



Provider Newsletter

Fall/Winter 2019



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Virginia Premier’s MLTSS Operations Coordination Department has a new fax number.

The new toll-free fax number is: 1- 800-846-4254.

Use this fax number when you need to send forms to the Preadmission Screening Team. This team evaluates individuals for long-term care services.

Send the DMAS 80 - Nursing Facility Admission, Discharge or Level of Care Change form and Providers/ Facilities or the DMAS 225 – Medicaid LTC Communication Form or the 421A – Hospice Enrollment/ Disenrollment Authorization Request Form to this fax number.

If you have any questions, please call 1- 877-719-7358 to speak with a representative of the MLTSS Operations Coordination Department.

Virginia Premier covers emergency care services

If one of our members experiences a sudden, unexpected medical condition and time permits, the member should contact their Primary Care Physician (PCP) for medical advice.

If they're unable to reach their PCP, or it's after hours, members should call the 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 member goes 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.

We cover emergency services under the following situations:

- To screen and stabilize a member without prior approval, where a prudent layperson acting reasonably, would believe 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, we have a review committee that evaluates new technology for its usefulness in the health care space. This committee, called our HQUM 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 HQUM committee evaluates the utilization, potential for harm, cost, clinical trials, and peer-reviewed medical literature. It's all part of our commitment to helping you provide the best care possible.



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 maintained the COMMENDABLE status in 2019. This status will be effective for 3 years for our Medallion 4.0 program.

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, the Healthcare Effectiveness Data and Information Set (HEDIS) Measures and Patient Satisfaction. More than 173 million people are enrolled in NCQA-Accredited health plans like Virginia Premier.

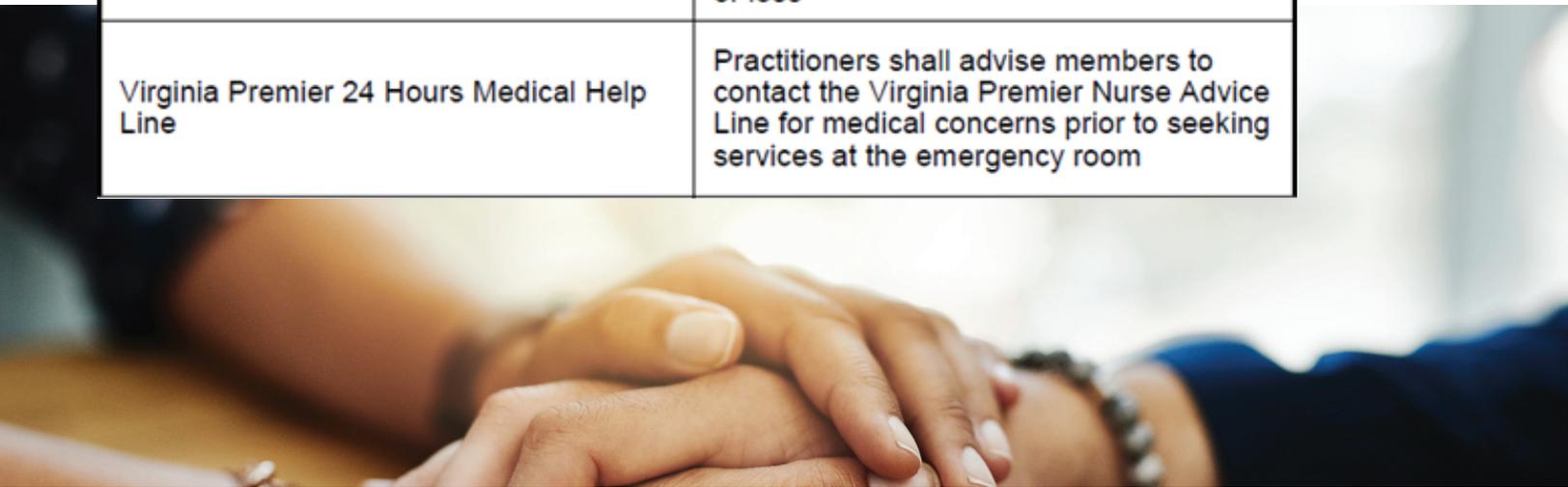
The new status means Virginia Premier is on track to meet its next accreditation goal, which is to be accredited at the Excellent status in the coming years. Virginia Premier received its first NCQA accreditation status in 2007. Since that time, Virginia Premier has maintained an ongoing focus on improving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

Provider Availability: Access and After-Hours Standards

Participating providers must comply with the following Virginia Premier access standards.

