



OB REGISTRATION FORM

*Complete and return this form for all obstetrical patients assigned to VPHP, Inc. Information is used by care management teams to educate members and coordinate care. **Please Fax This Form Back To VPHP, Inc. @ (800) 827-7192***

Patient Information																			
Member's Name:		Age:	Date of Birth:																
Current Address:			VPHP ID#																
Patient's Phone Numbers: (Home)		(Cell)	Today's Date :																
Alternate Phone Number:																			
Provider Information																			
Name of Facility:	Name of Obstetrician:	NPI Number:	Phone Number:	Fax Number:															
Patient History																			
Current Weight:	Pre-Pregnancy Weight	Height:	Last Menstrual Period:	Sonogram Performed:															
Date Prenatal Care Initiated:		Gravida:	Para:	EDC:															
		Live Births:	Ectopic:																
Risk Assessment																			
☐ Planned C-Section Indication: _____ Smoker Substance Abuse If yes, list: _____ HIV/AIDS STD IF yes, list: _____ IUGR Incompetent Cervix Other: _____ Do you consider this a High Risk Pregnancy? If yes, explain: _____ Additional Comments: _____ _____ _____ _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d3d3d3;"> <th style="text-align: center; padding: 5px;">Previous Adverse Pregnancy Outcomes</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">☐ Premature Births</td></tr> <tr><td style="padding: 5px;">☐ Stillbirths</td></tr> <tr><td style="padding: 5px;">☐ Fetal Death</td></tr> <tr><td style="padding: 5px;">☐ Fetal Abnormalities</td></tr> <tr><td style="padding: 5px;">☐ Fetal Complications</td></tr> <tr><td style="padding: 5px;">☐ Abortion</td></tr> <tr><td style="padding: 5px;">☐ Other: _____</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d3d3d3;"> <th style="text-align: center; padding: 5px;">Current Pregnancy Complications</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">Maternal Bleeding</td></tr> <tr><td style="padding: 5px;">Preeclampsia</td></tr> <tr><td style="padding: 5px;">Diabetes</td></tr> <tr><td style="padding: 5px;">Hypertension</td></tr> <tr><td style="padding: 5px;">Nutritional Deficit</td></tr> <tr><td style="padding: 5px;">Other: _____</td></tr> </tbody> </table>			Previous Adverse Pregnancy Outcomes	☐ Premature Births	☐ Stillbirths	☐ Fetal Death	☐ Fetal Abnormalities	☐ Fetal Complications	☐ Abortion	☐ Other: _____	Current Pregnancy Complications	Maternal Bleeding	Preeclampsia	Diabetes	Hypertension	Nutritional Deficit	Other: _____
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Virginia Premier Health Plan, Inc

Contact us:
 P.O. Box 5307 Richmond, VA 23220-
 Fax to Medical Management: 1-800-827-7192
 For Medical Management questions call toll free:
 1-888-251-3063
 All other questions call toll free: 1-800-727-7536



DURABLE MEDICAL EQUIPMENT (DME)
CERTIFICATE OF MEDICAL NECESSITY

This form is for prior authorization of durable medical equipment only. ALL APPROVALS AUTHORIZED THROUGH THE USE OF THIS FORM ARE SUBJECT TO THE ENROLLEE'S BENEFITS AND ELIGIBILITY.

Virginia Premier Health Plan, Inc
Contact us:
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Fax to Medical Management: 1-800-827-7192
For Medical Management questions call toll free: 1-888-251-3063
All other questions call toll free: 1-800-727-7536

Patient's Name

Patient's Date of Birth: ____/____/____

Patient's ID# _____

Patient's Address

City, State, Zip Code

Telephone Number

Type of Equipment/Supply/Appliance: _____

Please describe the patient's condition that warrants the requested equipment (include the ICD-9 code): _____

What other treatment modalities have been tried in the past?

What are your expected goals or outcomes for the patient?

How long will the patient need the equipment/supply/appliance?

Name/Phone Number of Preferred DME Vendor: _____ Phone #: _____

This Certificate of Medical Necessity has been sent to preferred DME Provider? ☐ **Yes** ☐ **No**

Name of Ordering Physician _____ Telephone Number: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____

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PRIOR AUTHORIZATION REQUEST FORM

EOC ID:



EnvisionRxOptions General Prior Auth Form

Phone: 855-872-0005 Fax back to: 877-503-7231

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Please indicate the patient's diagnosis below

Q2. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval

Q3. Please provide any supporting clinical statements (such as lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request)

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.



OUTPATIENT TREATMENT REPORT (OTR)

Virginia Premier Health Plan, Inc.
Richmond: PO Box 5307 Richmond, VA 23220-0307

Fax to Medical Management: 1-800-827-7192 For Medical Management questions call
toll free: 1-888-251-3063 All other questions call toll free: 1-800-727-7536

DATE OF REPORT:

Check one:

Initial OTR ☐

Subsequent OTR ☐

I. Patient Demographics:

Name:

DOB:

Medicaid #

Date(s) of TX since last OTR:

II. INITIAL: Presenting Problems/Precipitants/Criteria to Justify Dx // **SUBSEQUENT REVIEWS:** Current Pxs & Case Progress:

➤ **NOTE:** Add'l documentation may be attached to this OTR to demonstrate progress in TX / justify the need for cont'd TX.

III: Relevant HX / Previous TX / Substance Abuse Issues:

IV: DSM IV DX & Code# required for each DX. Please complete **ALL** five (5) Axes & Note changes on subsequent reviews.

Axis 1a:

Axis 2:

Axis 4:

Axis 1b:

Axis 3:

Axis 5:

(Currently)

(Past Year)

V: Current Psychotropic Medications & Prescribing MD:

MD:

	Drug Name	Dosage	Frequency
1.			
2.			
3.			

	Drug Name	Dosage	Frequency
3.			
4.			
5.			

VI: Short-Term Goals for the next 6 months:

1.

2.

3.

VII: Number of TX sessions over next 6 months & TYPE: I/T, F/T and/or G/T: _____ **Frequency of Visits:** _____

Clinician's Name & Title

(please print)

(Provider's signature)

Provider group or agency:

Provider's Address:

(#)

(Street)

(City)

(State)

(Zip)

Provider's Phone: ()

(area code)

(phone #)

Provider's Fax: ()

(area code)

(phone #)

➤ **Certain situations trigger a focused review of the medical necessity of care. The treatment plan may require additional data to assure that care is medically necessary.**



INITIAL OUTPATIENT TREATMENT REPORT (IOTR)

Virginia Premier Health Plan, Inc

Contact us:

P.O. Box 5307 Richmond, VA 23220

Fax to Medical Management: 1-800-827-7192

For Medical Management questions call toll free: 1-888-251-3063

All other questions call toll free: 1-800-727-7536

Patient Demographics:

Name: _____ DOB: _____ Medicaid# _____

Date(s) of TX since last OTR: _____

Please check all that apply for the member.

Behavioral Health

Requested # of Visits

Requested Start Date

Diagnosis _____

Please check all that apply for the member.

Substance Abuse

Requested # of Visits

Requested Start Date

Diagnosis _____

Clinician/Therapist Name & Title: _____

(please print)

(signature)

Provider Group or Agency: _____

Provider's Address: _____

(#)

(Street)

(City)

(State)

(Zip)

Provider's Phone: _____

()

(area code)

(phone #)

Provider's Fax: _____

()

(area code)

(phone #)

DO NOT WRITE BELOW THIS LINE: VPHP USE ONLY

Approved _____

visits

Authorization Number _____

Date Range _____

Total Visits Approved Year To Date _____

Additional Visits Requested/Require OTR _____

Revised 7/31/13

DATE / /

MEMBER NAME	DOB	/	/	SS#	-	-
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MEDICAID # _____ OUTPATIENT ☐ INPATIENT ☐

Virginia Premier Health Plan views psychological testing as a specialized component of the clinical assessment process. It is authorized under the mental health benefit via a two-(2) step process:

1. The treatment provider or the Primary Care Physician initiates a recommendation for one (1) hour consultation by the psychologist to evaluate the patient's need for testing and to complete this form.
2. Actual psychological testing must await direct pre-authorization by Virginia Premier Health Plan.

Psychological testing is to be done only when data necessary for diagnosis and/or treatment planning is unavailable by other means of assessment (i.e. clinical interviews, relevant history, application of DSM-IV criteria, structured checklists, consultation with other treatment providers, review of records and interviews with parents, teachers, and significant others, etc.)

TREATING PROVIDER/REFERRING CLINICIAN COMPLETES THIS SECTION

1. Name and Credentials: _____ Phone # _____
 _____ (Please print)
 _____ Fax # _____
 _____ (Signature)

2. Patient's Current Symptoms, Relevant Treatment and Medication History:

3. DSM-IV Diagnoses: Axis I _____ Axis II _____
(DX and code#) (DX and code#)

4. Referral Question(s) (Please list the specific clinical question(s) to be addressed by psychological testing):

5. List all that has been done to answer these clinical question(s) prior to requesting psychological testing (Please note any previous psychological testing, with dates and results):

6. How will requested psychological testing facilitate patient's treatment?

TESTING PSYCHOLOGIST COMPLETES THIS SECTION:

(Check One (1): Psych Testing ☐ or Neuropsych Testing ☐

1. Name and Credentials: _____ Phone # ()
 _____ (Please print) _____
 _____ Fax # ()
 _____ (Signature) _____

Test(s) requested	Time requested	Test(s) requested	Time requested
A.		D.	
B.		E.	
C.		F.	

Total time requested:

Proposed Date of Testing: _____

Virginia Premier Health Plan, Inc.

PO Box 5307 Richmond, Virginia 23220-0307 Phone 804-819-5151, ext. 5210 or 5235 – Fax 804-819-1727 / 877-689-2276

PO Box 1751 Roanoke, Virginia 24008-1751 Phone 888-338-4579 - Fax 540-344-8007 / 800-827-7192

PO Box 62347 Virginia Beach, Virginia 23466 Phone 757-461-0064 / 800-828-7989 - Fax 757-466-1133

Mental Health Clinical Case Management



2013 Quality Program Description

Approved by Virginia Premier Health Plan, Inc. Board of Directors and
Continuous Quality Improvement Committee (CQIC)

August 2000

Revision Date(s): 12/2001; 12/2002; 12/2003; 12/2004; 12/2005; 02/2007; 01/2008;
01/2009; 01/2010; **01/2011; 01/2012; 01/2013**

Executive Summary:
2013 Quality Program Description:
Effective: January 1, 2013



- **Purpose:** The Quality Program, at Virginia Premier Health Plan, has an ongoing mission to provide all members with optimal quality of care, access to care in a safe, culturally sensitive manner and to be compliant with NCQA and DMAS Standards. VPHP is committed to improving the communities where its members live through participation in public health initiatives at the national, state and local levels, and aspiring to meet public health goals, (e.g., Healthy People 2020, State goals, etc.). Oversight of the VPHP Quality Program is provided by the Health Quality and Utilization Management Committee comprised of the Chief Medical Officer, VPHP Medical Directors and network Practitioners. The role of the committee is to review, recommend, develop and implement best practices, to include clinical and service initiatives/programs.
- **Scope:** The Quality Program includes oversight and management of over 600 NCQA and DMAS process standards (spanning multiple departments), over 200 HEDIS Core and Sub-Measurements, clinical and service indicators and credentialing/recredentialing of over 12,000 practitioners and providers.
- **Program's Core Indicators:**
 - NCQA Accreditation (includes Clinical and Service Medicaid HEDIS® Measures)
 - (Achieve 90% or > on NCQA Internal Audits (Resurvey: 2nd Qtr 2013))
 - Member and Provider Satisfaction
 - Member Grievances and Appeals
 - Quality of Care/Service Indicators
- **Changes to the 2013 Quality Program Description:**
 - Revised the process for reporting deaths to DMAS from the 15th of each month to within 48 hours of receipt
 - Added End Stage Renal Disease DM Program to Clinical Indicators
 - Added Pharmacy Director to the Health Quality Utilization Management Committee
 - Transitioned to New HEDIS Application
- **2014 Quality Goals:**
 - Sustain 1st in the State and Top 30 Best Medicaid Plans Nationally Ranking
 - Achieve the 50th Percentile or greater for Targeted HEDIS Measures
 - Improve Member Satisfaction through CAHPS® Survey Education for membership, providers and internal staff

The VPHP Quality Program Description, Quality Work Plan and previous year's Quality Evaluation are reviewed and updated, at least annually, based on VPHP, DMAS, CMS and/or NCQA requirements.

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	G. Vice President, Member Operations	
	H. Vice President, Claims	
	I. Vice President, Systems Development	
	J. Corporate Compliance Officer/Government Relations	
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I. HISTORY

In 1995, Virginia Premier Health Plan, Inc. (VPHP) (formerly Virginia Chartered Health Plan, Inc.) opened its doors for business, as a for-profit Medicaid managed care organization, owned by University Health Systems of Virginia Commonwealth University. In 2010, VPHP became not-for profit. The National Committee of Quality Assurance (NCQA) accredited VPHP in 2007. The last NCQA accreditation survey, which was conducted in 2010, continued the VPHP —~~Ex~~cellence” status. VPHP is contracted exclusively with the Department of Medical Assistance Services (DMAS) to provide quality health care services to Medicaid and Family Access to Medical Insurance Security (FAMIS) eligible recipients in the Commonwealth of Virginia.

The plan’s current enrollment is approximately 175,415 and operates in 100 counties in Central, Tidewater, Southwestern and Western Virginia. There are approximately 15,000 practitioners in the network.

II. COMPANY PROGRAM OVERVIEW

A. MISSION STATEMENT

- Virginia Premier Health Plan, a managed care organization partnered with Virginia Commonwealth University Health System, meets the needs of underserved and vulnerable populations in Virginia by delivering quality driven, culturally sensitive and financially viable healthcare.

B. FUNCTION

- Provide the organization with an annual Quality Program Description, Quality Work Plan, and Quality Annual Evaluation
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and service
- Identify and address instances of substandard care including patient safety
- Track and monitor the implementation and outcomes of quality interventions
- Evaluate effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards

C. SCOPE/METHODOLOGY

The scope of the Quality Program is integrated within clinical and non-clinical services provided for VPHP members. The program is designed to monitor, evaluate and continually improve the care and services delivered by VPHP practitioners and affiliated providers, across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient and transitional settings and is designed to resolve identified areas of concern on an individual and system wide basis. The Quality Program will reflect the population served in terms of age groups, disease categories and special risk statuses and diversity. The Quality Program includes monitoring of VPHP's community focused-programs, practitioner availability and accessibility; coordination and continuity of care; and other programs or standards impacting health outcomes and quality of life.

The methodology of the Quality Program and activities includes the elements of: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, barrier analyses, trending, measuring, analyzing, interventions, development and implementation.

III. OBJECTIVES & GOALS

The primary objective of VPHP's Quality Program is to continuously improve the quality of care provided to members, which enhance the overall health status of VPHP members. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) information, internal quality studies, and health outcomes data. VPHP is committed to improving the communities where the members live through participation in public health initiatives on the national, state and local levels, and aspiring to meet public health goals, (e.g. Healthy People 2020, State goals, etc.).

The primary goals of the VPHP Quality Program:

- Continuously meet VPHP's Mission, regulatory and accreditation requirements
- Ensure the delivery of high quality, appropriate, efficient, timely, and cost-effective health care and services
- Improve the overall quality of life of members through the continuous enhancement of VPHP's comprehensive health management programs [in the areas of asthma, heart disease, Bipolar disorder, Schizophrenia, chronic obstructive pulmonary disease (COPD), diabetes, end stage renal disease, high-risk pregnancy and childhood weight and nutrition management].
- Develop and implement interventions focused on member integration
- Enhance quality improvement collaboration with all levels of care to include, but not limited to primary care, ob/gyn and behavioral health care
- Ensure a safe continuum of care through the application of VPHP's Member Safety Initiatives
- Improve health promotion/disease prevention messages and programs for members through quarterly member and provider newsletters and monthly mailings and reminders
- Review performance against clinical practice guidelines
- Continue to address improvements in member satisfaction through collaboration with network practitioners and providers and quarterly meetings with members
- Continue to address improvements in practitioner satisfaction via quarterly meetings with the practitioners
- Promote community wellness programs and partner with community services and agencies
- Promote and facilitate the use of quality improvement techniques and tools to support organization effectiveness and decision-making.
- Ensure culturally competent care delivery through collection of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication.

IV. 2013 PERFORMANCE INDICATORS

The performance indicators provide a structured framework in which to target and concentrate organizational (clinical and service) efforts. Through assessment and implementation of member-focused interventions, outcomes are measured. VPHP will maintain clinical and service improvement projects/activities that relate to key indicators of quality and utilizes data that is statistically valid, reliable, and comparable over time. All performance indicator outcomes are reported at the HQUM, CQIC and the Board, at least annually.

A. Clinical Indicators:

- NCQA Medicaid HEDIS® Measures
- Contract Specific DMAS HEDIS® Measures
- DMAS Performance Improvement Projects (PIPS)
- Chronic Care Survey
- Case Management Screening
 - Prenatal/Postpartum Care
 - Childhood Immunizations
 - Well-Child Visits 1st 15 Months
 - Lead Screening
 - EPSDT
- Disease Management (DM) Initiatives/Programs:
 - Asthma
 - Diabetes
 - Heart Disease
 - Childhood Weight Management and Nutrition
 - Mental Health
 - Heart Disease
 - Chronic Obstructive Pulmonary Disease (COPD)
 - End Stage Renal Disease (ESRD)

B. Service Indicators:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0
- Provider Satisfaction Survey
- Provider Access and Appointment Availability Survey
- Member Operations Average Speed to Answer (Timeliness)
- Board Certification

V. ORGANIZATIONAL STRUCTURE

- A. **The Board of Directors of VPHP (Board)** has ultimate authority, accountability and organizational governance for the Quality Program. The Board exercises its oversight of the program by reviewing and approving annually the Quality Program Description, Annual Evaluation and Work Plan for the subsequent year. Additional functions of the Board include review and approval of reports and ad- hoc studies. The Board meets at least annually.
- B. **Continuous Quality Improvement Committee (CQIC)** has delegated oversight of the Quality Program and reports to the Board. The CQIC consists of the Executive Staff of VPHP, all members with voting privileges vote. Appointment to the Committee is by virtue of Executive Staff position. The CQIC meets at least four (4) times a year.

The CQIC develops policies and provides direction for all activities described in the Quality Program and Quality Work Plan, including delegated Quality activities. Additional responsibilities of the Committee include:

- Reviewing targeted instances of potential poor quality, and provide guidance as needed
- Ensuring that the appropriate agencies receive required reports and any additional information as outlined by governmental regulators
- Reviewing and acting on requirements/recommendations of external quality review organizations
- Reviewing summary data with comparison to industry standard benchmarks and providing recommendations as appropriate
- The CQIC reviews the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and provider satisfaction data and then the data is shared with both the members and practitioners by way of newsletters, Advisory meetings and site visits. Medical Record Review outcomes are discussed at the CQIC meeting and shared with the practitioners in the network to ensure ongoing compliance and facilitate improvement. Deficient elements, related to the CAHPS® Survey or the Medical Record Reviews, regardless of activity, are targeted for process improvements. Outcomes are monitored, tracked over time and reported to the Committee at least annually, when required. Data and service activities include, but are not limited to:
 - Quality Improvement studies
 - Trended data from sentinel events
 - Quality of care and service data
 - Member and Practitioner Satisfaction Surveys (access and availability)
 - Medical record reviews
 - Appeals data
 - Grievance data
 - Over and under-utilization data

- C. **The Health Quality Utilization Management (HQUM) Committee**, effective January 2011, replaced The Utilization Management and New Technology Committee and the Quality Improvement Committee, an addendum to support committees to include Quality Satisfaction Committee, etc. are formed as needed and report to the CQIC. With the approval of the Board and/or CQIC, committees are created to meet specific organizational needs. Each committee operates to accomplish specific objectives and processes contained in the annual work plan. The CQIC provides direction to all committees and ensures coordination between committees.

