Gateway Health℠

NOVEMBER 2016

PROVIDER UPDATE

An Update for Gateway Health℠ Providers and Clinicians

THIS ISSUE

Important Phone Numbers

www.gatewayhealthplan.com

ADMINISTRATIVE/OFFICE STAFF

Food Security Assessment: Using the Hunger Vital Sign Tool to Screen for Food Insecurity

What is food insecurity?

Food insecurity in the United States affects one in seven households. It is defined as the inability to access food in a socially acceptable way, due to limited resources. Food insecurity is not synonymous with hunger or poverty. Many food insecure adults report that they do not feel the sensation of hunger. The American Academy of Pediatrics reports that 30 percent of food-insecure households are above 185 percent of the federal poverty threshold used for childhood nutrition assistance programs. Thus, poverty is not always an indicator of food insecurity.

Food insecurity is also not consistent. Rather it is cyclical, with the average American family completing the cycle of adequate-food-supply to inadequate-food-supply seven times per year. Winter months may necessitate that financial resources are directed toward heating costs instead of food. Summer months may create an increased financial burden for food because children in the household are not being provided with school meals. Families with children are twice as likely to experience food insecurity.

How does food insecurity affect my patients?

Food insecurity results in a sacrifice of food quantity and/or food quality. The ramifications of this sacrifice are pervasive. The jury is still out on whether the relationship between food insecurity and obesity is causal. Regardless of the nature of this relationship, however, these factors co-exist as consequences of social disadvantage.

Energy-dense foods are a cheaper way to obtain calories. It has been estimated that increasing the intake of saturated fats and added sugars by only one percent reduces the burden of food costs. The odds of having diabetes are doubled in low-income, food-insecure adults. Food insecurity is also associated with both hypoglycemia and hyperglycemia in diabetic adults and children.

Chronic diseases in general leave less money for food or less money for prescriptions. More than 30 percent of food insecure families report choosing between paying for food and paying for medical costs. Additionally, food insecurity-related depression and fatigue may decrease motivation for healthy behaviors.

ADMINISTRATIVE/OFFICE STAFF

Food Security Assessment: Using the Hunger Vital Sign Tool to Screen for Food Insecurity (continued)

What can I do about food insecurity?

The Hunger Vital Sign™ tool is a two-question validated food security assessment, originally created for the pediatric setting. This tool has 97 percent sensitivity and is now being used across diverse populations to identify food insecure individuals.

You can ask your patient these two simple questions to determine if they are at risk of food insecurity:

1. During the last year, did you ever worry whether the food in your house would run out before there was money to get more?
2. During the last year, was there ever a time when the food in your house just didn't last and there wasn't enough money to get more?

Any response other than "never" is indicative of food insecurity. Stigmatism and parental fear that children will be removed from the home necessitate that these questions be asked nonjudgmentally and preferably in the context of an ongoing relationship.

We believe that our network providers are well positioned to identify food insecure members using the Hunger Vital Sign assessment and to refer them to accessible healthy food and nutrition resources in local communities.

Sources:

American Academy of Pediatrics (2015). Policy statement: Promoting food security for all children. *Pediatrics*, 136 (5). doi: 10.1542/peds.2015-33001

Food Research & Action Center (October, 2015). Understanding the connections: Food insecurity and obesity. Retrieved from http://frac.org/pdf/frac_brief_understanding_the_connections.pdf

Lopez, A., Seligman, H. (2012). Clinical management of food-insecure individuals with diabetes. *Diabetes Spectrum*, 25 (1), 14-18. http://dx.doi.org/10.2337/diaspect.25.1.14

ADMINISTRATIVE/OFFICE STAFF

Gateway Health℠

Provider Update

November 2016

SPECIAL EDITION

NOTICE OF PRACTICE/PRACTITIONER CHANGES!

One of the many benefits to the Gateway Health member is improved access to medical care through Gateway's contracted provider network. To ensure our members have up to date and accurate information on availability, it is imperative that providers submit written 60 days advance notice of the following:

- Address changes
- Phone and fax number changes
- Changes to hours of operation
- Primary care practice (PCP) panel status changes (open, closed & existing only)
- Practitioner participation status (additions & terminations)
- Mergers and acquisitions

The Gateway Practice/Provider Change Request Form can be completed for conveying practice/practitioner changes or notice on your practice letterhead is acceptable. The form is available on gatewayhealthplan.com – select *Provider*, and then click on *Forms and Reference Materials*.

