A Newsletter for
Gateway Health℠ Providers and Clinicians

PROVIDER UPDATE

Gateway Health
A better way.℠

Annual Dentist Visit

PAGE 25

JUNE 2016

PROVIDER UPDATE

Gateway Health
A better way.℠

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ICON KEY:
- Green color for Medicare and Medicaid
- Light blue color for Medicare Assured
- Light yellow color for Medicaid

●●● OFFICE STAFF • MEDICARE & MEDICAID

CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

Gateway Health℠ has developed, approved and adopted clinical practice and preventive health guidelines for 2016 based on current national guidelines and other recognized sources. These evidence-based guidelines are promoted in an effort to improve health care quality and reduce unnecessary variations in care.

These guidelines are reviewed and approved annually by Gateway's Quality Improvement and Utilization Management Committee. A few key changes to the guidelines in 2016 include:

- Adoption of new clinical practice guidelines for **Substance Abuse and Palliative Care** (Medicaid and Medicare)
- **HIV Guideline** updates to the clinical indicators to align with regulatory stratifications
- **Routine and High Risk Prenatal Care Guideline** updates to risk-based laboratory screenings for Zika PCR and one hour 50 gm glucose
- **Adult Preventive Guideline** changes to various screening requirements and assessment timeframes

Guidelines* for 2016 include the following:

- Adult Preventive Care
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Cardiac Medical Management
- Child Preventive Care
- COPD
- Diabetes
- HIV
- Hypertension
- Major Depression in Adults in Primary Care
- Palliative Care
- Routine and High Risk Prenatal Care
- Schizophrenia
- Substance Abuse

These guidelines can be viewed at www.gatewayhealthplan.com under the "Quality Improvement: Guidelines and Resources" section.

**Guidelines may change*

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Gateway Health's Utilization Management (UM) decisions are based only on the appropriateness of care and services and existence of coverage. Gateway Health does not specifically reward practitioners or other individuals for issuing coverage or service denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Gateway Health monitors for both over and under utilization of care to prevent inappropriate decision making, identify causes and corrective action, and indicate inadequate coordination of care or inappropriate use of services. Gateway Health is particularly concerned about underutilization and monitors utilization activities to assure members receive all appropriate and necessary care.

MEDICAL NECESSITY DETERMINATIONS

The authorization process for medical necessity determinations at Gateway Health is accomplished through the application of the Pennsylvania Department of Human Services' definition of medical necessity. A service or benefit is medically necessary if it is compensable under the Medical Assistance program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Medical necessity determinations must be made by qualified and trained providers.

The Utilization Care Manager refers cases to the Gateway Medical Director and/or Physician Advisor for a medical necessity determination.

PEER REVIEW INFORMATION

Gateway Health offers providers the opportunity for peer reviews whenever a medical necessity decision is made to deny or reduce a service. The Utilization Management nurse phones the ordering or attending physician's office to review the details of the request and the physician's decision. The nurse will provide the Gateway Health physician's name and phone number so that you have the opportunity to discuss the decision, including the reason you believe the service is medically necessary. When calling the Gateway Health physician, please have the following information readily available to ensure a timely discussion with the appropriate physician:

- Name of the Gateway Health physician to whom you were directed to speak
- Member information, including the Gateway identification number and/or authorization number

DOCTOR PATIENT COMMUNICATION

Adding that "Special Touch" to Your Practice

Positive patient-provider interactions are vital to a member's overall health care experience. Whether it be a wellness visit or a simple call to the doctor's office, every interaction matters. Sufficiently communicating and educating your patients will help strengthen your relationship and positively impact their time with you.

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

- Smile
- Make eye contact between typing notes into the computer
- Avoid long silent pauses while using the computer
- Speak in terms the patient will understand
- Share reminders for appointments, immunizations and screening tests
- Suggest alternative physical activities to promote a healthy lifestyle

Remember, patients look to you in times of need, so it's important to make them feel comfortable and in good hands. Adding that "special touch" to each patient interaction will increase each patient's overall health care experience.

Thank you for your big contribution to our members' health and health care experience!