VI. PERSONNEL RESPONSIBLE FOR QUALITY PROGRAM

A. CHIEF EXECUTIVE OFFICER

The Chief Executive Officer (CEO) is responsible for all Plan activities, to include but not limited to, oversight of the implementation of the Quality Program. The CEO is responsible for monitoring the results of the health plan's quality of care and services, assuring that fiscal and administrative management decisions do not compromise the quality of care and service provided by VPHP. The CEO or designee chairs the Continuous Quality Improvement Committee. Findings and outcomes are discussed at the CQIC meetings, at least annually.

B. CHIEF MEDICAL OFFICER (CMO)/SENIOR, ASSOCIATE AND BEHAVIORAL HEALTH MEDICAL DIRECTORS

The Chief Medical Officer or designee is responsible for providing direction for the development and implementation of the Health Quality Utilization Management, and Credentialing Committee programs. The Medical Director(s) is responsible for peer review activities, and for collaboration with practitioners on the development and implementation of the Quality Program. The Medical Directors have substantial involvement with participating practitioners on a regular basis, acting as a clinical liaison, educator, role model and mentor to assist participating practitioners in achieving the Quality program's goals and objectives. The Medical Directors and the Behavioral Health Associate Medical Director report to the CMO and assists the CMO in carrying out all responsibilities and duties. The Behavioral Health Medical Director serves as a peer reviewer on behavioral health cases; assists in the development and implementation of quality improvement activities related to behavioral health by identifying member focused interventions to promote improved behavioral health outcomes, and other related matters and attends the CQIC, as needed. The Senior/ Behavior Health Medical Directors are standing and/or ad hoc members of the CQIC.

C. VICE PRESIDENT, QUALITY AND CREDENTIALING

The Vice President of Quality and Credentialing (VPQC) is responsible for the oversight, direction and strategic leadership of the Quality Improvement Program, which includes grievances, appeals, quality of care issues, regulatory activities involving quality, accreditation, and credentialing. The VPQC is responsible for the advancement of VPHP's quality strategy by designing, developing, implementing and conducting on-going evaluation of quality improvement activities, across the company, to measure and improve the quality of health care and service provided to members, to include delivering care in a culturally sensitive manner. The VPQC assists the CEO, the CMO, the VPHP Senior/Associate/Behavioral Health Medical Directors, and impacted VPHP Departments with related activities. The VPQC has oversight in assessing, analyzing and working collaboratively with the Executive Leadership Team to yield satisfactory clinical and service outcomes related to quality initiatives.

D. VICE PRESIDENT, MEDICAL MANAGEMENT

The Vice President of Medical Management (VPMM) is responsible for the oversight, direction and strategic leadership of the Utilization Management (UM) Program, which includes referrals, medical outreach, health education, disease management, case management and utilization management. The VPMM ensures consistency of the UM Program with other programs throughout VPHP, including the Quality Program. The VPMM assists the CEO, the CMO, the VPHP Senior/Associate/Behavioral Health Medical Directors, and impacted VPHP Departments with related activities. The VPMM monitors, tracks and trends key utilization data, oversees VPHP's health management programs and conducts an evaluation of program activities each year. The VPMM has oversight in assessing, analyzing and working collaboratively with the Executive Leadership Team to yield satisfactory clinical outcomes related to UM initiatives.

E. DIRECTOR, PHARMACY

The Director of Pharmacy (DP) is responsible for the monitoring, management and oversight of pharmacy data and costs at VPHP. The DP ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

F. VICE PRESIDENT, CONTRACTING/NETWORK DEVELOPMENT

The Vice President of Network Development/Contracting (VPND) has daily oversight and operating authority for provider services, contracting, recruitment, and retention activities/functions. The VPND ensures consistency of the Network Development/Contracting Program with other programs throughout VPHP, including the Quality Program. Provider Relations include managing communications with network providers. The CQIC works with Provider Relations and guides remedial action plans and communication with network clinicians. The VPND monitors standards associated with ongoing monitoring and remedial action for non-compliance with access standards as necessary. Network Development/Contracting ensures the network is sufficient in number and type of practitioners to assure accessibility, availability, after hours coverage and care is delivered in a culturally sensitive manner across VPHP's network.

G. VICE PRESIDENT, MEMBER OPERATIONS

The Vice President of Member Operations (VPMO) is responsible for the direct administrative and supervisory activities of Enrollment, Member Services, Transportation Services, Mail Operations and special projects. The VPMO ensures consistency of the Member Operations Program with other programs throughout VPHP, including the Quality Program. The VPMO will facilitate the integration of various operational systems within the organization. Member rights and responsibilities are published and distributed to both members and practitioners. The Member Advisory Committee (MAC) and annual CAHPS® survey are avenues for incorporating member suggestions and concerns into

quality initiatives. The Member Operations Department is represented on the CQIC, which oversees quality improvement efforts aimed at increasing member satisfaction.

H. VICE PRESIDENT, CLAIMS

The Vice President of Claims (VPC) is responsible for the oversight, direction and strategic leadership of the Claims Department, which includes operations, configuration and cost containment. The VPC ensures consistency of the Claims processes/procedures with other processes throughout VPHP, including the Quality Program when applicable. The VPC is responsible for oversight of resources responsible for the timely and accurate adjudication of claims as well as the creation and submission of encounter files to regulatory agencies. These areas function to support the overall success of timely and accurate claims adjudication and to provide key assistance to our provider/vendor network regarding claims.

I. VICE PRESIDENT, SYSTEMS DEVELOPMENT

The Vice President of Systems Development (VPSD) is responsible for the oversight, direction and strategic leadership of the Information Systems (UM) Program, which includes data management, integration and security. The VPSD ensures consistency of the IS Program with other programs throughout VPHP, including the Quality Program when applicable. The VPSD has daily oversight and operating authority for the enhancement and improvement of health and quality outcomes through the use, implementation and advancement of information systems and technology. The VPSD is responsible for ensuring data integrity and meeting the medical informatics and analytical needs related to the collection of quality improvement data necessary for HEDIS® and other internal quality improvement activities.

J. CORPORATE COMPLIANCE OFFICER/GOVERNMENT RELATIONS

The Corporate Compliance Officer/Government Relations (CCO) is responsible for the oversight, direction and strategic leadership of the Compliance Program, which includes compliance to the regulatory contracts, ensuring that all Protected Health Information (PHI) remains secure and confidential, organizational information (e.g., minutes) are confidential, proprietary and protected from discovery under the Health Care Quality Act of 1986. The CCO ensures consistency of the Program Integrity Department with other programs throughout VPHP, including the Quality Program. The CCO is also the VPHP regulatory liaison and responsible for submitting all regulatory reports to DMAS, as required per the State contract. Confidential materials are in secure files and/or areas, as deemed appropriate.

K. VICE PRESIDENT, HUMAN RESOURCES & ORGANIZATIONAL DEVELOPMENT

The Vice President of Human Resources/Organizational Development (VPHROD) is responsible for the oversight, direction and strategic leadership of the Human Resources Program, which includes training, development, recruitment and retention of qualified personnel. The VPHROD ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

L. CHIEF FINACIAL OFFICER/ VICE PRESIDENT, FINANCE

The Chief Financial Officer/Vice President of Finance (CFO) is responsible for the oversight, direction and strategic leadership of the Finance Operations, accounting, analytics, medical informatics, medical economics and payroll. The CFO has daily oversight and operating authority for VPHP fiscal responsibilities. The CFO ensures consistency of its processes/procedures with other programs throughout VPHP, including the Quality Program when applicable.

M. VICE PRESIDENT, STRATEGIC PLANNING AND BUSINESS INTEGRATION

The Vice President of Strategic Planning and Business Integration (VPSP/BI) is responsible for the oversight, direction and strategic leadership for VPHP, which incorporate strategy and business development. The VPSP/BI ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

VII. QUALITY PROGRAM: SUPPORT COMMITTEES

The CQIC core support committees are the (A) HQUM, the (B) Credentialing Committee, and other subcommittees as needed. Each of these committees and teams perform activities targeted for quality improvement and utilization management within relevant areas of managing scope. Findings and outcomes from each committee are reported to the CQIC, at least annually.

A. HEALTH QUALITY UTILIZATION MANAGEMENT COMMITTEE (HQUM)

The Health Quality Utilization Management Committee combines (1) Quality and (2) Utilization Management and New Technology Committee activities for the purpose of developing, implementing and managing the quality and utilization improvement processes, and providing overall direction and consultation to VPHP staff and practitioners on appropriate use of covered services. It meets quarterly. The committee members include:

Committee Structure:

- Chief Medical Officer (voting) – Chair
- Medical Director (Chair/voting) – Richmond
- Associate Medical Director (voting) – Roanoke
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician, Associate Medical Director (voting)
- Vice President, Medical Management (non-voting)
- Vice President, Quality and Credentialing (non-voting)
- Director of Pharmacy (non-voting)
- Resource staff (as needed non-voting)
- Statistician (as needed non-voting)

FUNCTIONS OF HQUM Committee:

- Approve and monitor the progress of the Quality Program Description, Annual Work Plan and Evaluation
- Approve and monitor the progress of the UM Program Description and Annual Evaluation
- Oversee, evaluates and analyzes quality activities for improvement opportunities such as CAHPS® and practitioner survey outcomes, appeals (upheld and overturned), patient safety data, grievances (quality of care and quality of service), and pharmacy utilization. Outcomes are tracked, trended and reported to the

CQIC for feedback and recommendations on improvement. Additionally, outcomes are shared with the members and practitioners at least annually.

- Oversee all quality pharmacy and utilization management and new technology activities
- Evaluate member and plan information compiled by the Quality Department
- Select and schedule initiatives based upon the needs of the population, external requirements, and likelihood of effective interventions
- Approve clinical performance standards and practice guidelines
- Recommends policy decisions
- Assist VPHP in complying with reviews and evaluations conducted and/or required by oversight authorities
- Ensures practitioner participation in the Quality Program through planning, design, implementation, or review
- Institutes needed actions
- Ensures follow-up, as appropriate
- Reviewing summary data of utilization management trends, sentinel events, and over and under utilization of services and evaluating opportunities for improvement.
- Reviewing and development of utilization management criteria for decision-making
- Approve clinical practice guidelines
- Monitoring and ensuring delegated UM functions.
- Countersigning appropriate denials, reviewing and rendering decisions on grievances resulting from denials of, or modifications in, requests for medical services from practitioners based upon medical necessity and treatment protocols. (If denied, appeals process is offered for all denials.)

1. QUALITY MANAGEMENT

VPHP participating practitioners and providers are required through a contractual agreement to cooperate with all quality activities and allow VPHP staff access to sites and VPHP member medical records.

(a) MEMBER SAFETY PROGRAM

VPHP is committed to providing quality services, enhancing the safety of members, practitioners, providers and staff while preserving its financial integrity and stability to continue its mission. The Member Safety Program (MSP) proactively identifies, evaluates and resolves potential safety issues. VPHP is not a direct provider of care and, therefore, has a special role in improving patient safety that involves fostering a supportive environment to help practitioners and providers improve the safety of their practices and the care they deliver. Practitioners who participate on the various quality committees also play an integral role in the MSP. A multidisciplinary team approach is utilized to implement the program. The team includes participants from the following departments:

- Quality: Grievances/Appeals, Accreditation, Quality and Credentialing
- Utilization Management: Medical Outreach, Health Education, Case Management, DM Utilization Review and Coordination
- Member Operations: Enrollment, Member Services, Transportation, and Mailroom
- Network Operations: Contract Management and Provider Relations
- Claims: Claims System Configuration, Cost Containment, Customer Service, Electronic Data Exchange,
- Information Systems: System Integration Team
- Compliance: Compliance and HIPAA Information
- Human Resources: Human Resources and Organizational Development
- Finance: Business Performance Analytics and Financial Analytics,

GOALS OF THE MSP

- To enhance the safety, quality, efficiency, and effectiveness of health care to ensure a safe and suitable healthcare environment
- To involve members and practitioners in the process
- To educate members and practitioners
- To obtain feedback that will result in significant improvements in healthcare delivery by:
 - Conducting health care assessments on each new enrollee

- Conducting surveys (i.e., CAHPS®), interviews, focus groups and sending letters
- To improve outcomes related to disease management programs or associated initiatives, i.e., prenatal and postpartum, diabetes, depression, pain management and asthma outcomes, Healthy Heartbeats, pediatric obesity, congestive heart failure, COPD, ESRD
- To investigate grievances and appeals in a timely and accurate manner
- To validate practitioner and provider credentials in a timely and accurate manner
- To enhance prevention efforts across the continuum of care
- To comply with all requirements related to safety and quality per state, federal, and other accrediting agencies standards and guidelines

SCOPE OF MSP

Scope of the VPHP MSP is broad-based and comprehensive. It includes:

- Sending prevention letters to members
- Educating members on how to communicate with their doctor
- Medical Outreach staff efforts
- Quarterly newsletters mailed and/or on website for providers and practitioners with reminders related to the delivery of quality healthcare
- Recognizing practitioners and providers who are leaders in quality and safety
- Practitioners who participate on the various quality committees—these practitioners also play an integral role in the MSP.

The program description is presented to the HQUM, CQIC and Board annually. Goals are set each year and outcomes are evaluated annually.

(b) MEMBER SAFETY INITIATIVES (MSI)

The following activities are ongoing initiatives that help assure VPHP enrollees receive the best healthcare on a continuous basis. The Plan assesses health care safety by using readily available administrative data (survey, claims, etc.), grievance data, and medical record data.

The MSIs are a set of indicators providing information on adverse outcomes following surgery, procedure, or childbirth. The indicators also include occurrences that are unusual or may indicate a concern in quality of care or service in either an inpatient or outpatient setting. The MSIs serve as the core factors that are reported monthly, quarterly, and/or annually (as applicable). The indicators are screened, investigated, analyzed, trended and monitored by the Quality Department. Indicators developed are followed by an in-depth assessment by the quality department and medical informatics departments. Outcomes are aggregated and reported to the CQIC, at least annually.

MSIs include:

- Sentinel Events: As defined by DMAS, a sentinel event is a death. However, VPHP defines a sentinel event (also known as a quality of care indicator) as one of the following:
 - Trauma suffered while in a healthcare facility/provider's office/HMO site
 - Surgery on wrong body part
 - Surgery on wrong patient
 - Loss of function not related to illness or condition
 - Rape in 24 hour care facility
 - Suicide in 24 hour care facility
 - Infant abduction or discharge to wrong family
 - Death

Deaths are reported to DMAS within 48 hours of receipt. Each sentinel event is investigated by a licensed, registered nurse in the quality area. Investigation assists the Plan to detect omissions in the process that occur during the delivery of care. Conducting root cause analyses on adverse events, such as sentinel events, enables the Plan to implement systemic modifications to prevent the event from reoccurring.

- Quality of Care Indicator: Any adverse event that is investigated by a nurse in the quality area. A Medical Director and/or the quality committees, if necessary, review indicators. The indicators are used to help the Plan identify potential adverse events that might need further study. Conducting root cause analyses on adverse events enables the Plan to implement systemic modifications to prevent the event from reoccurring. Indicators are received from various sources and include grievances, defined as any expression of dissatisfaction about any matter other than an —action.” Grievance defines the overall system that includes grievances and appeals that are handled at the managed care organization level; a complaint. A grievance can result from a medical record review and focused office visit, a practitioner report and other sources.
 - The VPHP Medical Director, acting as a first level peer reviewer, reviews all referrals for quality of care issues. These issues are presented to the HQUM and one or more of the CQIC Support Committees in an aggregated form.
 - All unresolved cases at the first level peer review will be submitted for second level peer review for determination of severity level and appropriate corrective action.
 - Final determinations regarding any serious disciplinary actions will require approval by the CQIC and/or the VPHP Board of Directors. VPHP will adhere to the reporting requirements of the VA State Medical Board, Office of Inspector General (OIG), the National Practitioners Data Bank (NPDB), and the VPHP Policies and Procedures.

- Credentialing: The process of verifying the credentials of a practitioner or provider, which ensures that each member is treated by a practitioner or provider licensed to conduct business in the Commonwealth of Virginia. (Further information contained in the credentialing section.) Any practitioner that is not on the Office of Inspector General is not paneled onto plan or terminated upon identification.
- Medical Record Review:
The objectives of the Medical Record Review (MRR) are:
 - Evaluate the structural integrity of the medical record
 - Evaluate the medical record for the presence of information that is necessary to provide quality care and determine the appropriateness and continuity of care
 - Evaluate the medical record for documentation that conforms to good medical practice
 - Assess and improve medical record keeping practices of practitioners who provide primary care
 - Conduct focused follow-up to improve medical records of primary care practitioners who do not meet VPHP medical record standards

Clinical reviewers are trained in the use of the MRR tool to collect data. Data summary and opportunities for improvement are reported to the plan's CQIC committee, as needed. MRR results are also disseminated to the practitioners and follow-up reviews are conducted as necessary and per the established plan policy.

For instances of suspected fraud, waste and/or abuse, at the practitioner/provider level (e.g., during MRR, site visits, quality of care issues/grievances and/or during the credentialing process) will be referred to the Compliance Department for investigation within 24 hrs of identification.

- Grievance Monitoring:
The objectives of grievance monitoring are:
 - Trend, evaluate and monitor grievances
 - Effectively resolve member or practitioner grievances in a timely manner
 - Identify opportunities for improvement in the quality of care and services provided to VPHP members and practitioners.

Issues are tracked, trended and aggregated by the Quality Manager. All Provider Care and Treatment and Access to Services/Providers grievances are forwarded to a nurse in the quality area to investigate and/or review for quality issues and/or referred for follow-up to Case Management or Provider Services. The Quality area applies VPHP policies to ensure timely response and resolution. Cases scored at a

higher severity level are forwarded to a Medical Director for review and possible review by the CQIC Committee.

Data related to administrative and quality of care/service issues are collected, reviewed and analyzed in aggregate for trends and opportunities for improvement. The aggregated data is presented to the designated CQIC Support Committee and to the CQIC, as needed. The regulatory reporting categories for quality of care and quality of service issues are Transportation, Access to Services/Providers, Provider Care and Treatment, MCO Customer Service, Administrative Issues, and Reimbursement Related Issues.

A Medical Director and/or one or more of the CQIC Support Committees conduct the final review of investigation outcomes. Members and practitioners are informed of investigation outcomes in writing or orally if received orally.

When members are not satisfied with the outcome of a grievance, an appeals process allows for inclusion of additional information and reconsideration of the issue. During the grievance resolution process, members are notified in writing and/or verbally of their right to file an appeal at any time, and provided the necessary information to file the appeal.

- Medical Outreach Activities/Health Education:
The Plan has ongoing outreach and health education efforts to ensure patients are informed of quality outcome results.
- Prenatal Outreach Activities:
Medical Outreach Representative (Workers) of Plan benefits and health information visit pregnant members on a routine basis to ensure that the member is living in a safe environment and attending their prenatal visits. Postpartum visits are scheduled with the mother to ensure that both mom and baby are residing in safe environments and assist the member in obtaining basic infant care supplies as needed.
- Vaccines for Children Program:
Physicians participate to ensure vaccines are available for Medicaid eligible population
- Medical Errors:
Medical errors are one of the Nation's leading causes of death and injury. A report, *To Err is Human: Building a Safer Health System*, by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. This means that more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS. The report concludes that the majorities of these errors are the result of systemic problems rather than poor performance by individual practitioners, and outlined a four-

pronged approach to prevent medical mistakes and improve patient safety.

