VirginiaPremier™
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# Provider Newsletter

Spring 2020

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# Medical Director's Corner

Let me begin by thanking you for everything you do to help us provide excellent health care and quality services to our members and your patients. We are so pleased you have contributed to Virginia Premier's success stories during this year. And we look forward to hearing more stories about your great work.

On behalf of Virginia Premier, I would like to thank you for everything that you have done to ensure our members and your patients have received the care that they needed during the COVID-19 pandemic. We recognize your sacrifice has been great. Virginia Premier fully supports you and together we will navigate this unprecedent and extraordinary time.

To assist you with the regulatory and business changes due to the COVID-19 pandemic, we have created a resource page at http://www.virginiapremier.com. We continue to monitor the pandemic and promise to keep you informed of updates. Please visit this resource page often as we continuously update it with current information.

### Sentara Healthcare and Virginia Premier

VCU Health System and Sentara Healthcare have finalized the transaction for joint ownership of Virginia Premier. Sentara Healthcare is now the majority owner, while VCU Health System retains a 20 percent ownership stake. Virginia Premier and Optima Health now operate as separate companies under Sentara Healthcare, each retaining their respective names and brands in the marketplace.

### HEDIS and NCQA

Lately, we have been focused on all of the elements of Healthcare Effectiveness Data and Information Set (HEDIS®) and the National Committee for Quality Assurance (NCQA) requirements as we prepare for audits of several of our lines of business.

You can assist us tremendously by providing the documents and records necessary to meet the NCQA standards. We encourage you to keep asking questions and please keep cooperating with the staff, especially the nurses who will visit your offices.

Call Virginia Premier at 1-804-968-1529 (TTY: 711), Monday-Friday, from 8:00 a.m. to 6:00 p.m. If you have any questions, or visit our website at **VirginiaPremier.com**.

### Clinical Practice Guidelines

Every year or two, we review and update our Clinical Practice Guidelines. Physicians who serve on Virginia Premier committees review and approve updated guidelines, which are evidenced-based with references. These guidelines cover acute and chronic care medical, preventive and behavioral conditions. Currently there are 14 Clinical Practice Guidelines.

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

You can review the Clinical Practices Guidelines by:

- Visiting **VirginiaPremier.com** and typing Guidelines in the Search feature listed on the home page and clicking on the results
- Requesting they be faxed to you
- Requesting they be emailed to you
- Requesting they be mailed to you

We alert you of the Clinical Practice Guidelines changes throughout the year. You can also call us at 1-804-968-1529 (TTY: 711).

**Pharmacy Directory**

Virginia Premier updates its pharmacy information monthly. Formulary changes are made to the website for each line of business, including programs for Medicaid and Medicare. EnvisionRX is Virginia Premier's Pharmacy Benefits Manager and is available 24-hours a day for questions at 1-855-813-0363 (TTY: 711), Monday to Friday, from 8:00 a.m. to 5:00 p.m.

Our Formulary is user-friendly for providers and members and can be found at **VirginiaPremier.com**.

**Updates to Virginia Premier Website-Medical Payment Guidelines**

In an effort to make it easier for our providers to better understand Virginia Premier's current medical payment policy, we have created a web page dedicated to highlighting our medical payment guidelines. Included on the new site are a list of continually updated medical policies that serve as guidelines for coverage decisions and assist with administering plan benefits. The policies express Virginia Premier's determination of whether certain services are medically necessary, and they are based upon a review of currently available clinical information.

These peer reviewed policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS) or by the Center for Medicare and Medicaid Services (CMS). Medical policies are not a substitute for clinical judgement or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits. The medical policies generally apply to all Virginia Premier's plans, although some variations may exist by plan type.

This page is now ACTIVE for our providers and can be found either by navigating to the virginiapremier.com website, then selecting the 'For Providers' dropdown and then choosing 'Medical Payment Guidelines', or just clicking on the hyperlink below:

**https://www.virginiapremier.com/providers/medical-payment-guidelines/**

**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.

**This Newsletter**

There are many articles in this newsletter. We hope you find this information helpful and encourage you to read the articles on the prevention of errors and the quality articles on safety. Remember, if you have any questions, please call 1-804-968-1529 (TTY: 711).

Enjoy the lovely spring season.

Warm regards,

**Mark E. Mattingly**
**MD, MBA, FCCP**

## EPIC Improves Quality of Life

At Virginia Premier, we don't just manage health conditions, we work to maintain better health, encourage healthy lifestyles and provide a higher quality of life. Research shows that hearing aids not only improve hearing, but quality of life, too.

Through our hearing program, Virginia Premier now offers name brand hearing aids through EPIC Hearing Services Plan (EPIC) at a low-or no-cost member co-pay.

