 2018, Beacon started providing Virginia Premier authorization numbers and we request that you please **include** the Virginia Premier authorization number received after August 1, 2018 on the claim. If you do not know your Virginia Premier authorization number, please use the provider portal to confirm your authorization number.

Clinical Practice and Preventive Care Guidelines

Define:

The objective of preventive care guideline review is to adopt and monitor the use of scientifically based preventive care guidelines for improving the quality of care provided relevant to the member population. The guidelines must relate to two of the practice guidelines that are the basis of the Disease Management Program (DM). The Asthma and Diabetes Programs were identified as the two programs to support the clinical practice guidelines and are evidence-based.

Measure:

Virginia Premier maintains the following Clinical Practice and Preventive Care Guidelines:

- ADHD
- Asthma
- Childhood Weight Management
- COPD
- Diabetes Mellitus
- Heart Failure Disease
- Pain Strategy
- Prenatal-Normal Pregnancy
- Preventive Care
- Preventive Prenatal High Risk
- Screening for Depression in Diabetes
- Sickle Cell Pain Crisis
- Smoking Cessation
- Stable Coronary Artery Disease
- Weight Loss Drugs for Adults & Criteria

Clinical Practice Guidelines (CPGs)	HEDIS Measure to Assess Compliance
ADHD Guidelines	Follow-up Care for Children Prescribed AHD Medication (ADD) including Initiation Phase and Continuation and Maintenance Phase
Asthma Guidelines	Asthma Medication Ratio (AMR) Ages 5 – 11 Ages 12 – 18 Ages 19 – 50 Ages 51 – 64 Total
Childhood Weight Management	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)
COPD Guidelines	Use of Spirometry Testing in the Assessment and Diagnosis of COPD Pharmacotherapy Management of COPD Exacerbation
Diabetes Mellitus Guidelines	HbA1c HbA1c poor control (>9%) HbA1c control (<8%) Eye exam (retinal) Medical Attention for Nephropathy BP control (<140/90 mm/Hg)
Heart Failure Disease (Cardiovascular)	Controlling High Blood Pressure Persistence of Beta-Blocker Treatment After a Heart Attack Statin Therapy for Patients with Cardiovascular Disease
Prenatal – Normal Pregnancy	Timeliness of Prenatal Care – received a prenatal care visit in the first trimester or 42 days after enrollment Postpartum Care – postpartum visit between 21 and 56 days after delivery
Preventive Care Guidelines	Selected measures on prevention and screening
Preventive Prenatal High Risk Guidelines	Chlamydia Screening
Screening for Depression in Diabetes	Diabetes Monitoring for People with Diabetes and Schizophrenia
Smoking Cessation Guidelines	Adult BMI Medical Assistance With Smoking and Tobacco Use Cessation
Stable Coronary Artery Disease Guidelines	Statin Therapy for Patients with Cardiovascular Disease Controlling High Blood pressure Aspirin Use and Discussion Influenza Vaccination Pneumococcal Vaccination Antidepressant Medication Management

Analyze:

All clinical practice guidelines were reviewed and/or updated on schedule during 2018. Guidelines are distributed to the practitioner network via our website (www.virginiapremier.com) and practitioners are notified by fax blast and newsletter of availability of guidelines on the website. Guidelines are available to members on the website (www.virginiapremier.com) and upon request.

Virginia Premier's Commendable Accreditation Status

It is with great pleasure and excitement to announce that Virginia Premier has received a new and improved accreditation status from the National Committee for Quality Assurance (NCQA). Virginia Premier is now accredited at a **Commendable** accreditation status (previously Accredited status), which meets Virginia Premier's strategic goal of reaching the next accreditation level in 2018!

The Accreditation Statuses, from the lowest to highest are:

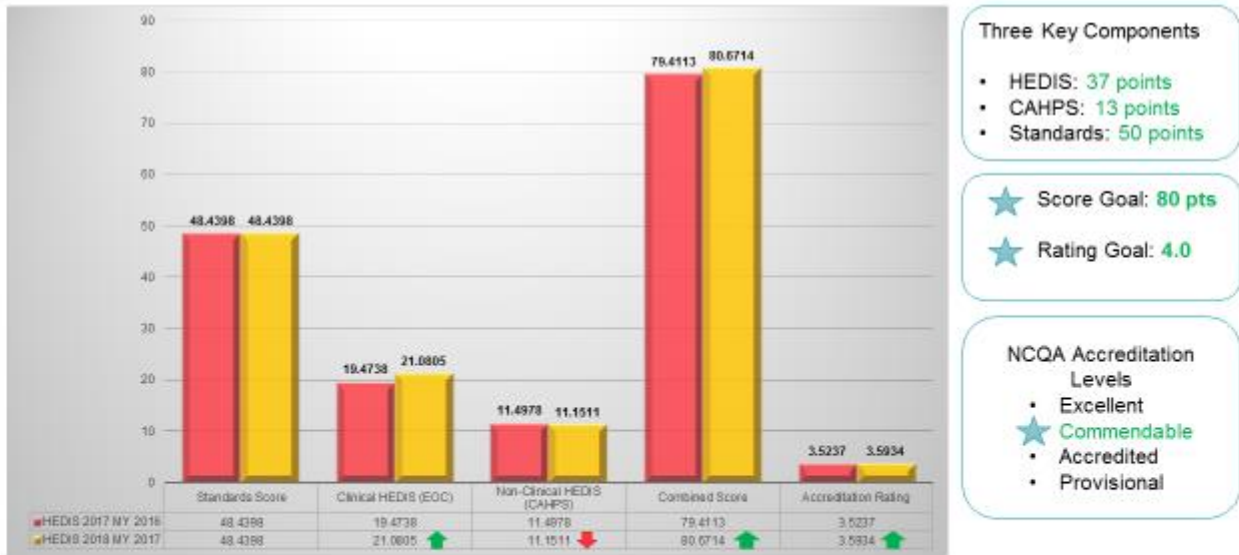
Denied	Provisional	Accredited	Commendable	Excellent

The NCQA is a rigorous assessment of health plans' structure and process, clinical quality and patient satisfaction. The three core components of the NCQA accreditation process includes: Standards (50), the Healthcare Effectiveness Data and Information Set (HEDIS) Measures (37) and Patient Satisfaction (13). More than 173 million people are enrolled in NCQA-Accredited health plans like Virginia Premier.

The new status means Virginia Premier is on track to meet its next accreditation goal, which is to be accredited at the **Excellent** status in the coming years. Virginia Premier received its first NCQA accreditation status in 2007. Since that time, Virginia Premier has maintained an ongoing focus on improving quality throughout the organization, especially in the areas of operational efficiencies and, HEDIS, member satisfaction and access to care.