- The Joint Commission:
During site visits, the Quality Staff educates and distributes The Joint Commission's National Patient Safety Goal –Do not use abbreviations." Annually, the —Do Not Use List" is communicated to the practitioners via the Provider Newsletter.

The National Patient Safety Goals, (NPSG) promote specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. The following list includes —Do Not Use" abbreviations that are often the cause of medical errors. VPHP educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations. The National Patient Safety Goals that are routinely provided to network practitioners and providers are given below:

National Patient Safety Goal on Abbreviations - 2013

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its —do not use" list of abbreviations as part of the requirements for meeting that goal. The purpose of the goals is to promote specific improvements in patient safety. The –Do Not Use" Abbreviation list may be found at:
http://www.jointcommission.org/assets/1/18/Official_Do_Not_Use_List_6_111.PDF

The goals, in their entirety, can be located at:
http://www.jointcommission.org/standards_information/npsgs.aspx

Each year, VPHP highlights the **–Do Not Use"** list, which is included under NPSG – 2B. In May 2005, The Joint Commission affirmed its "Do Not Use" list of abbreviations, acronyms, symbols and dose designations. The list was originally created in 2004 by the Joint Commission (formerly JCAHO) as part of the requirements for meeting NPSG requirement 2B (Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization). Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list.

VPHP supports the use of this list and encourage all practitioners and providers to utilize it in practice.

*The list applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms. *Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.*

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for ~~0~~ (zero), the number ~~4~~ (four) or ~~ec~~	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate confused for one another	Write "morphine sulfate" Write "magnesium sulfate"
Below, additional Abbreviations, Acronyms and Symbols (For possible future inclusion in the Official "Do Not Use" List)		
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write ~~greater than~~ Write ~~less than~~
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number ~~2~~ (two)	Write ~~at~~
cc	Mistaken for U (units) when poorly written	Write "ml" or ~~milliliters~~
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or ~~micrograms~~

The Joint Commission Last update 06/2012

Annually, VPHP reviews The Joint Commission (formerly JCAHO) National Patient Safety Goals for relevance to the care and services related to the VPHP practitioner and provider networks.

2. UTILIZATION MANAGEMENT

PREVENTIVE CARE GUIDELINES REVIEW

The objective of the Preventive Care Guideline Review is to monitor the use of scientifically based preventive care guidelines for improving the quality of care provided. VPHP continuously monitors the effectiveness of adopted preventive care guidelines. The HQUM Committee reviews and approves these guidelines based on the most current and reasonable medical evidence available from the US Preventive Services Task Force, the CDC and Healthy People 2020, National Health Promotion and Disease Prevention Objectives, as well as the state requirements for Medicaid i.e. EPSDT program. Findings and distribution schedule of the guidelines are discussed at the CQIC meetings.

NEW TECHNOLOGY

Responsible for reviewing new technology based on requests from providers and members as well as changes in the industry.

OVER AND UNDER UTILIZATION

Over and under utilization of services are monitored to ensure that members are receiving necessary care and service in the most appropriate setting.

The data is gathered from the following sources:

- Member and provider satisfaction surveys
- Grievance and appeals data
- Provider utilization data
- Pharmacy utilization reports
- Utilization management reports
- Quality of care reports
- Medical record/site visit reviews
- HEDIS® outcomes

(a) BEHAVIORAL HEALTH PROGRAM

The program outlines VPHP's efforts to monitor and improve behavioral health care. The behavioral health practitioner on the CQIC Support Committees is a medical doctor who acts as a consultant and provides feedback at the various quality committee meetings. Covered benefits include physician, outpatient and inpatient services for behavioral health and medical diagnosis. Members may self refer for the initial three (3) behavioral health visits of the benefit year. VPHP's UM/CM staff may authorize additional visits when a treating practitioner completes an outpatient treatment report and submits it to VPHP prior to rendering services. Authorization requests will not be reviewed retrospectively except in cases of emergency services.

GOALS OF THE PROGRAM

- Coordinate and provide high-quality managed behavioral healthcare services
- Sustain a formal Committee comprised of practitioners representing all VPHP geographical regions, numerous specialties, to include a behavioral health practitioner
- Meet requirements of the National Committee for Quality Assurance (NCQA®) and strive to meet the national 50th percentile for the Behavioral Health (HEDIS®) measures, Anti-depressant medication, Follow-up after Mental Health Admissions seven and thirty days and Follow Up Care for Children Prescribed ADHD medication.
- Improve the impact of behavioral health treatment on physical health status
- Patient satisfaction with care provided and all aspects of the delivery system

SCOPE OF THE PROGRAM

Quality of direct patient care in behavioral health while seeking care from network practitioners and in outpatient and inpatient settings for adults, adolescents and children

COORDINATION OF CARE

Licensed, behavioral healthcare case managers manage behavioral healthcare services for Plan members. The Plan benefit covers twenty-four hour clinical coverage for mental health services. Members have open access to participating behavioral health practitioners, up to a maximum of three visits in a benefit year. Four or more visits require preauthorization.

B. CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for oversight of activities of the Plan's Credentialing Program. Policies and procedures related to Credentialing are reviewed and approved by the CQIC. The committee meets at least 12 times per year and includes the CQIC Support Committees, with the addition of a voting VPHP Contracting/Network Development staff member.

Committee Structure:

- Senior Medical Director (voting) – Chair
- Chief Medical Officer – (voting) -Richmond
- Associate Medical Director (voting) – Roanoke
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician (voting)
- Vice President, Network Development or designee (voting)
- Vice President, Quality and Credentialing (non-voting)
- Vice President, Medical Management (non-voting)
- Resource staff (as needed non-voting)
- Statistician (as needed non-voting)

FUNCTIONS OF CREDENTIALING COMMITTEE:

- Reviewing all practitioner applicants to ensure compliance with credentialing requirements and ultimately making recommendations for approval or denial. If denied, the appeals process is offered.
- Reviewing all practitioner applicants for the following prior to recredentialing:
 - Selection criteria suitability
 - Medical record standards compliance
 - Member grievance trends
 - Results of quality review studies
 - UM activities
 - Member satisfaction surveys
 - Reviewing independent practitioners prior to credentialing and recredentialing
 - Giving periodic updates and annual evaluation of the credentialing program to the CQIC
 - Reviewing delegated credentialing activities
 - Sanctions and/or limitations related to state licensure and Medicaid/Medicare

CREDENTIALING AND RECREDENTIALING

VPHP conducts credentialing and recredentialing activities for physicians to include doctors of medicine, doctors of osteopathy, doctors of podiatry, doctors of obstetrics and/or gynecology, family nurse practitioners, licensed clinical social workers, psychiatrists, psychologists, and other licensed practitioners with whom it contracts to provide services to members.

The Credentialing Committee and Senior Medical Director make the final approval or denial decision on every practitioner. Upon approval or denial, a letter is mailed out within 60 calendar days of the decision, signed by the Senior Medical Director. Credentialing and recredentialing includes primary source verification in accordance with VPHP policies and procedures set forth by NCQA. Site visits will be conducted for complaints involving physical accessibility, physical appearance and adequacy of

waiting and examining room space, Site visit will also be conducted on a random basis for all network practitioners to ensure VPHP office site standards are met.

At the time of recredentialing, individual practitioner performance profiling is evaluated through consideration of information from: licensure sanction reports, Medicare/Medicaid sanction reports, adverse actions, member grievances, site visits, medical records reviews, quality improvement projects, and member satisfaction and utilization management data. Practitioners have access to an appeals process in the event of an adverse credentialing decision.

Office of the Inspector General (OIG): The Health and Human Services Office of Inspector General is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

CONTRACTUAL ARRANGEMENTS

(1) NON-DELEGATED

By signing the practitioner addendum to the Participating Provider Group Contract (PPG), the Consultant Agreement, the Medical Specialty Group Agreement, the Primary Care Physician Agreement, and/or a Hospital Agreement, network primary care practitioners (PCP) and groups, specialty practitioners, organizational providers, home health agencies, and hospitals agree to:

1. Abide by the policies and procedures of the VPHP Quality Program
2. Participate in peer review activity
3. Provide credentialing information as specified
4. Serve on the HQUM, Credentialing and/or specialty peer review committees, as necessary
5. Allow VPHP to collect information for the purposes of quality assessment and improvement
6. Cooperate with quality, disease, and case management, and/or grievance resolution, as necessary

(2) DELEGATED

Credentialing functions are delegated to contracted organizations. The delegated entities submit reports at least twice a year and undergo comprehensive audits of processes and files (as applicable) at least annually. Vendors that VPHP has entered into a contractual arrangement with are responsible for monitoring and evaluating the contracted services provided to VPHP members and providing VPHP with routine reports on quality findings and results of quality improvement activities. The delegated

entity develops its own Quality Program, in accordance with VPHP and NCQA standards and guidelines, when applicable.

Any delegation of responsibility for Quality, UM, Credentialing, or other activities must be approved by VPHP's CQIC and/or the CEO. The delegation will be conducted only after a written and signed agreement between the CEO of VPHP and the designated executive with signature authority of the vendor organization. Any such agreement shall specifically state the terms of the delegation and the policies and methods for oversight by VPHP. VPHP's oversight of delegated entities shall be at least annually, announced and unannounced, and in accordance with standards set forth by the National Committee for Quality Assurance (NCQA), DMAS and VPHP policies and procedures.

The CQIC is responsible for oversight of VPHP's delegated quality functions. Findings and outcomes related to delegated functions are reported to the CQIC, HQUM and Credentialing committees, as appropriate at least annually.

The Partners State-Wide Conference Call Meeting (formally called The Delegated Credentialing Partners State-Wide Conference Call Meeting) was established November, 2011. Meetings are held quarterly to ensure an ongoing exchange of information between VPHP and its quality and credentialing partners. The content of the meetings include VPHP policies and procedures (new, revised or terminated), accreditation outcomes, regulatory requirements and other pertinent information. Streamlining and simplification of activities and processes are also discussed during these meetings.

VIII. 2013 QUALITY PROGRAM ACTIVITIES

A. Monitoring Quality Performance Indicators - Clinical and Service HEDIS® Measures:

The purpose of HEDIS® is to ensure that health plans collect and report quality, cost and utilization data in a consistent way so that regulators, accreditors and the plan itself can compare performance across health plans regionally and nationally. VPHP uses HEDIS® measures to provide network practitioners and providers with a standardized assessment of their performance in key areas in comparison to plan-wide findings. All HEDIS® data is collected through claims and other healthplan systems and analyzed by NCQA certified software. VPHP implemented a new HEDIS Application in 2013 called Inovalon. VPHP conducts further analysis of HEDIS® results to better understand clinical outcome patterns and identify areas of improvement.

B. Monitoring Quality Performance Indicators –Surveys:

Members:

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

Practitioners:

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

C. Clinical Practice Guidelines:

The Quality Program develops and the HQUMC approves the clinical practice

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

D. Patient Safety:

Patient safety needs are addressed through the following activities: 1) review of grievances and determination of quality of care impact; 2) notification to patients, practitioners, and providers of medications recalled by the FDA 3) notification to the Quality Team of any potential quality or safety cases (e.g., re-admissions within 30 days when a premature discharge is a question, significant provider errors include pharmacy, unexpected deaths, missed diagnoses or treatments, missed follow-up, or insufficient discharge planning); 4) comprehensive site surveys and medical record keeping practices process, or in response to a Grievance or direction of one of the Quality Committee; 5) targeted and general member educational outreach; and 6) Encourage the completion, for at least 50% of the network physicians, especially primary care practitioners, to complete a cultural competency CME to aid in caring for members of diverse populations.

E. Disease Management:

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with, or at risk for, established medical conditions. VPHP's Disease Management Programs strive to: support the relationship between practitioners and their patients and reinforce the established plan of care; emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management; and continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health.

F. Credentialing Peer Review Activity:

Peer review is conducted according to the regulatory, accreditation, and VPHP established standards and/or laws and regulations. The Senior Medical Director, with the assistance of Associate Medical Directors, manages the peer review process. Cases requiring peer review are identified through member, practitioner, or provider grievances and other sources. The Senior Medical Director may perform peer review directly, or arrange for review by an appropriate committee physician or external physician reviewer, in accordance with VPHP's policies and Procedures. Remedial and disciplinary action shall be taken in a timely manner in accordance with the Plan's policy.

VPHP contracts with Medical Evaluation Specialists (MES) to provide external reviews for cases requiring specialties not represented by VPHP Medical staff or committee.

G. Management of Quality of Care Complaints:

All grievances or issues generated by members, practitioners, or providers, VPHP staff, state agencies, and other entities that involve quality of care, are handled appropriately per established policy that includes response to grievances. Member

contacts concerning access for a current illness or condition are routed to a clinician in VPHP's utilization management department. The clinician is accountable for timely assessment and resolution. The VPHP Medical Staff performs an objective review of all quality of care complaints and issues in accordance with VPHP's Policies and Procedures.

H. Quality Satisfaction Committee:

The Manager of Quality, who reports to the Vice President of Quality and Credentialing, chairs and is responsible for the VPHP Quality Satisfaction Committee. The Committee includes representatives from operational departments that have a direct impact on accreditation, member compliance and member and practitioner/provider satisfaction. (The Committee ensures that there is a coordination of activities, reduction/elimination in duplication of efforts, and streamlined activities to ensure maximum output and outcomes. This includes sharing of information that could be beneficial to all related satisfaction activities that could adversely impact the satisfaction level of members, practitioners/providers, consumers, regulators, accrediting organizations, and others, as well as a review and audit of VPHP processes, procedures, activities and programs.) This Committee also makes certain that collaboration and sharing of information occurs periodically to improve organization, membership and network-wide satisfaction. The organization annually makes information about its Quality Program available to member and practitioners.

The VPHP Quality Satisfaction Committee has been developed in response to growing VPHP, DMAS, and NCQA requirements/standards and the need for a more streamlined and collaborative process that encompasses organizational-wide satisfaction.

I. Web Site Committee:

The Application Systems Manager chairs the VPHP Web Site Committee. The Committee includes a representative from every operational department at VPHP, to include Quality. It ensures that the web site is accurate, current and valid, which ensures reliability and a high satisfaction level for members, practitioners, providers, consumers, regulators, accrediting organizations, and others who access the website for plan specific information. Website data and metrics are included in the Annual Quality Program Evaluation and discussed at the meetings during the year.

J. Quality Annual Evaluation:

The Chief Medical Officer and the Vice President of Quality and Credentialing, or designee presents the annual report for review and approval by the HQUM, CQIC and the Board of Directors. The report contains at a minimum: description of all measurement activity, findings from the analysis, and data in graphical display, recommendations to improve care, action plans and a summary of the progress made to improve care and services, and an evaluation of the Quality Program.

K. Quality Work Plan (See Attachment):

The Quality Program undertakes specialized quality initiatives in addition to those identified during the annual evaluation process. The areas of concentration for each year are defined in an annual Quality Work Plan, which tracks the data collection projects of the Quality Program for the year. Additional projects are developed in

response to member grievances and findings from performance measurement activities. In addition, the Quality Program will develop clinical practice guidelines in areas in which its evaluation reveals the greatest need for such guidelines. The guidelines will be in addition to the regular medical practices of the Plan.

IX. RECOMMENDATIONS FOR QUALITY PROGRAM FOR 2014

In 2014, VPHP will investigate the possible implementation of the following quality activities through effective and ongoing collaboration with other departments to problem solve and improve work processes across the organization. This is not to imply that these activities will be implemented by VPHP. The following are recommendations and/or topics for discussion to improve VPHP's quality activities:

- (1) Collaboratively support and work with the VCUHS to incorporate VPHP quality activities.
- (2) Identify and implement interventions that will lead to improved HEDIS® outcomes
Goal: 50th percentile or greater for all measures reported to DMAS and those measures used to calculate the Plan's annual HEDIS score
- (3) Continue as a member-centric organization by engaging members in plan processes; develop and implement new strategies that will gain greater and more diverse participation at the Member Advisory Committee meetings across all regions.
- (4) Proactively educate members, practitioners and providers on all patient safety materials that are available and ensure they obtain this information.
- (5) Develop and implement work plans, with defined interventions, for all HEDIS® measures < 50th percentile. The goal will be to sustain and or improve the following measures to the 50th percentile or greater. The measures include, but are not limited to:

Clinical

- Adolescent Well-Care Visits
- Well Child Care 3-6 years
- Well Child Care 15 months
- Childhood Immunizations
- Comprehensive Diabetic Eye Exams
- Breast Cancer Screenings
- Lead Screening in Children
- Cholesterol Management for Patients with Cardiovascular Conditions

Non Clinical

- Call Timeliness
- CAHPS

- Asthma-Appropriate Use of Medication (all age categories set forth by the HEDIS technical specifications)
 - Control of High Blood Pressure (140/90) among members diagnosed with hypertension
 - Antidepressant Medical Management
 - Follow Up After Hospitalization for Mental Illness – 7 and 30 Days
- (6) Collaborate with all organizational departments to incorporate quality initiatives into ongoing interactions with participating practitioners
 - (7) Continue VPHP Primary Care Physician Quality Incentive Program, which is a Pay-for- Performance program designed to create a collaborative, quality centered partnership with Physicians and Members to align incentives and reward quality of care improvements
 - (8) Continue to work with the Department of Medical Assistance Services Managed Care Collaborative Work Group to improve Follow Up After Admission for Mental Health Treatment (7 and 30 day follow up) and Adolescent Well Care Visits, or other activities as indicated based on compliance rates across the State of Virginia.
 - (9) Continue to identify strategies to ensure that participating primary care physicians open their panels, which will provide for increased availability and access to practitioners especially in the specialty hard to recruit areas such as orthopedics, pain management, behavioral health to name a few. The plan representatives will continue to retain and recruit quality practitioners.
 - (10) Continue to streamline processes that ensure quality outcomes for members through lean and cost-effective opportunities; identify opportunities for cost savings in disease management and quality programs.

X. RESOURCE ALLOCATION

In addition to the quality improvement support committees, the individuals below are directly allocated for quality improvement activities:

Chief Medical Officer (1)	(100%)
Medical Director (1)	(100%)
Associate Medical Director (1)	(100%)
Associate BH Medical Director (1)	(80%)
VP of Quality & Staff (12)	(100%)
(Includes Biostatistician)	
VP of Medical Management (1)	(80%)

Total Direct FTE Level: 20.0

The following Plan Personnel and/or designated departmental staff fully support and are fully engaged in quality improvement activities, as needed and in a timely manner:

- Chief Executive Officer
- Vice President, Network Operations/Development
- Vice President, Claims and Encounters
- Vice President, Information Technology
- Vice President, Human Resources and Organizational Development
- Vice President, Member Operations
- Vice President, Program Integrity
- Vice President, Finance
- Director of Pharmacy
- 2 Administrative Assistants

XI. FEEDBACK/COMMENTS:

Feedback related to VPHP's Quality Program, quality assurance and improvement activities, and clinical or service studies should be mailed to:

Medical Management Department - Quality
Attn: Vice President, Quality and Credentialing
600 E. Broad Street – Suite 400
P.O. Box 5307
Richmond, VA 23220-0307
Toll-Free #: (800) 819-5179
Fax #: (804) 819-5176

Comments and suggestions will be reviewed and assessed for quality improvement opportunities.