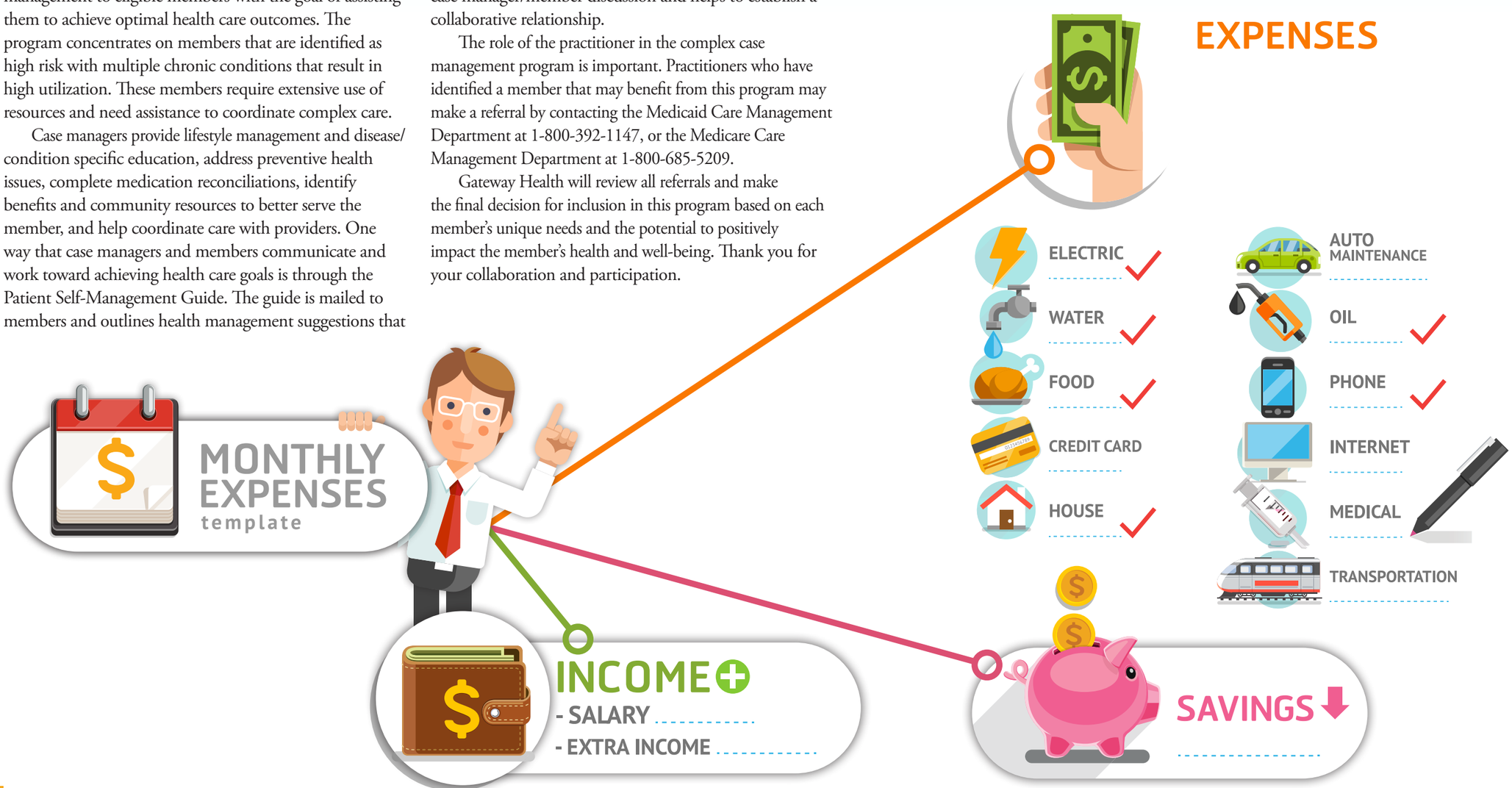
REFERRING MEMBERS TO THE GATEWAY HEALTH COMPLEX CASE MANAGEMENT PROGRAM

Gateway Health provides telephonic complex case management to eligible members with the goal of assisting them to achieve optimal health care 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 complex 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 health care 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 Care Management Department at 1-800-392-1147, or the Medicare Care Management Department at 1-800-685-5209.

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.