Please submit your change request via fax or mail.

Fax to: 1-855-451-6680
Mail to: Gateway Health℠
Provider Information Management
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

If you have questions about this Provider Update, please contact your Provider Relations Representative directly.

Provider Relations Department
Gateway Health℠

ADMINISTRATIVE/OFFICE STAFF

Member Satisfaction Survey Results Are In!

2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Thank you for your contribution to our members' well-being and healthcare experience! Whether it be a wellness visit or a simple call to the doctor's office, every interaction matters. Remember, patients look to you in times of need, so it's important to make them feel comfortable and in good hands.

Here are a few things to consider during you next patient interaction:

- Smile
- Make eye contact during patient interaction
- Speak in terms the patient will understand
- Suggest alternative physical activities to promote a healthy lifestyle
- Remind the patient of annual wellness visits and immunizations

Positive patient-provider interactions are vital to a member's overall healthcare experience. Effective communication and education will help strengthen your relationship and positively impact their time with you. Developing a trusting patient-provider relationship will increase each patient's overall healthcare experience. Gateway Health strives for excellence in providing members with quality care and services. Thank you for being at the forefront of our growing patient-provider success story.

Gateway Health Medicare Assured℠ 2016 CAHPS Survey Results

CAHPS Survey Measure	2016 Scaled Mean Survey Score for Medicare Contract H5932
Rating of All Health Care	81.6
Rating of Health Plan	85.3
Customer Service	88.0
Getting Care Quickly	74.4
Getting Needed Care	81.3
Coordination of Care	85.1
Flu Vaccine	68.8
Rating of Drug Plan	85.5
Getting Needed Prescription Drugs	90.2

CAHPS Survey Measure	2016 Scaled Mean Survey Score for Medicare Contract H9190
Rating of All Health Care	79.2
Rating of Health Plan	78.7
Customer Service	82.6
Getting Care Quickly	72.3
Getting Needed Care	74.1
Coordination of Care	82.8
Flu Vaccine	61.9
Rating of Drug Plan	80.1
Getting Needed Prescription Drugs	88.4

The scaled mean scores are a conversion of a standard mean to a 100 point scale, per CMS scoring methodology.

ADMINISTRATIVE/OFFICE STAFF

Member Satisfaction Survey Results Are In! (continued)

Gateway Health℠ Medicaid 2016 CAHPS Survey Results

CAHPS Survey Measure	2016 Summary Rates for Medicaid Children
Rating of All Health Care	87.18%
Rating of Health Plan	84.13%
Rating of Personal Doctor	88.17%
Rating of Specialist Seen Most Often	85.04%
Customer Service	84.38%
Getting Care Quickly	92.02%
Getting Needed Care	88.76%
Coordination of Care	81.63%

CAHPS Survey Measure	2016 Summary Rates for Medicaid Adults
Rating of All Health Care	73.67%
Rating of Health Plan	77.46%
Rating of Personal Doctor	78.14%
Rating of Specialist Seen Most Often	78.07%
Customer Service	91.46%
Getting Care Quickly	83.99%
Getting Needed Care	83.97%
Coordination of Care	82.68%

Summary rates represent the percentage of respondents who chose the most favorable response options, but not all questions are assigned a summary rate.

MEDICARE UPDATES

MODEL OF CARE OVERVIEW

Gateway Health℠ (Gateway) currently offers four Special Needs Plans (SNPs):

- **Gateway Health Medicare Assured Diamond℠** is a Dual Eligible Special Needs Plan (DSNP) that covers those who have Medicare Parts A & B and full Medical Assistance (Medicaid) or Qualified Medicare Beneficiary (QMB/QMB Plus) or Specified Low-Income Medicare Beneficiary (SLMB).
- **Gateway Health Medicare Assured Ruby℠** is a Dual Eligible Special Needs Plan (DSNP) that covers those who have both Medicare Parts A & B and receive assistance from the state [benefit categories: Specified Low-Income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI) or Qualified Individual (QI)].
- **Gateway Health Medicare Assured Gold℠ and Gateway Health Medicare Assured Platinum℠** are Chronic Condition Special Needs Plans (CSNPs) that cover those who have both Medicare Part A & B and at least one of the following chronic conditions: diabetes, cardiovascular disorder or chronic heart failure. There are no income requirements for the Chronic Condition Special Needs Plans.