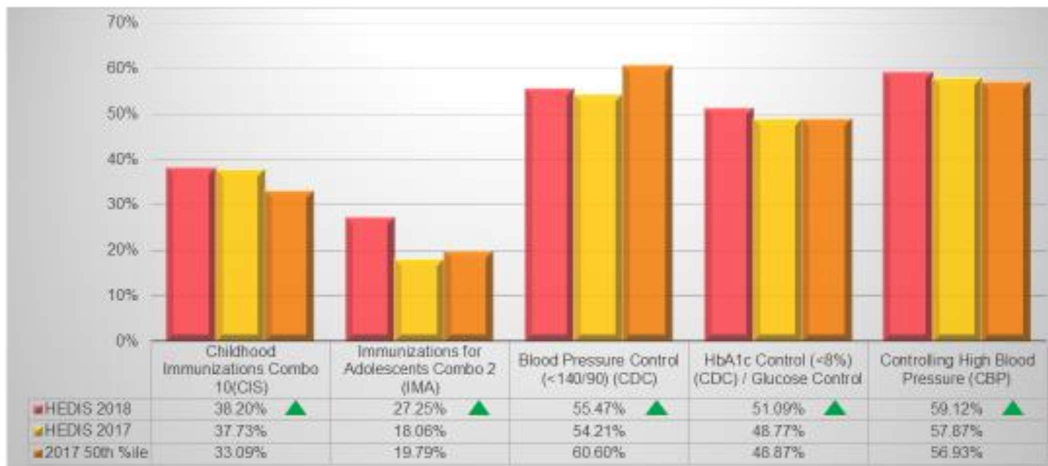
Please take a moment to review our overall outcomes:

NCQA Accreditation Trending Results



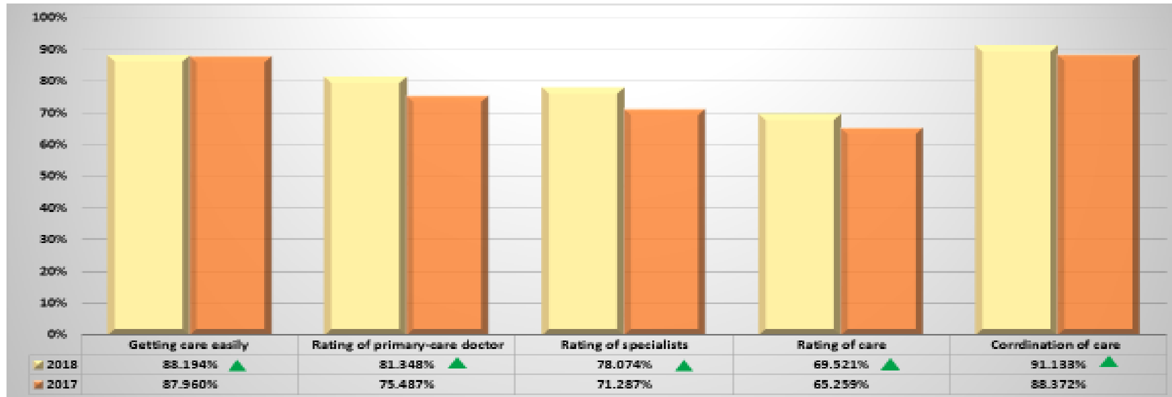
HEDIS Measurement

Virginia Premier's new and improved accreditation status is directly attributed to improvements in the HEDIS rates. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, and factors into the overall accreditation status. Certain HEDIS measurements are "triple weighted," due to their importance. In 2018, Virginia Premier posted improvements over 2017 in all five triple-weighted measurements for our Medicaid members (see the graph and Year over Year (YOY) comparisons below):



Member Satisfaction

We are pleased to announce we posted yearly improvement in five important measures of our Medicaid members' satisfaction as well (see the graph and the yearly comparisons below):



QUALITY IS A COMMUNITY EFFORT!

We are grateful for you--our provider community--and our members in helping us achieve this accomplishment. Give yourselves a round of applause because achieving an NCQA "**Commendable**" Accreditation Status is a huge accomplishment! We look forward to the continued partnerships.

Cultural Competency

At the core of both patient centeredness and cultural competence is the ability of the health care provider to see the patient as a unique person; to maintain unconditional positive respect; to build effective understanding; to explore patient beliefs, values and meaning of illness; and to find common ground regarding treatment plans.

Providers who incorporate the following guidelines into their practices may be able to work more effectively with patients and families who are from other cultures.

- Learn more about a patient's culture by attempting to establish how the family members interact. Initiate a discussion to determine how a family copes with crisis and/or serious illness, which will assist in developing more effective treatment options and/or discharge plan.
- Determine how long the family has been in the U.S. If a family has been in the U.S. less than a year, the more likely much of their native culture remains present.

- Be aware that some behaviors are rooted in specific cultures. One culture may require same gender healthcare providers. Individuals in other cultures may avoid eye contact as a sign of respect and should not be interpreted as a sign of indifference. A good practice is to ask the patient if there is something you don't understand about their culture.
- Maintain a list of trained medical interpreters whenever possible. Family members should not be used as interpreters, unless absolutely necessary. Information received through family members may not be accurate or objective and the patient may not be comfortable discussing certain things with a family members present.
- Note cultural differences that may affect care. For instance, in cultures where women are not allowed to make decisions, asking the mother to sign the consent form for a child may be contrary to a fundamental cultural belief.
- Provide resources and services to office staff to increase awareness and sensitivity to cultural differences. Do a search for information related to Cultural Competency and Cultural Diversity on the internet. There is a wealth of information available online, as well as, at a local library or book store.
- Be careful about stereotypes. Do not assume that everyone who comes from a specific country is alike. Culture and beliefs vary widely depending on regional and demographic differences.

Now available: A Cultural Competency Quiz that may be downloaded and completed on paper. Visit https://www.virginiapremier.com/assets/Cultural-Competency-Quiz.pdf to find the free course or contact us and we will fax or email you the Quiz.

For more information contact the Quality Department:

1-800-727-7536

Fax: 1-804-819-5171

Emergency Room Utilization

Virginia Premier covers emergency care services. If a Virginia Premier member experiences a sudden, unexpected medical condition and time permits, the member should contact their Primary Care Physician (PCP) for medical advice or, if unable to reach PCP or it is after hours, members should call the 24-hour Nurse Advice Line at 1-800-256-1982. In the event of a true emergency, Virginia Premier members should seek immediate medical treatment from the nearest emergency room.

When a Virginia Premier member presents to the ER without authorization from their PCP or Nurse Advice Line, and the situation does not appear to be an immediate risk to the member's health, emergency room staff should encourage the member to contact their PCP.

