VirginiaPremier™

Provider Manual

HMO Physicians, Providers and Hospitals

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Provider Manual

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Virginia Premier Medicare Advantage Plans

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Overview

About Virginia Premier

Virginia Premier's mission is to inspire healthy living within the communities we serve, especially those in need. We do this through innovation, strategic partnerships, and industry-leading healthcare. Founded in 1995 as a Medicaid HMO, Virginia Premier is the first and only nonprofit managed care organization in the Commonwealth, now serving more than 280,000 members statewide. It offers Medicare, Medicaid, and health insurance exchange plans. Virginia Premier is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Va., and VCU Health System based in Richmond, Va.

Our Vision

Using evidence-based approaches, Virginia Premier applies best practices to medical care to keep our members healthy. This means we:

- Collaborate with our network providers and our members to learn which actions get the best results.
- Try innovative delivery models to get health care to our members, and
- Partner with academic medical institutions as they conduct medical research and teach the next generation of doctors and nurses.

Contact Information

Provider Information Updates or Changes

In an effort to comply with both the Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS) regulatory mandates, Virginia Premier requires that all contracted providers report changes to addresses and other practice information electronically via www.VirginiaPremier.com or in writing immediately.

If a provider is operating under a delegated arrangement, it is therefore the responsibility of the delegated entity to report any and all provider information changes via the www.VirginiaPremier.com website or the Network Development department directly.

Information changes that require notice to Virginia Premier may include:

- Provider information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Phone Number
- Practice name
- Adding a Provider**
- Removing a Provider
- Medicare numbers

*Changes to tax ID numbers, practice name, or legal entity may require an amendment or new agreement. Consult with your dedicated Provider Service Representative for more information.

**Any new provider(s) must first be credentialed before rendering treatment/services to any Virginia Premier member.

Virginia Premier must request that any changes such as those reference above be submitted at least thirty (30) days prior to the effective date to ensure adequate time for system and directory updates.

Please go to https://www.VirginiaPremier.com/providers/provider-update-request-form/ to submit changes electronically.

Contact Us

Member Eligibility Inquiries:

- Visit: www.VirginiaPremier.com; or
- Telephone: Member Services call: 1-877-739-1370, opt. 3, then 4.

Virginia Premier's verification of eligibility does not guarantee payment. If it is confirmed that a member was not eligible on the date of service, payment will not be made. We strongly encourage providers to ask patients for their most up-to-date insurance status before rendering service(s).

Preauthorization and Notification:

Go to Virginia Premier's secured provider portal at https://www.VirginiaPremier.com/providers/elite/provider-portals/, or call the Referrals and Authorization Service Center at 1-888-251-3063.
Outpatient Authorizations Fax: 1-800-827-7192
Inpatient Admissions Fax: 1-877-739-1365

Provider Representatives and Relations:

Provider Services Representatives serve as the liaisons between contracted providers and Virginia Premier. Questions regarding contracting or PCP panels should be directed to your dedicated Provider Services Representative or by calling 1-877-739-1370, option 3, then 1.

Claims Inquiries:

Go to Virginia Premier's secured provider portal at https://www.VirginiaPremier.com/providers/elite/provider-portals/, or call 1-877-739-1370, option 3, then 2. Providers may also call the number listed on the back of the member's ID card.

Grievances and Appeals:

Contact the Grievances and Appeals team at 1-877-739-1370, option 3, then 2.
Fax: 804-649-9647

Pharmacy Provider Helpline-Envision Rx (24/7):

Contact the Pharmacy Helpline for prescription and/or medication assistance at 1-855-408-0100 Elite
Fax: 1-866-250-5178

Nurse Advice Line (24/7):

Contact the nurse advice line at 1-800-256-1982.

Other Important Numbers:

- Care Manager's Fax 1-877-739-1368
- Virginia Premier Advantage Elite Quality Fax 1-877-588-4033
- EDCD and Nursing Facilities Authorization Fax 1-877-794-7954

Virginia Premier Office Locations:

	Physical Address	**Mailing Address**	**Phone Number(s)**
Corporate Office	10800 Nuckols Rd, Glen Allen, VA 23060	PO Box 5307 Richmond, VA 23220	800-727-7536 804-819-5151
Roanoke Office	5060 Valley View Blvd NW Roanoke, VA 24012	PO Box 1751 Roanoke, VA 24012	540-344-8838 888-338-4597
Southwest (Bristol) Office	105 Village Cr Bristol, VA 24201	105 Village Cr Bristol, VA 24201	866-285-8963
Tidewater Office	825 Greenbrier Cr Suite 200 Chesapeake, VA 23320	PO Box 62347 Virginia Beach, VA 23466	757-461-0064 800-828-7989

NOVA/Winchester office: 5500 Cherokee Avenue, Ste.120, Alexandria, VA 23221. They do not have a po box. 804-819-5151 is the phone number they use

Provider Portal

Contracted providers may request access to Virginia Premier's secured provider portal. The URL is https://www.VirginiaPremier.com/providers/elite/provider-portals/. The secured portal can be used to verify eligibility, claims submission and status, authorization inquiries, and referral submissions. The www.VirginiaPremier.com website provides a variety of informational resources such as quick reference guides, No Prior Authorization (NPA) Search Tool, and provider training updates.

Claims Procedures

Verifying Member Eligibility

Providers are encouraged to confirm member eligibility by using either the Virginia Premier secured provider portal, calling the Members Services department or the number on the back of the member ID card.

Providers not currently registered on www.VirginiaPremier.com:

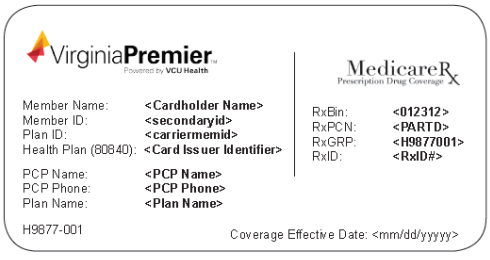
Go to the 'Providers' tab, then select 'Medicare', then 'Provider Portal'. Scroll to the bottom of the page, and click 'here' in the New Users section. Follow the on-screen instruction and prompts. Once registered, providers will have the option to verify member eligibility, submit CMS-1500 claims, confirm claim status, and have access to additional resources.

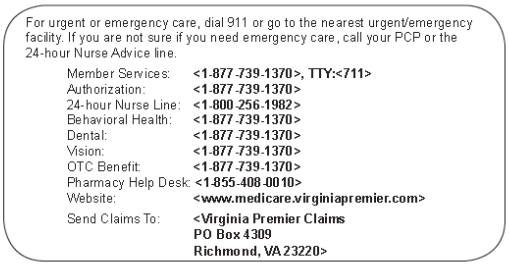
Eligibility via Phone:

- Call Virginia Premier Member Services at 1-877-739-1370 or the number listed on the back of the member's ID card
- Be able to provider member's identification number and any other authenticating information

Member Identification (ID) Card

Virginia Premier members will be issued an identification card upon enrollment which will contain benefit information and telephone numbers for benefit inquiries. Each member will be assigned a unique identification number by Virginia Premier. Virginia Premier will not use a member's social security number as an identifier in order to protect the member's privacy and comply with HIPAA regulations. Please reference the sample ID card below.





Co-payments, Deductibles & Co-insurance

Virginia Premier contracted providers may only ask for payment from covered members for any covered services that include co-payments, co-insurance, and/or deductibles at the time of service. Member out-of-pocket expenses are contingent on the plan type, so Virginia Premier highly encourages providers to verify eligibility at the time of service. Asking for payment in full upfront is strictly prohibited.

Provider Reimbursement and Claims

Providers participating with Virginia Premier are required by their participation agreement to submit claims in the required format for all services rendered. For outpatient services, a CMS-1500 claim form must be used for physician, ancillary or other provider type services. For hospital or facility, a UB04 claim form must be submitted. When submitting claims, a provider should refer to the most recent version of the following professional resources for coding accuracy including: the American Medical Association Physicians' Current Procedural Terminology (AMA/CPT Book), International Classification of Diseases, Revised Edition, Clinical Modification (ICD-10-CM) and HCPCS Level II Medicare Codes manuals.

For those providers that cannot submit on the corresponding CMS-1500 or UB04 claim form, a claim must be submitted through the Virginia Premier provider portal.

All claims submitted must be computer generated or typed to ensure accurate processing due to our claims imaging software. All required fields and appropriate CPT and diagnosis codes must be accurate on the claim form in order to be considered a clean claim. Virginia Premier cannot accept copied versions of claim forms. All claims must be submitted on original red and white claim forms.

Note: Handwritten claims are subject to be rejected.

Virginia Premier requires that all claims be submitted within the timeframes established in the provider contract. Please refer to your Virginia Premier contract for your specific timely filing period.