As a SNP, Gateway is required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC) Plan. The SNP MOC Plan is the architecture for care management policies, procedures and operational systems.

In accordance with CMS, the SNP MOC must provide the structure for care management processes and systems that will enable a Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals. A MAO must design separate MOCs to meet the special needs of the target population for each Special Needs Plan it offers.

Gateway has a MOC that has goals and objectives for the targeted populations and a specialized provider network, uses nationally-recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of beneficiaries, and adds services for the most vulnerable beneficiaries, including but not limited to, those beneficiaries who are frail, disabled or near the end-of-life.

The SNP MOC includes four main sections. Each section contains subparts called Elements.

MEDICARE UPDATES

MODEL OF CARE OVERVIEW (continued)

SNP Model of Care Elements

1. **Description of SNP Population** - Identification and comprehensive description of the SNP-specific population that addresses the full continuum of care of current and potential SNP beneficiaries, including end-of-life needs and considerations (if relevant). SNPs must include a complete description of specially tailored services for beneficiaries considered especially vulnerable using specific terms and details. This MOC section contains two Elements:
    - Description of Overall SNP Population
    - Subpopulation - Most Vulnerable Beneficiaries
2. **Care Coordination** - Care coordination helps ensure that SNP beneficiaries' health care needs, preferences for health services, and information sharing across health care staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, high-quality patient services (including services furnished outside the SNP's provider network) that ultimately lead to improved health care outcomes. This MOC section contains five Elements:
    - SNP Staff Structure
    - Health Risk Assessment Tool (HRAT)
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Care Transition Protocols
3. **Provider Network** - The SNP provider network is a network of health care providers who are contracted to provide health care services to SNP beneficiaries. SNPs must ensure that their MOC identifies, fully describes and implements the following elements for their SNP provider networks. This MOC section contains three Elements:
    - Specialized Expertise
    - Use of Clinical Practice Guidelines and Care Transition Protocols Model of Care Training
4. **Quality Measurement** - The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver high-quality health care services and benefits to its SNP beneficiaries. Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change. The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified, based on performance results. This MOC section contains five Elements:
    - MOC Quality Performance Improvement Plan
    - Measureable Goals and Health Outcomes for the MOC
    - Measuring Patient Experience of Care (SNP Member Satisfaction)
    - Ongoing Performance Improvement Evaluation of the MOC
    - Dissemination of SNP Quality Performance Related to MOC

MEDICARE UPDATES

MODEL OF CARE OVERVIEW (continued)

How the Model of Care Works for a Member

- Shortly after a member enrolls with any of the Medicare Assured plans, the member is given a Health Risk Assessment (HRA). The assessment is mailed to the member and the member is asked to complete all questions on the form. The member can return the assessment by mail, or if they prefer, to complete the assessment through the member portal or by telephone. If the form is not returned within a specified period of time, outreach calls will be made to the member to complete the assessment.
- The completed HRA is reviewed by the Interdisciplinary Care Team (ICT) and an Individualized Care Plan (ICP) is developed.
- The member's Individualized Care Plan is based on the HRA responses, claims data and input from the primary care physician (PCP) whenever applicable.
- The ICP is mailed to the member and available to the member's PCP, specialists and other ICT members as requested.
- The member receives a level of care management services as indicated on his/her ICP.
- At least annually, the member receives another health assessment to determine if the needs of the member have changed.
- Referrals for care management services can be made at any time through Gateway's internal processes or by the PCP, member or member's caregiver.

Other Important Information about Gateway's Model of Care

- Gateway recognizes that members' care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to receive the level of care management needed for their particular circumstance.
- Members may be referred for Care Management in a variety of ways:
  - Pennsylvania (PA) Providers may call 1-800-685-5212, option 1
  - Ohio (OH) Providers may call 1-888-447-4506, option 1
  - Kentucky (KY) Providers may call 1-855-847-6384, option 1
  - North Carolina (NC) Providers may call 1-855-847-6429, option 1
  - PA members may self-refer by calling 1-800-685-5212, option 1
  - OH members may self-refer by calling 1-888-447-4506, option 1
  - KY members may self-refer by calling 1-855-847-6384, option 1
  - NC members may self-refer by calling 1-855-847-6429, option1
  - Gateway employee via an internal process
- Oversight of the Model of Care Plan is handled by the Quality Improvement Department. Specific questions with regard to the Model of Care Plan should be addressed with your Gateway Provider Representative.