Virginia Premier covers emergency services under the following situations:

- To screen and stabilize the member without prior approval, where a prudent layperson acting reasonably, would have believed that an emergency medical condition existed. (A prudent layperson is a person who is without medical training

and who draws on practical experience to decide if there is a need to seek emergency medical treatment).

- If an authorized representative, acting for the organization, authorized the provision of emergency services.

Evaluation of New Technology

An ever-changing health care market presents new rules, regulations, trends, best practices, and increasing needs to adapt to new technology. As such, Virginia Premier has a review committee to evaluate new technology. Virginia Premier's review committee appraises the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health care procedures, pharmaceuticals, and devices. While reviewing new technology, the review committee evaluates the utilization, potential for harm, cost, clinical trials, peer-reviewed medical literature from appropriate government regulatory bodies (e.g., FDA and CMS), recommendations from professional societies, and opinions from specialists.

Federal Programs

Medicare Advantage Prescription Drug (MAPD)

Please be aware that our member ID cards will look a little different this year. Member ID cards for 2019 will not include PCP name. However, members will still be required to choose a PCP. Advantage Elite, Advantage Gold and Advantage Platinum will be effected by this change. The PCP will be back on the card in 2020.

MAPD is expanding, with coverage in 22 additional Eastern Virginia counties beginning January 1, 2019.

Open Enrollment for Individual and Family Plans

Virginia Premier will offer four plans on the health insurance exchange for 2019, representing three tiers of coverage: one bronze, two silver, and one gold. The plans will serve the counties of Amelia, Caroline, Chesterfield, Goochland, Hanover, New Kent, Powhatan, and the City of Richmond. Individual and Family plans will be listed online at the www.healthcare.gov website, and consumers will be able to sign up for them during the annual enrollment period from November 1, 2018 through December 15, 2018. After December 15, consumers will need a qualifying special election period to enroll.

Finance Corner

Electronic Funds Transfer (Direct Deposit)

We encourage Virginia Premier payees to choose the Electronic Funds Transfer (EFT) payment method. That will ensure that you will always get paid by direct deposit into your bank account

on the actual payment date (or within one day, depending on where you bank). This way, there is no delay in payment receipt for postal deliveries. If you would like to be set up for EFT payments for payments made through our legacy system (Medallion 3.0), please go to the Virginia Premier website and download the EFT Set up form and the instructions will be on that form.

For Virginia Premier Elite Plus, Virginia Premier Medallion Medicaid 4.0, Virginia Premier CompleteCare claims and all of the Medicare Advantage lines of business, you must register with our payment processing partner, PaySpan, to receive payments and remittances electronically.

To register, please visit www.payspanhealth.com. You will need your registration code and PIN and your bank routing and account numbers (available on your check stub received from PaySpan). If you do not know your registration code or PIN, please contact PaySpan Provider Services between 8:00 am to 8:00 pm (ET) at 1-877-331-7154, Option 1, or send an email to providersupport@payspanhealth.com.

Reminders Regarding Name or Legal Status Change

If you have changed your tax identification number, address, Medicaid provider number, legal business name, or if you have any other contractual changes, please forward a W-9, along with your changes, to the Contracting department. Doing this can avoid possible IRS regulated fines and/or impact on your payments. In addition, any changes made without a W-9 attached will possibly delay your payments.

Also, if you notice that the name on your check is not the name that matches your entity tax identification name submitted to the IRS, please contact the Contracting department promptly with the correct information. Please be mindful that we have to pay based on the name that agrees with the tax ID on record with the Internal Revenue Service (per our real-time TIN verification with the IRS). The name on your check is the same as that you will see on your 1099 form for tax reporting purposes at the end of the year.

Holidays

Payments will not be processed on banking holidays.

Fraud, Waste and Abuse Laws

The federal government has several laws prohibiting activities that may constitute fraud, waste or abuse:

False Claims Act (31 U.S.C. §§ 3729-3733)

The False Claims Act is a set of statutes that prohibits certain fraudulent conduct, including the knowing submission (or causing to be submitted) of false or fraudulent claims for payment, or claims for payment supported by false records or documentation, to the federal government, including federal health care programs. Lawsuits may be brought by whistleblowers under a “qui tam” action, requesting that the government intervene and take over the suit. Whistleblowers are entitled to a percentage of the ultimate recovery in a qui tam action.

Physician Self-Referral Law (the "Stark Law") (42 U.S.C. § 1395nn)

The Stark Law is a set of civil laws that prohibits physician referrals for certain services – those known as "designated health services" – to entities with which he/she or an immediate family member has a financial relationship, such as in investment interest or compensation arrangement, when those services are paid for by Medicare and other federal programs, unless an exception applies.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b)

The Anti-Kickback Statute prohibits knowingly and willingly exchanging anything of value for referrals or generating business involving items or services paid for by any federal health care program (e.g., Medicaid, Medicare, Tricare). Regulations offer "safe harbors" for certain arrangements that fit each of the applicable requirements. The Office of the Inspector General (OIG) can seek criminal penalties for violations both sides of the illegal transaction.

Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a)

The Civil Monetary Penalties Law ("CMPL") allows the OIG to seek civil monetary penalties for various types of fraudulent or prohibited conduct and violations of law, such as the Emergency Medical Treatment and Labor Act ("EMTALA"). Like the False Claims Act, the OIG can pursue a provider under the CMPL for false claims and violations of the Stark Law and Anti-Kickback Statute.

Exclusion (42 U.S.C. § 1320a-7)

The OIG has the authority to exclude providers from participation in federal health care programs for certain violations. Claims cannot be submitted to Medicare, Medicaid, or other federal program for any services (including health care, administrative or management services) performed or prescribed by an excluded individual or entity, or provided under the excluded individual's medical direction. Importantly, an organization that employs or contracts with an excluded individual may be liable for civil monetary penalties.

Report any suspected fraud, waste, or abuse by visiting www.virginiapremier.com/program-integrity/compliance-concern-reporting or the contact numbers below.

Program Integrity Officer: 1-804-819-5173

Compliance Helpline: 1-800-620-1438

Reports to Virginia Premier will remain confidential and can be anonymous.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS plays a major role in managed care in the USA. It measures quality performance in many areas of health care and standards of care in general. The HEDIS abstraction season begins in January 2019, and will go through May 2019. Each year HEDIS performance seems to get more and more challenging for health plans. There are 16 HEDIS measures for which we

will be requesting medical records, and we will need your continued cooperation and support as our HEDIS staff reaches out to your practice.

If you have questions about medical record retrieval please contact Nora Matthews, Quality Senior Manager at 1-804-819-5151 ext. 54161.