Submission Standards

Effective February 1, 2019, Virginia Premier will operate utilizing one Virginia Premier Payer ID: VAPRM or the Exchange Program ID: 251VA. This universal payer ID will be used for submission of electronic claims for the following lines of business under Virginia Premier:

- Medallion 3.0: VAPRM
- Medallion 4.0: VAPRM
- CCC Plus: VAPRM
- Dual Special Needs Plan (DSNP): VAPRM

Medicare Advantage Exchange Program electronic claim submission should be submitted utilizing Payer ID 251VA. Virginia Premier's Commercial Insurance Line of Business

Please begin making the necessary adjustments to your claims filing process. All electronic file submissions on or after February 1, 2019 must be submitted utilizing the Virginia Premier Payer ID: VAPRM or the Exchange Program ID: 251VA. Submitting electronic claim files utilizing any other Payer ID will be rejected. If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 am to 6:00 pm at 804-819-5151 or toll-free 800-727-7536, then select option 2 followed by option 6
Paper claims must be mailed. Faxed claims ***will not*** be accepted and will be returned to you. Virginia Premier Health Plan uses claims imaging software to process paper claims.

Below are some standard guidelines that every provider submitting paper claims should follow:

The font should be:
• Legible (Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended)
• In Black Ink
• Pica, Arial 10, 11 or 12 font type
• CAPITAL letters

The font must NOT have:
• Broken characters
• Script, Italics or Stylized font
• Red ink
• Mini-font
• Dot Matrix font

Do NOT bill with:
• Liquid correction fluid changes.
• Data touching box edges or running outside of numbered boxes (left justify information in each box).
Exception: when using the 8-digit date format, information may be typed over the dotted lines shown
in date fields, i.e., Item 24a.
• More than six service lines per claim (use a new form for additional services);
• Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-10-CM codes are sufficient);
• Stickers or rubber stamps (such as “tracer,” “corrected billing,” provider name and address, etc.);
• NHIC’s address at top of the form;
• Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks).
• Handwritten descriptions;
• Attachments smaller than 8 1/2 x 11.

The claim form must be:
• An original CMS-1500 printed in red “drop out “ ink with the printed information on back (photocopies are not acceptable);
• Size - 8½” x 11” with the printer pin-feed edges removed at the perforations;
• Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
• Thick enough (20-22 lbs.) to keep information on the back from showing through;
• Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strike-overs, crossed-out information or white out.

Handwritten claims ***will not*** be accepted**. If printed items are not correctly positioned within the corresponding boxes the claims will be processed incorrectly or rejected and sent back to the provider.**

CMS-1500 Required Fields:

Basic Information:
BOX 1: Check the appropriate box "Medicaid" for CCC+ or Medallion 4.0 and Medicare for MAPD and DSNP
BOX 1A: Enter the member's Virginia Premier I.D. number.
BOX 2: Enter the member's name (Last name, First Name, Middle Initial)
BOX 3: Enter member's date of birth (mm/dd/yyyy) and select appropriate gender (M or F)
BOX 4: Enter the member's name (Last name, First Name, Middle Initial) OR "SAME"
BOX 5: Enter the member's pick up address and telephone number
BOX 6: Required to check appropriate box
BOX 9: If 11d = yes, this field must be populated. Reject if blank
BOX 9A: If 11d = yes, this field must be populated. Reject if blank
BOX 9D: If 11d = yes, this field must be populated. Reject if blank
BOX 10: Must be populated, will reject if not populated
BOX 10A: Must be populated, will reject if not populated
BOX 10B: Must be populated, will reject if not populated. If "Yes" is selected, for auto accident or other accident, field 14 must be populated with accident date.
BOX 10C: Must be populated, will reject if not populated. If "Yes" is selected, for auto accident or other accident, field 14 must be populated with accident date.
BOX 11: If 10b is selected with a "YES", this must be populated. Reject if blank. If 11C is populated, 11 must be populated.
BOX 11A: Required if patient relationship is not "Self". If blank, reject
BOX 11C: Required is 11D is Checked yes
BOX 11D: if 11D = "YES" then 9, 9a, and 9d must be populated, If "NO" 9, 9a and 9d must be blank
BOX 12: Not Required
BOX 13: Not Required
BOX 14: If 10a, b or c is populated with "YES", this is required. Reject if blank.
BOX 15: This is used if there is another date outside of what is in field 14.
BOX 16: Not Required
BOX 17: 1. VPHP will allow blank values. If data is passed, then fields (17 & 17b) and segments must be populated. If not, reject claim as missing required information.
BOX 17A: Not Required
BOX 17B: Required if information entered in BOX 17- NPI # - Enter the 10 digit NPI
BOX 18: Not Required
BOX 19: Not Required
BOX 20: Not Required
BOX 21: Diagnosis Code - for transportation claims, use R68.89
BOX 22: Required for Corrected Claim Process. Use 7 in resubmission code and original claim number for Original Ref No.

BOX 23: 5 Digit Zip Code of Pickup Address for Medicare Claims
BOX 24A: Enter the date of service (mm/dd/yy)
BOX 24B: Enter the Place of Service Code - For Land Ambulance transports, use "41", Air Ambulance use "42"
BOX 24D: Enter the appropriate CPT code for the transport
Please place appropriate procedure code modifier in corresponding box to denote Ambulance Modifier listed in appendix B
BOX 24E: Enter the Diagnosis Pointer. The diagnosis pointer is the letter in BOX 21 where you entered code R68.89 (i.e. A, B, C, etc.)
BOX 24F: Enter the total charge amount for each line
BOX 24G: Enter the number of units or miles for each line
BOX 24J: NPI # - Enter the 10 digit NPI
BOX 25: Enter your Federal Tax ID number and check the box the "SSN" (Social Security Number) or "EIN" block
BOX 26: Required, Your host system tracking number
BOX 27: Required
BOX 28: Total Charge - Enter the total charges for the services in 24F lines 1-6
BOX 29: Not Required
BOX 30: Not Required
BOX 31: Sign and date here
BOX 32: Enter the address where the member was dropped off. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
BOX 33: Enter your billing address and phone number. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
BOX 33A: Enter your 10 digit NPI number

- You are required to bill in a service charge then mileage charge order. For every instance that a Land Ambulance Service Charge is billed, A0426, A0427, A0428, A0429, a mileage line must also be billed A0425.
- If billing Air Ambulance claims A0430 must be billed with A0435 and A0431 must be billed with A0436.
- Always bill using your NPI number.
- Individual Consideration Service charges must be approved in advance (NEA Only). Service Charges should be billed using CPT T2003 at 1 unit per dollar authorized.
- One claim form per trip leg. For trips with multiple legs the individual legs need to be billed on separate claim forms.
- Failure to place procedure code modifiers on CMS-1500 will result in claim rejection
- Place only the actual drop off address for the patient in box 32 must have 9 digit zip.

Note: It is very important that participating groups submit claims in accordance with the timely filing claims guidelines outlined in their agreement. We strongly encourage participating groups to educate their billing staff on the contractual claim submission terms in their agreement.

Claims not submitted in accordance with the timely filing guidelines will be denied.

Paper Claim Submissions

Paper claims should be submitted to the following address:

Virginia Premier
PO Box 4250
Richmond, VA 23220-8250

Transportation Claims

Virginia Premier
PO Box 4250
Richmond, Virginia 23220-8250

Electronic Filing Clearinghouses

Electronic claims can be filed with Virginia Premier by using one of the following clearinghouses:

Availity: 800-282-4548

McKesson (Relay Health): 800-981-8601

Virginia Premier strongly encourages providers to consider filing claims electronically which will reduce claims submission timeframes and increase account receivables payment for services rendered. Providers who wish to submit claims electronically must complete all necessary documents related to the process. A listing of participating clearinghouses along with enrollment forms can be accessed at www.VirginiaPremier.com. Please allow at least thirty (30) business days to complete this process. Providers are encouraged to contact their claims clearinghouses to confirm they are set-up to submit claims electronically. Submitting claims electronically without full clearance will cause claims processing delays.

Virginia Premier Medicare Advantage
Attention: EDI Enrollment Team
Fax: 804-819-5174
Email: vphp_edi@vapremier.com

API Provider Claim Submission

The 2015 General Assembly added language to the 2014-2015 Biennial Budget that requires all providers of Virginia Premier to acquire an NPI. This does not apply to transportation providers.

Virginia Premier providers are no longer able to use an API for billing or claims submissions to Virginia Premier.

Providers participating with Virginia Premier who require the ability to create and submit claims through our direct data entry portal will need to do the following prior to submitting their first claim:

- Go to www.VirginiaPremier.com
- Sign up for a new account through Health Trio Connect

You will receive a response within three to five (3-5) business days with your user name and temporary password. Submit your claims submission via or portal.

Clean Claim Submission

A "clean claim" is defined as a claim that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or with respect to which Virginia Premier has failed timely to notify the person submitting the claim of any such defect or impropriety.