••• OFFICE STAFF • MEDICARE & MEDICAID

REPORTABLE CONDITIONS

Gateway practitioners are contractually required to follow Gateway Health Quality Improvement (QI) programs including but not limited to, reporting certain diseases, infections or conditions as determined by Title 28, Chapter 27, §27.21a in the Pennsylvania Code. Gateway's reportable conditions policy has been established to detail this requirement and the methods by which practitioners will be notified of its necessity.

To request additional information or to obtain a copy of the reportable conditions policy, please contact **Gateway's Provider Services Department** at either **1-800-685-5209 (Medicare Providers)** or **1-800-392-1147 (Medicaid Providers)**. The regulations, which include the complete list of reportable conditions and timeframes for reporting, can be found via the Pennsylvania code website at **www.pacode.com**.

PRACTITIONER AND PROVIDER SATISFACTION SURVEY

Gateway conducted a Practitioner and Provider Satisfaction Survey from October 2015 to January 2016. The population sampled included primary care practitioners with a panel size greater than 50 members. The specialty care practitioners sample included high-volume specialists with at least 5 unique member visits and paid claims within the last year. Approximately 100 percent of the hospital network and a remaining sample of ancillary providers were also surveyed.

Gateway will continue to strive toward meeting the needs of our practitioner and provider network. Action plans are developed to improve those areas with deficiencies to assure ongoing improvement.

The complete survey results can be found on www.gatewayhealthplan.com under "Provider Updates, Forms and References." A few of the questions and overall satisfaction in specific areas are shown in this newsletter.

The percentages are summary rate scores based on the sum of the most favorable response options from those who answered the survey.

Gateway Health Medicare Assured℠
2015 Practitioner and Provider Satisfaction Survey Results

Question	2015 PCP	2015 SCP	2015 Hospital	2015 Ancillary
Continuity and Coordination of Care				
Use a computer or handheld device during your patients' visits to look up test results or other information, show information or order prescription medicines	78.8%	69.4%	N/A	N/A
Review patients' medications at each visit and ask if there are any medication questions at each visit	94.0%	91.2%	N/A	N/A
Routinely communicate test results to patients either by mail or phone	93.4%	88.7%	N/A	N/A
Gateway Representative and Communication				
Your overall satisfaction with the quality of service from your Gateway provider relations representative	92.3%	90.5%	58.3%	88.2%
Provider services and claims				
Your satisfaction with clean claims being paid in a timely manner	92.1%	89.3%	42.9%	82.5%
Your overall satisfaction with the claims review and/or appeal process	87.6%	81.4%	35.0%	73.7%
Utilization Management				
Your overall satisfaction with the UM process	87.7%	92.6%	94.4%	88.9%
Pharmacy Authorization Process, Staff, and Drug Formulary				
Your overall satisfaction with the Gateway pharmacy prescription authorization process	81.8%	87.5%	N/A	N/A
Overall Satisfaction and Loyalty				
Overall satisfaction with Gateway Health	88.4%	88.2%	60.0%	83.1%

Gateway Health℠
2015 Practitioner and Provider Satisfaction Survey Results

Question	2015 PCP	2015 SCP	2015 Hospital	2015 Ancillary
Continuity and Coordination of Care				
Use a computer or handheld device during your patients' visits to look up test results or other information, show information or order prescription medicines	84.7%	74.8%	N/A	N/A
Review patients' medications at each visit and ask if there are any medication questions at each visit	98.1%	93.9%	N/A	N/A
Routinely communicate test results to patients either by mail or phone	98.1%	92.2%	N/A	N/A
Gateway Representative and Communication				
Your overall satisfaction with the quality of service from your Gateway provider relations representative	91.7%	92.2%	58.3%	86.2%
Provider Services and Claims				
Your satisfaction with clean claims being paid in a timely manner	86.8%	88.9%	63.2%	71.1%
Your overall satisfaction with the claims review and/or appeals process	84.3%	82.4%	47.4%	61.2%
Utilization Management				
Your overall satisfaction with the UM process	89.9%	91.7%	100,0%	85.4%
Pharmacy Authorization Process, Staff and Drug Formulary				
Your overall satisfaction with the Gateway Pharmacy prescription authorization process	83.6%	86.8%	N/A	N/A
Overall Satisfaction and Loyalty				
Overall satisfaction with Gateway Health	90.2%	91.1%	65.2%	80.0%