Medicaid Expansion

Beginning January 1, 2019, Virginia residents will have access to low-cost health coverage through Medicaid Expansion. Open enrollment for Medicaid Expansion will begin November 2018 through December 2018 and will serve approximately 400,000 members in Virginia. Members under the Medicaid Expansion plan will be assigned to the CCC Plus or Medallion 4.0 plans. Eligibility is based on income and is primarily for individuals who fall under particular categories such as low-income children, pregnant women, the elderly, individuals with disabilities and parents who meet specific income thresholds. Medically complex members will be enrolled in CCC Plus and all others will participate in the Medallion 4.0 plan.

For those members new to Medicaid, DMAS will auto-enroll and bypass Fee-For-Service (FFS) enrollment for Governor's Access Plan (GAP), Plan First and Supplemental Nutritional Assistance Program (SNAP) members during the Phase I roll-out.

The Medicaid Expansion benefits will cover all ten Affordable Care Act (ACA) essential health benefits:

- Ambulatory patient services (outpatient services)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Grievances and Appeals

Contact Us First

If you have a problem or concern with any medical services that you provide, please contact us first. Virginia Premier promises to honor your rights as our plan provider and will take your

concerns seriously. We are here to listen to you, and will work with you to try to reach a satisfactory solution.

Sometimes a more formal process is needed to address your concern. This is usually either a **grievance** or an **appeal**.

What Is a Grievance?

Filing a grievance means going through the process of making a complaint to Virginia Premier.

Complaints would be about services you received or our plan's coverage, for example:

- Problems getting an appointment
- Having a long wait for your appointment
- Missed or late transportation trips
- Receiving incorrect bills from providers
- Disrespectful behavior from a provider or medical staff member (i.e., doctor, nurse, clinic, hospital staff, etc.)

What Is an Appeal?

If Virginia Premier decides to deny you coverage or to pay for a medical service, you can appeal that decision. You can also appeal services if they were only partially approved or if your coverage was stopped for any of (or part of) those services. We will then look into whether we should reverse our decision.

Among other things, the services could be:

- Admission requests
- Health care services
- Supply items
- Prescription drugs

An appeal request must be initiated within 60 days of the denial date. Appeals can be submitted to Virginia Premier by you or your provider.

If you have any questions, please call the Grievances and Appeals Department at 1-855-813-0349 to speak with a representative. Our office hours are 8:00 am to 5:00 pm, Monday through Friday (however, messages, faxes, and emails are checked and received 8:00 am to 8:00 pm, seven days a week).

To start the grievance or appeal process, send bills and letters of denial to:

Mail: Virginia Premier
Grievances and Appeals
PO Box 5244
Richmond, VA 23220-0244

Fax: 1-800-289-4970 (Medicare appeals)
1-877-307-1649 (Medicaid appeals)

Email: grievancesandappeals@vapremier.com

Medical Record Keeping Practices: Policies and Best Practices

Virginia Premier requires participating physicians and providers to maintain adequate medical records and documentation related to the care and services provided to Virginia Premier members. All communication and records pertaining to our members' health care must be treated as confidential. No records, other than those allowed by law, may be released without the written consent of the member, or of their legal guardian in the case of a minor. The medical record assures the continuity, accuracy, and integrity of the medical treatment of our members, not only for the participating provider for also for all other health professionals who assist in the member's care.

At a minimum, participating providers are required to have office policies and procedures for medical record documentation and maintenance which follow NCQA standards. Records must be:

- Accurate and legible, containing adequate clinical data to support utilization management activities and adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider.
- Safeguarded against loss, destruction, or unauthorized use
- Maintained in an organized fashion for all members receiving care and services.
- Accessible for review and audit by DMAS, contracted External Quality Review Organizations, or Virginia Premier Medical Management staff

Virginia Premier has established standards for medical record documentation and maintenance. These standards address medical record content, organization, confidentiality, and maintenance. Virginia Premier requires medical records to be maintained by all affiliated practitioner offices and/or medical center locations in a manner that is current, detailed, and organized, which permits effective and confidential patient care and Quality review. Medical record standards have been established to facilitate communication, coordination, and continuity of care and to promote efficient and effective treatment.

Medical record-keeping practices may be assessed for:

- Member grievances
- Quality of Care (QOC) indicators
- Sentinel events
- Practice specific member surveys
- Reports from Virginia Premier employees
- Credentialing Department ongoing monitoring process
- Other Quality initiatives

Virginia Premier Quality Staff will assess during an office site visit:

- Facility accessibility, appearance and adequacy
- Safety

- Adequacy of medical supplies and practices
- Medical record-keeping practices
- Availability of appointments

The purpose of office site reviews is to ensure practitioners meet Virginia Premier, regulatory and accreditation site standards for quality, safety, and accessibility. Practitioners who do not meet Virginia Premier's site visit assessment performance threshold will be required to create, document, and implement a corrective action plan within a specified time frame. If deficiencies are not resolved within a six month time frame, they will be presented to the Chief Medical Officer and/or the Credentialing Committee to begin a review process with the practitioner.

Waiver Audit Site Visits (CCC Plus only)

When determined by the Department of Medical Assistance Services, waiver audit site visits will be conducted to assess operational and medical management aspects for providers delivering interventions to members receiving waivered services. Audits will focus on the areas specified by DMAS.

Virginia Premier Bereavement Program

The loss of a child is one of the most difficult things a person or family can experience. The support received during bereavement is very important to helping someone cope with their loss. You may receive that support from family, church members, friends and others. Virginia Premier recognizes the challenges our members face coping with intense grief, and would like to contribute to the member's support system.

Upon the death of a child or infant, we will send a sympathy card, a brochure, a bereavement booklet and a "Living with Loss" magazine to help during their time of loss.

Additionally, if you are treating a member that has been faced with a loss, you can contact a Case Manager to refer the member who will assess their needs, and assist with needed services.

Member ID Cards

If a member has another PCP's name on their member ID card but comes to your office for a medical visit you can still see that member as long as you are a participating provider with Virginia Premier.

Virginia Premier strongly encourages PCP offices to have the member either call and change their PCP during the office visit or to have the member complete a PCP Change Request Form that is located in the Forms Library on the Virginia Premier website.

Practitioner Rights and Responsibilities

A. To Correct Erroneous Information

Virginia Premier's policies do not preclude practitioners' rights to review and correct erroneous information obtained and used to evaluate their credentialing application from outside primary sources. Such information could include, but is not limited to malpractice insurance carriers, state licensing boards, etc., with the exception of references, recommendations, or other peer-review protected information, if applicable. Virginia Premier is not required to reveal the source of information if the information was not obtained to meet organizational credentialing verification requirements or if the law prohibits disclosure.