Preauthorization and Notification (Utilization Management)

Virginia Premier requires either an authorization or notification before certain services may be rendered to a Virginia Premier member. Providers are encouraged to review the Virginia Premier preauthorization list known as the NPA Search Tool, found on www.VirginiaPremier.com under the Utilization Management section.

Virginia Premier's list of services requiring preauthorization and notification is subject to change. Changes to the preauthorization list are communicated through provider notices in accordance with agreements.

Providers can initiate an authorization or notification by contacting the Medical Management department at 1-888-251-3063.

Providers need to be prepared to offer the following information when requesting an authorization or notification:

- Subscriber's name and date of birth
- Member's ID number
- Actual date of service or hospital admission
- Date of proposed procedure as applicable
- Corresponding procedure codes
- Bed type: inpatient or outpatient
- TIN of treatment of facility (where service is being rendered)
- TIN of servicing provider (provider performing service)
- Applicable ICD diagnosis code

- Caller's telephone number
- Attending physician's telephone number

Authorization Decision Timeframes

The following timeframe for decision requirements apply to service authorization requests:

Standard Authorization Decisions

For standard authorization decisions, Virginia Premier shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

- The member or the provider requests extension; or
- Virginia Premier justifies to CMS upon request that the need for additional information is in the member's interest.

Expedited Authorization Decisions

For cases in which a provider indicates, or Virginia Premier determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Virginia Premier will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service.

Virginia Premier may extend the three (3) business day turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or Virginia Premier justifies to CMS a need for additional information and how the extension is in the member's interest.

Disclaimer: Authorization/Notification is not a guarantee of payment. Billed services remain subject to the review for medical necessity, appropriate setting, billing and coding, plan limitation and eligibility at the time of service.

Inpatient Services

Virginia Premier requires prior authorization for services provided in an inpatient setting. Understanding that emergent admissions are possible, Virginia Premier requires immediate notification of any inpatient status for Medicare Advantage members. Providers can obtain an inpatient authorization by calling Medical Management at 1-888-251-3063.

Radiological Services

For services above routine X-rays, prior authorization is required and can be obtained by National Imaging Associates, Inc. (NIA). NIA provides utilization management services for outpatient diagnostic radiological service (i.e. CT, CTA, CCTA, MRI, MRA, and PET scan) and Nuclear Cardiology imaging procedures. Providers can reach NIA by calling 1-800-642-7578 or

through the NIA website (www.RadMD.com). Note: routine X-rays do not require prior authorization. Providers can confirm whether or not a procedure requires an authorization by using the NPA Search Tool found www.VirginiaPremier.com under the Utilization Management section.

Advanced Beneficiary Notice (ABNs)

Virginia Premier members must be notified in advance when a provider believes there is a strong possibility that a specific service will not be covered by Virginia Premier. The notification may either be verbal or written; however, Virginia Premier encourages all providers to document the discussion and code claims appropriately. The CMS approved Advanced Beneficiary Notice (ABN) may serve as their appropriate documentation.

Advanced Coverage Determinations (ACDs)

For procedures or services that may be experimental, investigational or have a limited benefit coverage, Virginia Premier encourages providers request an advanced coverage determination on the member's behalf prior to providing service. The member may be contacted if additional information is needed. ACDs for members may be initiated by submitting a written request to:

Virginia Premier
Attention: Medical Management Department
PO Box 4250
Richmond, VA 23060

Referrals

The Primary Care Physician (PCP) is responsible for referring Medicare Advantage members to in-network providers. There is not a referral requirement for services provided by in-network providers. Providers and members alike need to be aware that there is no benefit for services provided by out-of-network providers with the exception of specific service types. Members need to understand that if they elect certain services to be provided by out-of-network providers, they will likely be financially responsible for covering the out-of-network provider's invoice.

Members may be referred to an out-of-network specialist with prior authorization from Virginia Premier in the following circumstances:

- Virginia Premier's contracted providers are unable to provide the specialty service required for the member's medical care.
- Virginia Premier does not have a provider in the network with appropriate training or experience.
- To avoid interruption of care for services prior authorized by another health plan or Medicare prior to enrollment with Virginia Premier.

Inpatient Services

Virginia Premier requires prior authorization for services provided in an inpatient setting. Understanding that emergent admissions are possible, Virginia Premier requires immediate notification of any inpatient status for Medicare Advantage members. Providers can obtain an inpatient authorization by calling Medical Management at 1-888-251-3063.

Additional Contact Info:

Central Virginia / Fredericksburg / Western / NOVA	
Address	Virginia Premier Medicare Advantage Attention: Referral Coordinator 600 East Broad Street, Suite 400 Richmond, Virginia 23219-1800
Phone	804-819-5151, press 3 1-888-251-3063
Fax	804-819-5186 1-866-284-1057
Roanoke	
Address	Virginia Premier Medicare Advantage Attention: Referral Coordinator 5060 Valley View Boulevard NW Roanoke, Virginia 24012
Phone	540-344-8838 1-888-338-4579
Fax	540-344-8007 1-800-827-7192
Tidewater	
Address	Virginia Premier Medicare Advantage Attention: Referral Coordinator 3388 Princess Anne Rd., Suite 2000 Virginia Beach, Virginia 23456
Phone	888/251-3063
Fax	877-739-1364 Admissions Only: 877-739-1365

Provider Reimbursements

Claims are processed promptly if approved or denied within the timeframe outlined by the provider agreement or applicable regulatory mandates. In order for claims to be paid promptly the claim must be submitted electronically or by paper and the claim must not involve investigations for coordination or benefits (COB), pre-existing conditions, member eligibility, or subrogation (i.e., a “clean claim”).

The time frame for claims submissions, if not otherwise specified within the provider agreement or applicable state or federal law is as follows:

- 180 days from the date of service for all provider types
- Reconsideration request must be submitted in writing within 60 days of the date on the last Virginia Premier claim determination notice or remittance advice

Providers are reimbursed in accordance to the payment model outlined in the provider agreement. Contact Provider Services at 1-877-719-3690 for questions or clarifications.

Terms of payment are outlined in the provider agreement. Payment is not only subject to the terms within the agreement, but to additional variables such as:

- Member's eligibility on the date of service
- If the service is a covered benefit
- If the services are deemed medically necessary
- If prior approval was obtained as applicable to the service provided
- Billed amount
- Member's cost-share amounts due from the member and/or coordination of benefits from another payer
- Payment adjustments based on coding edits

Specialist Providers

Reimbursements for specialist services is dependent upon referral authorization and corresponding documentation. All specialist claims must include an authorization number, when applicable, or an inpatient authorization number which must be shown in box 23 of the CMS-1500 or box 64 of the CMS UB-04 form. If the authorization number is not on the claim, the claim may be rejected. Virginia Premier members may not be balanced for this type of rejected claim.

Office Procedures

This section details the expectations of policies and procedures as it pertains to provider office operations.

Medical Records

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to Virginia Premier Medicare Advantage members. All communications and records pertaining to our member's health care must be treated as confidential. No records may be released without the written consent of the member or their designated caregiver. The medical record is the mechanism that maintains and ensures the continuity, accuracy and integrity of clinical data. The medical record serves as the primary resource for information related to patient treatment, not only for the participating physician, but also for other health professionals who assist in patient care.

- At a minimum, participating physicians are expected to have office policies and procedures for medical record documentation and maintenance, which follow NCQA standards and ensure that medical records are:
  - Accurate and legible
  - Safeguarded against loss, destruction or unauthorized use
  - Maintained in an organized fashion for all members receiving care and services, and accessible for review and audit by CMS or contracted External Quality Review Organizations
  - Readily available for Virginia Premier's Medical Management staff with adequate clinical data to support utilization management activities
  - Comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider

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, and 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.

Note: Virginia Premier applies federal and state guidelines as it relates to medical record documentation.

Virginia Premier requires that the provider's medical records be accessible for grievance and appeal processing, claims reconsideration, customer service inquiries, peer review studies, risk management review, utilization, and other initiatives.

Participating providers must expeditiously comply with Virginia Premier's grievance and appeal request for medical record documentation due to the stringent time frames established by CMS and/or the state agency for insurance processing. Virginia Premier only requires medical documentation for the specific time period in question. The submitted medical documentation must include at a minimum: office notes, lab/test results, referral documents, telephone records, and any consultation reports as applicable. Faxed medical records should be submitted with sensitivity and confidence that it is being sent to the intended recipient.

Fees for producing medical records are considered part of the office administration overhead and are to be provided to members and Virginia Premier at no cost, unless state regulations or the agreement stipulates otherwise.