XII. 2013 Quality Program Description Signature Page

APPROVED BY:

VPHQ HQUM Committee Chair

Date

VPHQ Continuous Quality Improvement Committee

Date

VPHQ Board of Directors

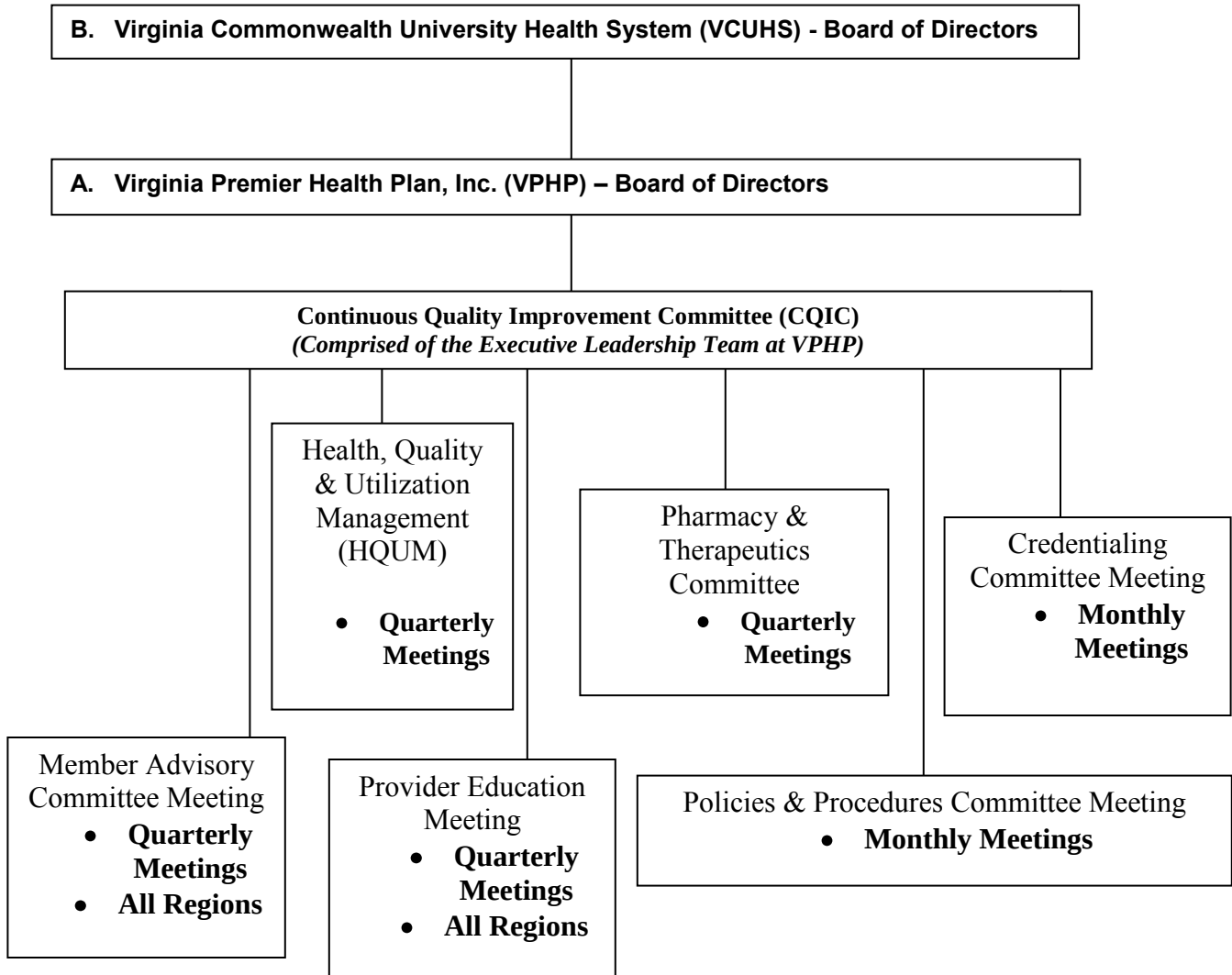
Date

Original Date: August 2000

Revised Date(s): 12/2001;
12/2002;
12/2003;
12/2004;
12/2005;
02/2007;
01/2008;
01/2009;
01/2010;
01/2011;
01/2012;
01/2013;

Effective Date: January 1, 2013

XIII. VPHP Organizational Chart



```

graph TD
    CEO[James Parrott  
CEO] --> CMO[Renee Miskimmin, MD  
Chief Medical Officer (CMO)]
    CEO --> VPQM[Jamie McPherson, MBA, MPA, BSN  
Vice President, Quality & Credentialing]
    CMO --> SMD[Melvin Pinn, MD  
Senior Medical Director]
    CMO --> AMD[William Butler, MD  
Associate Medical Director]
    CMO --> PharmDir[Javier Menendez, R.Ph  
Pharmacy Director]
    CMO --> PharmTech[Pharmacy Technicians (2)]
    CMO --> JLevenson[James Levenson, MD  
Psychiatry, Assistant Medical Director (contracted)]
    CMO --> BSood[Bella Sood, MD  
Psychiatry, Assistant Medical Director (contracted)]
    CMO --> MRizwan[M. Rizwan Ali, MD  
Psychiatry, Assistant Medical Director (contracted)]
    CMO --> VPMM[Linda Hines, RN, MS, MBA  
Vice President Medical Management (Dual Report)]
    VPQM --> BioStat[Bio-Statistician (1 part-time)]
    VPQM --> VACANT[VACANT Manager, HEDIS]
    VPQM --> HEDISA[HEDIS/Appeals Nurse (6)]
    VPQM --> CPO[Kimberly Paige  
Manager, Credentialing Operations]
    VPQM --> CS1[Credentialing Specialist I (3)]
    VPQM --> CS2[Credentialing Specialist II (1)]
    VPMM --> TWebb[Tamika Webb,  
Manager, Quality]
    VPMM --> QS[Quality Specialist (2)]
    VPMM --> JFeeney[John Feeney  
Quality Project Mgr]
    VPMM --> GAC[Grievance/Appeal Coordinator (2)]
    VPMM --> EWilson[Eric Wilson  
Director, Health Services]
    VPMM --> BBarfield[Brenda Barfield, RN  
Director, DM & Wellness]
    EWilson --> EDN[ED Review Nurse (3)]
    EWilson --> RCollier[Regina Collier  
Referral Assistant Manager]
    EWilson --> CC[Referral Coordinator (12)]
    EWilson --> CG[Celestine Green, RN, MBA  
Sr. Clinical IS Manager]
    EWilson --> CAS[Clinical Application Support Specialist (1)]
    EWilson --> MMA[Medical Management Analyst (1)]
    BBarfield --> TMA[Tidewater Medical Management Assistant (1)]
    BBarfield --> KM[Kate Maas, Maternal Clinical Health Program]
    BBarfield --> CM[Carol Morgan, RN  
DM Supervisor]
    BBarfield --> DM[Disease Mgmt (4)]
    BBarfield --> SOB[Sheila Barnes  
Outreach Assistant Manager]
    SOB --> MO[Medical Outreach (6)]
    SOB --> MOM[Martha Meadows  
Outreach Assistant Manager]
    MOM --> MO2[Medical Outreach (10)]
    MOM --> HE[Health Educator (3)]
    D[Deanna Talley  
Director, UR/CM] --> MCallahan[Margaret Callahan, RN  
Sr. Manager, Roanoke Medical Management]
    D --> DH[Dorinda Hunter, RN  
Sr. Manager, Richmond/Harrisonburg Medical Management]
    MCallahan --> KFF[Kathy Folks, RN  
Roanoke Medical Mgmt Supervisor]
    MCallahan --> UR1[UR / CM]
    MCallahan --> RMA[Roanoke Medical Management Assistant (1)]
    MCallahan --> FSCM[Far Southwest Case Manager (1)]
    DH --> NST[Nicole Stukes-Stith, RN  
Richmond Medical Mgmt Supervisor]
    DH --> UR2[UR / CM]
    DH --> EW[Elizabeth Welch, RN  
Harrisonburg Medical Mgmt Supervisor]
    DH --> UR3[UR / CM / PCC]
    DH --> PS[Patricia Swetham, RN  
CM & UM Supervisor]
    PS --> UMRN[UM Review Nurse (4)]
    UMRN --> PCC2[PCC]
  
```

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @Jan 2013 Mtg
		2/21	2/20	4/18	5/22	7/18	8/21	10/17	11/20	
Annual Reports: Medical Management and Quality Improvement										
2012 Medical Management Annual Evaluation		X	X							
2012 Quality Improvement Annual Evaluation		X	X							
2013 Disease & Case Management Program Descriptions		X	X							
2013 UM Program Description - POST TO THE WEBSITE		X	X							
2013 Quality Improvement Program Description - POST TO THE WEBSITE		X	X							
2013 Credentialing Program Description - POST TO THE WEBSITE		X	X							
Medical Management: UM/Case Management, Disease Management		Linda Hines								
Disease Management										
DM Satisfaction Survey	QI 8 J			X (Update)	X (Update)			X (Outcome)	X (Outcome)	
Top DM Conditions	QI 8 A, C			X	X					
Referral Sources Analysis	QI 8 C			X	X					
Member Participation Rate in DM	QI 8 G			X	X					
Effectiveness of 2 Chronic Disease Programs		QI 8 K								
• Chronic Disease # 1: Asthma				X	X					
• Chronic Disease # 2: Diabetes				X	X					
Case Management										
Effectiveness of CM and Outcomes		QI 7 H, I								
■ Opportunity #1				X	X					
■ Opportunity #2				X	X					
■ Opportunity #3				X	X					
Case Management Outcomes	QI 7							X (Outcome)	X (Outcome)	
Population Assessment	QI 7A			X	X					
Referral Sources Analysis	QI 7 B			X	X					
CM Satisfaction Survey	QI 7 G			X (Update)	X (Update)			X (Outcome)	X (Outcome)	
Chronic Care Survey: Perception of Mental & Physical Health Status				X (Update)	X (Update)			X (Outcome)	X (Outcome)	

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @Jan 2013 Mtg	
		2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20		
Continuity & Coordination of Care											Jamie McPherson
Opportunities for Improvement: Continuity & Collaboration of Medical Care											QI 10 A
☐ ■ Opportunity # 1				X (Update)	X (Update)			X (Outcom e)	X (Outcom e)		
■ Opportunity # 1				X (Update)	X (Update)			X (Outcom e)	X (Outcom e)		
Medical & BH Healthcare											
☐ ■ Opportunities for Collaboration	QI 11 A			X (Update)	X (Update)			X (Outcom e)	X (Outcom e)		
■ Collaborative Actitives Between Medical & BH Healthcare	QI 11 B			X (Update)	X (Update)			X (Outcom e)	X (Outcom e)		
Quality Improvement, Accreditation, & Credentialing											Jamie McPherson
Accreditation											
NCQA: Accreditation Metrics of Department and or File Outcomes (i.e., Audit Calendar for 2013)				X	X			X (Outcom e)	X (Outcom e)		
Credentialing											
Credentialing Process											
• Avg Days from App Received to Completed										X	
• Avg Days from Attest Date to Credentialed										X	
•Number of Providers Credentialed										X	
Oversight of Delegated Entities											
•Total Delegates										X	
• # of NCQA Accredited Delegates										X	
• # of Non-NCQA Accredited Delegates Requiring an Audit										X	
• # of Audits Completed										X	
• Required Audit Conducted										X	
• Required Audit Conducted or Scheduled										X	
• Onsite Audits with a Passing Score										X	

Activities		NCQA Std	HQU M	CQIC	HQU M	CQIC	HQU M	CQIC	HQU M	CQIC	CY 2012 Rpt @Jan 2013 Mtg
			2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	
Quality Improvement											
► Grievance & Appeals		QI 6 B									
• Grievances per Month											X
• Grievance Categories											X
• Avg Days to Grievance Resolution											X
• Appeals per Month											X
• Approved Appeals by Category											X
• Percent of Appeals Approved											X
• Avg Days to Resolve: Grievances & Appeals											X
Cultural, Ethnic, Racial, & Linguistic Needs											
Cultural Competency CME/CEU Completion							X	X			
	Develop objectives & plan for serving culturally & linguistic diverse membership	QI 1 A 11 RR 3 A 5					X	X			
	Assess Cultural, Ethnic, Racial, & Linguistic Needs of Members						X	X			X
Practitioner Golden Globe Award		QI 1-3					X	X			
Medical Record Review - CPG & Annual Review		QI 12 B					X	X			
Sentinel Events		QI 1-3					X				X
Bereavement Program		QI 1-3					X				X
► DMAS QIP											
• EQRO Report							X	X			
• PIP: Increasing Well Child Visits - First 15 months							X	X			
• PIP: Childhood Immunizations							X	X			
QI Resource Allocations Report		QI 1 A 10					X	X			
Practitioners & Members Informed of QI Program and Quality Data (New) •Member Newsletter •Provider Newsletter •Website			X	X							
Clinical Practice Guidelines - POST TO THE WEBSITE											
• Adoption, Approval, Updating, & Distribution of Guidelines		QI 9 A					X	X			
• Performance Measurement Against 4 Clinical Practice Guidelines		QI 9 C					X	X			
HEDIS Data Analysis Reports		QI 1 B									
2011 Annual MCO Comparison Report		Jamie McPherson									

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @Jan 2013 Mtg
		2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	
Quarterly HEDIS Rates										
For Nov 2013										
• Member Compliance (per Administrative Database)									X	
• HEDIS Performance Improvement Opportunity Identification, Intervention, & Analysis									X	
HEDIS Clinical Measures Reports										
Prevention Related to HEDIS® Measures										
•Childhood Immunizations Status: Combo 2 & 3								X	X	
•Lead Screening in Children								X	X	
•Breast Cancer Screenings								X	X	
•Cervical Cancer Screenings								X	X	
•Chlamydia Screens in Women								X	X	
Well Care Related to HEDIS® Measures										
•Well Care Visits (1st 15 months)								X	X	
•Well Care Visits (3-6 years of life)								X	X	
•Adolescent Well Care Visits								X	X	
Weight, Nutrition & Exercise Related to HEDIS® Measures										
•BMI										
• Child BMI: 3 - 11 Years								X	X	
•Child BMI: 12 - 17 Years								X	X	
•Adult BMI: 18 - 74 Years								X	X	
•Nutrition								X	X	
•Physical Activity								X	X	
Chronic Disease Related to HEDIS® Measures Reports										
Asthma: Use of Appropriate Meds: 5 - 56 Years								X	X	

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @ Jan 2013 Mtg
		2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	
Diabetes										
•HgA1c Testing								X	X	
•HgA1c < 7.0%								X	X	
•HgA1c < 8.0%								X	X	
•HgA1c > 9.0% (poor control								X	X	
•Retinal Eye Exam								X	X	
•LDL- C Screening								X	X	
•LDL-C < 100								X	X	
•Blood Pressure Control (<140/90)								X	X	
•Blood Pressure Control (<130/80)								X	X	
•Nephropathy Screening								X	X	
Heart Disease										
•Controlling High Blood Pressure								X	X	
•LDL -C Screening								X	X	
•LDL-C <100								X	X	
•Persistence to Beta Blocker Treatment after a Heart Attack								X	X	
Behavioral Health										
•Follow-Up Care Within 7 Days After Hosp for Mental Illness								X	X	
•Follow-Up Care Within 30 Days After Hosp for Mental Illness								X	X	
•Follow-Up Care: ADHD								X	X	
•Antidepressant Med Management:										
■Continuation Phase								X	X	
■Initiation Phase								X	X	
■Continuation & Maintenance Phase								X	X	
Maternity Related to HEDIS® Measures										
•Prenatal - Timeliness of Prenatal Care								X	X	
•Prenatal - Fequency of Prenatal Care								X	X	
•Post Partum Care								X	X	

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @Jan 2013 Mtg
		2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	
HEDIS Non-Clinical Measures Reports										
Active Board Certifications for the Following:										
•Family Medicine Practitioners								X	X	
•Pediatricians								X	X	
•Geriatricians								X	X	
•Internal Medicine Physicians								X	X	
•OB/GYN Physicians								X	X	
•Other Physicians Specialties								X	X	
Telephone Communication With Plan Members										
•Call Answer Timeliness					X	X	X	X	X	
•Abandonment Rate					X	X	X	X	X	
Network Development: Contracting & Provider Services	Patrick McMahon									
Practitioner Satisfaction Survey				X (Updat e)	X (Updat e)			X (Outco me)	X (Outcome)	
BH Practitioner Telephone Access Standards Survey	QI 5 C			X (Updat e)	X (Updat e)			X (Outco me)	X (Outcome)	
PCP & BH Practitioner Appointment Access & Availability Survey	QI 5 A, B			X (Updat e)	X (Updat e)			X (Outco me)	X (Outcome)	
Pay for Performance				X	X			X	X	
Provider Network Assessment QI 4										
• Regional Performance						X	X			
• Ensuring Primary Care Practitioner Availability to include ethnicity and race						X	X			
• Total Number Of PCPs/1000 Members						X	X			
• Total Number Of PCPs With Open Panels As A Percentage Of Total Number Of PCPs						X	X			
• Total Number Of PCPs With Open Panels/1000 Members In Each Region						X	X			
• Geo Access Maps (New)						X	X			
• Provider Education (PEM) Meeting Attendance						X	X			
Practitioner Grievances						X	X			

Activities		NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012 Rpt @Jan 2013 Mtg
			2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	
Member Operations		Harold Brooks									
Telephone Communications with Plan Members											
IVR System: Impact to Member Ops HEDIS Measures											
Pivotal System: Impact to Member Ops HEDIS Measures					X						
• Total Calls Offered/Answered - English											X
• Total Calls Offered/Answered - Spanish											X
• Call Hold Time											X
• Talk Time											X
• Quality Call Monitoring											X
CAHPS Survey											
• Response Rate					X (Update)	X (Update)	X (Outcome)	X (Outcome)			
• CAHPS Adult Survey							X (Outcome)	X (Outcome)			
• Child Survey							X (Outcome)	X (Outcome)			
• CCC Survey							X (Outcome)	X (Outcome)			
Identification of Opportunity for Improvement, Intervention & Analysis based on CAHPS or Complaints Analysis (New)		QI 6 B					X	X			
Member Advisory Committee (MAC) Meetings Attendance							X	X			
Information Systems											
HEDIS® Systems Management							X	X			
UM/Case Management Systems Management							X	X			
Virginia Premier Website											
• Usability Testing Results		QI 5 I			X	X			X	X	
• Visitor Overview					X	X			X	X	
• All Traffic Sources					X	X			X	X	
• Traffic Sources Overview					X	X			X	X	
• Top Content by Title					X	X			X	X	
• Visits from Virginia Cities					X	X			X	X	

Activities	NCQA Std	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	HQUM	CQIC	CY 2012
		2/16	2/21	4/19	5/15	7/19	8/21	10/18	11/20	Rpt @Jan 2013 Mtg
Compliance										
Gloria Reynolds										
CMS Integrity Audit						X	X			
Policy Review Compliance (inclusive of annual P&P calendar)						X	X			
Mandatory Employee Education										
• HIPAA Training						X	X			
• Conflict of Interest						X	X			
Auditing & Monitoring						X	X			
Compliance: Regulatory & Privacy Practice						X	X			
Confidentiality Form (Committee Doctors)						X	X			
Human Resources										
Crisis Intervention Course Attendance				X	X			X	X	



**2014 Commonwealth Coordinated Care by VA Premier
Credentialing Program Description
Effective: January 1, 2014**

Annually, the following oversight committees shall approve this document:

- **The Commonwealth Coordinated Care by VA Premier Credentialing Committee**
- **The Continuous Quality Improvement Committee (CQIC)**



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I. DEFINITIONS:

The acronyms, phrases, words and terms used in this document shall have the following meanings unless the context specifically states otherwise:

1. **Ambulatory Surgical Center (ASC):** Medicare defines ASCs as a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. ASCs must be certified as meeting the requirements for an ASC and must enter into a participating provider agreement with the Centers for Medicare & Medicaid Services (CMS). An ASC can either be:
 - ❑ Independent (not part of a provider of services or any other facility)
 - ❑ Operated by a hospital (under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, the facility:
 - Elects the coverage and is covered as such unless CMS determines that there is good cause to do otherwise
 - Is a separately identifiable entity that is physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a nonreimbursable cost center on the hospital's cost report
 - Meets all requirements regarding health and safety and agrees to the assignment, coverage, and payment rules applied to independent ASCs
 - Is surveyed and approved as complying with the conditions for coverage for ASCs
2. **Atypical Providers:** Atypical providers are those providers that are not typically credentialed under NCQA, however do provide services to Medicaid beneficiaries. Requirements for atypical providers have been established by the Virginia Administrative Code (VAC) under sections 12 VAC 30-120-940, -950, -960, -970, -980; 12 VAC 40-60-10; and 12 VAC 30-60-300.
3. **Board:** The Board of Directors of Virginia Commonwealth University Health Systems (VCUHS). The Board of Directors (the "Board") has ultimate authority, accountability and responsibility for the Credentialing evaluation process (the "Credentialing Program") and has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Board is comprised of top executives, including legal counsel, employed by the Virginia Commonwealth University Health System, which owns CCCVP. Community practitioner(s), the CEO of CCCVP, CMO, Vice President of Medical Management, Vice President of Quality and Credentialing and other VCUHS executives attend the Board meetings, as required.
4. **CAQH:** Council for Affordable Quality Healthcare; Manages the Universal Credentialing Initiative by which a practitioner can submit a single application to one central database to meet the needs of all of the health plans and Networks participating in the CAQH effort. Practitioners may easily update their information online or via fax anytime, and will confirm once each quarter that the data on file is complete and accurate. CAQH is a coalition of more than 20 of America's

largest health plans and Networks and three principal health plan associations working together to help improve the healthcare experience for consumers and physicians. There is no cost for CAQH participation for the practitioners. The health plans pay a cost to access the information.