Virginia Premier policies and procedures state the practitioner's right to correct erroneous information submitted by a source. The policy clearly states:

- The time frame for changes
- The format for submitting corrections
- The person to whom corrections must be submitted
- The documentation of receipt of the corrections
- How practitioners are notified of their right to correct erroneous information (avenues identified under *right to review information*, above, are appropriate).

Upon acceptance by the Committee, each new practitioner and provider, as applicable, is provided training materials in compliance with Privacy Rule workforce training mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

B. To Review Information

Virginia Premier ensures that practitioners can access their own information obtained by Virginia Premier during the credentialing process and used to support their credentialing application. Practitioners shall be notified in writing of this right via one or more of the following methods:

- Applications
- Contracts
- Practitioner and/or Provider manuals
- Provider Newsletters
- Mail
- Email
- Fax
- Website
- Other Suitable Method

C. To Be Informed of Application Status

Virginia Premier's policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the

credentialing staff or another department receives a request it shall be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department within one business day for follow-up and resolution by the Credentialing staff within 72 hours of initial receipt.

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee
- Answer any questions the practitioner may ask

Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner:

- Practitioner's full name
- Practitioner's primary office location
- Practitioner date of birth
- The name, city and state of the school the practitioner graduated
- Year practitioner joined the Virginia Premier Network

D. To Be Notified of His/Her Rights

Each prospective and existing practitioner has the right to be notified of the aforementioned rights and will be notified via one of the methods listed under "Right to Review Information" described above.

Practitioners Golden Globe Award (PGA)

Virginia Premier grants an annual award to recognize and promote outstanding participating practitioners who promote safe clinical practice, delivery of quality care and who voluntarily broaden their scope of practice through education and community involvement. Virginia Premier will announce the outstanding recipient of the Practitioner Golden Globe Award through the provider and member newsletters. Practitioners as well as members are encouraged to nominate a practitioner to be recognized by Virginia Premier through the nomination form found at www.virginiapremier.com/assets/PGGABrochure1.pdf.

Procedures for Requesting Medication and Accessing the Formulary

Have you ever written a prescription and then wondered if it would be covered for the patient when they got to the pharmacy? Or, has your patient called you complaining that their medication needed prior authorization?

You can learn more about the pharmacy benefits our members receive by visiting Virginia Premier's website: www.virginiapremier.com

The pharmacy section of our website includes information about our formulary, how to obtain prior authorization, coverage of diabetic supplies, and OTC medications, and more.

Please note that for Medallion 4.0 and CCC+ Virginia Premier is required to follow the Department of Medical Assistance (DMAS) Common Core Formulary. The DMAS Common Core Formulary includes all the preferred drugs on DMAS' Preferred Drug List (PDL). Preferred drugs are those that are available to members without prior authorization.

Utilization management limitations may exist to ensure that drugs are being prescribed within the **Food and Drug Administration's** (FDA) recommended dosages. If you prescribe a drug that require prior authorization, please submit a request for coverage determination to EnvisionRx. The request will be reviewed and completed within 24 hours as long as no additional clinical information needs to be obtained.

Providers can submit a request for a medication to EnvisionRx with any of the following:

- Telephone: 855-872-0005(Medallion 4.0) 844-838-0711(CCC+)
- Fax: 877-503-7231
- Electronic submissions:
  - CoverMyMeds
  - SureScripts
  - PromptPA (Envision's online Coverage Determination Tool)

If you have any questions about covered drugs, authorizations, or limits, please call EnvisionRx at 1-855-872-0005 or visit our website at www.virginiapremier.com/providers.

Provider Availability: Access and After-Hours Standards

Participating providers must comply with the following access standards for Virginia Premier members:

Service	Virginia Premier Standard
Appointment for health assessment, EPSDT screens, general physical exams, first examinations (preventive)	Scheduled within 30 days of request.
Initial health screens for new members under EPSDT regulations (preventive)	Scheduled within 30 days of request and completed within 3 months of enrollment date.

Appointment for Routine primary care and specialty care (non-urgent care for symptomatic conditions)	Scheduled within 14 calendar days of request.
Routine primary care	Scheduled within 30 calendar days of the enrollee's request. Excludes appointments for routine physicals, regularly scheduled visit to monitor a chronic condition if the schedule calls for visits less frequently than once every 30 days, for routine specialty care like dermatology,
Average wait time in PCP office	No more than 30 minutes following appointment time.
Specialist appointment (non-urgent referral)	Scheduled within 30 calendar days or sooner of the request.
Initial assessments for pregnant women or persons desiring family	Scheduled within 10 days.
Maternity Care – First Trimester	Scheduled within 14 calendar days.
Maternity Care – Second Trimester	Scheduled within 7 calendar days.
Maternity Care – Third Trimester	Scheduled within 3 business days.
High Risk Appointments	Scheduled within 3 business days.
Urgent appointments	Provided within 24 hours of enrollee's request.
Emergent appointments	Immediately and/or referred to emergency facility.
Access to after-hours care	Answering service / machine provides instructions on how to access care.

Service	Virginia Premier Standard
Appointment for Behavioral Health / Substance Abuse Services	i. Care for non-life threatening emergency within 6 hours. ii. Urgent Care within 48 hours. iii. Routine visits within 10 business days. Follow-up visit after inpatient admission within seven (7) calendar days.

Answering Telephone Hold	Within two (2) to (4) four rings 30 seconds or less
Virginia Premier 24 Hours Medical Help Line	Practitioners shall advise members to contact the Virginia Premier Nurse Advice Line for medical concerns prior to seeking services at the emergency room

Virginia Premier's Electronic Claims Submission

This provider notification includes key updates for managing the submission of electronic claims for:

- Virginia Premier Elite Family and Virginia Premier Elite Individual plans (Medallion 4.0)
- Virginia Premier Elite Plus (our CCC Plus / MLTSS plan)
- Virginia Premier Advantage Elite, Advantage Gold and Advantage Platinum (our MAPD plans)
- Medallion 3.0 (run out)

Effective **December 1, 2018**, all claims submitted electronically must be submitted through the appropriate clearinghouses and with the assigned payer ID for the product line. Claims that are not submitted with the appropriate Payer ID may be denied or rejected. You will have an opportunity to resubmit the denied or rejected claims to the correct clearinghouse / payer ID for payment as long as you are within your timely filing period. A Payer ID Table is listed at the bottom of this document. The Payer ID Table can also be found on our website at: www.virginiapremier.com/assets/VPHP-EDI-Clearinghouse-Table-102412.pdf

Language Assistance

Virginia Premier complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English and need language assistance services (free of charge) they are available to you.