Provider Claims Reconsideration / Provider Termination / Member Grievances

A. Provider Claims Reconsideration Process

If a provider disagrees with the coverage/payment determination made by Virginia Premier upon receipt of the paper or automated remittance advice, providers may contact Virginia Premier via the provider portal found at www.VirginiaPremier.com or submit a written correspondence to dispute the determination. For written correspondence Virginia Premier requires that providers submit the request using the proprietary form found at www.VirginiaPremier.com, within the Provider Resources section, and recommends including all applicable documentation required to properly consider reprocessing the claim. Reconsideration requests should be mailed to Virginia Premier at:

Virginia Premier Medicare Advantage
P.O. Box 4250
Richmond, Virginia 23220-0244

B. Provider Termination Appeal Process

Providers have the right to review the termination decision by the Network Development Committee, in accordance with the Medicare regulations found at 42 C.F.R. §422.202. Virginia Premier requires that the provider submit in writing a request for the panel review within 30 days of the date of termination notice. If the provider fails to submit the request within the allotted timeframe, the provider's right to appeal is waived.

Virginia Premier requests that the provider address the letter to the group identified in the termination notice letter, and the request should include any relevant written information to be considered by the Network Development Committee. Only written information submitted will be considered. The Network Development Committee will review the appeal prior to the effective date of the termination date referenced in the letter. The Committee will provide a written decision to the provider upon conclusion of the review.

The appeal process is considered aligned with the termination rights set forth in the Provider's Agreement, and/or where applicable within State and Federal law and regulation.

C. Member Grievance/Appeal Process

This section applies to members of Virginia Premier's Medicare Advantage plans who are not satisfied with the health plan's performance, or the services received from a provider. A plan grievance may be filed by a current or former member or his/her authorized representative.

Virginia Premier will accept requests from Medicare Advantage members and/or providers for urgent appeals, and from prescribing physicians if the member is a Medicare Part D plan member. The physician or the member must request this appeal within 60 calendar days from the date of our decision. If the member or provider would like to file an expedited appeal, Virginia Premier can be reached by phone or fax.

For an Expedited or Standard Appeal, phone or fax:

Grievances and Appeals Phone Number: 877-739-1370

Grievances and Appeals Fax Number: 804-649-9647

Grievances and Appeals Mailing Address:

Virginia Premier
Attn: Grievance & Appeals
P.O. Box 5244
Richmond, VA 23220

Covered Services

For Virginia Premier to consider payment, a service must be medically necessary and covered by the member's plan contract. The health plan identifies whether services are deemed medically necessary. A Provider can verify coverage and excluded services by calling Virginia Premier's Member Services department at the number listed on the back of the Member's ID card. Please note that all services may be subject to applicable co-payments, deductibles, and co-insurance.

Virginia Premier is not a provider of clinical judgement; therefore, does not control treatment recommendations made by the provider in its network. A provider's clinical judgement is independent of Virginia Premier.

Compliance / Ethics

Liability Insurance

Virginia Premier requires all providers possess and provide evidence of insurance coverage in accordance with the Provider's Agreement upon request.

Compliance and Fraud, Waste and Abuse Requirements

The Program Integrity department was established to support Virginia Premier's commitment to the highest standards of conduct, honesty, integrity and reliability in our business practices. Program Integrity is about **"Doing the right thing"** for the right reasons.

The Program Integrity program is designed to assist the organization to uphold our continued commitment in making proper and ethical decisions. The compliance and integrity program applies to officers, directors, employees and affiliated associates such as providers, vendors, and subcontractors. It consists of the following: policies and procedures, Code of Conduct, compliance oversight, education and training, monitoring and auditing, enforcement and discipline, and detection and prevention of fraud, waste, and abuse.

If you have questions or concerns related to:

- Potential Fraud, Waste, or Abuse
- Standards of Professional conduct
- Confidentiality
- Notice of Privacy Practices
- Potential Conflicts of Interest
- Or other regulatory requirements or laws, such as Sarbanes-Oxley and Stark Law

Call the Compliance Helpline: 1-800-981-6667, 24 hours a day, 7 days a week, or go on-line to: Corp_compliance@sentara.com. Use our anonymous form.

If you have any questions regarding Compliance or HIPAA, you may also contact our Program Integrity department at 1-800-727-7536.

Corporate Compliance and Integrity Plan

Virginia Premier is committed to establishing, adopting, and implementing - through education of officers, directors, employees and affiliated professionals of Virginia Premier - a culture and collective attitude that will promote the prevention and detection of conduct that does not conform to federal and state laws and federal and state health care program requirements. Virginia Premier maintains a policy of "zero tolerance" for fraud, waste, and abuse in every aspect of our business.

Product / Plan Overview

Health Maintenance Organization (HMO)

Virginia Premier's Medicare Advantage Gold, Platinum, and Elite products are CMS-approved Health Maintenance Organizations ("HMOs"), which require members to select a PCP to coordinate their care. Generally, a PCP is from one of the three disciplines:

- Family Physician – A physician who specializes in the care of all members of a family regardless of age.
- Internist – A physician who specializes in internal medicine and gives non-surgical treatment of medical conditions.
- Pediatric – A physician who specializes in the development, care, and diseases of children.

Contracted HMO PCPs agree to accept health plan members as referenced in the Provider Agreement. The health plan insists that the provider must not refuse new members until he/she can reasonably demonstrate his/her panel size has reached its maximum capacity for adding new members. If a PCP requests that his/her panel be closed to new members, the PCP must request that his/her panel be closed to all third-party payers with whom the PCP contracts. Validation and proof may be requested regarding the size and adequacy of the physician panel.

Note: The contracted PCP is responsible for coordinating care in his/her absence.

Access to Care

In an effort to comply with CMS requirements, accrediting and regulatory agencies, Virginia Premier has established specific standards for participating physicians that are summarized below. These standards were developed to ensure that Virginia Premier's Medicare Advantage members have access to health services.

Medicare Providers Access Standards:

Virginia Premier insists that all covered services be geographically accessible and consistent with local patterns of care while ensuring that no Medicare Advantage member residing within the service area travel an unreasonable distance to obtain covered services. Virginia Premier requires that the following services be available within the applicable serving area:

- Access to medical coverage 24 hours a day, 7 days a week
- Urgent and non-emergent appointments within 24 hours
- Urgently needed services must be provided to Medicare members

- Non-urgent, but attention needed, appointments within one week
- Routine and preventive care or well-child appointments within 30 days.

Virginia Premier recommends that all physicians adopt the standards referenced below:

- Respond to urgent calls within 15 minutes; respond to routine calls within the same business day
- Respond to after-hours urgent calls within 15 minutes; non-urgent calls within 30 minutes
- Specialty care within 21 business days

Note: If state regulations are more stringent, they take precedence over these standards.

Member/Provider Incompatibility

Virginia Premier recognizes that the physician-patient relationship is a personal one and may become unsatisfactory to either party. Virginia Premier has established procedures that allow for the smooth and orderly transfer and re-assignment of members and PCPs.

- All member transfer requests, whether from the member or the PCP, will be reviewed by Virginia Premier to determine the appropriateness of the request. Member transfer requests that involve quality-of-care issues will be forwarded to our Medical Director for review.
- Decisions regarding member transfer requests will be made effective the 1st day of the following month. The member, the provider, and the Interdisciplinary Care Team (ICT) will receive written notification of PCP transfers. The notification will include the effective date of the transfer.
- The new PCP is responsible for contacting the member's former PCP to arrange for the transfer of any medical records, Plan of Care (POC) and to inform the ICT of the change in order to ensure continuity of care.
- Member listings will appear in the following month's statement.

At Member's Request:

Members have the right to change their PCP with or without cause. Members must contact Virginia Premier's Member Services department to initiate the change. Member Services staff will identify and document the reason for a Primary Care Physician change. We will monitor changes to identify possible trends to be addressed through our Quality Program.

At the PCP's Request:

Primary Care Physicians have the right to request that a member be transferred to another participating PCP. Requests for member transfers may be initiated by telephone, but must also be submitted in writing to Virginia Premier's Provider Services department and should include the reason(s) for the request. All decisions regarding such transfers shall be made and become

effective as soon as administratively feasible, but in any event decisions shall be made within (60) days from the date of the request. In the event that a PCP wishes to dismiss a patient from their panel, the provider is still responsible for providing that member with Primary Care Services, participating in the ICT, and facilitating the POC until the transfer to another PCP has taken place. In addition, the Primary Care Physician is required to share with the new Primary Care Physician or other provider any and all Medical Records related to the member's care. Mail or Fax your request to:

Virginia Premier
Member Services Department
P.O. Box 4466
Richmond, Virginia 23220-0307
FAX: (804) 819-5187

Pharmacy

Formulary

The plan has a *List of Covered Drugs (Formulary)*, we call it the "Drug List" for short. We have two formularies, one for Virginia Premier Advantage Elite and one for Virginia Premier Advantage Gold and Platinum.

The Formulary:

- Provides quantity, form, dosage, and prior-authorization restrictions for certain drugs;
- Requires generic drug prescription usage whenever possible. These drugs are listed with the generic name on the Medicare Formulary. If a Member requests a brand name drug when a generic drug is available, the Member may be responsible for additional charges;
- Provides a framework and relative cost information for the management of drug costs;
- Provided on the website and is updated monthly.