5. **Clean Practitioner or Provider:** A practitioner or provider who fully meets the standards, guidelines, and/or criteria for network participation
6. **CMS:** Centers for Medicare and Medicaid Services headquartered in Baltimore, MD; Under the direction and oversight of the U.S. Department of Health and Human Services; Social Security Act, Titles 18, 19 and 21.
7. **CQIC:** Continuous Quality Improvement Committee; Committee of CCCVP that is comprised of the executive leadership team. Although credentialing decisions are not made to this committee, decisions may be reported.
8. **Credentialing Process:** Includes both the credentialing and recredentialing of independently licensed practitioners and/or organizational providers; initial credentialing is conducted prior to a practitioner or provider being presented to the Credentialing Committee for approval; recredentialing is conducted within three (3) years of the initial credentialing process.
9. **Delegated Credentialing:** Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.
10. **DMAS:** The Department of Medical Assistance Services, in the Commonwealth of Virginia; an agency of the Commonwealth of Virginia regulated pursuant to the Social Security Act 19.
11. **Dual Credentialing:** A practitioner (typically an internal medicine practitioner) or provider who is educated and medically trained to provide medical care in two specialties (i.e., internal medicine and gastroenterology, etc.)
12. **Dual Contracting:** A practitioner that is contracted directly with CCCVP and also with a contracted delegated entity.
13. **High-Volume:** Fifty (50) or more members on a participating practitioner's or provider's panel.
14. **Independent relationship:** Exists when the organization selects and directs its members to see a specific practitioner, provider or group of practitioners or providers, including all practitioners or providers whom members can select as primary care practitioners (PCP).
15. **Licensed independent practitioner or provider (LIP):** A practitioner or provider who does not work under the auspices or authority of another practitioner or provider.
16. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for," In layman's terms, it means a temporary and/or covering practitioner.
17. **MMP Plan:**
18. **Medical Directors:** CCCVP's staff of Medical Director(s); employed Medical Directors include:
 - Chief Medical Officer (CMO): The CMO is responsible for providing direction for the development and implementation of the Credentialing, Quality Improvement, Utilization Management and New Technology, and other Medical Management programs.
 - Senior Medical Director: The Senior Medical Director is responsible for peer review activities and the collaboration with Practitioners on the development

- and implementation of the Credentialing Program and is Chairman of the Credentialing Committee; classified as an administrative medical director.
- Associate Medical Director: The Associate Medical Director assists the Senior Medical Director in carrying out all responsibilities, as required.
 - Administrative Medical Director– CCCVP’s Staff Medical Director who is not required to be credentialed because s/he does not provide direct office based, and/or hospital care to CCCVP members. The Medical Director’s license and malpractice shall be verified to ensure they are unrestricted, current and/or valid, and shall be included in the Human Resources File. Board Certification is not required, although preferred. In the event the Medical Director participates in a University or other teaching program advising others, the unique teaching program will assume any further credentialing request.
 - Non-Administrative Medical Director – CCCVP’s Staff Medical Director who is required to be credentialed by CCCVP because s/he performs patient care duties and/or provides office/hospital care to the members of the Plan. The practitioner also has hospital privileges.
19. **Member:** An individual residing in the Commonwealth of Virginia and eligible for CCCVP services.
20. **Nationally Recognized Accrediting Entity/Body:** An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to managed care health insurance plans pursuant to national standards. The following entities are examples of nationally recognized accrediting entities/bodies:
- **JCAHO:** Joint Commission on Accreditation of Healthcare Organizations
 - **NCQA:** National Committee for Quality Assurance; an accrediting body overseeing a variety of health plan functions and ensures quality.
21. **Network Practitioner:** Accredited and/or verified person who has entered into a contractual agreement with CCCVP to provide healthcare services to its members and follow all established plan policies and procedures.
22. **Organizational Providers:** Medical Organizational providers include: hospitals home health agencies including infusion services providers, durable medical equipment companies, skilled nursing facilities, free standing surgical centers (of any type – gynecology and/or obstetrics - birthing centers, ophthalmology – laser surgery centers, urological surgery centers, dental surgery centers, cardiac surgery centers, orthopedic surgery centers, free standing hospice centers and rehabilitation facilities. Behavioral health organizational providers include: inpatient, residential, and ambulatory. Please note: By listing all types of organizational providers in no way imply that all said providers referenced are covered under CCCVP benefit structure.
23. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG’s List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164

By E-Mail: HHSTips@oig.hhs.gov

By TTY: 1-800-377-4950

By Mail:

Office of Inspector General

Department of Health and Human Services

Attn: HOTLINE

330 Independence Ave., SW

Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare's Customer Service Center at **1-800-MEDICARE (1-800-633-4227)**.

24. **Primary Source Verification:** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner/provider. Examples include medical school, graduate medical education program, and state medical board.
25. **CCCVP:** Commonwealth Coordinated Care by Virginia Premier; a wholly owned, Virginia nonprofit corporation that is a subsidiary of Virginia Commonwealth University Health Systems; Medicare product line of business.

II. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

Virginia Commonwealth University Health Systems Board of Directors (“Board”) has ultimate authority, accountability and responsibility for the Credentialing evaluation process (“Credentialing Program”) and has delegated full oversight of the Credentialing Program to the Credentialing Committee (“Committee”). The Credentialing Committee accepts the responsibility of administering the Credentialing Program and having oversight of operational activities, which include making the final decision, (i.e., approve, table, or deny) for all practitioners and providers regarding network participation. At least annually, the Credentialing Program Description or other comparable report will be presented to the Credentialing Committee, Continuous Quality Improvement Committee (CQIC), and/or the Board.

(See Credentialing Structure and Governance Organizational Chart - Attachment 1).

III. PURPOSE

CCCVP currently has policies and procedures in place for credentialing and recredentialing based on the NCQA and DMAS requirements. CCCVP fully understands that it will be responsible for developing and implementing additional policies and procedures according to the requirements in the three-way contract between VGP, DMAS and CMS. All Policies and Procedures are updated yearly at a minimum to ensure ongoing compliance, however policies can be reviewed and updated sooner if a change in requirements needs to be reflected in established or new policies.

Currently, the Credentialing Program ("Program") of Commonwealth Coordinated Care by Virginia Premier(CCCVP) is comprehensive and on-going to ensure that its practitioners and providers meet the standards of professional licensure and certification; thereby assuring the competency of practitioners and providers/entities delivering care within the CCCVP Network. The process enables CCCVP 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 at initial credentialing, re-credentialing and between credentialing and re-credentialing cycles. Additionally, the Program emphasizes and supports a practitioner's and provider's ability to successfully manage the health care of network members.

The Credentialing Program of Commonwealth Coordinated Care by Virginia Premier(CCCVP) shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables CCCVP 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 recredentialing 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.

The Credentialing Program enables CCCVP to ensure that all practitioners and providers are continuously in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, the Department of Medical Assistance Services (DMAS) or designee requirements, the National Committee for Quality Assurance (NCQA) standards, Commonwealth Coordinated Care by Virginia Premier policies and procedures, and any other applicable regulatory or accreditation entity's requirements and/or standards.

The CCCVP Credentialing and Recredentialing standards shall be reviewed by clinical peers that are members of the CCCVP Credentialing Committee. All employed and contracted practitioners/providers are subject to peer review.

IV. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Composition:

The Chief Medical Officer is responsible for the oversight and operation of the Credentialing Program and serves as Chairperson, or may appoint a Chairperson, with equal qualifications. The Chief Medical Officer, CEO of CCCVP, and the Virginia Commonwealth University Health Systems Board Chairman must review, approve, sign and date the Annual Credentialing Program each year.

The Committee is a peer-review body that includes participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, obstetrics/gynecology, geriatrics, etc.) and specialty care to include, but not limited to, behavioral health. Allied health representatives specializing in rehabilitation therapy (physical, occupational, speech, language), audiology, orthotics, prosthetics, social work, non-physician mental health (psychologist) therapy etc. may be appointed to serve as non-voting members, on an ad-hoc basis. Members may be appointed as members, rotated or removed from the Committee at the sole discretion of the Committee Chairperson.

B. Responsibilities/Duties:

The Committee shall be responsible for the credentialing process of all independently licensed practitioners. Its purpose is to monitor all credentialing activities and delegated credentialing arrangements, to include, but not be limited to:

- ❑ Receive and review the credentials of all practitioners being credentialed or recredentialed who do not meet the organization's established criteria. 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 give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care.
- ❑ Establish, implement, monitor, and revise policies and procedures for CCCVP credentialing and recredentialing
- ❑ Report to the CQIC, Board and other appropriate authorities, as required
- ❑ Annual Review of the Credentialing Program Description
- ❑ Other related responsibilities

The Committee Chairperson or his/her designee may review and sign off on a list of the names of clean practitioners and providers who fully meet the established criteria before, between, and after each Committee meeting. At the next scheduled Committee Meeting, these approved practitioners will be presented to ensure network participation decisions are recorded in the meeting minutes.

C. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee, which meets at least monthly and/or as deemed necessary by the Chairperson. The Committee action may be implemented in the absence of a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained. Voting members include only the Committee Physicians and the Vice President of Network Development or his/her designee. Non-voting members include the Credentialing Manager, the Vice President of Quality, Accreditation and Credentialing, the Vice President of Medical Management and/or other Plan representatives.

D. Minutes and Reports:

Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The Committee will be responsible for reviewing minutes for accuracy. Minutes shall be securely retained electronically and manually.

E. Confidentiality Policy:

It is the policy and procedure of CCCVP to consider all credentialing documents received from the practitioner, verification sources for the purposes of credentialing and subsequently retained as a result of the credentialing process as confidential. The mechanisms, in effect, to ensure the confidentiality of information collected in this process are as follows:

- ❑ Access to such documents will be restricted to: (1) The practitioner or provider being credentialed, pursuant to the requirements outlined in this document below titled "Erroneous, Incomplete or Illegible Information," (2) Committee Members, (3) Board Members, (4) CCCVP Credentialing Staff, and (5) Other specific individuals as designated by the Board and/or CCCVP's CQIC.
- ❑ The limited number of staff with access to the credentialing database is required to have individual user names and passcodes to access credentialing related information.
- ❑ Credentialing materials, all of which are contained within the Medical Management Department, are secured via a passcode protected door in which entry must be gained.

F. Conflict of Interest:

No person may participate in the review and evaluation of any professional practitioner or provider with whom s/he has been in a group practice,

professional corporation, partnership, corporation, limited liability company or similar entity whose primary activity is the practice of medicine or where judgment may be compromised. The Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the Credentialing Committee in the presence of a conflict of interest.

V. THE CREDENTIALING PROGRAM: PRACTITIONERS

Scope of Credentialing:

The scope of the Credentialing Program is comprehensive and includes all practitioners that have an unrestricted, current and valid license and a National Provider Identification (NPI) number. All licensed practitioners and groups of practitioners who provide care to CCCVP members are credentialed. Practitioners who are certified or registered by the state to practice independently and provide care to CCCVP members are also credentialed.

Nurse practitioners and physician assistants may participate in the network under the credentials of a supervising, participating physician if s/he has a National Provider Identification (NPI) Number.

A. Practitioners who will be credentialed and reviewed on an ongoing monitoring basis include:

- ❑ Practitioners who have an independent relationship with CCCVP at an outpatient setting. An independent relationship exists when CCCVP selects and directs its members to see a specific practitioner or group of practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential some practitioners with whom it holds independent contracts.
- ❑ Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
- ❑ Dentists who provide care under CCCVP's medical benefits.
- ❑ Nonphysician practitioners who have an independent relationship with CCCVP, as defined above, and who provide care under the organization's medical benefits.
- ❑ Hospital based practitioners who have an independent relationship with CCCVP and an outpatient setting:
 - Anesthesiologists with pain-management practices
 - Cardiologists
 - University faculty who are hospital based and who also have private practices
- ❑ Dentists providing care under medical benefits:
 - Endodontists
 - Oral surgeons
 - Periodontists
- ❑ Nonphysician practitioners who may have an independent relationship with CCCVP and provide care under CCCVP's medical benefits:
 - Behavioral health practitioners
 - Nurse practitioners
 - Nurse midwives

- Optometrists
- Physical therapists
- Occupational therapists
- Vision Services providers providing care under medical benefits
- Speech and language therapists

B. Types of practitioner files audited (internally) during the year to ensure ongoing compliance:

- Medical practitioners:
 - Medical doctors (MD)
 - Dentists (DDS/DMD)
 - Chiropractors (DC)-only applicable to FAMIS Members under the Medicaid line of business
 - Osteopaths (DO)
 - Podiatrists (DPM)
 - Nurse Practitioners (NP, PNP, ANP)
- Behavioral health practitioners:
 - Psychiatrists and other physicians
 - Addiction medicine specialists
 - Doctoral or master's-level psychologists who are state certified or licensed
 - Master's-level clinical social workers who are state certified or licensed
 - Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
 - Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently

Additional types of practitioners, not listed above, may also be credentialed and subject to the same policies and procedures, as those listed in this document, to ensure ongoing quality for the CCCVP members. However, internal files reviews may be restricted to the practitioners listed above.

C. Practitioners who do not need to be credentialed:

- Practitioners who practice exclusively within free-standing facilities and who provide care for CCCVP members only as a result of members being directed to the facility
- Dentists who provide primary dental care only under a dental plan or rider
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which CCCVP delegates utilization management (UM) functions
- Covering practitioners (e.g., locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)

- ❑ Practitioners who practice exclusively within Community Service Boards (CSBs), Health Departments (HD), Federally Qualified Health Centers (FQHCs), or Rural Health Centers (RHCs)
- ❑ Practitioners who practice exclusively within the inpatient setting and provide care for CCCVP members only as a result of members being directed to the hospital or another inpatient setting:
 - Pathologists
 - Radiologists
 - Anesthesiologists
 - Neonatologists
 - Perinatologists
 - Emergency room physicians
 - Hospitalists
 - Telemedicine consultants
- ❑ Practitioners who practice exclusively within free-standing facilities in which practitioners may practice exclusively and provide care for Commonwealth Coordinated Care by Virginia Premier members only as a result of members being directed to the facility:
 - Mammography centers
 - Urgent-care centers
 - Surgicenters
 - Ambulatory behavioral healthcare facilities
 - Radiology centers
- ❑ Practitioners who practice exclusively within Ambulatory behavioral health care facilities:
 - Psychiatric and addiction disorder clinics

VI. STANDARDS OF PARTICIPATION: PRACTITIONERS

- Professional Criteria:

CCCVP accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each professional practitioner must meet minimum standards for participation in CCCVP's Network. These guidelines are intended to comply with CCCVP, DMAS, or its designee, NCQA, or any other applicable regulatory and/or accreditation entities where applicable.

- Minimum Standards for Participation include:

- ❑ Unrestricted (no limitations), current and valid professional licensure to practice in Virginia, or other state where CCCVP membership may receive care, especially in bordering states (TN, WV, NC and DC).
- ❑ Current and valid Federal DEA Certificate for practitioners with the

authority to write prescriptions, as applicable, for practice. When a practitioner waives his/her prescriptive authority, or has restricted prescriptive authority, the DEA Form must be completed. **(See ATTACHMENT 2: DEA FORM)**

- ❑ Preferred Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have relevant education (Residency) in his/her practicing specialty. New graduates must become board-certified within five (5) years of completing an approved residency or fellowship-training program in their practice area. Board certification requirements may be waived upon review of the Credentialing Committee if the practitioner has five (5) years of verified relevant work history and/or has unrestricted, current active privileges in the specialty area at a participating hospital in their respective service area.
- ❑ Current, unrestricted clinical privileges at a participating hospital, if applicable, or evidence of coverage/transfer arrangement with a privileged participating practitioner. Admission arrangements with a hospitalist group within a JCAHO accredited or Critical Access hospital is acceptable.
- ❑ Acceptable twenty-four (24) hour coverage system. Coverage system should include twenty-four (24) hour telephone coverage and arrangements for alternate care of patients in case of absence, through another professional practitioner that is consistent with CCCVP and/or payor's policies, procedures, standards and/or criteria.
- ❑ Acceptable, current and valid malpractice insurance in the amount \$1 Million per incident and \$3 Million per aggregate per year or as determined satisfactory by the Credentialing Committee. Current professional liability insurance coverage in a minimum amount equal to the amounts as in effect under § 8.01-581.15 - Limitation on recovery in certain medical malpractice actions is preferred.
- ❑ Absence of a history of denial or cancellation of professional liability insurance, involvement in malpractice suits, arbitration or settlement or evidence that the history does not suggest an ongoing substandard professional competence or conduct.
- ❑ Absence of health problems including drug or alcohol abuse, which might adversely affect judgment or competence, so as to substantially impede the professional practitioner's ability to perform the essential functions of his/her practice/profession.
- ❑ Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, health care organization, managed care organization, governmental health care program; or evidence that this history does not suggest an on-going substandard professional competence or conduct.
- ❑ Absence of a history of criminal/felony convictions or indictments or evidence that this history does not suggest an effect on current professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.

- Exclusion Criteria:
 - CCCVP shall, upon obtaining information or receiving information from a verifiable and reliable source, exclude from participation all practitioners that may fall in any of the following categories (references to the Act in this Section refer to the Social Security Act):
 - Entities, which could be excluded under § 1128(b)(8), as amended of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of any of the following crimes:
 1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
 2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended)
 3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary
 - Practitioners who appear on the Office of Inspector General exclusions report.
 - Practitioners who have a suspended or terminated license to practice.