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



Timeliness of Prenatal and Postpartum Care and OB Registrations

Please help us encourage our members to receive timely prenatal and postpartum care! Our members should have their first prenatal visit in their first trimester and within six weeks of enrolling with us (42 days). They should have their timely postpartum visit within 7-60 days after delivery.

Virginia Premier rewards our members if they enroll in our Healthy Heartbeats (HHB) Prenatal Care Program and seek timely and consistent prenatal and postpartum care. We also offer a \$25 incentive to our providers for helping us to identify a Virginia Premier pregnant member. All you need to do is fill out our OB Registration Form for OB patients assigned to Virginia Premier. The form can be faxed back to us at 1-800-827-7192. Once a claim is submitted (see code for authorization on the OB Registration Flier), the provider will then receive the incentive.

Positive Parenting and The BASICS Principles

Virginia Premier offers classes to its members to encourage positive parenting using a positive discipline approach. This approach helps members build a relationship that is based on trust and connection with their child. The purpose of Positive Discipline is to teach parents or guardians to use a kind but firm approach to raise a child to become independent and confident. The approach is taught by using effective educational material, role playing, interactive activities, to display positive ways for parents to interact with their child and overcome challenges.

Virginia Premier also assists parents by teaching them how to enhance communication and have a better understanding between parent and child while using the BASICS child development method. If you have any questions or would like more information, please contact Virginia Premier's EPSDT Coordinator at 1-757-461-0064 Ext. 54635.



Understanding Your Patient's Prescription Coverage

Currently, Virginia Premier has four plans: Virginia Premier Advantage (MAPD), Virginia Premier Elite Plus (Commonwealth Coordinated Care Plus), Virginia Premier Medallion 4.0, and Virginia Premier Individual and Family Plans. Each plan has their own unique formulary. The plans are outlined below with the links to their respective formularies on our website.

- **Virginia Premier Advantage**
 - Virginia Premier Advantage Elite is our Dual Special Needs Plan (D-SNP) and has a one tier formulary. Prices are set by brand vs generic. **Click here to learn more.**
 - Virginia Premier Advantage Gold (HMO) and Platinum (HMO) plans have a five tier formulary. **Click here to learn more.**
- **Virginia Premier Medallion 4.0**
 - Medallion 4.0 is required to follow a Common Core Formulary set by the Department of Medical Assistance Services (DMAS). **Click here to learn more.**
 - Medallion 4.0 FAMIS follows a formulary set by Virginia Premier and mandates generic only drugs. **Click here to learn more.**
- **Virginia Premier Elite Plus**
 - Virginia Premier Elite Plus Non-Dual members follow the Common Core Formulary set by DMAS. **Click here to learn more.**
 - Virginia Premier Elite Plus Dual members follow a Medicaid Non-Part D/OTC Wrap Formulary. This formulary mainly covers over-the-counter medications, since the member's primary Part D coverage should cover most other medications. **Click here to learn more.**
- **Virginia Premier Individual and Family Plans**
 - All plans follow a six tier formulary. **Click here to learn more.**

In addition to downloadable PDF formularies, we also have a helpful formulary search tool on our website for each of our formularies. Our drug search tool allows you to look up medications by name to determine the formulary status, including if your drug is covered, or if there are any limits on it. For example, a drug may need:

- **Prior authorization (PA)**
 - In these cases, the prescriber must provide additional information to support the request for the drug before it will be covered.
- **Step therapy (ST)**
 - This means that you must try one or more other formulary drugs before a step therapy drug is covered. These other formulary drugs treat the same condition as the step therapy drug.
- **Quantity limit (QL)**
 - This is a limit on the amount of a formulary drug covered within a certain time period. Often, quantity limits are in place to make sure drugs are being prescribed within FDA recommended dosages.

Authorizations and limits help make sure that the drug is being used safely and appropriately. If you are prescribing a drug that needs authorization, you can submit a request to our pharmacy benefit manager (EnvisionRx), and the request will be reviewed to determine if coverage is allowed. To submit a request for authorization, please contact EnvisionRx by phone or fax at the numbers below or submit a request electronically through CoverMyMeds, SureScripts, or Envision's own PA tool, PromptPA.