Medicare Part B Prescription Drugs

Members receive coverage for drugs covered under Part B of Original Medicare through their Virginia Premier Advantage plan. Members may have up-to a 20% cost--share of drugs covered under Medicare Part B.

Medicare Part D Prescription Drugs

Virginia Premier Advantage Elite plan copayment structure is based off low-income subsidies levels that are determined by the Centers for Medicare and Medicaid Services (CMS).
Virginia Premier Advantage Gold and Platinum provide a five-tier copayment/cost-share drug list. Copayments and cost-shares vary depending on the tier in which the prescription drug falls. Tiers include:

- Tier 1: Preferred generic drugs
- Tier 2: Generic drugs
- Tier 3: Preferred brand drugs

- Tier 4: Non-preferred brand drugs
- Tier 5: Specialty drugs

Coverage Exclusions and Limitations

If Medicare does not pay for a drug it will be excluded from coverage for Virginia Premier Advantage. The member is responsible unless the requested drug is found upon appeal to be a drug that is not excluded under Part D and Virginia Premier Advantage should have paid for or covered it because of the Member's specific situation.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories.
- Off-label use is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then the Plan does not cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Virginia Premier Advantage may not cover for reimbursement under the Virginia Premier pharmacy benefit contract. For details please call Virginia Premier Member Services for more information.

Quality and Safety Initiatives

Virginia Premier Advantage implements utilization management edits that require CMS submission and approval that is applied at the point-of-sale. Utilization Management edits include:

- Prior Authorization (PA)
- Step Therapy (ST)
- Quality Limits (QL)

As part of the Quality and Safety Initiatives, all prescriptions are screened to detect and address the following:

- Review for potential drug therapy problems due to therapeutic duplication
- Age/gender related contraindications
- Over-utilization and underutilization

- Drug-drug interactions
- Drug-allergy contraindications
- Clinical abuse/misuse

A review of prescriptions is performed before the drug is dispensed. These are concurrent drug reviews and are clinical edits at the point-of-sale (at the pharmacy counter).
In addition, Virginia Premier uses drug utilization review edits for clinical safety evaluations for the following:

- Acetaminophen (APAP) dosages greater than 4,000 mg per day
- Claims that exceed a cumulative Morphine Equivalent Dose (MED) of 90 to 199
- Opioid medication claims within 60 days of filling a buprenorphine product

Virginia Premier Advantage's goal is to ensure the appropriate and safe use of opioid medications while still providing member access.

Part D Coverage Determinations

A coverage determination is a decision about whether a Part D drug prescribed is covered by the plan and the amount, if any, the member is required to pay for the prescription. Drugs that are non-formulary or coverage is restricted may be requested for a coverage determination.
When a coverage determination is requested, Virginia Premier Advantage will provide a decision no later than 72 hours and for drugs that a member has already paid for within 14 calendar days.
For more information regarding how to request a Coverage Determination visit www.virginiapremier.com/members/medicare-complaints-grievances-and-appeals.

Medication Therapy Management Program Information

Virginia Premier Advantage has a Medication Therapy Management Program (MTM) that meets the Medicare Modernization Act requirements and is approved by CMS for the program year. The MTM Program is not considered a part of the plan's benefit but is no cost to member with multiple health conditions and who take multiple medicines. The MTM Program is aimed in helping members and doctors make sure the medications are working to help with complex health needs.
Virginia Premier Advantage has contracted with Envision Pharmaceuticals Services to deliver MTM services to eligible members.
Members eligible for the MTM program will be identified and auto-enrolled on a quarterly basis. We offer this program to members who meet certain criteria established by the Centers for Medicare and Medicaid Services (CMS). For information about Virginia Premier's MTM program criteria, visit our website at www.virginiapremier.com/members/medicare-pharmacy-benefits.

Mail Order Prescription Drug Program

Virginia Premier Advantage has multiple mail order pharmacies in our network such as Curant Health and EnvisionRx Mail Order. You can find a network pharmacy by visiting our website or calling Member Services.

Member Transition Process

Virginia Premier's transition fill policy meets the immediate needs of our valued members. It allows the member sufficient time to work with his or her prescribing physician to switch to a therapeutically equivalent formulary medication, or to complete the coverage determination process.
As a new or continuing member in our plan, they may be taking drugs that are not in our formulary (drug list). Or, they may be taking a drug that is in our formulary but they ability to get it is limited. For example, you may need prior authorization from us before they can fill their prescription. A temporary supply of the non-formulary or coverage restricted drug may be authorized.

For more information on Virginia Premier's transition fill policy, visit our website www.virginiapremier.com/members/medicare-pharmacy-benefits/

Credentialing

Credentialing and Re-credentialing Program Description Overview

The Credentialing Program of Virginia Premier shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables Virginia Premier to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care between credentialing and re-credentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to successfully manage the health care of network members in a cost-effective manner.

Virginia Premier Board of Directors (the "Board") has ultimate authority, accountability and responsibility for the Credentialing evaluation process (the "Credentialing Program"). The Board has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Credentialing Committee accepts the responsibility of administering the Credentialing Program, having oversight of operational activities, which includes, but is not limited to, making the final approval or denial decision on all practitioners and providers, as applicable.

Credentialing Committee Structure and Activities

The Chief Medical Officer or designee is responsible for the oversight and operation of the Credentialing Committee, and serves as Chairperson or may appoint a Chairperson, with equal qualifications. The Credentialing Committee is a peer-reviewed body that includes representation from a range of participating practitioners including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, obstetrics and gynecology) and specialty practice. Allied health representatives include mental health, rehabilitation, etc., and may be appointed to serve as non-voting members, on an ad-hoc basis. Members may be appointed or requested to attend the meeting representing Virginia Premier's internal staff.

Receive and review the credentials of all practitioners being credentialed or re- credentialed who do not meet the organization's established criteria, and to offer advice which the organization considers. This includes evaluating practitioner files that have been identified as problematic (e.g., malpractice cases, licensure issues, quality concerns, missing documentation, etc.).

Review practitioner credentials and consider the credentialing elements before making recommendations about a practitioner's ability to deliver care.

Establish, implement, monitor, and revise policies and procedures for Virginia

Report to the HQUM and other proper authorities, as required.

Annual Review of the credentialing program description, and other related objectives.

Process and Requirements

Virginia Premier credentials all practitioners prior to being admitted into the Virginia Premier Medicare Network. The intent of the process is to validate and/or confirm credentials information related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly.

Each practitioner must submit a legible and completed application, a consent form that is signed and dated, a confidentiality form that is signed and dated, and any other required documentation. Practitioners may also submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). Upon notification from the prospective practitioner that his/her application is filed with CAQH, Virginia Premier's credentialing staff will promptly download the application to initiate the credentialing process.

The following information is obtained and verified according to the standards and using the sources listed under Initial Credentialing:

Completed Virginia Premier application
Copy of the unrestricted *(no limitations)*, current and valid license or license number for the participating practitioner
Copy of the unrestricted *(no limitations)*, current DEA Certificate, if applicable
Copy of the medical malpractice policy face sheet
Copy of the board certificate or highest level of education; proof of education, training and competency
Copy of the current Curriculum Vitae, which must include work history *(gaps or interruptions in work history 6 months or greater must be explained)*
Primary Source Verification of associated credentialing documentation
The Office of the Inspector General and the CMS Exclusions List will be checked monthly to ensure practitioners meet the specifications of CMS and are eligible for participation.
The Credentialing Committee's final decision *(The practitioner shall be notified within 60 calendar days of the Committee's decision)*

Primary Source Verification

The Virginia Premier credentialing staff will conduct primary source verification as required by the most current and applicable Virginia Premier, CMS, and/or NCQA guidelines. Virginia Premier will contact the appropriate sources for verification of the various elements of the applicant's application. These verifications may be completed in the form of documented phone calls, faxes and/or Internet website print outs.

Termination without Cause:

Per regulatory guidelines, Virginia Premier will notify a provider in advance of terminating his/her agreement. Please refer to the timeframes specified in the Provider Agreement. Virginia Premier withholds the right to terminate any individual provider or provider location within the timeframe referenced in the termination process of the Provider Agreement, unless state or federal law specifies otherwise.

Virginia Premier requires that a provider electing to terminate participation with Virginia Premier products, a written notice of the pending termination in accordance with the terms specified in the Provider Agreement.

Note: Virginia Premier has developed a process to notify Members of an impending termination of any provider. Virginia Premier requires advanced notice in order to effectively comply with federal and state law, and accrediting agencies.

Note: Virginia Premier reviews the Department of Human Services and OIG exclusion list frequently as defined by federal and state law. Should a provider appear on the current OIG list of excluded, Virginia Premier will take immediate action to remove the provider from participating in the Virginia Premier network, and take any corrective actions as applicable. Other sanctions such as loss of licensure are also grounds for immediate dismissal from participating with Virginia Premier.