D. Quality of Practice Criteria:

- Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices which meet DMAS or its designee, NCQA, CCCVP, or any other standards adopted by CCCVP.
- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by CCCVP.
- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by CCCVP.
- CCCVP retains the right to approve/deny new practitioners/providers based on quality issues, and to terminate individual practitioners/providers for same. Termination of individual practitioners/providers for quality of care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners/providers. CCCVP has a prescribed system of appeals available, which must be followed.

E. Business Administrative Criteria:

- ❑ Professional practitioner(s) must maintain CCCVP access standard requirements at the majority of the ambulatory service sites where a member may be seen.
- ❑ Professional practitioner(s) area of specialty must fill a network need as determined by CCCVP. CCCVP reserves the right to deny participation, on a case-by-case basis if need does not exist for a particular specialty and if such action is deemed in the best interest of the network.

VII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

CCCVP credentials all practitioners prior to being admitted into the CCCVP network. The intent of the process is to validate and/or confirm credentials related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Committee Meeting and/or Committee Decision.

Each practitioner must submit a legible and completed application, signed and dated consent form, signed and dated confidentiality form, signed and dated Master Agreement, and all other required documentation. The following information is obtained and verified according to the standards and utilizes sources listed under Initial Credentialing:

- ❑ Completed CCCVP or CAQH application, which includes a current and signed attestation and addresses. Application includes the following information:
 1. Reasons for inability to perform the essential functions of the position, with or without accommodation
 2. Lack of present illegal drug use
 3. History of loss of license and/or felony conviction
 4. History of loss or limitation of privileges or disciplinary actions
 5. Current malpractice insurance coverage
 6. Attestation as to the correctness and completeness of the application
- ❑ Copy of the unrestricted (no limitations), current and valid license or license number for the participating practitioner
- ❑ Copy of the current and valid DEA/CDS Certificate, if applicable
- ❑ Copy of the medical malpractice policy face sheet, or completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts.
- ❑ Copy of the board certificate or highest level of education; proof of education, training and competency in specialty for which practitioner is seeking participation status in the CCCVP network.
- ❑ Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year (Gaps or interruptions in work history)

- 6 months or greater must be explained). CV or work history must cover the previous five years.
- ❑ Quality measures (may include initial credentialing site visit)
 - ❑ Primary Source Verification of associated credentialing documentation
 - ❑ Practitioner explanation of any adverse actions including 1) Any limitation in ability to perform the functions of the position, with or without accommodation; 2) History of loss of license and/or felony convictions; 3) History of loss or limitation of privileges or disciplinary activity; 4) Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.
 - ❑ Cultural Competency Quiz/Course (may be waived at Plan's discretion)
 - ❑ The Credentialing Committee's final decision (the practitioner shall be notified in writing within 60 calendar days of the Committee's decision)

Practitioners may submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). All applications are stored electronically under each practitioner's individual record in the credentialing database.

B. Primary Source Verification:

The CCCVP credentialing staff will conduct primary source verification as required by the most current and applicable CMS, DMAS or its designee, NCQA, and other CCCVP adopted guidelines. CCCVP accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification with appropriate reference documentation (i.e., the name of the person who provided verification, the date of the call, and the verifier's name). The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff member who receives the information-noting source and date. Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DMAS or its designee, NCQA, and/or CCCVP-approved web-site source.

To meet verification standards, all credentials must be valid at the time of the Credentialing Committee's decision per Table VII-7(b) below and the specific time limits as set forth by CMS, DMAS or its designee, NCQA, CCCVP and any other applicable regulatory and/or accreditation entities:

Table VII-A:

Primary Source Information:	Acceptable Sources:
❑ Credential: License ❑ Verification Time Limit: 180 calendar days*	❑ State Agency

Primary Source Information:	Acceptable Sources:
Must confirm that practitioners hold a valid, current state license or certification, which must be in effect at the time of the Committee's decision; must verify licenses or certification as applicable in each state where practitioners provide care for plan members; <u>verification must come directly from the state licensing or certification agency</u>; if the plan uses the Internet to verify state licensure or certification, the Web site must be from the appropriate state licensing agency. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	
☐ Credential: DEA or CDS Certificate ☐ Verification Time Limit: 180 calendar days * Must be effective at the time of the credentialing decision; must be verified in each state in which the practitioner cares for plan members. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	☐ A copy of the DEA or CDS certificate ☐ Documented visual inspection of the original certificate ☐ Confirmation with the DEA or CDS Agency ☐ Entry in the National Technical Information Service (NTIS) database ☐ Entry in the American Medical Association (AMA) Physician Master File ☐ Confirmation from the state pharmaceutical licensing agency where applicable
☐ Credential: Education and Training ☐ Verification Time Limit: None for graduation from medical or professional school and/or completion of residency. The organization must verify the highest of the three levels of education and training obtained by the practitioner. 1. Graduation from medical or professional school 2. Residency, if appropriate	Graduation from medical school (MD, DO): ☐ Medical School ☐ AMA Physician Master File ☐ American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA ☐ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after

Primary Source Information:	Acceptable Sources:
3. Board certification, if appropriate Printout from state licensing agency's Web site: The plan may use a dated printout of the licensing agency's Web site in lieu of a letter or other written notice as long as the site states that the agency verifies education and training with primary sources and indicates that this information is current; NCQA does not require the plan to obtain written confirmation from the licensing board if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution; the plan must include a copy of the relevant state statute as proof Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and not be re-verified. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	1986. ❑ Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association that it performs primary source verification. ❑ State licensing agency, if the state agency performs primary-source verification. At least annually, the organization must obtain written confirmation from the state-licensing agency that it performs primary source verification. ❑ Sealed transcripts: If a practitioner submits transcripts to the organization that are in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary-source verification if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program. Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification

Primary Source Information:	Acceptable Sources:
❑ Credential: Board Certification ❑ Verification Time Limit: 180 calendar days* Is not required, but must be verified if practitioner lists it on the application. If practitioner is board certified, verifying board certification fully meets standards for education and training. Verifies if applicable. Must be verified through one of the following sources: AMA, ABMS, ABA, AOA, AAMC. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	from the AMA. Please refer to the applicable CMS, DMAS or its designee, and NCQA standards required for non-doctors of medicine and osteopathy. Also, please refer to CCCVP's Credentialing Policies and Procedures. (MD, DO) board certification: ❑ ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. ❑ AMA Physician Master File. ❑ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ❑ Appropriate Specialty board State licensing agency, if the state agency performs primary-source verification of board status. At least annually, the organization must obtain written confirmation from the state-licensing agency that it performs primary-source verification. Please refer to the applicable CMS, DMAS or its designee, NCQA standards for required for non-doctors of medicine and osteopathy. Also, please refer to CCCVP's Credentialing Policies and Procedures.

Primary Source Information:	Acceptable Sources:
❑ Credential: Hospital Privileges ❑ Type of Privileging: Full, Active (or equivalent status) and Current at a participating COMMONWEALTH COORDINATED CARE BY VIRGINIA PREMIERhospital Verification must be completed prior to presentation to CCCVP Credentialing Committee.	❑ Contact the hospital identified on the practitioner's application and use the hospital roster, fax, or other mode to confirm privileges
❑ Credential: State and Federal (Medicaid and Medicare Sanctions, Restrictions on Licensure or Limitations on scope of practice, Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status ❑ Verification Time Limits: 180 cal days of Credentialing Meeting The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review and a decision Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	Sources for Licensure Sanctions: Physicians: ❑ Appropriate state agencies ❑ Federation of State Medical Boards (FSMB) ❑ Healthcare Integrity and Protection Databank (HIPDB) ❑ National Practitioner Databank (NPDB) Nonphysician behavioral healthcare professionals: ❑ Appropriate state agency ❑ HIPDB ❑ State licensure or certification board Sources for Medicare/Medicaid Sanctions ❑ AMA Physician Master File entry ❑ Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General ❑ FSMB ❑ HIPDB ❑ List of Excluded Individuals and Entities (maintained by OIG), available over the Internet ❑ Medicare and Medicaid Sanctions and

Primary Source Information:	Acceptable Sources:
	Reinstatement Report, distributed to federally contracting organizations ❑ NPDB ❑ State Medicaid agency or intermediary and the Medicare intermediary ❑ PalmettoGBA.com – Opt In/Opt Out Website ❑ System for Award Management (SAM) ❑ Medicare Exclusions Database (MED) Please refer to the applicable CMS, DMAS or its designee, NCQA, standards for required for non-doctors of medicine and osteopathy. Also, please refer to CCCVP's Credentialing Policies and Procedures.
❑ Credential: Malpractice Insurance ❑ Verification Time Limit: 180 calendar days* The plan must obtain confirmation of the past five years of history of malpractice settlements; the five-year period may include residency or fellowship years, however the plan does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ National Practitioner Data Bank (full report or PDS query) ❑ Malpractice Carrier
❑ Credential: Work History ❑ Verification Time Limit: 180 calendar days* NCQA does not require primary-source verification of work history; the organization must obtain a minimum of five years of relevant work history through the practitioner's application or CV; relevant	❑ CV Completed Work History section on application ❑ Documented visual verification

Primary Source Information:	Acceptable Sources:
experience includes work as a health professional; if the practitioner has practiced fewer than five years from the date of verification of work history, it starts at the time of initial licensure; experience practicing as a nonphysician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding six months must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; if a practitioner has had continuous employment for five years or more, then there is no gap and no need to provide the month and year, if the year meets the intent; verbal communication must be appropriately documented in the credentialing file; <u>a gap in work history that exceeds one year must be clarified in writing.</u> Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	

* 180 days begins calculating on the date of the practitioner's attestation, or the first signed PSV, whichever is first. The end of the calculation period is the date of the CCCVP Credentialing Committee decision.

C. Practitioner Office Site Quality: Site Visit and Medical Record Keeping/Treatment Practices Assessments/Surveys:

CCCVP conducts an office site visit at initial credentialing, randomly and/or if it receives a member grievance/complaint about the quality of a practitioner's office related to the following criteria:

- ☐ Physical Accessibility (handicapped accessible, well lit exam rooms, posted office hrs)
- ☐ Physical Appearance
- ☐ Adequacy of Waiting- and Examining-Room Space

Member grievances will be monitored for all practitioner sites at least every six months. Follow-up site visits will be conducted at least every six months until the threshold is met.

A random sampling, of all practitioner offices, is evaluated against applicable regulatory and accreditation standards, which have been adopted and incorporated into CCCVP policies and procedures.

The office-site criteria include standards and thresholds for each of these categories.

- ❑ Physical Accessibility (handicapped accessible, well lit exam rooms, posted office hrs)
- ❑ Physical Appearance
- ❑ Adequacy of Waiting- and Examining-Room Space
- ❑ Availability of Appointments (timeliness of routine office visits, urgent visits)
- ❑ Adequacy of Treatment Record Keeping

CCCVP Staff discuss office documentation practices and medical record keeping/treatment reviews with practitioners or staff during site visits. This discussion includes methods on how to keep consistent information and ensure confidentiality of member records. Quality assurance forms, helpful aids, cultural competency information, advance directive information, safety brochures, etc. are given to practitioners or their staff during quality site visits.

CCCVP assesses medical/treatment records for orderliness and documentation practices. To ensure member confidentiality, the Quality Improvement Coordinators may review “blinded” medical/treatment records. Actual records are reviewed during random site visits conducted to ensure CCCVP office site and MR standards are met. Model records can also be reviewed instead of an actual record. As the review of medical/treatment record keeping practices may include clinical elements, clinical staff conducts these reviews.

The established performance threshold of 90% must be met for site visits and medical record keeping practices. If the assessment falls below the threshold, the practitioner will be required to develop and submit a corrective action plan. The Quality staff person will work collaboratively with the practitioner’s office to institute interventions to correct any quality deficiencies.

In the event that the practitioner does not resolve the initial concern within the identified timeframe, the Quality staff person will forward the quality issues to the Committee Chairperson and/or the Credentialing Committee for further guidance and action. The practitioner’s office shall be re-evaluated at least every six months until the deficiency is resolved.

There will be documented follow-up visits for offices that have had deficiencies. If the concern remains unresolved, the Committee Chairperson or his/her designee may recommend to the Credentialing Committee that the practitioner not be credentialed or recredentialed.

VIII. RECREDENTIALING: PRACTITIONERS

- A. CCCVP recredentials all practitioners within three (3) years of their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect a practitioner's ability to perform the services that s/he is under contract to provide.

All application requirements detailed in Section: VII-A are applicable to the recredentialing process. All verification time frames detailed in Table: VII-B are applicable to the recredentialing process.

Each practitioner must complete and sign the CCCVP or CAQH Recredentialing Application that includes the professional questions and attestation that the information given is correct and gives CCCVP the right to verify the information. The following information is obtained and verified according to the standards and utilize the sources listed under Initial Credentialing:

- ☐ State licenses (unrestricted, current and valid)
 - ☐ DEA/CDS certificate (if applicable; if DEA expires, the DEA Form must be completed)
 - ☐ Additional Education, if applicable
 - ☐ Board certification
 - ☐ Hospital affiliations/status of clinical privileges
 - ☐ Malpractice coverage
 - ☐ Malpractice claims
 - ☐ Sanction information
 - ☐ Proof of completed Cultural Competency quiz (or assessment of comparable course)
- B. The recredentialing process shall include performance-monitoring information. Sources of such information may include one or more of the following:
- ☐ Member grievances/complaints
 - ☐ Member and Practitioner/Provider satisfaction surveys
 - ☐ Utilization Management
 - ☐ Risk Management
 - ☐ Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
 - ☐ Site Assessment
 - ☐ Medical Record Keeping Practice/Treatment Assessments

Please Note: A practitioner will receive one of the following designations from the Committee:

A	Approved without reservation
B	Approved with reservation (follow up within one year)
C	Not approved because of insufficient data
D	Not approved (final decision)

After a practitioner has been credentialed, CCCVP shall not prohibit or otherwise restrict any participating (or nonparticipating) practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, a member who is a patient about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment;
3. The opportunity for the individual to refuse treatment and/or express preferences about future treatment decisions.

Participating practitioners must provide information regarding treatment options, including the option of no treatment, in a culturally competent manner. They must ensure that enrollees with disabilities have effective communication regarding treatment options and/or decisions with participants throughout the health system.

IX. PRACTITIONER RIGHTS:

A. To Correct Erroneous Information

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

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

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

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

B. To Review Information

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

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

C. To Be Informed Of Application Status

CCCVP's policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the credentialing staff or another department receives a request it shall be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department within one business day for follow-up and resolution by the Credentialing staff within 72 hours of initial receipt.

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

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

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

- ☐ Practitioner's full name
- ☐ Practitioner's primary office location
- ☐ Practitioner date of birth
- ☐ The name, city and state of the school the practitioner graduated
- ☐ Year practitioner joined the COMMONWEALTH COORDINATED CARE BY VIRGINIA PREMIERNetwork

D. To Be Notified Of His/Her Rights

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

X. FILE RETENTION

Credentialing files shall be retained for at least seven years. Credentialing files are considered protected and confidential. Each practitioner has an electronic file in the credentialing database. Offices containing practitioner files shall be secured, as practical or business appropriate, after normal business hours. Archived files are shipped offsite to a secure file retention company with a file destruction date set to seven years post Committee meeting. A list of these files is maintained for reference and is secured by employee password. Electronic files are backed up every evening.

XI. REINSTATEMENT

If a practitioner is credentialed and leaves the network voluntarily or in such a way that CCCVP has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may re-enter the network within thirty (30) calendar days. S/he must submit a written explanation to include activities during the absence, and complete a recredentialing application. The practitioner will not have to go through the primary source verification process if all documents remained unrestricted, current and valid during the absence period. The Committee Chairperson and/or the Committee retain the authority to approve or disapprove absences, on a case-by-case basis, regardless of the time frame absent from the network.

CCCVP has the right to make the final determination about which practitioners/providers may participate within its network. If CCCVP documents unfavorable information (e.g., malpractice claims, deficient site visits and sanctions) about a specific practitioner/provider during the credentialing or recredentialing process, it may credential or recredential the practitioner/provider.

XII. ONGOING MONITORING

CCCVP monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) against practitioners when it identifies occurrences of poor quality. CCCVP acts on important quality and safety issues in a timely manner by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Chief Medical Officer or designee will address it immediately; engage the Committee if necessary, and appropriate action(s) will be taken to ensure quality. On an ongoing monitoring basis, CCCVP collects

and takes appropriate intervention and/or action by:

❑ **Collecting and reviewing Medicare and Medicaid sanctions**

CCCVP will review sanction information within 30 calendar days of being posted on the OIG Report Website.

❑ **Collecting and reviewing sanctions or limitations on licensure:**

CCCVP will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, CCCVP will query for this information at least every six months.

❑ **Collecting and reviewing grievances/complaints:**

CCCVP may evaluate both the specific grievance/complaint and the practitioner's history of issues. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level three (3) rating is assigned, or if a practitioner has a combination thereof, the information will be presented at the next Committee Meeting for discussion.

❑ **Collecting and reviewing information from identified adverse events:**

CCCVP monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the nature of the adverse event, CCCVP will implement actions and/or interventions based on its policies and procedures when instances of poor quality is identified.

XIII. NONDISCRIMINATORY PRACTICES

CCCVP conducts each Committee meeting in a nondiscriminatory manner and does not make decisions based on practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures, or practice demographics.

A heterogeneous Committee will be maintained and all committee members responsible for credentialing decisions sign a statement affirming non-discrimination for credentialing decisions.

Periodic audits of practitioner grievances/complaints will also be conducted to determine if there are grievances/complaints alleging discrimination.

The following procedures will be followed by CCCVP staff and/or Committee Members to ensure a nondiscriminatory credentialing process:

- ❑ Prior to presenting an issue practitioner at the Credentialing Committee or other committee meeting, identifying information such as the practitioner or provider's name, social security number, address, telephone number, race, gender, etc. are **blinded** on each record by the Credentialing Department staff. Identifying information on reports such as the Office of Inspector General (OIG). National

- Practitioner Data Bank (NPDB), Department of Health Professions (DHP), and other credentialing bodies are omitted.
- ❑ The types of procedures, member demographics, etc. are never incorporated into the credentialing process.
 - ❑ In the event that a practitioner or provider's identity is known by a Committee member, the Chairman of the Credentialing Committee supports the abstention of the Committee member from discussion and/or voting on the practitioner.

In credentialing practitioners, CCCVP shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner, prospective or existing, who is acting within the scope of his or her license or certification under state law solely on the basis of the license or certification.

If a practitioner or group of practitioners is declined network participation, the reason for denial by the Committee shall be communicated in writing within 60 calendar days of the Committee's final decision.

This prohibition does not preclude CCCVP from refusing to grant participation to a practitioner if there is no network need.

XIV. PROVISIONAL CREDENTIALING

CCCVP can on an as needed basis and when in the interest of members make practitioners available prior to completion of the entire initial credentialing process. In this case, CCCVP will provisionally credential practitioners who are applying to the organization for the first time. A practitioner may only be provisionally credentialed once. A practitioner must fully meet all criteria as a clean practitioner to be eligible for provisional credentialing. All required PSVs, application, and signature requirements, along with required documentation as outlined in Section VII of this document will be conducted prior to presentation to the Credentialing Chairperson.

Practitioners that have been provisionally credentialed will be presented to the Credentialing Committee within the 60 calendar day period after the Credentialing Chairperson's approval of the provisional practitioner.