The chart below shows the coverage offered to our members through our different health plans:

| EPIC's Program | | | |
|---|---|---|---|
| Virginia Premier Medicare Advantage Elite (HMO SNP) | Virginia Premier Medicare Advantage Gold (HMO) | Virginia Premier Medicare Advantage Platinum (HMO) | Virginia Premier Elite Plus |
| • Routine hearing exam<br>• Hearing benefit: $1,250 max benefit every three years | • Routine hearing exam<br>• Hearing benefit: $750 max benefit every three years | • Routine hearing exam<br>• Hearing benefit: $1,000 max benefit every three years | • Routine hearing exam<br>• Hearing benefit: $1,250 max benefit every three years |

Interested in learning more about this benefit? Contact EPIC at 1-866-445-2284 (TTY: 711), Monday to Friday, from 9:00 a.m. to 9:00 p.m. EST, or online at **www.epichearing.com/VirginiaPremier**.

# Bright Smiles. Healthy Starts.

According to the Virginia Oral Health Coalition, nearly half of Virginia's third graders experience tooth decay, which can lead to poor nutrition and missed school hours. Tooth decay has become a chronic childhood disease in America.

Pediatricians, you play an important role in ensuring a child is set up for a healthy life and can help promote oral health care, including cavity prevention, starting with babies as young as six months.

### Using Fluoride Varnish

Fluoride varnish can be given for a total of six applications from six months of age to three years. Dental referrals should be made at the child's 12-month well-child visit.*

Our team at Virginia Premier educates members on the importance of oral health. And we thank you for your support in promoting fluoride varnish and positive dental care practices starting in infancy.

### Getting reimbursed is easy

Fluoride varnish applications are reimbursed by Standard Fee Service Medicaid and all Managed Care Medical Plans just like other medical procedures. Use the procedure code assigned to the Fluoride Varnish procedure below:

| Diagnostic Code | Procedure Code | Description | Reimbursement |
|---|---|---|---|
| V07.31<br>Prophylactic fluoride administration | 99188 | Topical fluoride varnish; therapeutic application for moderate to high risk patients | $20.79 |

### Questions?

Call Virginia Premier at 1-804-968-1529 (TTY: 711), Monday to Friday, from 8:00 am to 6:00 pm.

**Sources: The Virginia Coalition for Oral Health and the Virginia Department of Health*

## Practitioners Golden Globe Award (PGA)

Once a year Virginia Premier recognizes an outstanding participating practitioner who promotes safe clinical practice, delivery of quality care and who voluntarily broadens his or her scope of practice through education and community involvement. You, our members, and your staff are encouraged to contact us for a nomination form for Virginia Premier's Practitioner Golden Globe Award (PGA). Call the Quality Department at 1-800-727-7536, extension 51716. We will respond to each message within 1 business day.

Nominations for this prestigious award will be accepted through December 31, 2020. The Quality Department will select the winner of this award based on the HEDIS information supplied in the nomination. The winner of this award will be announced through our provider and member newsletters.

In addition to receiving the award, the Practitioner Golden Globe winner will receive a luncheon for his or her team and will be recognized with an article in our provider and member newsletters. We will also submit a press release to the local newsletter on his or her behalf.

We are looking for the provider you feel goes the extra mile, and we want to hear from you why your provider should be the next Virginia Premier Golden Globe Winner. Contact us to nominate your physician. Tell us what makes your provider stand out from the rest and why he/she should receive this honor. We'll do the rest.

## 2020 Quality Initiatives (QI) Program, Goals and Updates

Our QI Program helps our member get high quality health care at an affordable price. We are working to improve public health in the areas where our members both work and live by concentrating on both national and local public health initiatives and goals. We use a quality improvement process that looks at areas that may impact our members. We put programs in place where we see areas of concern. Then we use satisfaction surveys to get member feedback on how to improve our services in order to improve the overall quality of care.