*__Action Required__ – Please go to gatewayhealthplan.com, click on Provider and then Model of Care to complete the attestation to acknowledge you have reviewed and understand Gateway's Model of Care information.

BEHAVIORAL HEALTH

Gateway's Depression Management Program: A Tool for Primary Care Physicians

In 2016, the U.S. Preventative Services Task Force (USPSTF) updated its recommendations to include a routine screen for depression in the general adult population. Primary care physicians are often on the frontline in treating mood disorders and the emotional aspects of chronic physical disease states. Gateway Health wants to support you in the care of these patients.

The Gateway Depression Management Program is offered to all of our Medicare members. In this telephonic case management program, a licensed behavioral health clinician screens the member for depression using an evidenced-based screening tool to identify symptoms and issues of concern. They also work with the member to educate them with regard to symptoms, to identify community-based mental health supports, and to address medication management (adherence, reconciliation of medications) through regular follow-up calls to the member. If the member needs to be referred to a psychiatrist or counseling services, the case manager can make this connection.

The case manager can follow-up with your practice to provide feedback and to assist your practice in the navigation of the mental healthcare system. To make a referral or to request information (program brochures or available screening tools) for your office, please contact Kevin Knaus, Supervisor of Behavioral Health Case Management, at 412-918-8783.

PROGRAMS AND BENEFITS

Quality Improvement Evaluation

Quality Improvement Program Results

Annually, Gateway Health evaluates the Quality Improvement and Utilization Management (QI/UM) Program to assure the delivery of quality care to its members. The QI/UM Program is evaluated to:

1. Ensure alignment with its mission and assure that the goals and objectives are being met;
2. Assess improvements in the quality of clinical care and quality of service; and
3. Evaluate the overall effectiveness of the QI and UM Programs.

These findings are used to guide our future quality improvement activities. The review of our 2015 program is complete and here are highlights of how we performed:

QUALITY SCORES - MEDICARE H5932 PA

Star Rating

Gateway achieved an overall 3.5 star rating for care provided to our Medicare members. Star ratings range from 1 (lowest) to 5 (highest). Our goal is to attain a 4 star rating. Star ratings are posted each year in the fall on the Medicare website.

HEDIS

Our HEDIS scores demonstrated improvement and achievement in higher NCQA Quality Compass Benchmarks. A few examples to share with you:

- **W15 - Well Child Visits in the First 15 months (Medicaid)**. This measure looks for six or more well visits by 15 months of age. Our final reported rate of 71.39% is above the Quality Compass 75th percentile benchmark.
- **OMW - Osteoporosis Management in Women who had a Fracture (Medicare)**. This measure requires either a bone mineral density test OR prescription for a drug to treat osteoporosis in the six months post fracture. The final reported rate of 40.70% is above the Quality Compass 75th percentile benchmark.
- **CDC - Diabetes Eye Exam (Medicaid & Medicare)**. This measure requires a retinal or dilated eye exam by an eye care professional **OR** a *negative* retinal or dilated eye exam by an eye care professional. The final Medicaid reported rate of 54.74% and the final Medicare reported ate of 70.32% are at the Quality Compass 50th percentile benchmark.

PROGRAMS AND BENEFITS

Quality Improvement Evaluation (continued)

Practitioner/Provider Satisfaction Survey - Medicare

Annually, Gateway conducts a practitioner/provider satisfaction survey to evaluate how satisfied you are with various aspects of Gateway services. A few highlights of the survey results:

- 98% of PCPs routinely communicate test results to patients
- Specialists report a 92% overall satisfaction rate from their Gateway provider relations representative.

Additional survey results can be found on Gateway's website at gatewayhealthplan.com and in the June 2016 edition of the *Provider Update* newsletter.

Member Satisfaction Survey

Annually, a survey is conducted to a random sample of our members to evaluate their satisfaction with Gateway. The survey is conducted by an outside certified survey vendor. A few highlights of the **Medicaid** child member survey results:

- Rating of Healthcare: 68.9%, an increase compared to 2014 rate of 67.2%
- Getting Care Quickly: 92.9%, an increase compared to 2014 rate of 92.7%
- How Well Doctors Communicate: 93.5%, a decrease compared to the 2014 rate of 95.1%

QUALITY SCORES – MEDICARE H9190

HEDIS

Our HEDIS scores demonstrate that more members are receiving diabetes care in the following areas and both measures performed at the Quality Compass 75th Percentile Benchmark:

- **CDC – Diabetes HbA1c Testing.** The rate is 95%.
- **CDC – Diabetes Medical Attention for Nephropathy.** The rate is 94%.