- For Elite Individual Medallion 4.0 , call 1-800-727-7536; Monday through Friday, excluding certain holidays, from 8:00 am to 8:00 pm.
- For Elite Plus (CCC Plus /MLTSS), call 1-877-719-7358, Monday through Friday, excluding certain holidays, from 8:00 am to 8:00 pm.
- For Virginia Premier/Kaiser Permanente Medallion 4.0, call 1-855-249-5025, Monday through Friday, excluding certain holidays, from 7:30 am to 9:00 pm.
- For Virginia Premier Medicare Advantage, call 1-877-739-1370, From October 1 to February 14, we are open daily from 8:00 am to 8:00 pm, 7 days a week, excluding

certain holidays. On weekends and certain holidays from February 15 to September 30, your call will be handled by our automated phone system.

- For Exchange, call 1-833-672-8075, Monday through Friday, excluding certain holidays, from 8:00 am to 6:00 pm, and Saturdays from 8 am to 2 pm.

Additionally, Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who will help you reach Virginia Premier's Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States free of charge.

Complete List of Acceptable Clearinghouses

Claims must continue to be submitted to the existing clearinghouses under the payer IDs listed for those clearing houses until the program closes out and claims are no longer accepted and/or through the timely filing run-out period.

Plan	Clearinghouse	Current Payer ID
Elite Individual Medallion 4.0	Availity - https://www.availity.com/	VAPRM
	Relay Health / Change Healthcare – https://www.changehealthcare.com/	VAPRM
Medallion 3.0 (Program ends 11/30/18)	Availity - https://www.availity.com/	837 Professional: 54176 837
	Relay Health / Change Healthcare - https://www.changehealthcare.com/	837 Professional: 54176 837 Institutional: 12K83
	Benchmark Systems / Antworks - http://antworks.healthcare/	837 Professional: 2245
	Claim Logic / Trizetto - https://www.trizettoprovider.com/	VAPRE
	Gateway EDI / Trizetto - https://www.trizettoprovider.com/	837 Professional: 54176
	The SSI Group - http://thessigroup.com/	837 Professional: 99999-
	Zirmed / Waystar - https://www.waystar.com/	Z1088
	Availity - https://www.availity.com/	837 Professional: VPCCP 837

CompleteCare	Relay Health / Change Healthcare - https://www.changehealthcare.com/	837 Professional: VPCCP 837
Elite Plus (CCC Plus /MLTSS)	Availity - https://www.availity.com/	VPEP1
	Relay Health / Change Healthcare - https://www.changehealthcare.com/	MLTSS
Preferred (Exchange)	Availity - https://www.availity.com/ Relay Health / Change Healthcare - https://www.changehealthcare.com/	251VA
Medicare Advantage Elite (DSNP)	Availity - https://www.availity.com/	VPELT
	Relay Health / Change Healthcare - https://www.changehealthcare.com/	VPE
Medicare Advantage Gold and Platinum	Availity - https://www.availity.com/	837 Professional: MAPDP 837
	Relay Health / Change Healthcare - https://www.changehealthcare.com/	VPMAD

Members transitioning from the Medallion 3.0 to the Medallion 4.0 Program

Based on the dates and regions listed in the table below, members will be transitioning from their Medallion 3.0 program to their Medallion 4.0 program, which may not be the same Managed Care Organization. As a result, claims must be managed by service date. For all claim service dates where the member was enrolled under Medallion 3.0, file these under the appropriate Medallion 3.0 clearing house and Payer ID for ONLY those service dates that fall under the member's Medallion 3.0 enrollment. This may require that a claim be split to file some services to Medallion 3.0 and the remaining services to Medallion 4.0.

Please note, this does not apply to inpatient facility claims. Inpatient facility claims should be filed to the appropriate product line based on date of admission.

Region	Date for Medallion 4.0 Clearinghouse Submission
Tidewater	August 1, 2018
Central Virginia	September 1, 2018
Northern Virginia / Winchester	October 1, 2018
Charlottesville / Western	November 1, 2018
Roanoke / Alleghany	December 1, 2018

Southwest	December 1, 2018

Example: A member living in Central Virginia receives services from 8/30/18 through 9/5/18. In this case, the provider will submit separate claims:

- to the Medallion 3.0 clearinghouse for services received 8/30/18 through 8/31/18, and
- to the Medallion 4.0 clearinghouse for services received 9/1/18 through 9/5/18

Contact Us: If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 am to 6:00 pm at 1-804-819-5151 or toll-free 1-800-727-7536.

Virginia Premier will be moving to a **universal payer ID** in the future. More to come.

2018 QI Program, Goals, and Updates

Virginia Premier's Quality Program (QP) helps our member get high quality health care at an affordable price. The program's goal is to have a process that looks at, measures, and evaluates the quality of care and your services. Our aim is to improve the overall quality of care.

The better our care is, the healthier our members will be. Virginia Premier cares about our members health. That's why we also work to make the areas where our members live better by working on both national and local public health initiatives and working towards public health goals. Virginia Premier uses a quality improvement process that looks at areas that may affect our members. We then put programs in place to work on the areas of concern. Also, we utilize satisfaction surveys to get our members feedback on how to improve our services.

The primary goals of the Virginia Premier Quality Program:

1. **Goal:** Achieve 1st in the Commonwealth and Top 30 Best Medicaid Plans National NCQA Ratings.

   Update: We have achieved Commendable NCQA status! Accreditation is not a one-time event, but an ongoing journey to support quality services for customers, members and practitioners. Virginia Premier is committed to excellent services to our customers and have an ongoing plan to monitor the progress towards the goal of excellence. Virginia Premier was ranked as one of the Top 3 Health Plans in Virginia during 2016. Virginia Premier scored above average on Living with Illness compared to other Health Plans. Virginia Premier scored average compared to all other Health Plans in the areas of Doctor's Communicating with our members by explaining things well and including members in the decisions about their care; Getting Care when the members needed it; Keeping Kids Healthy by getting regular checkups and important shots to help protect them against serious illness and Taking Care of Women by getting tests for breast cancer and cervical cancer and moms getting care before and after their baby is born to keep them both healthy.

2. **Goal:** Achieve the 75th Percentile or Greater for Targeted HEDIS® Performance Incentive Award (PIA) Measures.

   Update: We achieved 82% of our PIA measures. The PIA was developed as a pay for performance program that will assess MCO performance based on measures DMAS determines instrumental to achieving the goals of managed care. Three clinical and three administrative measures are used in this program, such as:

   - Timely claims processing
   - Timely data reporting
   - Foster care assessments
   - Controlling high blood pressure
   - Timeliness of prenatal care
   - Childhood immunizations (Combo 3)

We have reviewed the outcomes related to the HEDIS indicators (for example: childhood immunizations, diabetes care, and prenatal/postpartum visits) at the doctor offices. Based the results with the indicators mentioned above, there were areas identified that targeted interventions needed to be put in place to increase the outcomes. The programs put in place will make certain that the Virginia Premier members are receiving the best care, promptly and the health plan meets the national goals related to quality of care.