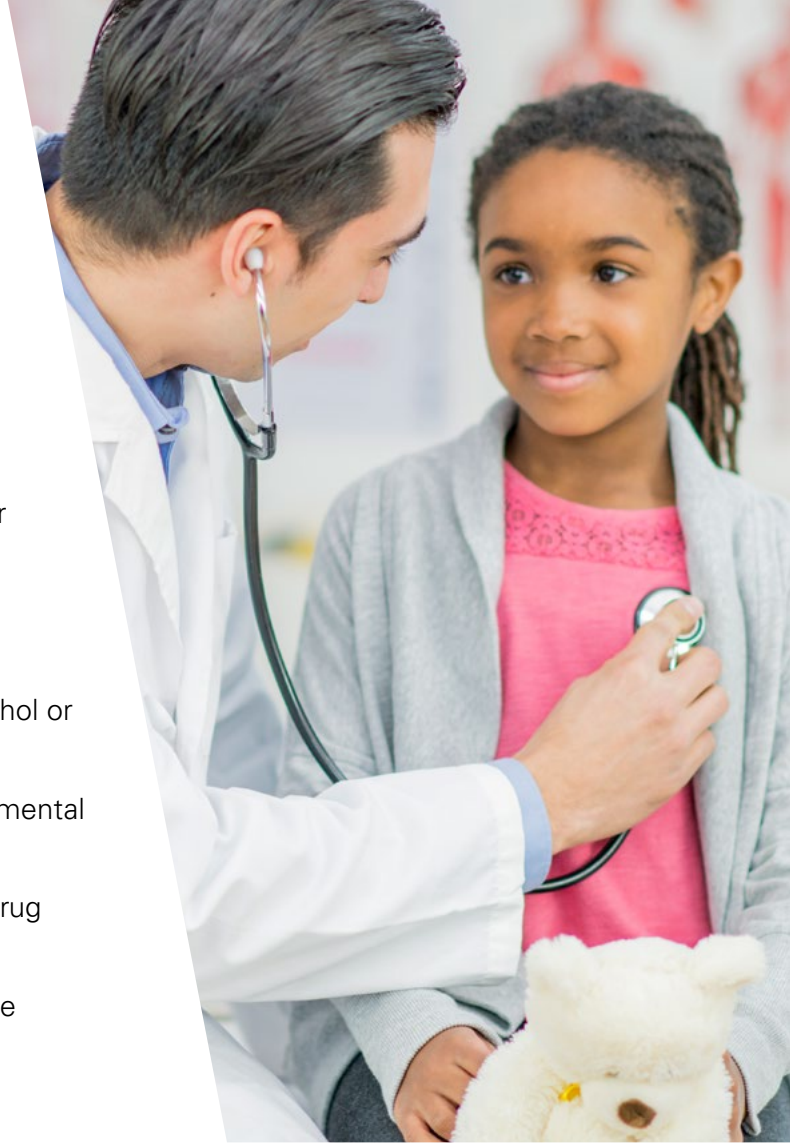
**The primary goals of our QI Program are:**

1 **To achieve the statuses of "First in the Commonwealth" and "Top 30 Best Medicaid Plans in National NCQA Ratings"**

**Update:** We have maintained an NCQA status of commendable. Accreditation is not a one-time event, but an ongoing journey to support quality services for customers, members and practitioners. We are committed to providing excellent services to our members, and we have an ongoing plan to monitor our progress toward the goal of excellence. Our mission is to inspire healthy living within the communities we serve with a focus on those in need. We were ranked as one of the top 3 health plans in Virginia during 2016. We also scored above average on Living with Illness compared to other health plans. We 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 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 our members tests for breast cancer and cervical cancer and getting care to moms before and after their baby is born.

2 **Achieve the 75th percentile or greater for Targeted HEDIS® Performance Incentive Award (PIA) Measures**

**Update:** As of 2020 a Performance Withhold Program (PWP) was developed. The PWP is an adaptation of the Performance Incentive Award Program (PIA). Like the PIA, the PWP includes measures designed to evaluate quality by setting performance standards and expectations for MCO's. It is based on measures that DMAS determines instrumental to achieving the goals of managed care. The goal is to meet the national 50% percentile benchmark for each measure. The Performance Withhold Program Measures are listed below for each Line of Business.



**Medallion 4.0**

1. Adolescent Well-Care Visits
2. Childhood Immunization Status – Combo 3
3. Prenatal and Postpartum Care
4. Comprehensive Diabetes Care
5. Asthma Admission Rate
6. Follow-up After Emergency Department Visits for Mental Illness

**MLTSS**

1. Follow-up after Emergency Department visit alcohol or other drug dependence
2. Follow-up after Emergency Department visit for mental illness
3. Initiation and engagement of alcohol and other drug dependence treatment
4. COPD and asthma in older adults admissions rate
5. Comprehensive diabetes care
6. Heart failure admissions rate

## 3 Improve the member experience through CAHPS Survey education for membership, providers and internal staff

**Update:**

**Members CAHPS®**
Surveying member experience provides us 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 help 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, we prioritize improvement initiatives that are most meaningful to members.

**Practitioners**
Surveying practitioner satisfaction, access and availability provides us with information on our practitioner's experience with the plan and our members. Practitioner satisfaction is assessed in several ways, but the primary measurement tools are the Provider Satisfaction Survey, 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.