Network Development

- 3,607 new practitioners credentialed

PROGRAMS AND BENEFITS

Quality Improvement Evaluation (continued)

Member Satisfaction Survey

Annually, a survey is conducted to a random sample of our members to evaluate their satisfaction with Gateway. The survey is conducted by an outside certified survey vendor. A few highlights of the **Medicare** member survey results:

- Health Plan Customer Service: 88.3% received 5 stars
- Rating of Health Plan: 77.2% received 4 stars
- Annual Flu Vaccine: 71.2% received 4 stars, a decrease from 68.6% in 2014, but still received 4 stars

PROGRAMS AND BENEFITS

Gateway Health℠ Launches Member Rewards Program

Medicaid Members to Get Rewarded for Healthy and Preventive Behavior

Gateway Health provides a number of benefits that help our members get healthy and stay healthy. And to help them get the most out of their plan, we are introducing the ***Goodness Rewards℠ Program***.

Medicaid members will be given opportunities to earn gift cards for completing preventive exams and screenings such as:

- Prenatal and postpartum visits
- Well-baby visits
- Adolescent wellness visits
- Dental check-ups
- Diabetic A1C testing
- Blood pressure screening (coming in 2017)

Preparing for Patient Interaction

Medicaid members will receive information in November on the ***Goodness Rewards Program***, including which healthy activities they can complete to earn a reward. Since our providers play a critical role in helping our members stay healthy and manage their health conditions, you will likely be receiving scheduling requests for the various exams, tests and screenings.

We thank you in advance for supporting Gateway Health and the ***Goodness Rewards Program***. We share your goal of a higher quality of care for your patients, along with better outcomes.

COMING IN 2017

The *Goodness Rewards Program* will be expanded to include Medicare members.

Medicare members can currently earn a $50 reward for completing a preventive care visit. You may see an increase in scheduling for the preventive care visit. You will need to sign a card that the member brings in.

IMPORTANT PHONE NUMBERS

MEDICARE ASSURED IMPORTANT PHONE NUMBERS

FOR INQUIRIES, PLEASE CALL PROVIDER SERVICES
MONDAY – FRIDAY, 8 A.M. – 4:30 P.M.
1-855-847-6380 (KY)
1-855-847-6430 (NC)
1-888-447-4505 (OH)
1-800-685-5209 (PA)

TTY/TDD (FOR ALL DEPARTMENTS)
24 HOURS A DAY, 7 DAYS A WEEK
711 or
1-800-648-6056 (KY)
1-800-735-2962 (NC)
1-800-750-0750 (OH)
1-800-654-5988 (PA)

MTM (Transportation Services)
MONDAY – FRIDAY, 8 A.M. – 5 P.M.
SATURDAY 9 A.M. – 1 P.M.
1-844-549-8363 (KY, NC and OH)
1-866-670-3063 (PA)
TTY is 1-800-855-2880

VOIANCE LANGUAGE SERVICES
24 HOURS A DAY, 7 DAYS A WEEK
(Offers bilingual interpreters at a special Gateway rate)
1-866-742-9080, ext. 1
www.voiance.com/gateway

MEDICAID IMPORTANT PHONE NUMBERS

CALL TO INQUIRE ABOUT:

MEMBER PROGRAMS
MONDAY - FRIDAY, 8:30 A.M. - 4:30 P.M.
1-800-392-1147
- Care Management, select option 1
- Maternity/MOM Matters®, select option 2
- Asthma/ Cardiac/ COPD/ Diabetes, select option 3
- Preventive Health Services/ EPSDT/Outreach, select option 4

FRAUD AND ABUSE AND COMPLIANCE HOTLINE
24 HOURS A DAY, 7 DAYS A WEEK
1-800-685-5235

(Voicemail during off hours. The call will be returned the next business day.) Please do not leave multiple voicemail messages or call for the same authorization request on the same day.

TTY/TDD (FOR ALL DEPARTMENTS)
MONDAY - FRIDAY, 8 A.M. - 5 P.M.
711 or
1-800-682-8706