- **Virginia Premier Medallion 4.0, FAMIS, and Elite Plus**
 - Envision phone: 1-800-872-0005
 - Envision fax: 1-877-503-7231
- **Virginia Premier Advantage**
 - Envision phone: 1-855-408-0010
 - Envision fax: 1-866-250-5178
- **Virginia Premier Individual and Family Plans**
 - Envision phone: 1-833-626-1350
 - Envision fax: 1-877-503-7231

Our formulary is reviewed quarterly by a Pharmacy and Therapeutics (P&T) committee that consists of medical directors and pharmacists from Virginia Premier, as well as medical directors and pharmacists from the community. During the P&T review, committee members discuss and vote on the criteria used to evaluate pharmacy coverage determinations and exceptions, like those listed above. The P&T committee also reviews and discusses formulary updates and changes.



Utilizing Generic Hepatitis C Medications

Currently our Medicaid lines of business, Virginia Premier Elite Plus and Virginia Premier Medallion 4.0, follow the Preferred Drug List (PDL) created by DMAS (Department of Medical Assistance Services, or the state Medicaid agency), which is known as the Common Core Formulary (CCF). The CCF is a list of preferred medications, dictated by DMAS, that are covered for all Virginia Medicaid recipients. The CCF applies to all Virginia Medicaid Managed Care Organizations (MCOs), so medication coverage and limitations are consistent across all plans. Hepatitis C agents are designated as a “Closed” drug class by DMAS. In a “Closed” drug class, only specific drugs in a therapeutic class are listed on the formulary. MCOs cannot add additional medications to “Closed” drug classes on their formulary. The current Common Core Formulary for Hepatitis C medications includes two “Preferred” agents: Mavyret® and sofosbuvir/velpatasvir (generic Epclusa®). All Hepatitis C Drugs (Preferred and Non-Preferred) require prior authorization approval before coverage.

Additionally, there are currently two Hepatitis C authorized generic agents on the market: the authorized generics for Epclusa® (PDL/CCF Preferred) and Harvoni®. Authorized generics are identical to the brand, as they have the same active and inactive ingredients. This differs from a generic drug, because generics can have different inactive ingredients from the brand. In order for a generic drug to come to market an Abbreviated New Drug Application (ANDA) must be submitted. Authorized generics do not have to undergo ANDA submission, because they are protected under the brand’s New Drug Application.

These two authorized generics are marketed by Asegua, a subsidiary of Gilead, the manufacturer of Epclusa® and Harvoni®. Increasing the utilization of these two authorized generics, when clinically appropriate, can greatly reduce the total cost of health care for Hepatitis C patients.

Out-of-Network Referral Requirements

The Primary Care Physician (PCP) oversees the medical care and services provided to the member. Out-of-network referrals require plan notification and authorization.

Members are encouraged to coordinate their care through their PCP. As an HMO, Virginia Premier requires authorization for out of network services.

Plan-directed care is to be the financial responsibility of the health plan and/or its contracted network but in either case, not the responsibility of the member.

Plan-directed care includes care the member believes they were instructed to obtain, or authorized to receive and such instruction and/or authorization was provided by a health plan representative. A representative of the health plan includes plan-contracted physicians.

If a PCP directs care to an out-of-network provider, including laboratory services, an authorization must be obtained.

For services that require prior authorization, it becomes extremely important that Virginia Premier authorization procedures are followed.

If a member receives care at the direction of his/her primary care physician or network specialist, believing that such care was verbally or otherwise authorized by the physician, the member cannot be held financially responsible. In such cases when the referring network physician fails to follow authorization requirements, CMS allows the plan to hold the physicians financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

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's, regulatory and accreditation site standards for quality, safety, and accessibility. Practitioners who do not meet Virginia Premier's site visit assessment performance threshold 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.

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: **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.

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 (HIPAA).

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.

2019 Quality Improvement (QI) Activities and Programs

Our Quality program is committed to providing members with care that is safe, culturally-sensitive and compliant with NCQA Standards. We are also committed to improving the health and resources found within the communities we serve by participating in public health initiatives at the national, state and local levels.