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

**Update:** We conduct a Member Advisory Committee (MAC) meeting survey in English and Spanish at the end of each MAC meeting. Our members rated the meetings very favorable. There were 8 scheduled MAC meetings in 2019, with 120 members attending. A wide range of topics was covered, including: Child Safety, Women's Health, Pregnancy Programs, Mental Health, Holiday Depression, Domestic Violence, Smoking Cessation, Diabetes, Asthma and Allergy Awareness and Eye Exams. We engage our members by evaluating the recommendations that they include in the survey. We also encourage our non-English speaking members to attend our MAC meetings and we provide interpretation services and translated documents to those who need 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** **Ensure a safe continuum of care through the application of our Member Safety Program (MSP) initiatives**

**Update:** We include patient safety materials in both the Member and Provider newsletters (e.g. "Questions to Ask Your Doctor" and "20 Tips to Prevent Medical Errors"). We also provide (cont.) practitioner offices with National Patient Safety Goals when we conduct 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** **Review performance against clinical practice guidelines.**

**Update:** Clinical practice guidelines are developed for areas which, upon evaluation, have the greatest need for direction. These guidelines are complementary to the established medical practices of the plan. Practitioners are educated regarding our 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** **Continue to address improvements in practitioner satisfaction via quarterly meetings with the practitioners.**

**Update:** Provider Education Meetings (PEM) are held four or more times each year in each service region. Local provider service representatives and representatives from various departments present provider updates and address questions from the provider community. In 2019, our PEM meetings throughout the five regions were very well attended. Improvement strategies include notifying providers about upcoming meetings via the provider newsletter and website, enhancing the quality of the PEM meetings and providing a high-level summary in the PEM invite of the topics to be discussed in the meeting.

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

**Update:** We annually analyze 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 relevant, culturally targeted materials. We analyze interpreter availability and develop educational materials to meet the cultural and linguistic needs of our members.

To learn more about the Quality Initiatives (QI) Program, visit our website at **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 by calling the Quality department at 1-800-727-7536.

## Healthcare Effectiveness Data and Information Set (HEDIS) Announcement

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 began in January, 2020 and went through May, 2020. 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.

## False Claims Act - What are the Penalties?

In our last couple of newsletters, we discussed the several laws prohibiting activities that may constitute fraud, waste or abuse. One is the Federal Claims Act, which includes a "qui tam" or whistleblower provision that encourages individuals to come forward and report misconduct involving false claims. In case you missed these articles, you can view our recent newsletters online at **virginiapremier.com/providers/medicaid/provider-resources/**.

**Below are the consequences of violating this Act**

**1. Substantial Penalties.** Penalties are evaluated on a per claim basis, which means the total penalty sought could end up being substantial. Although the text of the statute states that the penalties per claim can range from $5,000 to $10,000, those are subject to inflation. As of 2018, the potential penalties per claim climbed to a minimum of $11,181 and a maximum of $22,363 per claim.

**2. Treble (3x!) Damages.** Treble damages means the government takes the amount it lost due to paying the false claims and multiplies that number by three.

**3. Exclusion.** Providers found to have violated the FCA may be excluded from participating with federal health care programs, which means that they can no longer submit claims to Medicare, Medicaid, and other programs for services rendered.

Report any suspected fraud, waste, or abuse by visiting: **www.virginiapremier.com/programintegrity** 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.**

# Provider Updates

### Where to Find Provider Updates Online

Make sure to stop by **virginiapremier.com/providers/medicaid/provider-resources/** to catch up on the latest information about:

- Best practices for submitting claims with authorizations
- Opioid drug management program
- List of HCI edits
- Vendor transition
- CMHRS and ARTS claims processing
- Virginia Premier behavior health authorization request
- Sample member IDs
- Virginia Premier universal payer ID
- Online resources and more
- Provider Call Center - How to contact us
- Utilization review process
- Important information concerning electronic claims submission
- No authorization required for UI services

## Clinical Practice and Preventive Care Guidelines

**Define**

The objective of the Preventive Care Guidelines 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 evidence-based programs to support the clinical practice guidelines.

**Measure**

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

- ADHD Guidelines
- Asthma Guidelines
- Childhood Weight Management
- COPD Guidelines
- Diabetes Mellitus Guidelines
- Heart Failure Disease
- Pain Strategy Clinical Practice Guidelines
- Prenatal - Normal Pregnancy
- Preventive Care Guideline
- Preventive Prenatal High-Risk Guideline
- Screening for Depression in Diabetes
- Sick Cell Pain Crisis Guideline
- Smoking Cessation Guideline
- Stable Coronary Artery Disease Guideline
- Weight Loss Drugs for Adults & Criteria (cont.)