XV. CREDENTIALING APPEAL REVIEW PROCESS

The Committee shall implement a mechanism to resolve disputes with participating practitioners regarding actions by the organization that relate to either: a participating practitioner's status within the network or any action by the organization related to a practitioner's professional competency or conduct. **(See ATTACHMENT 3: APPEALS PROCESS)** In the case of a practitioner where the Committee makes an adverse determination and rejects the application, the Committee shall specify one of the two following reasons for the adverse determination:

- ❑ **Business or Administrative**
 - Not related to the practitioner's competence or professional conduct
- ❑ **Competence and Professional Conduct – Quality Related**
 - As it affects or may affect the health and welfare of a member
 - Occurrences of this type, for physicians and non physicians, may be reported to the National Practitioner's Data Bank, the Department of Health Professions, Licensing and Regulation, American Medical Association, Office of Inspector General, Department of Health and Human Services and/or Department of Medical Assistance Services.

The Committee shall review all available information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate network privileges. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., close panels to all new members, remove all members from a practitioner's panel, restrict a practitioner to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVI. ORGANIZATIONAL PROVIDERS

- A. CCCVP conducts initial assessments and re-assessments of organizational providers to evaluate and confirm that the organizational provider has met regulatory and quality requirements as set forth by CCCVP policies and procedures, DMAS, NCQA standards, and any other applicable regulatory entities. Organizational providers will be re-assessed within three (3) years of the last assessment date.
- B. Each organizational provider must meet minimum standards for participation with CCCVP. These guidelines are intended to comply with regulatory and accreditation standards established by DMAS or its designee, NCQA, CCCVP, and the laws of the Commonwealth of Virginia. The CCCVP standards for participation include:
 - ❑ A valid, unrestricted (no limitations) license to do business and operate in any state where CCCVP has membership.
 - ❑ Appropriate, as recognized by industry standard, professional liability insurance and comprehensive general liability insurance. If the organizational provider self-insures for medical malpractice insurance, evidence must be provided of the established policy, adequacy of funding, and any reinsurance provisions.
 - ❑ Unrestricted, current professional and business licenses,

registrations, permits and certifications in good standing on all professional staff members, including certified nurses and aides that may be called upon to deliver services, equipment and supplies.

- ❑ The provider is in good standing with State and Federal regulatory bodies and complies with all federal, state, local, city and county laws and regulations currently in effect or later enacted by these agencies as relates to services rendered to members.
- ❑ The provider has been reviewed and approved by an accrediting body (see the accrediting bodies table immediately below); and if not, a site assessment will be conducted initially and within every 3 years thereafter. The survey results will then be communicated to the organizational provider seeking a contractual agreement with CCCVP's Credentialing and Contracting Departments.
- ❑ The Provider agrees to report changes in its licensure, certification, accreditation, ownership and location to CCCVP within five (5) calendar days of the change.

C. Accrediting bodies accepted by CCCVP are as follows:

American Academy of Sleep Medicine	AASM
Accreditation Association for Ambulatory Health Care	AAAHHC
Accreditation Commission for Health Care, Inc.	ABOC
American Association for Accreditation of Ambulatory Surgery Facilities, Inc	AAAASF
American Board for Certification in Orthotics and Prosthetics	ABCOP
American College of Radiology	ACR
American Speech Language Hearing Association	ASLHA
Critical Access Hospital	CAH
Commission on Accreditation of Rehabilitation Facilities	CARF
Centers for Medicare and Medicaid Services Survey Dates/Results	CMS
Council on Accreditation for Children and Family Services, Inc	COA
Department of Behavioral Health and Developmental Services Survey Dates/Results	DBHDS
Healthcare Facilities Accreditation Program	HFAP
The Compliance Team, Inc.- Exemplary Provider (DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc)	TCTDMEPOS
National Association of Speech and Hearing Center	NASHC
Rehabilitation Facilities Community	CHAP
The Joint Commission	JCAHO
Det Norske Veritas Healthcare, Inc. (DNV) - Hospitals • Accreditation Program Name: National Integrated Accreditation for Healthcare Organizations (NIAHO) • Approved by CMS: 09-26-08 (per Federal Register)	DNV Healthcare/ NIAHO
Board For Orthotist/Prosthetist Certification	BOC
Continuing Care Accreditation Commission (CARF-CCAC)	CCAC

D. Accreditation Standards include:

- ❑ Acute Care Hospital, Rehabilitation Hospitals, Psychiatric Hospitals, Partial Day Facilities: All Hospitals shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO, CAH, or DNV/NIAHO. All Hospitals shall have Medicare approval unless written documentation of non-applicability is accepted by CCCVP.
- ❑ Skilled Nursing Facility (SNF): This service is not covered under the CCCVP Medicaid product line.
- ❑ Ambulatory Surgery Centers: All Ambulatory Surgery Centers shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC). All Ambulatory Surgery Centers shall have Medicare certification unless written documentation of non-applicability is accepted by CCCVP.
- ❑ Home Health (HH) Equipment Suppliers and Durable Medical Equipment (DME) Suppliers: All HH and DME Equipment Suppliers shall meet JCAHO accreditation standards for equipment management services and shall participate with Medicare or Medicaid. CMS or CCCVP site surveys are also conducted, if the entity is not accredited.
- ❑ Home Infusion therapy Suppliers and Home Health Agency Suppliers: All Home Infusion therapy Suppliers and Home Health Agency Suppliers shall be accredited by JCAHO for home infusion or home care or be accredited by the Community Health Accreditation Program (CHAP) in conjunction with Medicare or Medicaid certification. When applicable, the following may be substituted if the stated level of accreditation is absent/pending:
 - Site Review– conducted by CCCVP Quality Staff
 - Copy of License
 - Written plan for pursuing accreditation

E. Initial Assessment of Organizational Providers:

The organizational provider must submit a legible, complete and signed Master Agreement and Application. CCCVP contracting staff shall review the agreement for completeness.

CCCVP verifies licensure and liability insurance and confirms organizational providers are in good standing with state and federal regulatory bodies and approved by an accrediting body.

Credential to be Verified	Verification Source
License for: Home Health Agencies Hospitals & Ambulatory Care Centers Skill Nursing Facilities	State Medical or Professional Licensing Board
Malpractice	Certificate of Insurance (COI) obtained directly from the organizational provider.
Medicare/Medicaid Certification	Certification letter obtained directly from the organizational provider; OIG Exclusions listing
Accreditation	See the grid above.
Medicare/Medicaid Sanctions	Office of the Inspector General Website (OIG), System for Award Management (SAM), Medicare Exclusion Database (MED)

F. Re-Assessment of Organizational Providers:

CCCVP re-verifies organizational providers within three years of their last assessment date. The intent of the process is to identify any changes that may affect an organizational provider's ability to perform the services they are under contract to provide.

Organizational providers may be asked to complete and sign an "Organizational Provider Re-Assessment" Application or comparable documents. The following information is obtained and verified according to the process for initial credentialing:

- ☐ Licensure
- ☐ Malpractice coverage Medicare/Medicaid Certification Accreditation

G. Tracking: Initial, ongoing and re-assessment outcomes of contracted organizational providers (medical and behavioral health) will be tracked and documented by a Quality staff person in the following format:

Name of Organization	Type of Organization	Prior Validation Date/License Status	Current Validation Date/License Status	Prior Accredited Validation Date/Body Status	Current Accredited Validation Data/Body/Status	Prior Site Visit Date/Body Status	Current Site Visit Date/Body Status
Mega X	Ambulatory	4/1/2004; Active	4/5/2007; Active	4/10/2004; Name; Active	4/15/2007; Name; Active	NA	NA
Getting Better	Residential	3/2/2004; Active	3/17/2007; Active	NA	NA	2/2/2004; CMS Compliant	2/10/2007; CMS Compliant

XVII. ATYPICAL PROVIDERS:

Atypical providers are those providers that do not have credentialing requirements as per NCQA, however do provide services to Medicaid beneficiaries and are regulated under the Virginia Administrative Code.

Entities or providers covered under this section are:

- Adult Day Health Care - Regulations: (12 VAC 30-120-940(B)); (12 VAC 30-120-940(C)) and 12 VAC 40-60-10 et seq and EDCD Waiver Manual: Chapter II, Pages 11-17
 - Agency Directed Personal Care - Regulation: (12 VAC 30-120-950(D)) and EDCD Waiver Manual: Chapter II, Pages 8-11
 - Agency Directed Respite Care – Regulation: (12 VAC 30-120-960(D)) and EDCD Waiver Manual: Chapter II, Pages 8-11
 - Personal Emergency Response System (PERS) - Regulations: (12 VAC 30-120-970(D)) and (12 VAC 30-120-970(E)) and EDCD Waiver Manual: Chapter II, Pages 17-19
 - Consumer Directed Services (Service Facilitation) – Regulation: (12 VAC 30-120-980 (D)) and EDCD Waiver Manual: Chapter II, Pages 19-21
 - Consumer Directed Services (Personal Care Aide) – Regulation: (12 VAC 30-120-980 (D)(10)) and EDCD Waiver Manual: Chapter II, Pages 21-22
 - Nursing Facility- Regulation: (12 VAC 30-60-300) and EDCD Waiver Manual: Chapter II
1. Organizational Providers who meet the following criteria are approved for credentialing and recredentialing by the Credentialing Department if there is:
 - a) Completed CCCVP application, which includes a current and signed attestation and addresses
 - b) Copy of the current and valid medical/business/facility license.

- c) Copy of the malpractice policy face sheet or completed liability information section on the application, to include policy number, effective dates of coverage, and coverage amounts where applicable
- d) Copy of the current accreditation certification, if applicable
- e) Quality measures (may include initial credentialing site visit to include an assessment of Americans with Disability Act (ADA) requirements) or some other policy and/or procedure
- f) Primary Source Verification of associated credentialing documentation
- g) Criminal Background Check History, to include sexual offenses, for the following Personal Assistants, Respite Care Assistants, Adult Day Health Care Workers, Registered Nurses, and Licensed Practical Nurses
- h) Verification that the provider is in good standing and has met all State and Federal regulatory requirements.
- i) Confirmation every three years that the provider continues to be in good standing with State and Federal regulatory bodies

XVIII. DELEGATED CREDENTIALING:

- A. CCCVP enters into delegated agreements with organizations to perform credentialing and recredentialing for prospective and existing CCCVP practitioners. Through the execution of a pre-site audit of policies, procedures and files (when available), a contractual agreement, annual assessment (after the initial assessment) of policies, procedures and files, and reporting requirements, CCCVP ensures the following:
 - ❑ Each delegate follows CMS, DMAS or its designee, NCQA, CCCVP and other required regulatory and accreditation requirements, as specified.
 - ❑ At least semi-annual reporting and the exchange of data is conducted in a timely, efficient, and effective manner.

CCCVP retains the right of accountability and oversight for credentialing and recredentialing activities of practitioners (to include behavioral health) in all instances and even if CCCVP delegates all or part of these activities. CCCVP retains the right to make the final decision to approve, deny, suspend, or terminate a practitioner, provider, vendor, or sites in situations where it has or has not delegated decision-making. Annually, CCCVP establishes and implements written procedures to ensure effectiveness. Requirements and rights are reflected in the delegation agreements.

The following criteria must be met in order for CCCVP to enter into a delegated agreement:

- ❑ The delegated entity shall provide CCCVP data and information as requested per the delegated credentialing agreement.
- ❑ The delegated entity shall provide documentation to CCCVP describing how data collection, information development, and verification processes are performed.
- ❑ CCCVP is provided sufficient and clear information on database functions that include any limitations of information available from the

delegated entity (for example, practitioners not included in the database); the time frame for delegated entity responses to requests for information; and a summary overview of quality control processes relating to data integrity, security, transmission accuracy, and technical specifications.

- ❑ CCCVP and delegated entity agree upon the format for the transmission of credentialing information for individuals from the delegated entity.
- ❑ CCCVP can easily discern which information transmitted by the delegated entity is from a primary source and which is not.
- ❑ For information transmitted by the delegated entity that can expire (for example, licensure, board certification), the date the information was last updated from the primary source will be provided by the delegated entity upon request.
- ❑ The delegated entity certifies that the information transmitted to CCCVP accurately presents the information obtained by the entity.
- ❑ CCCVP can discern whether the information transmitted by the delegated entity from a primary source is all of the primary source information in the agency's possession pertinent to a given item or, if not, where additional information can be obtained.
- ❑ CCCVP can engage the quality control process of the delegated entity when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.

CCCVP ensures through an initial onsite pre-delegation audit and annual delegated audits thereafter that the following standards are met:

- ❑ The credentialing information collected and maintained in the verification process is accurate, up-to-date and supported by documentation.
- ❑ The delegated entity utilizes designated equivalent sources.
- ❑ The delegated entity queries the NPDB for information on adverse clinical privilege action taken by a health care entity.
- ❑ CCCVP obtains information regarding changes in a practitioner's credentialing status from the accredited hospital or delegated entity to which it delegates credentialing.

All delegated practitioners are subject to approval by the Chief Medical Officer or designee, CCCVP Credentialing Committee and/or Committee Chairperson at initial credentialing and recredentialing.

- B. In the event CCCVP contracts with a delegate and the delegation arrangement includes protected health information (PHI) by the delegate, the delegation agreement will include the following provisions to ensure PHI will remain protected:

- ❑ A list of the allowed uses of PHI
- ❑ A description of delegate safeguards to protect the PHI from inappropriate use or further disclosure

- ❑ A stipulation that the delegate will ensure that subdelegates have similar safeguards
- ❑ A stipulation that the delegate will provide individuals with access to their PHI
- ❑ A stipulation that the delegate will inform the organization if inappropriate uses of PHI occur
- ❑ A stipulation that the delegate will ensure PHI is returned, destroyed or protected if the delegation agreement ends.

Please note the following:

- ❑ If CCCVP conducts annual file audits of delegates one year, it is not required to conduct annual file audits the subsequent year if the delegate does not credential or recredential any practitioners before the next file audit is scheduled to occur. In this case, the delegate is required to submit proof that it did not credential or recredential any practitioners in between audit cycles. CCCVP shall maintain and meet all delegation oversight.
- ❑ A practitioner can participate under a delegated agreement and also be credentialed by CCCVP as a licensed independent practitioner. Please refer to the section on Dual Credentialing/Contracting. These providers are referred to as “dually contracted” providers.
- ❑ CCCVP conducts at least bi-annual meetings with all contracted, delegated credentialing partners to ensure ongoing CCCVP, regulatory and accreditation compliance. Simplification of processes is also discussed at the statewide meetings.

XIX. DUAL CREDENTIALING and CONTRACTING

A. Dually Credentialed:

- i. CCCVP grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to CCCVP, and if not, there must be satisfactory evidence, as determined by CCCVP, of experience and hours of practice in the desired specialties. These types of practitioners are considered “dually credentialed” practitioners. For example: An internal medicine doctor can act as a primary care physician and a specialist.

B. Dually Contracted:

- i. CCCVP considers those practitioners contracted directly with CCCVP as a licensed, independent practitioner and also with a contracted delegated entity as “dually contracted” practitioners.



2014 Credentialing Program Description Signature Page:

Effective Date: July 1, 2014

APPROVED BY:

CCCVP Chief Medical Officer or designee

Date

CCCVP Continuous Quality Improvement Committee Chairperson or
designee

Date

CCCVP Board of Director's Chairperson or designee

Date

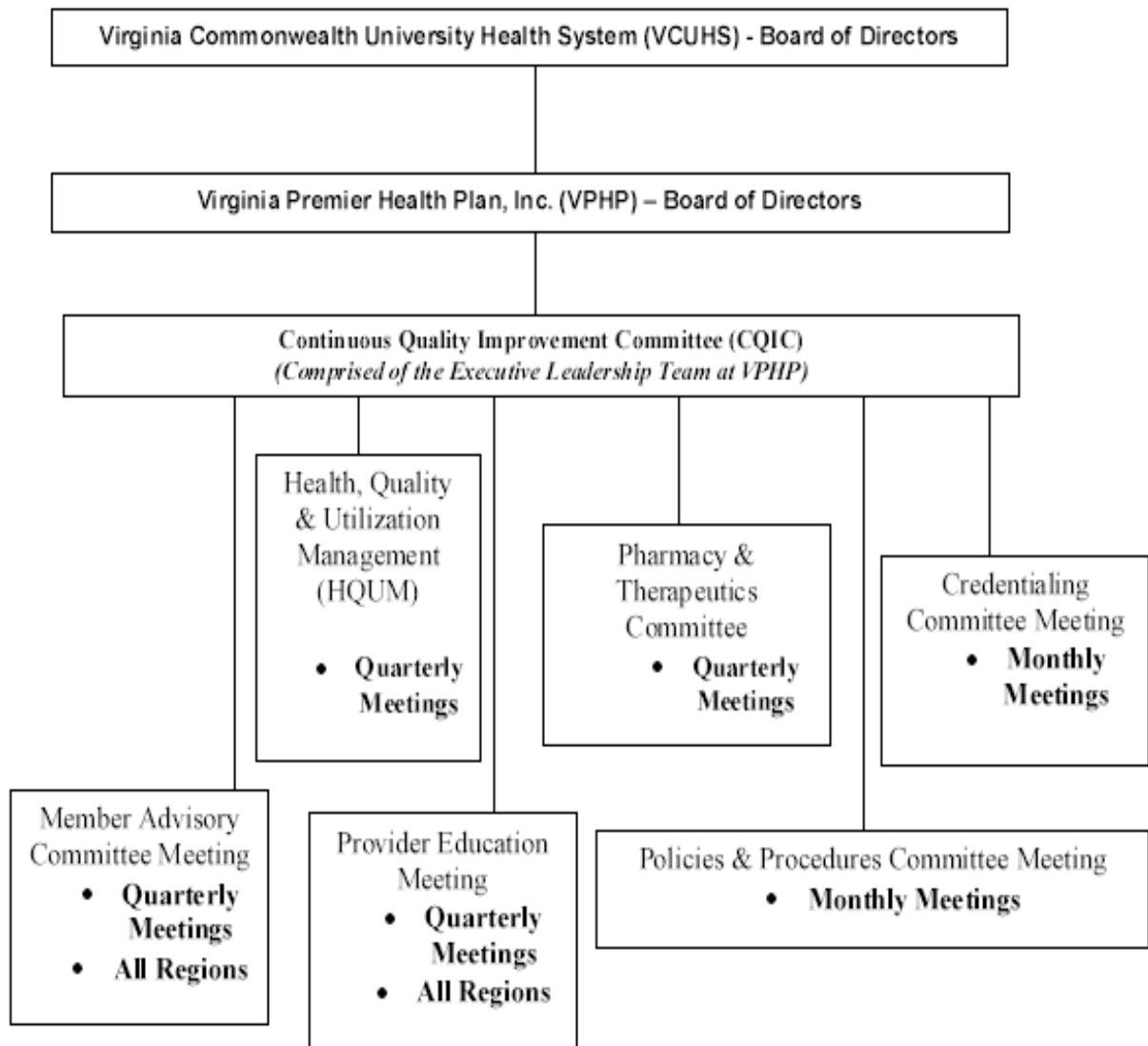
Original Date: **July 2014**

Reviewed Date(s):

Revised Date(s):

Attachment 1: Credentialing Structure and Governance

VPHP Organizational Chart



Attachment 2: DEA/CDS Certificate Form

The Commonwealth Coordinated Care by Virginia Premier (CCCVP) Drug Enforcement Agency (DEA)/Controlled Drug Substance (CDS) Form serves as proof that the provider (noted below) does not hold a current and valid DEA/CDS Certificate and Number, issued by the Drug Enforcement Agency of the U.S.