You can find our Quality Improvement (QI) program on our website at: <https://www.virginiapremier.com/providers/medicaid/medical-management/quality-initiatives/>

You can also request a copy by calling us at 1-800-727-7536.

Major Accomplishments in 2019

We achieved most of the activities in our work plan for 2019. Activities that weren't completed have been considered for continuation in 2020.

2019 Accomplishments:

- Member Satisfaction Rate of 98% via CAHPS Survey (NCQA, 2019)
- NCQA standards scoring of 100% (NCQA, 2019)
- Rated as one of the "Top" Virginia-based health plans on Accreditation Scoring (NCQA, 2019)
- HEDIS-on-site Medical Record Review scoring of 100% (HSAG, 2019)

2020 Quality Program's Core Indicators:

- NCQA Accreditation Scoring
- Achieve 90% or greater on NCQA Internal Audits
- Member Satisfaction Rating
- Member Grievances and Appeals data
- Quality of Care/Service Indicators

2020 Quality Goals:

- Achieve first in the Commonwealth and Top 30 Best Medicaid Plans via NCQA Rating
- Achieve the 75th percentile or greater for targeted HEDIS Performance Withhold Measures
- Maintain or Improve Member Satisfaction rating via the CAHPS survey
- Achieve an NCQA STAR rating of 4.0 or greater for Medicaid health plans

References

National Committee for Quality Assurance. (2019). NCQA health insurance plan ratings 2019-2020: Summary Report. Retrieved from <http://healthinsuranceratings.ncqa.org/2019/Default.aspx>

Availability of UM Criteria

To ensure we render the most appropriate Utilization Management (UM) decisions, we use clinically-based criteria, and consider the individual circumstances of each authorization request. 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.



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 their perspective. It allows members to let us know how we are doing, and how their doctors are meeting their health care needs. The survey asks about their access to medical services and their doctor's communication skills.

What does the CAHPS Survey ask our members 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 our members about the care they receive?

- 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

Members receive CAHPS surveys in the mail, and they also receive reminders about the survey over the phone. We encourage our members to complete the survey either way.

Notification to our Members:

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.

Consumer Assessment of Healthcare Providers and Systems - Population Health and Quality Data Management 2018 vs 2019 Results

Medallion 4.0 Adult CAHPS

Top Three Measures: Our plan had the highest NCQA Quality Compass® All Plans percentile rankings for these three measures:

MEASURE	VALID N	2019 SUMMARY RATE SCORE	2018 SUMMARY RATE SCORE	CHANGE*	QC ALL PLANS PERCENTILE RANKING	NCQA QUALITY COMPASS ALL PLANS	GAP
Getting Care Quickly	170	89.1%	83.9%	5.2	96th	82.1%	7.0
Getting Needed Care	186	88.0%	82.8%	5.2	92nd	82.4%	5.6
Rating of Specialist (8-10)	127	85.8%	78.3%	7.6	83rd	82.1%	3.7

Bottom Three Measures: Our plan had the lowest NCQA Quality Compass® All Plans percentile rankings for these three measures.

MEASURE	VALID N	2019 SUMMARY RATE SCORE	2018 SUMMARY RATE SCORE	CHANGE*	QC ALL PLANS PERCENTILE RANKING	NCQA QUALITY COMPASS ALL PLANS	GAP
Rating of Health Care (8-10)	240	71.3%	75.3%	-4.1	22nd	74.6%	-3.4
Health Promotion and Education	233	70.8%	68.5%	2.3	21st	73.5%	-2.7
Shared Decision Making	105	77.3%	79.3%	-2.0	18th	79.5%	-2.1

Current Measure Improvement Interventions:

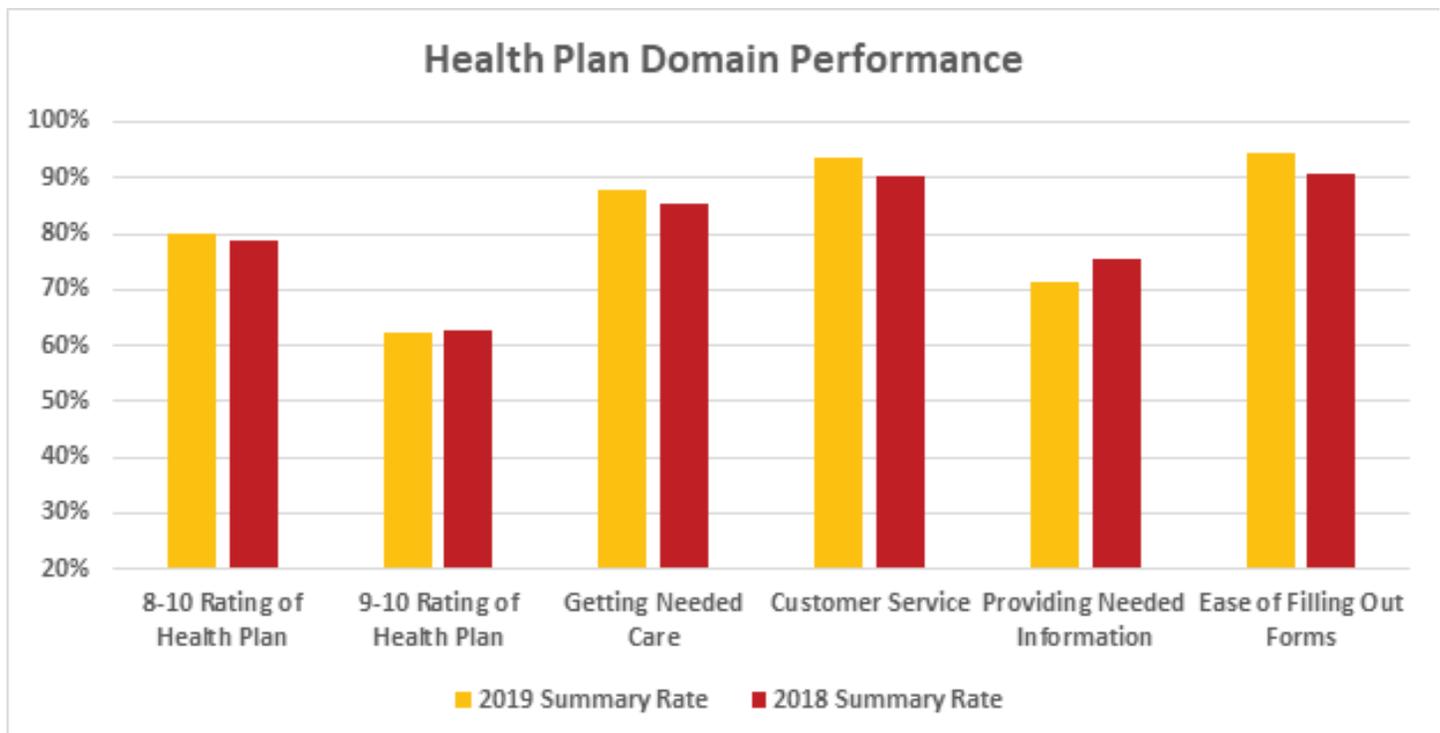
- Care Coordination - Individualized Care Plan, Interdisciplinary Care Team meeting
- Provider Services - Revised language to provider education materials to discuss health care with patients, parents and guardian. Provider Education Meetings are held quarterly
- Marketing – We are updating our website to include provider resources with conversational material
- Quality and Safety - Premier Population Health events, supplying providers with care gaps to initiate dialogue, enhance member engagement, and optimize health literacy