| Clinical Practice Guidelines (CPGs) | HEDIS Measure to Assess Compliance |
|---|---|
| ADHD Guidelines | Follow-up care for children prescribed AHD Medications (ADD) including inhibition phase and continuation and maintenance phase |
| Asthma Guidelines | • Asthma Medication Ration (AMR)<br>• Ages 5-11<br>• Ages 12-18<br>• Ages 19-50<br>• Ages 51-64<br>• 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<br>• Pharmacotherapty management of COPD<br>• Exacerbation |
| Diabetes Mellitus Guidelines | • HbA1C<br>• HbA1C poor controls (9%)<br>• HbA1C control (8%)<br>• Eye exam (retinal)<br>• Medical attention for nephropathy<br>• BP control (140/90 mm/Hg) |
| Heart Failure Disease (Cardiovascular) | • Controlling high blood pressure<br>• Persistence of beta-blocker treatment after a heart attack<br>• 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<br>• Postpartum are - 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<br>• Medical assistance with smoking and tobacco use cessation |
| Stable Coronary artery disease guidelines | • Statin therapy for patient with cardiovascular disease<br>• Controlling high blood pressure<br>• Aspirin use and discussion<br>• Influenza vaccine<br>• Pneumococcal vaccination<br>• Antidepressant medication management |

**Analyze**

Guidelines are distributed via our website (**VirginiaPremier.com**), and practitioners are notified by newsletter of the availability of guidelines on the website. Guidelines are also available upon request.

## Timeliness of Prenatal Care and OB Registrations

Please help us encourage our members to receive timely prenatal care in their first trimester and within 42 days of enrolling with us. Virginia Premier incentivizes to our members if they enroll in our Healthy Heartbeats Prenatal Care Program and seek timely and consistent prenatal 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. The form can be faxed back to us at 1-800-827-7192. Upon receipt of the OB Registration Form, our staff will enter an authorization code. You should then submit a claim using a primary diagnosis code of pregnancy - G9000 - and the authorization code. You will then receive the $25 incentive.*

*Only one incentive will be paid to an OB Group per member pregnancy. For example: if doctors A and B are in the same group and see the same member during her pregnancy, only one incentive will be reimbursed.

**virginiapremier.com/providers/medicaid/forms-library/**

## Keeping you in the loop

### Communications Sent to Our Members

In the first portion of this newsletter, we went over some of the news and updates we have for you, our doctors and providers. But now we'd like to shift gears a little.

In the section that follows, we'd like to show you some of the updates we've been sending to your patients, our members.

We're partners, after all, so we want to keep you in the loop.

## Bringing Quality Care to our Members

Virginia Premier is committed to continuously improving the quality of care provided to our members and enhancing their overall health. Each year, we look at several measures that may impact our members' health and then find for ways to improve.

Here are a few of the 2019 measure results for our Medicare members. We've also included tips on how you, the member, can help make sure you get all the health care you need.

**Measure result:** Over 16% of Medicare members who were discharged from the hospital for behavioral health reasons were readmitted within 30 days. This is higher than the national average.

**What you can do:** Be sure to keep any appointments with your doctor within 14 days of being discharged. That way, you're more likely to stay healthy at home, rather than having to go to the hospital again.

**Measure result:** There were 1,305 emergency room visits per 1,000 Medicare members. This is much higher than the target of 507 per 1,000 members.

**What you can do:** Many illnesses -- such as colds, flu, fever, bladder infection, strains and sprains -- can be treated in an urgent care center or your doctor's office. Only go to the emergency room if there's no other option.

**Measure result:** Among our Medicare members with diabetes, 75% of them were taking cholesterol-lowering medications. Our goal is to get this number up to 83%.

**What you can do:** If you have diabetes, ask your doctor about these medications, which can help you avoid complications that can occur with diabetes.

**Measure result:** Fifty-eight percent of our Medicare members were screened for colorectal cancer. Our goal is to get this number up to 73%.

**What you can do:** Make an appointment with your doctor for a wellness visit. Ask about being screened for colorectal cancer and other health conditions.

## Our Bereavement Programs

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. We recognize the challenges you may face coping with intense grief, and would like to contribute to your support system.

For our Medicaid members who suffer the loss 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 a doctor who is treating one of our members who has been faced with a loss, you can refer that member to one of our Case Managers. They can assess their needs and assist with services.

Virginia Premier offers an Adult Bereavement Program for Medallion, MLTSS, and MAPD members/families. There are community resources available to assist members and families who have suffered the loss of a loved one. With members/families at the core of our existence, the Virginia Premier Adult Bereavement Program Team and Quality RNs ensure to provide the essential community resources to help cope during difficult times.

If you have questions, please contact our Member Services Department at 1-(800)-727-7536 Monday-Friday, 8:00 am-8:00 am

## Complex Case Management Referrals

We offer Case Management to all of our members to help coordinate their health care. Once you enroll with us, you will be contacted by Case Management to complete an assessment that will help us to determine what needs you may have. This assessment is very brief and can be done over the phone in a matter of minutes. The results of this screening are sent to a Case Manager (CM) for review. If the Case Manager (CM) identifies areas where we can assist you with care, such as managing a chronic condition like Diabetes, they will contact you for more information. We also offer case management to members by referrals from both inside and outside of our organization. This means that you, your caregiver or family member, and any of your physicians or care providers can contact us to assist you with getting services.

