Gateway Health℠

OCTOBER 2016

PROVIDER UPDATE

An Update for Gateway Health℠ Providers and Clinicians

THIS ISSUE

Important Phone Numbers

www.gatewayhealthplan.com

ADMINISTRATIVE/OFFICE STAFF

Gateway Health℠

Provider Update

October 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 & fax number changes;
- Changes to hours of operation;
- Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only);
- Practitioner participation status (additions & terminations) and;
- 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 www.gatewayhealthplan.com – select *Provider*, and then click on *Forms & 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

New Provider Authorization Portal

Gateway Health providers now have access to a new Provider Authorization Portal. The portal can be accessed by clicking the existing Provider Authorizations link. The new Authorization Portal was built into a new integrated Gateway platform that includes all of the functionality of the original and also includes new features such as:

- Overall application optimization and enhancements resulting in a faster and more robust experience.
- Modern design built for use on desktop, tablet or mobile devices.
- Enhanced authorization form workflows and functionality.
- More information and feedback available regarding submitted Authorizations.
- Advanced authorization submission search functionality.
- Batch claims lookup that allows quick and full search criteria for completed claims.
- Additional provider self-service features coming soon that include Secure Messaging and Document Exchange.

Complex Case Management (Medicaid)

Referring Members to the Complex Case Management Program

Gateway Health provides telephonic Complex Case Management to eligible members with the goal of assisting members to achieve optimal healthcare outcomes. The program concentrates on members that are identified as high risk with multiple chronic conditions that result in high utilization. These members require extensive use of resources and need assistance to coordinate care.

Case Managers provide lifestyle management and disease/condition-specific education, address preventive health issues, complete medication reconciliations, identify benefits and community resources to better serve the member, and help coordinate care with providers. One way that Case Managers and members communicate and work toward achieving healthcare goals is through the Patient Self Management Guide. The guide is mailed to members and outlines health management suggestions that the member has agreed to work on. The guide promotes a Case Manager-member discussion and helps to establish a collaborative relationship.

The role of the practitioner in the Complex Case Management program is important. Practitioners who have identified a member that may benefit from this program may make a referral by contacting the Medicaid Special Needs Case Management department at 1-800-392-1147, Option #2. Be ready to provide your 10-digit NPI number. Gateway Health will review all referrals and make the final decision for inclusion in this program based on each member's unique needs and the potential to positively impact the member's health and well-being. Thank you for your collaboration and participation.

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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 Centers for Medicare and Medicaid Services (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, 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.

ADMINISTRATIVE/OFFICE STAFF

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

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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.

POLICY UPDATES

MP-022-MD-PA Negative Pressure Wound Provider Summary (Medicaid)

CLINICAL MEDICAL POLICY	
Policy Name:	Negative Pressure Wound Therapy in the Outpatient Setting
Policy Number:	MP-022-MD-PA
Approved By:	Medical Management
Provider Notice Date:	10/1/2016
Original Effective Date:	12/1/2016
Annual Approval Date:	8/8/2017
Revision Date:	NA
Products:	Pennsylvania Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

Disclaimer

Gateway Health℠ medical payment and prior-authorization policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Gateway Health provides coverage under the durable medical equipment benefits of the Company's Medicaid products for medically necessary electrically powered vacuum assisted wound closure therapy. Example of wounds that may be eligible for Negative Pressure Wound Therapy meeting the medical necessity requirements include: Chronic Stage III or IV pressure ulcers, neuropathic ulcers, venous or arterial insufficiency ulcers, traumatic or surgical wounds, wounds refractory to standard wound regimens, burns, and complications of surgically created wounds.

*The full version of this medical policy is available on the Gateway provider website at:
http://gatewayhealthplan.com/MedicalPolicies

POLICY UPDATES

MP-029-MD-PA Passive Oscillatory Devices Provider Summary (Medicaid)

CLINICAL MEDICAL POLICY	
Policy Name:	Passive Oscillatory Devices in the Outpatient Setting
Policy Number:	MP-029-MD-PA
Approved By:	Medical Management
Provider Notice Date:	10/1/2016
Original Effective Date:	12/1/2016
Annual Approval Date:	8/8/2017
Revision Date:	NA
Products:	Pennsylvania Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

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Gateway Health℠ medical payment and prior-authorization policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Gateway Health provides coverage under the durable medical equipment benefits of the company's Medicaid products for medically necessary passive oscillatory/high-frequency chest wall oscillation devices. Coverage may be provided for the following conditions based upon the medical policy medical necessity guidelines: cystic fibrosis, chronic bronchiectasis and chronic neuromuscular disorders.