3. **Goal:** Improve the member experience through CAHPS Survey education for membership, providers and internal staff.

   Update: *Members CAHPS®*
   Surveying member experience provides Virginia Premier with information on our members' experience with the plan and their practitioners. Member experience is assessed in several ways, but the primary measurement tool is Medicare CAHPS®. Results from this survey helps the Plan identify areas of member dissatisfaction and opportunities for improvement. Based on the results along with other member satisfaction feedback mechanisms, such as the Member Advisory Committee Meetings, Virginia Premier prioritizes improvement initiatives that are most meaningful to members.

   Practitioners
   Surveying practitioner satisfaction, access and availability provides Virginia Premier with information on our practitioner's experience with the plan and their members. Practitioner satisfaction is assessed in several ways, but the primary measurement tool is the Provider Satisfaction Survey and the Access and Availability Survey and the After Hours Survey. Results from these surveys help the organization identify areas of practitioner dissatisfaction and opportunities for improvement. Based on the results, along with other practitioner feedback mechanisms such as the Provider Advisory Committee Meetings, Virginia Premier prioritizes improvement initiatives that are most meaningful to practitioners and members.

   > We conduct a Member Advisory Committee (MAC) meeting survey at the end of each MAC meeting. We engage our members by evaluating recommendations provided by the survey. We also encourage our non-English speaking members to attend our MAC meetings and provide interpretation services and translated documents to those who attend and require them. During 2016, 15 MAC meetings were held throughout the Tidewater, Richmond, and Bristol regions. 250 members were invited per meeting. The overall MAC meeting attendance rate for 2016 was 6.1% which mirrors 2015. An improvement strategy put in place is to recruit and increase attendance in remote office areas.
   >
   > The CAHPS Survey on The Getting Needed Care satisfaction composite score ranked in 76th percentile. The Getting Care Quickly Composite ranked above the 75th percentile with the Health Promotion and Education also ranking above the 75th percentile. Overall, six out of the nine measures utilized for the CAHPS Adult survey were above the HEDIS/CAHPS 50th percentile.

4. **Goal:** Develop and implement interventions focused on member integration.

   Update: We conduct a Member Advisory Committee (MAC) meeting survey at the end of each MAC meeting. We engage our members by evaluating recommendations provided by the survey. We also encourage our non-English speaking members to attend our MAC meetings and provide interpretation services and translated documents to those who attend and require them. A member representative is selected to be "the voice" of our members, to bring forth any issues or concerns to improve our program.

5. **Goal:** Ensure a safe continuum of care through applying Virginia Premier's Member Safety Initiatives.

   Update: We include patient safety materials in both the Member and Provider newsletter (i.e. Questions to Ask Your Doctor and 20 Tips to Prevent Medical Errors). We also provide practitioner offices with National Patient Safety Goals when conducting site visits. In addition, we give practitioners national standards for culturally and linguistically appropriate services. Practitioners participate on various quality committees and play an integral role in the MSP.

6. **Goal:** Review performance against clinical practice guidelines.

   Update: Clinical practice guidelines are developed in areas in which its evaluation reveals the greatest need for such guidelines. The guidelines are complementary to the established medical practices of the Plan. Practitioners are educated regarding the Virginia Premier's clinical practice guidelines via the web site, provider newsletters, site visits and the Provider Manual. Practitioners are informed that they may receive a paper copy of the guidelines upon request.

7. **Goal:** Continue to address improvements in practitioner satisfaction via quarterly meetings with the practitioners.

   Update: Provider Education Meetings (PEM) are held in each service region, four (4) or more times a year. Local provider service representatives and representatives from various departments present provider updates and address questions with the provider community. In 2015, Virginia Premier Health Plan, Inc. held 19 PEM meetings throughout the five regions and had a grand total of 407 attendees. Improvement strategies are notify providers about upcoming meetings via provider newsletter and website, enhance quality/topics at the PEM meetings and provide a high level summary of the topics discussed in the PEM invite.

8. **Goal:** Ensure culturally competent care delivery through collection of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication.

   Update: We analyze annually the demographic data to identify significant culturally and linguistically diverse populations within our membership. We enhance our current patient-focused quality improvement activities to address specific cultural and linguistic barriers using culturally targeted materials addressing identified barriers. We analyze interpreter availability and developed educational materials to meet the cultural and linguistic needs of our members.

Update: Top (most members paneled) 25 PCPs in each region are encouraged to complete a cultural competency course; continue to make the practitioner community aware of the growing needs related to cultural competency and serving diverse populations by encouraging every participating practitioner to complete Virginia Premier's recommended Cultural Competency CME or one of their own choosing. 341 cultural competency surveys were completed during calendar year 2016. This is an increase of 21% over previous year (2015). To encourage course completion, the Quality nurses take cultural competency course information when visiting practitioner offices.

To learn more about the Quality Initiatives or Program visit our website at www.virginiapremier.com and download a full copy of the Quality Program Summary. The QI Program can be found on the website by selecting the Medical Management Section and then selecting Quality. You can also request a copy of the QI Program by calling Quality at 1-800-727-7536.

Requesting Authorizations

This is a reminder of current policy.

Virginia Premier currently requires prior authorization for inpatient and certain outpatient services (e.g., out-of-network referrals, specified diagnostic tests) based on clinical appropriateness. In an effort to ensure timely and accurate payments of associated claims, providers rendering these services should verify that the necessary prior authorization has been granted by Virginia Premier.

Please remember to utilize our no prior authorization (NPA) look-up tool (www.virginiapremier.com/npa/NPA_Search.html) on the provider portal and obtain appropriate prior authorization from Virginia Premier's Utilization Management (UM) department. Failure to obtain prior authorization where required may result in a denial of the claim. We value your partnership and work to ensure that every Virginia Premier member receives quality health care.

What is CAHPS?

The CAHPS survey is a set of questions that's used to find out how members feel about their health care. It takes a look at health care from your perspective. It allows you to let us know how we're doing, and how your doctors are meeting your health care needs. The survey asks about your access to medical services and your doctor's communication skills.

What does the CAHPS Survey ask about doctor communication?

- Does your doctor explain things in a way that's easy to understand?
- How often does your doctor listen to you carefully?
- How often does your doctor respect what you say?
- Does your doctor spend enough time with you?

What does the CAHPS Survey ask about doctor health care?

- How often do you and your doctor talk about specific things you could do to prevent illness?
- How often does your doctor tell you there is more than one option for your treatment?
- Does your doctor talk with you about the pros and cons of each choice for your treatment?
- When there is more than one option for your treatment, does your doctor ask which choice you think is best for you?