Health Care Domain Performance

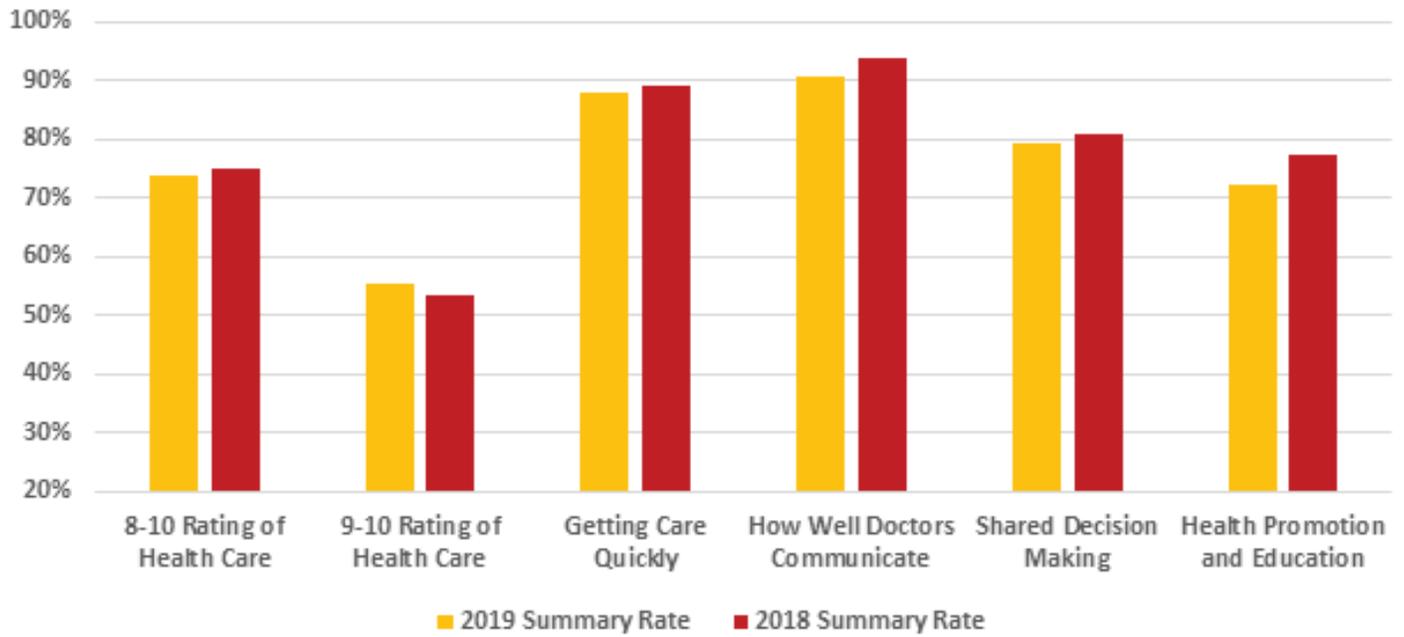
MEASURE	2019 Summary Rate	2018 Summary Rate	CHANGE*	2018 QC Percentile
8-10 Rating of Health Care	73.80%	75.00%	-1.20%	39th
9-10 Rating of Health Care	55.40%	53.50%	1.90%	56th
Getting Care Quickly	87.90%	89.30%	-1.40%	93rd
How Well Doctors Communicate	90.70%	93.90%	-3.20%	32nd
Shared Decision Making	79.40%	81.10%	-1.70%	46th
Health Promotion and Education	72.40%	77.30%	-4.90%	36th
Coordination of Care	89.20%	90.10%	-0.90%	96th
8-10 Rating of Personal Doctor	84.60%	89.80%	-5.20%	82nd
9-10 Rating of Personal Doctor	73.70%	74.90%	-1.20%	94th
8-10 Rating of Specialist	88.00%	86.00%	2.00%	95th
9-10 Rating of Specialist	68.30%	71.50%	-3.20%	58th