Quality / Disease Management

Quality Management

Virginia Premier offers a variety of Quality Management programs and initiatives. Providers interested in additional information are encouraged to reach out to the Provider Services department for more information.

Quality Management Initiatives: Providers that participate agree to assist Virginia Premier with the operationalizing of its quality programs:

- **Medical Record Review –** Virginia Premier conducts medical record audits to meet the requirements of accrediting agencies and state and federal law. Virginia Premier is not responsible for ensuring the accuracy of completeness of records.
- **HEDIS –** Health Effectiveness Data and Information Sets is a set of clinical quality measures. Virginia Premier holds the right to conduct medical record audits to identify care gaps for Virginia Premier members.
- **CAHPS –** The Consumer Assessment of Healthcare Providers and Systems is a survey tool that provides Virginia Premier with member satisfaction feedback regarding the care and services from a physician.

Nurse Advice Line

The Primary Care Physician is the primary source of medical care for our members, and acts as the health care manager for their access to other sources of medical care. The PCP must provide (or arrange coverage for) 24-hour access for the purpose of rendering medical advice, determining the need for emergency or after hours services and/or for providing authorization.

To support the PCP in this important role, Virginia Premier employs the services of a professional Nurse Advice Line available 24 hours a day, 7 days a week. We provide the member direct access through an RN for medical triage and health questions to assist our members in determining the most appropriate level of care for their condition. The responding nurse will give self-care instructions, provide notification back to Virginia Premier's care manager, the member's PCP, the LTSS provider, or direct the member to a physician or facility for routine, urgent or emergency care. During normal business hours, members are instructed to contact their PCP for medical advice.

The Nurse Advice Line also provides the member with Case Management support. The nurse can provide the member with an appropriate course of action, including (but not limited to) medical advice, directing the member to an appropriate care setting, and referral to a care manager, including a physician if necessary. We ensure that if care management needs are identified for a

member, the Virginia Premier staff person following up on the member's issue has access to, and is familiar with, the enrollee's Individualized Care Plan. After hours, in non-emergent situations, members may contact the Nurse Advice Line at: 800- 256-1982. The same number is used for Care Management Support.

Chronic Care Management and Case Management

Chronic Care Management Program:

Virginia Premier offers disease-specific programs as additional support to members and their physicians. These programs are designed to complement a physician's treatment regimen and empower the member through education and support. Physicians can identify those they believe are viable candidates to participate in disease management programs by contacting the Medical Management department at 1-877-739-1370, Monday through Friday, 8:00 am to 5:00 pm EST. All programs are coordinated with the member's care manager as part of the Interdisciplinary Care Team (ICT). If the member has a Targeted Case Manager (TCM) through the Community Services Board (CSB), the disease manager will work with the TCM to coordinate care through the ICT.

Virginia Premier provides Chronic Care Management programs for the following chronic conditions: Asthma, Heart Disease, Heart Failure, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Bipolar Disorder / Schizophrenia, Childhood Weight and Nutrition Management, Diabetes, Cancer (breast, lung, colorectal, hematological), and Chronic Kidney Disease (Stage 3-Dialysis).

Case Management:

Virginia Premier offers an intensive Integrated Case Management Program to assist the most vulnerable members. The ICT works closely with the member, family, caregiver, PCP, ICT and Medicare plan to coordinate health care services across the continuum of care. Care Managers may also intervene when members demonstrate non-adherence to their treatment plan. Circumstances that warrant referral to the Care Management Team may include but are not limited to:

- Presence of progressive, chronic, or life-threatening illness
- Need for inpatient or outpatient rehabilitation
- Terminal illness
- High-risk pregnancies
- Acute/traumatic injury, or an acute exacerbation of a chronic illness
- Complex social factors
- Multiple hospitalizations or emergency room visits

Preventive Health and Wellness Programs

Virginia Premier understands the important role of health education in preventing illness. We are proactive in our approach to health education and actively seek to identify members who may benefit from our programs. The Virginia Premier Health Education Department works closely with all other departments in Medical Management to assist with identification of members for health education services. Medical Outreach, Case Managers and Chronic Care Managers perform assessments which include questions on health status and interest in health education classes or information. These surveys are then shared with health education to develop an individualized approach to presenting information to the member.

Virginia Premier values the importance of health education as a tool to stay healthy and empower the member. Virginia Premier offers health education services that include:

- Exercise Program through Silver & Fit (if member chooses)
- Nutrition and Weight Loss
- Smoking Cessation

One-on-one coaching sessions are provided if the member is not able to access a class at one of our locations, or if a barrier to learning is identified.

For more information about Virginia Premier's health education services, contact our Health Education Department.

Rights and Responsibilities

Physician/Practitioner Rights and Responsibilities

Providers Must:

Meet all Virginia Premier credentialing and recredentialing requirements as defined by Virginia Premier and accrediting agencies.
Must possess a professional degree and a unrestricted license to practice medicine in Virginia and bordering states.
Be able to clearly define and provide documented experience, background, abilities, any malpractice information as requested, disciplinary sanctions or actions, and the physical and mental health status.
Possess an unrestricted Drug Enforcement Administration (DEA) certificate, or if applicable a state Controlled Dangerous Substance (CDS) certificate.
Possess a Clinical Laboratory Improvement Amendment (CLIA) as applicable
Be a clinical staff member in good standing with partnered hospital network systems, and must not have privileges revoked.
Provide in writing to Virginia Premier within 24 hours of any revocation or suspension of DEA, CLIA, professional licensures, or hospital systems privileges.
Not discriminate against members based on payment, age, race, color, national origin, religion, sex, sexual preference, and health status.
Not discriminate against Virginia Premier members and non-members.
Provide physician accessibility to members 24 hours a day, 7 days a week.
Provide an on-call and after-hours service by a participating and credentialed Virginia Premier provider.

Practitioner Rights

Right to Application Status: Each provider has the right to check the status of his/her application, correct erroneous information, and the right to review any information obtained during the credentialing process, at any time.

Right to Confidentiality of Information: Credentialing information is considered highly confidential; therefore, information obtained from NPDB, OIG, DHP, AMA, etc. may not be provided via telephone.

- **Right to Appeal Adverse Quality Decisions:** If a provider is denied network participation due to quality issues, the provider has the right to appeal that denial. Please be aware that quality denials may need to be reported to the appropriate authorities.

- **Right to a Nondiscriminatory Process:** Virginia Premier's credentialing process is nondiscriminatory. It is the plan's policy to not discriminate based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or patients treated. Please be aware that this does not preclude the plan from including in its network practitioners who meet certain demographic or specialty needs. It does not preclude the plan from denying participation to a provider, if the network is adequate.

- **Right to be informed of Credentialing Outcomes:** Credentialing decisions will be communicated to providers, in writing, within 60 calendar days from the plan's final decision.

- **Right to a Timely Application Process:** Applications will be processed with in accreditation and/or regulatory guidelines. The Plan will make every attempt to process applications within 90 calendar days of receipt in the Credentialing Department.

Member Rights

- Timely access to their PCP and referrals to specialists when medically necessary or as needed and timely access to all covered services, both clinical and non-clinical.
- Not be balance billed by any provider for any reason for covered services or flexible benefits.
- Not be discriminated against due to; medical conditions, including physical and mental illness, claims experience, receipt of health care and medical history.
- Treatment with quality care, respect and dignity - regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for their care.
- Have health care services twenty-four (24) hours a day, three hundred and sixty-five (365) days a year, including urgent, emergency and post-stabilization services.
- Choose a Virginia Premier Primary Care Physician (PCP) from the provider directory. You can find the Provider Directory online or call Member Services for assistance. Work with their PCP to help establish a proper patient/physician relationship.
- Make their own doctor/PCP appointments to be seen in their private office at Their convenience.

Change their personal Virginia Premier doctor and choose another one from the Virginia Premier's Provider Directory (you can find the provider directory online or call Member Services for assistance)

- Not to be treated against their will.
- To see their doctor/PCP, get covered services; get their prescriptions filled within a reasonable period of time. They should not be afraid to ask their doctor/PCP questions.

- Call Member Services to file a complaint/grievance about Virginia Premier or to file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.
- To privacy and to have your medical records and personal health information kept private unless they sign a permission form.
- Have timely access to their medical records in accordance with applicable State and Federal laws. They may be required to sign for release of those records.
- Participate with their doctor in making decisions about their health care, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.
- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood, regardless of the cost or benefit coverage. They can also receive 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 specified in Federal regulations on the use of restraints and seclusion.
- Free exercise of rights and the exercise of those rights that does not adversely affect the way Virginia Premier and its providers treat their members.
- Receive information about Virginia Premier, its services, costs, providers, network pharmacies, drugs, and Members' Rights and Responsibilities.
- To know the names and qualifications of the physicians and health care professionals involved in their medical treatment.
- Make suggestions regarding Virginia Premier's Member Rights and Responsibilities statement, which are found in the member handbook.
- Rights to reasonable accommodations.
- To use Advance Directives (such as a Living Will or a Power of Attorney).
- Virginia Premier will provide information to members about advance directives and any changes made in state law as soon as possible but no later than 90 days after the effective date of change.
- A right to a copy of the Privacy Notice annually or when requested.