*The full version of this medical policy is available on the Gateway provider website at:
http://gatewayhealthplan.com/MedicalPolicies

MEDICARE UPDATES

Medicare CMS Update

REMINDER FOR MEDICARE PROVIDERS:

Effective February 1, 2017, the Centers for Medicare & Medicaid Services (CMS) will require nearly all prescribers – including physicians, dentists, nurse practitioners and physician assistants – to enroll in Medicare in order to prescribe drugs for patients enrolled in Medicare Part D. This change will enable CMS to better combat fraud and abuse within the Part D program through verification of providers' credentials.

In accordance with this change, Gateway Health℠ will not cover drugs prescribed by providers who are not enrolled in Medicare effective February 1, 2017 except in very limited circumstances. If you need assistance with the process of enrolling or have additional questions, please visit go.cms.gov/PrescriberEnrollment.

MEDICAID UPDATES

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.

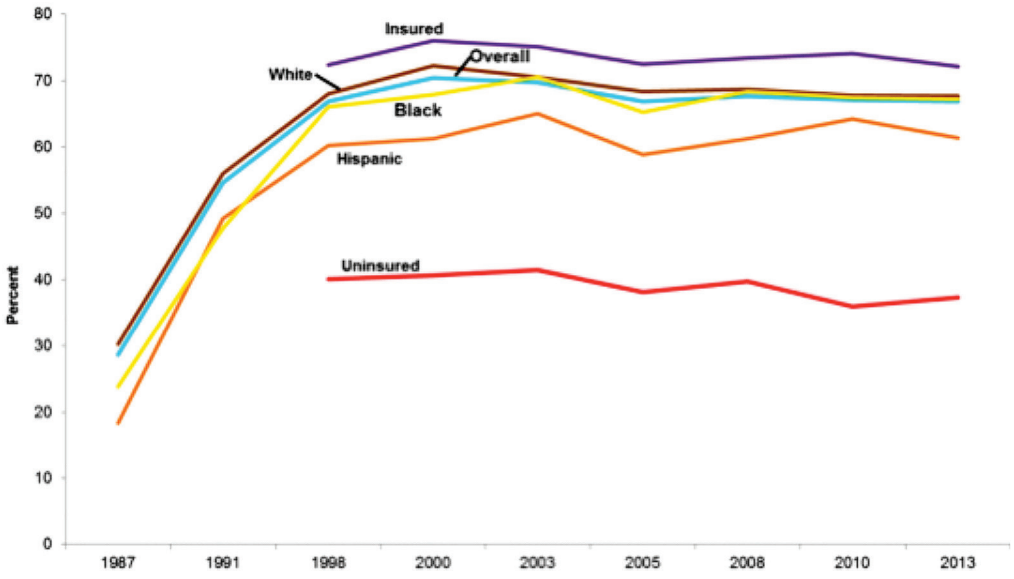
CLINICAL UPDATES

Breast Cancer Awareness

Every October, we take time to recognize the severity of breast cancer, the strength of all of those who have suffered through the disease, and the memory of those who lost their battle. Despite the fact that breast cancer receives great national attention and the most research funding for cancers[1], this disease is still the second leading cause of cancer deaths for women in the United States[2].

The benefit of regular screening for early detection and prevention of cancers, including breast cancer, is well established. However, there are a large number of eligible women who still choose not to get a regular mammogram. The table below from the American Cancer Society shows mammography trends over the past 30 years by ethnicity and insurance coverage. For the last 15 years, the screening rate has remained relatively unchanged for all categories.

Mammography Rates from 1987-2013 (American Cancer Society)



As a provider, you have the opportunity to positively impact the number of Gateway Health members who receive this important screening. A provider recommendation can be a powerful tool to motivate a member to get screened, especially high risk women with no recent mammogram*. It can be helpful to assess breast cancer risk, document all exclusions for screening, and use a reminder system to notify you when a member needs to be screened. We encourage all providers to have this conversation with members who are due for a mammogram and assist them in accessing this test. You can make a difference in the lives of our members.

Sources

1. Carter, A. J., & Nguyen, C. N. (2012). A comparison of cancer burden and research spending reveals discrepancies in the distribution of research funding. *BMC Public Health*, 12(1). doi:10.1186/1471-2458-12-526

2. U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2013 Incidence and Mortality Web-based Report.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2016. Available at: www.cdc.gov/uscs.

*Current USPSTF recommendation is for women ages 50-75 years at normal risk to have a mammogram every two years.

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