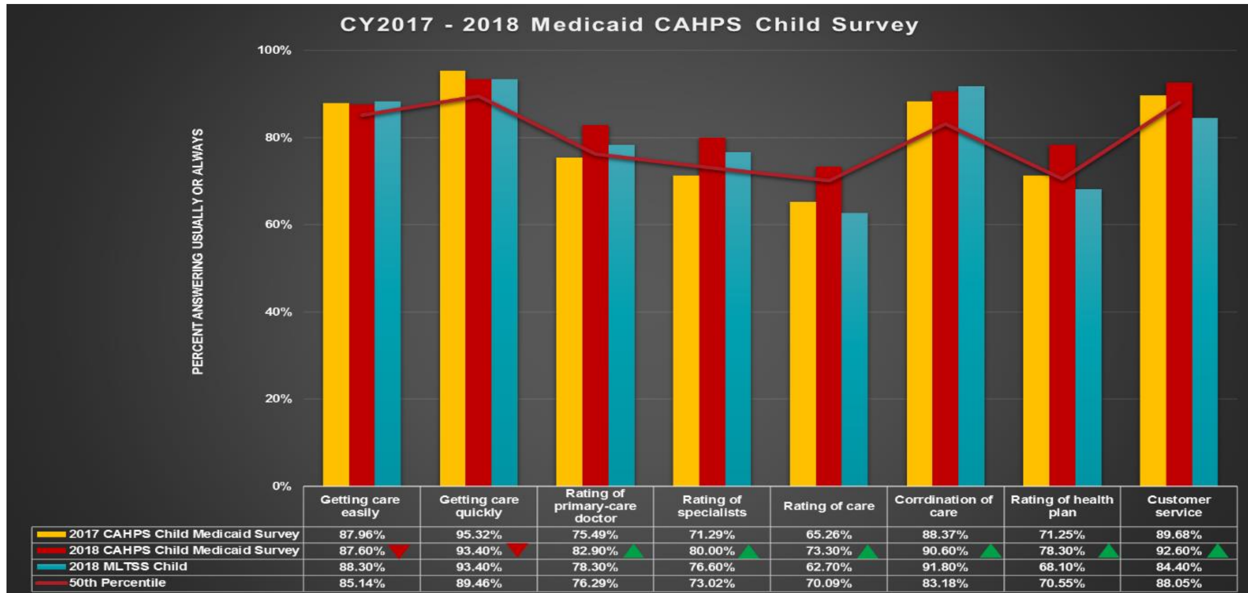
Survey Administration Timeline

CAHPS Surveys are mailed out to members, and members will be called with a reminder about the CAHPS survey. We encourage you to complete the survey. You may choose to complete the survey over the phone if you'd like.

Please take the time to complete the survey, and tell us how we're doing! If you have questions, please contact SPH Analytics Customer Service at 1-877-476-7538, Monday through Friday, 9 am to 5 pm.

CY2017 – 2018 Medicaid CAHPS Child Survey Analysis

- 2017 CAHPS Child Medicaid Survey
- 2018 CAHPS Child Medicaid Survey
- 2018 MLTSS Child Survey
- 2017 NCQA 50% Percentile Benchmark for Child



	Getting care easily	Getting care quickly	Rating of primary-care doctor	Rating of specialists	Rating of care	Corrdination of care	Rating of health plan	Customer service
2017 CAHPS Child Medicaid Survey	87.96%	95.32%	75.49%	71.29%	65.26%	88.37%	71.25%	89.68%
2018 CAHPS Child Medicaid Survey	87.60%	93.40%	82.90%	80.00%	73.30%	90.60%	78.30%	92.60%
2018 MLTSS Child	88.30%	93.40%	78.30%	76.60%	62.70%	91.80%	68.10%	84.40%
50th Percentile	85.14%	89.46%	76.29%	73.02%	70.09%	83.18%	70.55%	88.05%

CY2016 – 2018 Medicaid CAHPS Adult Survey Analysis

- 2016 CAHPS Adult Medallion Survey
- 2017 CAHPS Adult Medallion Survey
- 2018 CAHPS Adult Medallion Survey
- 2017 NCQA 50% Percentile Benchmark for Adult

Member Rights and Responsibilities

To help you stay informed on important regulations, we wanted to list out all of your patients' rights and responsibilities. As you may be involved in some of them, it's important for you to know.

To start, it is our policy to treat your patients with respect. We also care about keeping a high level of confidentiality to respect their privacy. Your patients' rights and responsibilities with Virginia Premier are listed below, and they can also be found on our website at: www.virginiapremier.com.

With Virginia Premier, your patients have the right to:

- All covered services described in our Member Handbooks.
- Treatment with quality care, respect, dignity and a right to privacy.
- Health care services 24 hours a day, 365 days a year. This includes urgent, emergency and post-stabilization services.
- Their own Virginia Premier doctor or Primary Care Physician (PCP).
- Change their personal Virginia Premier doctor. They may also choose a new one from our Provider Directory.
- Set up their own doctor or PCP visits, and be seen in your office when it works for you.
- Not be treated against their will.
- Ask questions of their doctor or PCP
- Call Member Services to file a complaint/grievance about Virginia Premier.
- File an appeal if they are not happy with the answer to their inquiry (question), their complaint/grievance, or the care they received.
- Have their and/or their child's medical records kept private unless they sign a permission form.
- Have timely access to their and/or their child's medical records (they may need to sign a release form).
- Work with their doctor in making choices that deal with their health care.
- Have their and/or their child's doctor tell them about any treatment choices they may have, no matter what the cost or benefit coverage.
- Get a second opinion from Virginia Premier's network of providers.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as written in other Federal regulations on the use of restraints and seclusion.
- Freely exercise their rights without any change in the way Virginia Premier and its providers treat you.
- Get information about Virginia Premier, its services, practitioners, providers and member's rights and responsibilities.
- Make suggestions about Virginia Premier's member rights and responsibilities statements listed in this document.

Your patient's responsibilities with Virginia Premier

- Choose their and/or their child's Virginia Premier PCP from the list of our doctors. (See Provider Directory).
- Get their and/or their child's health care through our list of PCP's and hospitals and other health care providers.
- Keep doctor's appointments or call to cancel them at least twenty-four (24) hours ahead of time.
- Carry their and/or their child's Virginia Premier and Medicaid ID member card with them at all times.
- Tell the doctor that they and/or their child are/is a member of Virginia Premier at the time they speak with the doctor's office.
- Give their PCP and other providers honest and complete information about their and/or their child's health to care for them.
- Learn the difference between emergency and urgent care.