This form allows providers to be credentialed or recredentialed, avoid suspension and possibly termination from the CCCVP Network. The form must be completed in its entirety, signed and dated by the provider. By doing so, the provider attests that all information entered on this form is accurate, truthful and will be adhered to.

SECTION 1: To be completed by the provider

By initialing below, the provider agrees to the following:

1. I, _____, do not hold a valid and current DEA/CDS Number and Certificate.
2. I, _____, shall not write medical or other prescriptions for medications for health plan members until I have duly notified VPG (as referenced in #3).
3. I, _____, shall notify and/or submit a copy of my valid and current DEA/CDS Certificate and Number to CCCVP within five (5) business days of receipt and/or notification.

SECTION 2: Covering Provider Information - To be completed by the provider

During the period in which I agree not to write medical or other prescriptions, the following physician, who is a participating provider, shall write prescriptions on my behalf:

Name of Covering Provider: _____
Address of Covering Provider: _____

Phone Number of Covering Provider: _____

SECTION 3: To be completed by the provider

Printed Name of the Provider

Signature of Provider

Date

SECTION 4: Office Use Only - To be completed by the Health Plan Representative

Printed Name of Health Plan Representative

Date

Vistar Key# or Medicaid Id#

Attachment 3:

Commonwealth Coordinated Care by Virginia Premier Credentialing/Recredentialing Appeals Process

A. Overview:

Commonwealth Coordinated Care by Virginia Premier, Inc. (CCCVP) Credentialing Staff shall verify the information set forth in the application. The Credentialing Committee (“Committee”) approves or denies all prospective and existing practitioners/providers based on CCCVP policies and procedures and regulatory and accreditation standards.

CCCVP and/or the Committee does not make credentialing/recredentialing decisions based solely on a practitioner’s/provider’s race, ethnic/national identify, gender, age, sexual orientation or type of procedure (e.g. abortions) or patient (e.g. Medicaid) in which the practitioner/provider specializes. This does not preclude CCCVP or the Committee from including in its network practitioners/providers who meet certain demographic or specialty needs (ex. to meet cultural needs of members).

The Committee shall make the final credentialing/recredentialing decision. The Committee shall implement a mechanism to resolve disputes with participating practitioners/providers regarding actions by the organization that relate to either: a participating practitioner’s/provider’s status within the provider network or any action by the organization related to a practitioner’s/provider’s professional competency or conduct.

CCCVP reserves the right to overturn all appeal (1st and or 2nd) panel decisions. No further appeal rights shall apply.

In the case of any practitioner/provider for which the Committee makes an adverse decision, the Committee shall distinguish between a recommendation based on the following two ***Denial Categories:***

- **Business or Administrative Denials:**

If the Committee decides not to accept an application of a practitioner/provider for business or administrative concerns (i.e., not related to the practitioner’s/provider’s competence or professional conduct), the first and second level appeal procedures, as applicable, shall be followed and as established below should the practitioner/provider exercise his/her right to appeal.

- **Competence and Professional Conduct Denials**

If the Committee decides not to accept an application of a practitioner/provider based upon a concern related to a practitioner's/provider's competence and /or professional conduct, the first and second level appeal procedures, as applicable, shall be followed and as established below should the practitioner/provider exercise his/her right to appeal.

Competence and Professional Conduct Denials may be reported to the National Practitioner's/Provider's Data Bank, the Department of Health Professions, the American Medical Association, the Department of Medical Assistance Services, the Office of the Inspector General and any other entity as required or deemed appropriate, as this type of denial may affect the health and welfare of a member.

The Committee shall review all available information and notify each practitioner/provider, via certified mail, of its decision to decline, suspend, reduce or terminate network privileges. In the event of an adverse event and prior to termination, a range of actions to improve performance may be offered to the practitioner/provider (i.e., close panels to all new members, remove all members from a practitioner/provider's panel, restrict a practitioner/provider to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc). All practitioners/providers adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing/ recredentialing.

(1) *Denial Notification Process:*

The Credentialing Staff, on behalf of the Committee, shall notify the practitioner/provider by mail of the denial. The Contracting Staff, on behalf of the Committee, shall notify a participating practitioner/provider of suspension, reduction or termination of privileges in CCCVP's network. The Chairman of the Committee and/or the designated person of the Committee shall sign all credentialing/recredentialing denial letter(s).

Each notice shall:

- (1) State the reason for the denial
- (2) Notify the practitioner/provider that s/he has the right to declare his/her intention to appeal by completing the Appeal Request Form and forwarding it to CCCVP within thirty- (30) calendar days after receiving the denial notice

B. Receipt of an Appeal Process – Applicable to 1st and 2nd Level Appeals:

Upon receipt, of an appeal request (regardless of type), Quality Appeal Staff shall:

- 1) Confirm the appeal request is received within 30 calendar days of the adverse decision
- 2) Acknowledge receipt of the appeal, in writing, within 5 business days
- 3) Notify the Chair of the Credentialing Committee, Vice President of Quality &

Credentialing, and the Quality Manager of the appeal request within 48 hours of receipt of the written appeal request

- 4) Final decisions, at the conclusion of **each** appeal level, shall be communicated to the practitioner/provider, in writing, within 45 calendar days via **certified** mail.

C. Appeal Levels:

1st Level “Standard” Appeal:

- All steps under Section B, **Receipt of an Appeal Process**, as applicable, shall be followed.
- The Chairman of the Committee shall appoint an impartial 1st level appeal panel. The panel shall consist of, at least, 3 qualified individuals to include, but not limited to plan representatives, committee members, committee practitioner/providers, and/or network practitioner/providers.
- From the 3 qualified individuals, at least one must be a participating practitioner/provider who:
 - 1) Holds an active, unrestricted license to practice medicine or a health profession
 - 2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)
 - 3) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate
 - 4) Are neither the individual who made the original adverse decision, nor the subordinate of such an individual
 - 5) Is not otherwise involved in network management or in direct economic competition with the appealing practitioner/provider
 - 6) Is a clinical peer of the appealing practitioner/provider

1st Level “Expanded” Appeal – At the discretion of the Chairman of the Committee:

- All steps under Section B, **Receipt of an Appeal Process**, as applicable, shall be followed.

- If the appealing practitioner/provider is not satisfied with the 1st Level Appeal Decision and/or the Chairman of the Committee decides to include an expanded review, based on the complexity of the request, the 1st Level Expanded Appeal process will be followed, as described below:
- The Chairman of the Committee or designee shall forward the 1st Level Appeal Request, and all associated documents, for an “*expanded*” review to be conducted by an impartial, external quality review organization.

2nd Level Appeal Hearing:

- If the appealing practitioner/provider is not satisfied with the 1st Level Appeal Decision (standard and/or expanded), s/he can request a 2nd Level Appeal Hearing. The panel shall consist of at least three (3) qualified individuals that were not a member of the 1st Level Appeal Panel, to include, but not limited to plan representatives, committee members, committee practitioner/providers, network practitioner/providers and/or external, quality review organization practitioner/providers.
- All steps under Section B, **Receipt of an Appeal Process**, shall be followed, to include informing the practitioner/provider:
 - Of the acceptance, place, time and date of the hearing
 - That the hearing shall be scheduled no less than thirty- (30) calendar days from the date of the request from the practitioner/provider, unless the practitioner/provider voluntarily agrees to an earlier hearing
 - Of the list of witnesses (if any) expected to testify at the hearing on behalf of the Committee
 - That s/he may submit additional written evidence, including statements by any relevant source, to correct the record or erroneous information, as it relates to the reasons for the adverse decision(s), within thirty- (30) calendar days
 - The right to a hearing may be forfeited if the practitioner/provider fails, without good cause, to appear
 - In the hearing, the practitioner/provider involved has the right: (i) to representation by an attorney or other person of the practitioner’s/provider’s choice, (ii) to a record of the proceeding, copies of which may be obtained by the practitioner/provider upon payment of reasonable charges associated with preparation of the record, (iii) to call, examine and cross-examine witnesses, (iv) to present evidence determined to be relevant by the hearing chairperson and/or committee designated above, regardless of its admissibility in a court of law, and (v) to submit a written statement at the close of the hearing

- If the practitioner/provider decides to be represented by an attorney or to have an attorney present to advise him or her at the hearing, the practitioner/provider shall notify the Chairman of the Credentialing Committee at least five- (5) calendar days before the hearing.
- From the 3 qualified individuals, at least one must be a participating practitioner/provider who:
 - 1) Holds an active, unrestricted license to practice medicine or a health profession
 - 2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)
 - 3) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate
 - 4) Are neither the individual who made the original non-certification, nor the subordinate of such an individual
 - 5) Is not otherwise involved in network management or in direct economic competition with the practitioner/provider
 - 6) Is a clinical peer of the appealing practitioner/provider

D. Exclusions:

- Practitioners/Providers who meet the criteria below are not eligible for the appeals process:
 - 1) A breach in the practitioner/provider's contract with CCCVP
 - 2) Failure to follow and/or adhere to CCCVP's policies and procedures
 - 3) A suspended, revoked or terminated license with the Board of Medicine, or other applicable regulatory agencies
 - 4) Listed on the OIG Exclusions List

PLEASE NOTE:

- At all appeal levels, the practitioner/provider has the burden of establishing that s/he meets CCCVP's standards for participation.
- At all appeal levels, the practitioner/provider may submit additional written evidence to correct the record of erroneous information within thirty- (30) calendar days of his or her intention to appeal.
- At the Plan's discretion, all appeals filed after the 30-calendar day timeframe are at risk for not being accepted. Appeals received outside of the 30 calendar day timeframe for filing shall be reviewed on a case-by-case basis.

- The practitioner/provider will have exhausted all appeal rights at the conclusion of the 2nd Level Appeal Hearing process, if the case progresses to the 2nd Level Appeal Hearing stage.
- The recommendation of the Appeal's Panel and/or CCCVP shall be final.
- The decision reached by the 1st and 2nd Level Appeal panels shall become a part of the record presented to the Chairman of the Committee, the Committee, any other Quality Committee(s) and/or CCCVP.
- CCCVP's Appeal process is modeled after the requirements in the Health Care Quality Improvement Committee Act of 1986. The practitioner/provider has no procedural rights, other than those set forth herein or required by law.
- CCCVP reserves the right to make the "final" decision (i.e., uphold or overturn) at all appeal, panel and/or hearing levels (i.e., 1st or 2nd), and no further appeal rights shall apply.

Commonwealth Coordinated Care by Virginia Premier Appeal Request Form

Practitioner's Name: _____

Medicaid Id #: _____

Practitioner's Specialty: _____

Practitioner's Address: _____

Practitioner's Phone #: _____ Fax #: _____

Practitioner's E-Mail: _____

CCCVP's Denial Reason: _____

Practitioner's Rebuttal: _____

(If additional space is required, please attach using a separate sheet of paper.)

Additional Comments: _____

I am requesting the type of appeal review checked below. I understand that I am not required to attend document investigations.

Regular Review and Appeal Document Investigation

Expanded Review and Appeal Document Investigation

Expanded Review and Appeal Hearing (only applicable to expanded review and appeal cases)

*All appeals will be governed under the Regular Review or the Expanded Review and Appeal's process unless otherwise noted.

Practitioner's Signature: _____

Date: _____

Please note: The Appeal Request Form must be completed, signed and dated by the practitioner who is filing the appeal in order to be considered valid. If there is supporting documentation, please attach it to the Appeal Request Form.

Practitioner Golden Globe Award (PGA) Nomination Form

Date: _____

Practitioner's Name and Credentials: _____

Practice Location: _____

Practitioner's/Point of Contact Phone #: _____

Practitioner's/Point of Contact Fax #: _____

Practitioner's/Point of Contact Email Address: _____

Date the accolade was awarded and/or professional health care innovation was instituted: _____
mm/dd/yy

Brief description of the accolade and/or professional health care innovation to be recognized:

If nominating with an accolade, please attach a copy of the accolade to serve as proof.

Accomplishments cannot be published without proof of receipt (Letterhead of awarding organization preferred). Providers have a better chance of winning the award if they: participate in the P4P Program, utilize Electronic Prescribing, have Electronic Medical Records.

Verification/Nominator Contact: Name _____

Phone _____ E-mail _____

I agree, by signing and dating this form, that all information included and/or attached is true and accurate.

Signature of Nominator

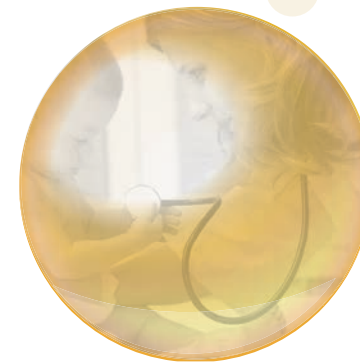
Date

Virginia Premier, in its sole discretion, will select the annual winner of the Practitioner Golden Globe Award.

Fax to: 804.819.5171 Attn: Quality Project Manager



Exhibit I- Practitioner Golden Globe Award



Practitioner Golden Globe Award



**Recognizing Practitioners for
Quality Care and Services**

About the Award

Virginia Premier Health Plan (VPHP) values quality and safety, especially when coordinating and managing care for our members. In an effort to promote, enhance and salute excellence, the Plan has developed and implemented a physician recognition program.

Requirements for Participation

1. The practitioner's license must be unrestricted, current and valid.
2. The practitioner must be in good standing with VPHP.

Good Standing: Most recent site visit score and medical record keeping scores meet the Plan's thresholds; the practitioner submits quality information, recredentialing applications, etc. per policy; and the practitioner continuously follows and adheres to VPHP's policies and procedures.

3. The practitioner cannot have grievances/ complaints filed against him/her in the last 12 months prior to being published in the Newsletters and/or on the Website.
4. The practitioner cannot have any quality issues in the last 12 months noted on the National Practitioner Data Bank Report, Department of Health Professions – Board of Medicine Sanctions Report, the Office of the Inspector General Sanctions Report or Department of Medical Assistance Services (DMAS).
5. The practitioner cannot be involved in any pending legal issues that could impede the safe care of members.
6. The practitioner must have documentation of taking a cultural competency course.

7. The practitioner or nominator must complete the designated form and submit with the accolade and/or an explanation and examples of current professional innovations in health care that have improved the health status of recipients.

Benefits of Participation

Exemption:

A practitioner may be exempt from random site visits and random medical record keeping reviews. *(Only applicable if the practitioner has received the NCQA Physician Practices Award.)*

Recognition:

Members, colleagues, and the public will have access to this information via member and provider newsletters and notification of the recognition will be on the VPHP website within 30 days from PGA award presentation: www.vapremier.com.

Quality Commitment:

Practitioner exemplifies commitment to quality, excellence and continuous health education.

Receipt of an Award from VPHP

(awarded to one practitioner annually):

VPHP encourages each practitioner that is recognized to proudly display the award in his or her office where visible.

**Do not submit duplicate recognition/awards.*

Specifics of the Program

Who is eligible?

All participating VPHP practitioners, of any specialty. This includes all medical, allied health, and behavioral health practitioners.

Who can nominate a practitioner?

The practitioner, on his/her own behalf, office staff, a VPHP participating colleague, a member, or VPHP employee can submit the form.

What accolade(s) and /or professional innovations are eligible for recognition?

Practitioners can be recognized if he/she has received an award and/or special designation in his/her field, appointment to a health related Local, State or National Committee, has received recognition for any of the National Committee for Quality Assurance programs, Centers for Medicare and Medicaid Services (CMS) and DMAS. Also recognized are physicians that have instituted health improvement programs in their practice to reach a specific group of patients to meet their health care needs.

When will the nominated eligible practitioners be recognized?

Nominated Practitioners will be recognized quarterly.

How many PGA Awards will be presented in one year?

One award will be presented per year.

Where will the annual accolade be published?

The winning practitioner will be recognized in the Member and Provider Newsletters and on the VPHP Website.

How does the practitioner participate?

The practitioner/nominator must complete the PGA form.

How often can a practitioner be awarded a PGA by VPHP?

Once every 5 years.

20 Tips to Prevent Medical Errors

What are Medical Errors?

Medical errors happen when something that was planned as a part of medical care doesn't work out.

Medical errors can occur in the entire health care system:

- Hospitals
- Clinics
- Outpatient Surgery Centers
- Doctors' Office
- Nursing Homes
- Pharmacies
- Patients' Homes

Errors can involve:

- Medicines
- Surgery
- Diagnosis
- Equipment
- Lab reports

They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high salt meal.

Most errors result from problems created by today's complex health care system. But errors also happen when doctors and their patients have problems communicating. For example, a recent study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work.

What can you do? Be involved in your health care

- *The single most important way you can help to prevent errors is to be an active member of your health care team.* That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results. The following are some specific tips, based on the latest scientific evidence about what works best.

Medicines

- *Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.* At least once a year, bring all of your medicines and supplements with you to your doctor. "Brown bagging" your medicines can help you and your doctor talk about

them and find out if there are any problems. It can also help your doctor keep your records up to date, which can help you get better quality care.

- *Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.* This can help you avoid getting a medicine that can harm you.
- *When your doctor writes you a prescription, make sure you can read it.* If you can't read your doctor's handwriting, your pharmacist might not be able to either.
- *Ask for information about your medicines in terms you can understand – both when your medicines are prescribed and when you receive them.*
 - What is the medicine for?
 - How am I supposed to take it, and for how long?
 - What side effects are likely? What do I do if they occur?
 - Is this medicine safe to take with other medicines or dietary supplements I am taking?
 - What food, drink, or activities should I avoid while taking this medicine?
- *When you pick up your medicine from the pharmacy ask: Is this the medicine that my doctor prescribed?* A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88 percent of medicine errors involved the wrong drug or the wrong dose.
- *If you have any questions about the directions on your medicine labels, ask. Medicine labels can be hard to understand.* For example, ask if "four doses daily" means taking a dose every 6 hours around the clock or just during regular waking hours.
- *Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you're not sure how to use it.* Research shows that many people do not know how to measure liquid medicines. For example, most people use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices like marked syringes can help you measure the right dose. Being told how to use the devices helps even more.
- *Ask for written information about the side effects your medicine could cause.* If you know what might happen, you will be better prepared if it does – or, if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicines can help patients recognize problem side effects and then give that information to their doctor or pharmacist.

Hospital Stays

- *If you have a choice, choose a hospital at which many patients have the procedure or operation you need.* Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.
- *If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.* Hand washing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether health care workers washed their hands, the workers washed their hands more often and used more soap.

- *When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home.* This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

Operation

- *If you are having an operation, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done.* Doing the operation at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site operations are 100 percent preventable. The American Academy of Orthopedic Surgeons urges its members to sign their initials directly on the site to be operated on before the operation.

Other steps you can take

- *Speak up if you have questions or concerns.* You have a right to question anyone who is involved with your care.
- *Make sure that someone, such as your personal doctor, is in charge of your care.* This is especially important if you have many health problems or are in a hospital.
- *Make sure that all health professionals involved in your care have important health information about you.* Do not assume that everyone knows everything they need to.
- *Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't).* Even if you think you don't need help now, you might need it later.
- *Know that "more" is not always better.* It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
- *If you have a test, don't assume that no news is good news.* Ask about the results.
- *Learn about your condition and treatment by asking your doctor and nurse and by using other reliable sources.* For example, treatment recommendation based on the latest scientific evidence is available from the National Guidelines Clearinghouse at <http://www.guideline.gov/>. Ask your doctor if your treatment is based on the latest evidence.

Exhibit K – Clinical Practice Guidelines

<https://www.vapremier.com/providers/medical-management/quality-initiatives/>