We have multiple programs that are completed in the community. Once you join our community wellness programs, you may be referred to a Case Manager, if there is a need. Our internal Utilization Management (UM) department will use payment information from your doctor to refer you to a Case Manager. We see this as a chance to connect with and offer case management services to our members. We also run daily, monthly, and quarterly reports that help us identify members with needs. These reports show any recent hospital stays, ER visits, or even a prescription refills. We want you to have the care you need and deserve.

Also, if you or your loved ones are having a hard time getting the care or services that you need, need help finding a doctor, or are in a place where you just don't know what you need, we are here to help. Our Case Managers are available Monday through Friday, excluding certain holidays, from 8:00 am to 5:00 pm. Please contact us at 1-800-727-7536 (press option 3 for Medical Management, and then option 4 for Case/Care management).

And for our doctors and providers, if you have a member that you have identified as needing Case Management services, please contact us at 1-800-727-7536 (press option 3 for Medical Management and then option 4 for Case/Care management). You can also go to our website to complete and fax the Case Management referral form at:
**virginiapremier.com/members/medicaid/health-programs/casecare-management-services/**

# Grievances and Appeals

### Contact Us First

If you have a problem or concern with a provider or any medical services you receive, please contact us first. We promise to honor your rights as our member and take your concerns seriously. We are here to listen, and 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.)

We alert you of the clinical practice guidelines changes throughout the year. You can also call us at 1-804-968-1529 (TTY: 711).

### What Is an Appeal?

If we decide 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 for Medicaid and Medicare, and 180 days of the denial date for the Healthcare Exchange (Note that the COVID-19 pandemic may have impacted the appeals timeline. Please check with up to date COVID-19 communication channels for confirmation). Appeals can be submitted to us 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@virginiapremier.com

## 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.

We expect doctors and/or providers to actively engage with members in discussions related to their expressed advance directive wishes and document the details of those discussions in the member's medical records. We 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.

## 10 Questions to ask your doctor

Do you know the right questions to ask?

1. What is the test for?
2. How many times have you done this procedure?
3. When will I get the results?
4. Why do I need this treatment?
5. Are there any alternatives?
6. What are the possible complications?
7. Which hospital is best for my needs?
8. How do you spell the name of that drug?
9. Are there any side effects?
10. Will this medicine interact with medicines that I'm already taking?

# 20 Tips to Help Prevent Medical Errors

**Patient Fact Sheet**

Medical errors can occur anywhere in the health care system: in hospitals, clinics, surgery centers, doctors' offices, nursing homes, pharmacies, and patients' homes. Errors can involve medicines, surgery, diagnosis, equipment, or lab reports. These tips can help you get safer care.

One in seven patients in hospitals experiences a medical error. They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal.

Most errors result from problems created by today's complex health care system. But errors also happen when doctors and patients have problems communicating.

**What You Can Do to Stay Safe**

The best way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results.

**Medicines**

1. Make sure that all of your doctors know about every medicine you are taking. This includes prescription and over-the-counter medicines and dietary supplements, such as vitamins and herbs.
2. Bring all of your medicines and supplements to your doctor visits. "Brown bagging" your medicines can help you and your doctor talk about them and find out if there are any problems. It can also help your doctor keep your records up to date and help you get better quality care.
3. Make sure your doctor knows about any allergies and adverse reactions you have had to medicines. This can help you to avoid getting a medicine that could harm you.
4. When your doctor writes a prescription for you, make sure you can read it. If you cannot read your doctor's handwriting, your pharmacist might not be able to either.
5. Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you get them:
    - What is the medicine for?
    - How am I supposed to take it and for how long?
    - What side effects are likely? What do I do if they occur?
    - Is this medicine safe to take with other medicines or dietary supplements I am taking?
    - What food, drink, or activities should i avoid while taking this medicine?
6. When you pick up your medicine at the pharmacy, ask: Is this the medicine that my doctor prescribed?
7. If you have any questions about the directions on your medicine labels, ask. Medicine labels can be hard to understand. For example, ask if "four times daily" means taking a dose every 6 hours around the clock or just during regular waking hours
8. Ask your pharmacist for the best advice to measure your liquid medicine. For example, many people use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help measure the right dose. (cont.)

9. Ask for written information about the side effects your medicine could cause. If you know what might happen, you will be better prepared if it does or if something unexpected happens.

**Hospital Stays**

10. If you are in a hospital, consider asking all health care workers who will touch you whether they have washed their hands. Hand washing can prevent the spread of infections in hospitals.

11. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will follow at home. This includes learning about your new medicines, making sure you know when to schedule follow-up appointments, and finding out when you can get back to your regular activities. It is important to know whether or not you should keep taking the medicines you were taking before your hospital stay. Getting clear instructions may help prevent an unexpected return trip to the hospital.