Supplemental Member Rights

Virginia Premier members also have the right to:

- To see an in-network doctor in a timely manner based on the access standards listed in this document under the section called: Access to Health Care Standards.
- Get emergency care and family planning services in- or out-of-network without prior authorization. Family planning services, preventive services, and basic prenatal care do not need preauthorization, but the member should get care from an in-network doctor/provider.

- To obtain care from a doctor/provider acting within the lawful scope of practice. Virginia Premier may not prohibit, or otherwise restrict, a member's doctor/provider from advising or advocating on behalf of a member who is his/her patient related to the member's health condition, medical care or treatment choices, including any other treatment that may be self-administered.
- Have the doctor's medical record indicate whether or not the member has completed an advance directive.
- Not have the doctor/provider condition the delivery of care or discriminate against a member based on whether he/she has completed an advance directive form.
- To contact Virginia Premier staff that have been trained on advance directives and ask questions, if needed.
- File any type of grievance, including those related to advance directives, with Virginia Premier by calling the toll free line at 1-877-739-1370, the Center for Medicare Services, the Bureau of Insurance and the Department of Health.
- Give female members direct access (no referral needed) to a woman's health doctor/provider in the network for covered routine and preventive care services. This is in addition to the member's assigned primary care doctor/provider if that person is not a women's health doctor/provider.
- Have his/her health care needs and information discussed and given to the doctors/providers they want. The member is advised to sign a release form with their current provider in order to have the information released.
- Confidentiality when coordinating care including medical records, member information and appointment records for the treatment of sexually transmitted diseases.
- To be held harmless (not responsible for the bill or extra costs) if out-of-network services are given to a member for emergency care or care that has been preauthorized.
- To see in-network doctors/providers with the same office hours as those for other patients who may not have Medicaid like private commercial insurance members and or other types of Medicaid members (fee-for-service), if the doctor/provider sees only Medicaid members.
- To see a doctor of his/her choice based on language and/or race and one who is sensitive to the member's cultural needs, including those who cannot speak English well and those with different cultural and racial backgrounds.
- To obtain information in different formats (i.e., large print, braille, etc.), if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
- To have any service that has been stopped, reactivated, if a member's location is known.

Member Responsibilities

- Choose a Virginia Premier Primary Care Physician (PCP) from the provider directory. The provider directory can be found online or call member services for assistance. Work with their PCP to help establish a proper patient/physician relationship.
- Get their health care from a participating PCP, hospital or other health care provider.
- Keep their doctor's appointments or call to cancel them at least twenty-four (24) hours ahead of time.
- Carry their member ID card with them at all times.
- Inform Virginia Premier if they have other health insurance coverage.
- Tell the doctor that they are a member of Virginia Premier at the time that they speak with their doctor's office.
- Give their PCP and other providers honest and complete information they need about their health to care for them.
- Learn the difference between emergency and urgent care. Know:
    - What an emergency is
    - How to keep one from happening
    - What to do if one happens
- Follow plans and instructions for care given by their physician.
- Understand their health problems and discuss and/or agree upon a treatment plan with their physician.
- Advise their PCP of visits to other doctors so that he can be kept informed about the care that they are receiving.
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices.
- Let Virginia Premier know if they have any problems, concerns or suggestions on how we can work better for them.
- Take into advisement the recommendations of the Case Managers and other health care professionals at Virginia Premier.

Members' right regarding their protected health information

- **Right to Inspect and Copy** – Patients have the right to inspect and copy medical information that may be used to make decisions about their benefits. However, this does not include behavioral health management notes.
- **Right to Amend** – Patients have the right to amend medical information about them that they feel is incorrect or incomplete. The request should be in writing and provide a reason that supports the request to amend.
- **Right to an Accounting of Disclosures** – Patients have the right to request a list of disclosures made by the provider of medical information about them. The

request should be in writing and specify the time period in question of the disclosures.

- **Right to Request Restrictions** – Patients can request a restriction or limit on the medical information used or disclosed about their treatment, payment or health care operations. This restriction or limit includes information disclosed to someone who is involved in the patient's care, like a family member or friend. The provider does not have to agree to any restrictions or limits to information.
- **Right to Request Confidential Communications** – Patients have the right to request that a provider communicate with them about medical matters in a certain way or at a certain location. For example a patient may request that communication to them only be made at work or by mail.
- **Right to be notified of a Breach** – Patients have the right to be notified in the event the provider or their business associate discovers a breach of unsecured protected health information.
- **Privacy Right to a Paper Copy of the Notice of Practices** – Patients have the right to receive a paper copy of the provider's Notice of Privacy Practices.

Accreditation

Virginia Premier accreditation requirements by accrediting agency. Accrediting agencies typically evaluate the Plan and provider performance using a specific accrediting criteria.

National Committee for Quality Assurance (NCQA)

Virginia Premier has partnered with NCQA to evaluate the organization's quality improvement (QI) infrastructure, examine QI processes, and identify validation that QI activities have produced measurable improvement in both clinical and service areas of the organization.

Virginia Premier organizes information for NCQA based on the data obtained from participating provider's claims detail and medical records. The HEDIS program measures both Plan and provider performance in many different clinical areas to produce a consumer report. The reports are compiled to assist consumers with selecting a health care plan, physicians and their affiliates. HEDIS measures can be modified annually to reflect advances in clinical intervention and to identify areas requiring improvement.

Delegation

Virginia Premier may enter into a delegated arrangement with select providers. Delegation is a process by which the health plan grants the required permissions and authority to complete specific functions on its behalf, such as credentialing, utilization management, and claims payment. Such functions may be completely or partially delegated.

Full delegation is defined as allowing all activities of a specific function to be completed by the delegate. Partial allows some activities of a specific function to be delegated. Decisions and expectations of the delegated functions is determined by the provider type and the terms within the agreement. Please contact Virginia Premier's Provider Services Team for additional information on delegation at 1-877-739-1370.

Providers that have entered into a delegated arrangement with Virginia Premier must comply with the expectations outlined in this Manual and the Delegated Services arrangement.

Appendix: Virginia Premier D-SNP

Model of Care (MOC) Overview

The Model of Care is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a designated program. The MOC consists of:

- Specific target populations
- Measurable goals
- Interdisciplinary Care Team (ICT)
- Provider network with expertise and use of clinical practice guidelines
- Health risk assessment
- Individualized care plans
- Communication of network
- Care management of the most vulnerable subpopulations
- Performance and health outcomes measures

Specific Target Populations

Virginia Premier Advantage Elite is a Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within Virginia Premier's Advantage Elite servicing area. Virginia Premier's Advantage Elite members have demonstrated the eligibility requirements and have been enrolled in Medicare Part A, Part B and Medicaid benefits. Members may be enrolled in the Virginia Premier Elite Plus (MLTSS) Plan as their Medicaid benefit.

To better understand the MOC, it is imperative to identify the specific target population covered under Virginia Premier. Dual Eligible Special Needs (D-SNP) members are those who have diagnoses or clinical conditions that place these individuals at high risk for poor health outcomes. These individuals have an increased risk due to a combination of risk factors such as being elderly with two or more health conditions, being socially isolated, having limited access to food or transportation, and being at increased risk for making poor health choices. Virginia Premier identifies the following groups as the most vulnerable members who will be in the D-SNP:

- Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury)
- Individuals with physical or sensory disabilities
- Individuals requiring skilled nursing facilities
- Individuals with serious and persistent mental illnesses
- Individuals with complex or multiple chronic conditions
- Individuals who are frail/elderly or end of life

Measurable Goals

The purpose of the MOC is to improve the care and services provided to members. The MOC works to ensure:

- Access to essential medical, behavioral, and social services
- Access to affordable care
- Coordination of care through an identified primary point of contact
- Seamless transitions of care across health care settings, providers, and health services
- Access to preventive health services
- Improvement of member health outcomes
- Appropriate utilization of services

Interdisciplinary Care Team (ICT)

The ICT is a group of individuals that participates in the development and implementation of a person-centered care plan that includes appropriate interventions that assist members with achieving their self-identified health goals. The ICT may include, but not be limited to:

- Member**
- Family member(s), caregiver, or legal representative**
- Care Manager**
- Primary Care Physician**
- Social Worker
- Disease Management
- Health Educator
- Specialist

- Targeted Case Management (for members with behavioral health needs)
- Pharmacy
- Medical Directors

**Core composition of the ICT team for all members

The frequency of these ICT meetings are contingent upon the member's health needs and preferences. The Care Manager will arrange for ICT meetings at the member's and/or their representative's availability and supply ICT participants. ICT meetings will occur telephonically and participants will have access to the ICP and pertinent health information with permission from the member or his/her representative.