Health Care Domain Performance

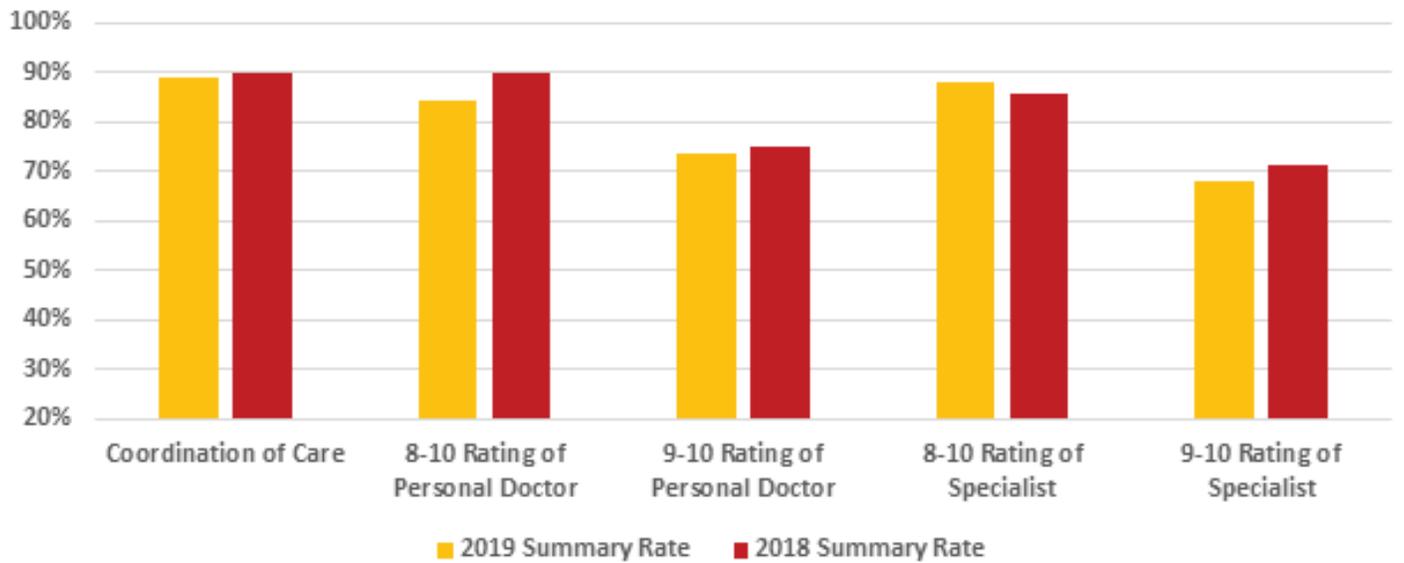
MEASURE	2019 Summary Rate	2018 Summary Rate	CHANGE*	2018 QC Percentile
Flu Vaccinations (Adults 18-64)	56.00%	57.70%	-1.70%	98th
Advising Smokers and Tobacco Users to Quit	83.80%	84.00%	-0.20%	92nd
Discussing Cessation Medications	59.50%	60.00%	-0.50%	81st
Discussing Cessation Strategies	57.40%	54.40%	3.00%	90th
Shared Decision Making	79.40%	81.10%	-1.70%	46th