**Surgery**

12. If you are having surgery, make sure that you, your doctor, and your surgeon all agree on exactly what will be done. Having surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. Surgeons are expected to sign their initials directly on the site to be operated on before the surgery.

13. If you have a choice, choose a hospital where many patients have had the procedure or surgery you need. Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.

**Other Steps**

14. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.

15. Make sure that someone, such as your primary care doctor, coordinates your care. This is especially important if you have many health problems or are in the hospital.

16. Make sure that all your doctors have your important health information. Do not assume that everyone has all the information they need.

17. Ask a family member or friend to go to appointments with you. Even if you do not need help now, you might need it later.

18. Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.

19. If you have a test, do not assume that no news is good news. Ask how and when you will get the results.

20. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources. For example, treatment options based on the latest scientific evidence are available from the Effective Health Care Web site. Ask your doctor if your treatment is based on the latest evidence.

## Watch Me Grow

Watch Me Grow is our Early Periodic Screening Diagnostic and Treatment (EPSDT) Program for newborns, and all ages up to 21. This program is designed to educate and remind members of wellness visits and vaccinations. Members may receive reminder calls and text messages to help stay up to date on wellness visits and vaccinations. Members are also invited to use a new service called Text4kids. Text4kids provides educational messages to parents/ guardians of children ages 1-18. Text4kids will provide education on health related topics to include developmental milestones, wellness visits, dental visits, and other important areas.

# News for Service Facilitators

**Outline of the Areas of Enforcement: Incomplete and Untimely Submission, and Adverse Transition Period Notification**

This is notification that effective January 1, 2019, Virginia Premier requires providers to submit the DMAS 98R (see the form below) with their authorization requests for new services, and existing service requests that require an increase or decrease to a member's current service authorizations. If we do not receive a DMAS 98R with the provider's request, the provider will receive a fax back indicating that we received an incomplete submission.

Provider authorization requests will not be processed until receipt of the DMAS 98R. Providers will have two business days from the date they receive the fax back form to submit the DMAS 98R; failure to meet the two business day turnaround time shall result in an automatic withdrawal of the provider's service authorization request.

Additionally, effective January 1, 2019, Virginia Premier enforces the 10 business day transition period for par-approved or par-denied service authorizations when personal care service authorizations are submitted after the requested start date. We will honor existing service requested hours during this 10 business day transition period to allow members to safely transition to their approved service hours.

**(a)** For service authorization with hours that exceeds a member's LOC CAP, Virginia Premier will only approve service hours within the member's maximum authorize hours based on the members LOC from the start date on the service authorization form to the day prior to the date Virginia Premier received the authorization.

**Example #1**: Virginia Premier receives a personal care service authorization request that exceeds member's LOC on 12/17/18 for 56 hours. Member's LOC is B (cap personal care hours= 30 hours). We will approve 30 hours of personal care from 12/13/18 to 12/16/18. If the clinical review supports approval of the additional 26 hours, We will approve 56 hours of personal care starting on 12/17/18 x six months.

**Example #2**: Virginia Premier receives a service authorization request for hours within member's LOC on 12/20/2018 with a service start date of 12/5/18. We will review the request and initiate the approved service hours starting on 12/20/18 (date service authorization was received) x six months.

<Virginia Premier Elite Plus>
<PO Box xxxx>
<Richmond, VA xxxxx-xxxx>
<Toll-Free: xxx.xxx.xxxx (TTY: 711)>
<www.virginiapremier.com>

<Name>
<Address Line 1>
<Address Line 2>
<Address Line 3>

Request Date:
Member Name:
Member ID:
Member DOB:

## INCOMPLETE SUBMISSION/DOCUMENT REQUEST FORM:

**Provider:**

**Received Date:**

**Fax Number:**

**Date:**

**Dear Provider:**

**An incomplete submission was received. In order to process your request additional documents are required to process your request.**

**Please submit the following missing documents:**

| | | |
|---|---|---|
| ☐ UAI | ☐ DMAS 97 A/B | ☐ DMAS 225 |
| ☐ DMAS 95 | ☐ DMAS 98 | ☐ DMAS 300 |
| ☐ DMAS 96 | ☐ DMAS 99 | ☐ DMAS 301 |
| ☐ DMAS 97 | ☐ DMAS 100 | ☐ DMAS 302 |
| ☐ DMAS 100 A | | |

**Please contact us if you have questions concerning the submission process.**

**Toll-free: 1-877-719-7358**

**Fax: 1-877-794-7954**

## 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 our 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 that 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. We require medical records to be maintained by all affiliated practitioner offices and/or medical center locations in a manner that is current, detailed, and organized. This 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

Our Quality Staff will conduct an office site visit and assess:

- 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. For 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.

**Waiver Audit Site Visits (CCC Plus only)**

When determined by the Department of Medical Assistance Services (DMAS), 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.