Clinical Practice Guidelines

Virginia Premier conducts a welcome call with each new member to initiate a health risk assessment tool (HRAT). The HRAT determines the medical, psychological and environmental needs of the member. This assessment is also used to determine the level of care management the member will require and serve as the foundation for developing the ICP.

Care Manager

A registered nurse who has demonstrated the appropriate level of education and experience to provide care management services for the D-SNP population. The Care Manager conducts a comprehensive assessment of the member's health and psychosocial needs in collaboration with the member, family, providers, social agents, and other participants of the care team.

Care Managers will:

- Conduct in-depth assessments to determine the services the member will need.
- Convene and lead the interdisciplinary care team (ICT).
- Employ a person-centered approach based on each member's strengths, needs and preferences through involvement of the member, their family, their caregiver(s), and members of the Virginia Premier care team and a network of community-based supports in the care planning and care delivery process.
- Develop an individualized care plan (ICP) with the member, their family and caregivers coordinated by the Interdisciplinary Care Team (ICT) to fully address and adhere to the member's strengths, needs and preferences.
- Utilize community-based resources as available to help support the member's needs and preferences.
- Coordinate with the member's Medicare plan to ensure appropriate utilization
- Promote the member's ability to actively exercise their rights and responsibilities.
- Provide ancillary program referrals such as disease management services for individuals with chronic conditions to obtain disease-specific education and support.

- Educate members regarding the importance of self-care, prevention, and health maintenance

Health Risk Assessment Tool (HRAT)

The HRAT is an assessment conducted to evaluate a member's physical condition, cognitive functioning, behavioral health, frailty and functional needs. This assessment is administered within the first ninety (90) days of enrollment to the plan. Once the initial HRAT has been completed, the assessment will then occur on an annual basis. The Member Engagement Representative (MERs) are primarily responsible for conducting the HRAT with the member and/or his/her caregiver.

The HRAT identifies the potential need for specific case/disease management and potential care management needs based on medical or psychosocial issues.

The HRAT assesses the following:

- Member's perception of health status
- History of hospital and ER utilization
- Substance use
- Caregiver supports
- Pain level
- Chronic medical and/or behavioral health conditions
- Number of medications taken
- Fall screening and mobility limitations
- Special care needs such as Durable Medical Equipment (DME)
- Weight gain/loss patterns.
- Behavioral health screenings

Individualized Care Plan (ICP)

The ICP is a person-centered, comprehensive plan designed to address the member's strengths, specific needs and preferences that includes but is not limited to:

- Prioritized goals based on member and/or caregiver needs and preferences
- Time frame for evaluation of the goals, interventions and resolution of problems
- Resources to be utilized
- Transition/continuity of care
- Collaborative approaches
- Medication management
- Self-management plan
- Outcomes measures
- Social/community service needs

- End of life needs
- Advance care planning (such as advance directives)
- Condition-specific educational needs
- Integrated elements of other care plans (such as home health or targeted case management)

The initial step in developing the ICP is completion of the HRAT with the member and/or caregiver. The Care Manager then engages the member and/or their caregiver along with the ICT in developing the ICP. The ICP is a working document and may have updates as the member completes goals or wishes to add additional goals/preferences to the plan. Additionally, if a member experiences a triggering event such as a change in their health condition or hospitalization, the ICP will be updated to include these changes by the Care Manager, member, and ICT.

Communication of Network

The MOC must include effective, and in some cases enhanced and technologically advanced, communication methods. Virginia Premier utilizes many different methods when communicating with members and providers.

Member Communication

- Member Services Call Center
- Newsletters
- Brochures
- Reminder Mailings
- Website
- Member Meetings
- Focus Groups

Provider Communication

- Provider Visits
- Provider Training
- Peer Review Committees
- Provider Meetings
- Provider Services Call Center
- Newsletters
- Website
- Personalized faxes
- Face-to-face meetings

Performance and Health Outcome Measures

Centers for Medicare & Medicaid Services (CMS) Star Rating system is a primary component to the measurement of Virginia Premier. Utilizing star measures allows Virginia Premier to observe and report changes year over year. This also allows Virginia Premier to understand the quality of care delivered to the members and the care model's effectiveness.

Glossary

Abuse	The use of health services by recipients which is inconsistent with sound fiscal or medical practices and that results in unnecessary costs to the Virginia Medical program or in reimbursement for a level of use or pattern of services that is not medically necessary, or (ii) provider practices which are inconsistent with sound fiscal or medical practices and that result in (a) unnecessary costs to the Virginia Medicaid program, or (b) reimbursement for a level of use or a pattern of services that is not medically necessary or that fails to meet professionally recognized standards for health care.
Appeal	A request from a member, attending physician, provider or facility to reconsider a decision made by Virginia Premier to reduce or deny covered services.
Authorization	The process of obtaining prior approval from the health plan before rendering specified services or procedures to a member.
Centers for Medicare & Medicaid Services (CMS)	The federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act. CMS provides program oversight for Medicaid Managed Care.
Claim	An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.) billed electronically or on HCFA 1500 or UB 04.
Clean Claim	A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title 1816 (c)(2)(b) and 1842(c)(2)(B) of the Social Security Act.
Complaint	Any oral or written communication made by or on behalf of a member expressing dissatisfaction with any aspect of the Health Plan's, providers, or State's operation, activities or behavior regardless of whether a remedial action is requested.

Co-payment	The member's portion of the payment due at the time of service.
DMAS	Department of Medical Assistance Services (DMAS) administers a number of programs in the State to assist needy Virginians. These programs include the Medicaid Program, the Indigent Health Care Trust Fund, the State and Local Hospital Program and the Family Access to Medical Insurance Security Plan (FAMIS).
DSS	Department of Social Services (DSS).
D-SNP	"D-SNP" stands for "Dual Eligible Special Needs Plan." It's a program for people who are on both Medicare and Medicaid.
Emergency	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
Enrollment Broker	An independent broker who enrolls recipients in the Medicaid HMO plans, and who is responsible for the operation and documentation of a toll free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment and may include recipient marketing and outreach.
Fee-for-Service	The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This payment is contrasted with capitation, which pays per person, not per service.
Fraud	Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.
Grievance	Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are

	not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Member's rights, as provided for in 42 C.F.R. § 438.400. Grievances are overseen by the Virginia Premier Continuous Quality Improvement Committee (CQIC) and are related to the availability, delivery or quality of health care services including the utilization review decisions that are adverse to the member or the payment or reimbursement of health care service claims.
HMO	Health Maintenance Organization (HMO). A medical care organization to deliver and finance health care services to its members for a fixed prepaid premium. A primary care physician must provide or authorize all services provided to members. Members must use in-network physicians.
Health Risk Assessment (HRA)	A comprehensive assessment of a Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS and social needs
Interdisciplinary Care Team (ICT)	A team of professionals that collaborate, either in person or through other means, with the member to develop and implement a Plan of Care that meets their medical, behavioral, long-term care and supports and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the member's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.
Managed Care	Use of a planned and coordinated approach to provide health care with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.
Medical Necessity	Services sufficient in amount, duration, scope and environment to improve health status.
Medicare	Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and

	treatment of illness or injury. Medicare Part C provides Medicare member's with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.
Member	An individual who is eligible for Medicare/Medicaid and who is currently enrolled with Virginia Premier. All members are assigned a PCP to provide and/or coordinate all health care services.
Minimum Data Set	Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly and whenever there is a significant change in an individual's condition.
Model of Care (MOC)	The Model of Care is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a designated program.
NCQA	National Committee on Quality Assurance – a not-for-profit organization performing accreditation review of managed care plans.
Network Provider	The health care entity or health care professional that has a contract with Virginia Premier or its subcontractor to render covered services to members.
Non-participating Provider	Non-participating Provider – a health care entity or health care provider who is not contracted with Virginia Premier to provide services to members. Often referred to as an "out-of-network" provider.
PCP	Primary Care Physician (PCP) – a generalist trained physician in Internal Medicine, Family Practice, Pediatrics or OB/GYN, who is responsible for providing the majority of care to individuals and providing case management when additional services are required.
Plan of Care (POC)	A plan, primarily directed by the member, and family members of the Member as appropriate, with the assistance of the Member's Interdisciplinary Care Team to meet the medical, behavioral, long-term care and supports and social needs of the Member.

Urgent Care

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours (24) could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Virginia Premier is an HMO and HMO SNP organization with a Medicare contract. Enrollment in any Virginia Premier plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network] may change at any time. Notice will be provided when necessary.

From October 1 to February 14, we are open daily from 8:00 am to 8:00 pm, 7 days a week, excluding certain holidays. On weekends and certain holidays from February 15 to September 30, your call will be handled by our automated phone system.

Virginia Premier Health Plan, Inc. is a fully-owned subsidiary of VCU Health.

Making Virginia healthier together.

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