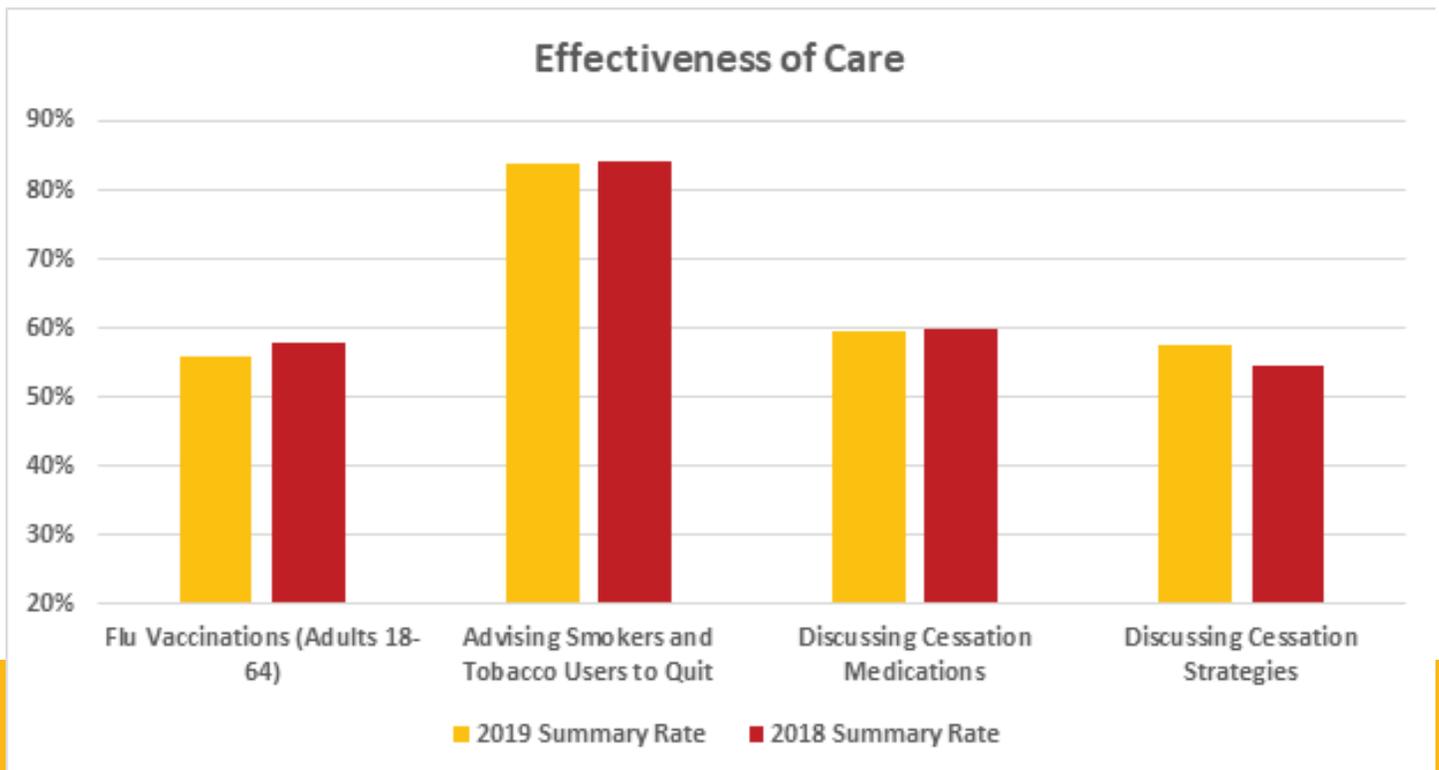


Health Care Domain Performance



Health Care Domain Performance





Jiva

To enhance our performance improvements, we are transforming our online authorization request process. And the first step in this transformation is the implementation of our new population health management system, Jiva.

We will use Jiva for all lines of business, and it will replace the current Clear Coverage process through the provider portal. Jiva is integrated with IQ connect, the new Change Healthcare product designed to implement the InterQual prior authorization standards.

The overall system is designed to provide the following:

- Improvements in efficiencies and decision turnaround time.
- Reduction of documentation duplication and follow-up phone correspondence.
- Future functionality, including Member Centric View and Care Gaps.
- Comprehensive status on historical prior authorization requests.
- Implementation of the new Virginia Premier Prior Authorization List (PAL).
- Ability to provide immediate approval authorization requests as designated by the our PAL process and the subsequent documentation of authorization numbers.

Coordination of Care

Our Chronic Care Management program, formerly known as our Disease Management program, reinforces the education you provide to your patients about managing their chronic conditions. Through the program, our Registered Nurses help your patients reach their health goals by providing verbal education over the phone, mailing them written educational materials, and providing medical equipment such as a digital scale, digital blood-pressure cuff, glucometer, or peak flow meter. If your patient has a chronic care condition, they can call our toll-free number (866) 243-0937, Monday through Friday, from 8:00 am to 5:00 pm (except holidays).

Coordination of Care is done by a Primary Care Provider (PCP), and it helps ensure that our members' needs and preferences for health services and sharing information with their other providers are met over time. Coordination of Care can help:

- Communication between the PCP, Behavioral Health provider and any specialist.
- Ensure that all providers are aware of test, procedures and services to avoid unnecessary duplication of services.
- Shared decision-making between providers.

What Does Coordination of Care Mean for Our Members?

- Most importantly, it means their safety.
- Communication between the PCP and all other providers helps to ensure that medical errors do not occur.
- Communication between the member and their PCP allows them to be more involved in their own health care.
- Members are more likely to receive the preventive care and services that are needed to remain healthy when their care is coordinated.

Does Everyone Need Coordination of Care?

Yes, especially the following populations:

- Children with special needs
- People with disabilities and complex medical conditions
- Behavioral health patients

What's addressed in Chronic Care Management?

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Behavioral Health
- Coronary Artery Disease
- Hypertension
- Chronic Kidney Disease
- Cancer (Breast, Lung, Colorectal, Hematologic)
- Childhood Weight Management

We are committed to our members' good health. Coordination of Care is a very important part of keeping our members healthy.

Cultural Competency

At the core of both patient centeredness and cultural competence is the ability of the healthcare 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 inservices 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. Search our website **www.virginiapremier.com** for "Cultural Competency" to find free courses or contact us and we will fax or email you the Quiz.*

For more information contact the Quality Department:
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**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.