## Claims Reconsiderations

As a reminder, in the event that you are not satisfied with a payment decision or determination, you have the right to request a reconsideration by completing and submitting the Virginia Premier Claims Adjustment form. This form and additional information can be found on our website, **VirginiaPremier.com**.

Reconsiderations/appeals of a claim must be submitted and received in writing within 60 days of the date of the remittance received for the claim in question. The request should clearly explain why you disagree with the claim decision. Virginia Premier will follow the standard reconsideration timeframes- outlined in 42 CFR §422.590, which allows the health plan 60 calendar days from receipt of the request to respond in writing. The decision will contain detailed information to include further reconsideration/appeal rights if the decision is not fully favorable. Documentation that is submitted after the reconsideration/appeal request has been filed may result in an extension of the decision/response timeframe.

**https://www.virginiapremier.com/wp-content/uploads/ClaimAdjustmentRequestForm.pdf**

## Provider Rights and Responsibilities

### A. To Correct Erroneous Information

VPHP'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. VPHP 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.

VPHP 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

VPHP ensures that practitioners can access their own information obtained by VPHP 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

VPHP'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 VPHP 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.

# Changing from a Pediatrician to a Doctor Who Cares for Adults

If you're between the ages of 18 and 21, it's a good time switch from a pediatrician (a doctor for children and teens) to a doctor who cares for adults.

### How you can switch to your new doctor

First, start to look for a new doctor. You can use our online Find a Provider tool to see all of the doctors available in our network. It's a long list, so give us a call. We can help narrow down your search.

Then, get a copy of your immunization (shots) record from your pediatrician. You'll need to show it to your new doctor. If you're not up to date on your shots, then your new doctor can help you get caught up.

After you select one, transfer your medical records to your new doctor. Your pediatrician can help you with this. You may need to sign an authorization form.

Finally, schedule your first appointment with your new doctor. Make sure you bring your:

- Insurance card
- Treatment histories
- Immunization record

If you have any more questions, or you'd like a little more help, talk with your pediatrician about transitioning your care. They'll be able to walk you through the steps.

**NOTE:** If you take any medications, make sure you have enough until your next appointment with your new doctor. This is because there may be a short gap before you're able to see your new doctor. And that doctor will want to talk with you first before writing a prescription.

# CM Program & How to Make Self-referrals / Coordination of Care

### Coordination of Care

If you're not sure what coordination of care is, you need not worry. Coordination of care is what it sounds like. Your care – including your doctors, services, insurance and medicines – is coordinated, or organized. The goals of care coordination are to:

- Improve health care
- Improve health and wellness for those with complex and special needs
- Integrate services around member needs
- Ensure members receive appropriate services and desirable treatment outcomes

Your Primary Care Provider (PCP) leads the coordination and ensures that your needs and preferences for health services are met by:

- Increasing communication among your PCP, Behavioral Health provider, and any specialists as part of your care.
- Making sure that all members of your care team are aware of any tests, procedures and services you're scheduled to receive.
- Sharing decision making among all of your providers.

**What Does Coordination of Care Mean for You?**

Virginia Premier has care coordinators and care managers willing and ready to help you coordinate your medical, behavioral health, and substance abuse services. They will assist you and your providers in the authorization process for services, organizing and scheduling treatment meetings, and finding additional resources and referrals. Care coordinators at Virginia Premier can influence and assist with ensuring:

- **Safety** - Communication between your doctors helps to ensure that medical errors do not occur.
- I**nvolvement** - Communication between you and your doctor allows you to be more involved in your own health care.
- **Better Care** - You are more likely to receive the preventive care and services you need to remain healthy when care is coordinated.

You can contact Virginia Premier Member Services if you are interested in connecting with a care coordinator or care manager.

**Does Everyone Need Coordination of Care?**

No, but it can be helpful for those with:

- Children with special health needs
- High-risk pregnancy
- Disabilities and complex medical conditions
- Behavioral health needs

**How Can You Help with Coordination of Care?**

- Ask your behavioral health provider to give your PCP updates on your care.
- Ask your specialists to send reports to your PCP.
- Be sure your PCP knows about any specialists you are seeing, and why you are seeking care from the specialist.
- Give your PCP a list of all the medications you are taking.

If you don't already have a care coordinator or care manager, you can call Virginia Premier Member Services to ask for one to be assigned. We will then do an assessment to see if care coordination is right for you.

## Language Assistance Services

If your patient speaks a language other than English, language assistance services are available to your patient free of charge. The patient can call their plan's Member Services line.

VirginiaPremier™
Powered by VCU Health

P.O. Box 5307
Richmond, VA 23220-0307

**Call us at 1-804-968-1529 (TTY: 711)**
**or visit us online at VirginiaPremier.com**

**Hours of Operations**
**Monday - Friday; 8:00 am – 6:00 pm**

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