PROVIDER MANUAL AND GATEWAY AT A GLANCE (GAAG)

The 2016 Medicare Assured℠ Provider Policy Procedure Manual and the Medicare Assured℠ Gateway At A Glance are available on our website. Please reference this material for the most current information

MEDICAL RECORD REQUESTS: TIME IS OF THE ESSENCE*

Gateway Health regularly conducts a review of our providers' medical records to assure compliance with criteria as specified in the Medical Record Review Standards. The standards, which incorporate a core set of critical factors were developed and approved by Gateway Health's Quality Improvement/Utilization Management Committee and adhere to regulatory requirements as prescribed by various contracts.

From time to time, Gateway will submit an ad hoc request for medical records to review in order to ensure regulatory compliance. We ask that providers in our participating network respond to these requests within 15 days in the event such a request is received. These requests are separate from those made for operational purposes, such as those to investigate quality of care issues, complaints/grievances, or serious adverse effect cases.

Complying with Gateway's medical record requests in a timely fashion is more than just a contractual responsibility – it's a state and federal requirement. Please do your part to ensure that you and Gateway are in compliance so that we can all continue to provide the very best quality care to your patients, our members.

In addition to providing Gateway with medical records upon request, providers are required to transfer member medical records, or copies of records, to newly designated PCPs, specialists or treatment facilities within 15 business days from receipt of the request from the Pennsylvania Department of Human Services, its agent, the member or the member's new treating practitioner - without charging the member. Gateway's membership includes vulnerable individuals, some of whom suffer from severe or chronic illnesses. Continuity of care, or the seamless sharing of information between health care providers, is essential across all the touch-points within these patients' care in order to make the informed decisions which will ensure their well-being. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs and medical errors.

Please contact your provider relations representative with any questions, or to access the medical record review standards, you can visit Gateway's website at www.gatewayhealthplan.com, click on the provider tab then Quality Improvement: Guidelines and Reference. Here you will see a list of all the Medical Record Review Standards.

*This article initially appeared in the June 2015 Provider Newsletter

GATEWAY HEALTH NOTICE OF PHONE NUMBER CHANGE

In an effort to better serve you and our members, Gateway Health would like to inform you that beginning June 20, we will retire several phone numbers to help streamline services.

A fax blast was sent out on May 20 to announce to all participating providers and hospitals. **Beginning June 20, 2016** the only phone numbers you need to dial are the following:

Pennsylvania Medicaid Phone Number Updates

Pennsylvania Medicaid 1-800-392-1147

TTY/TDD will now be 711 or 1-800-654-5984

Medicare Assured Phone Number Updates

Medicare Assured (KY) 1-855-847-6380
Medicare Assured (NC) 1-855-847-6430
Medicare Assured (OH) 1-888-447-4505
Medicare Assured (PA) 1-800-685-5209

TTY/TDD phone number is now (711) or state-specific TTY #s

Medicare Assured (KY) 1-800-648-6056
Medicare Assured (NC) 1-800-735-2965
Medicare Assured (OH) 1-800-750-0750
Medicare Assured (PA) 1-800-654-5984

These phone numbers will now be the same for Utilization Management, Care Management, Pharmacy, Provider Services and Provider Credentialing. When you dial these numbers, a voice prompt message will instruct you to the appropriate department. To proceed with your call, you must Press 1 to enter your 10-digit NPI or Press 2 to enter your 9 digit tax identification number. If you do not have either of these numbers, please call us back when you have secured one of these key provider identification criteria.

Beginning June 20, and for the first month of the phone number change, when you dial the old number, a voice recording will inform you that the old phone numbers are retired and will automatically transfer you to the new numbers.

HOW TO REQUEST A DRUG BE ADDED TO THE FORMULARY

Providers may request the addition of a medication to the formulary.

Requests must include the drug name, rationale for inclusion on the formulary, role in therapy and the formulary medications that may be replaced by the addition. The Pharmacy and Therapeutics (P&T) Committee will review and consider these requests. All requests should be forwarded in writing to:

Gateway Health
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pharmacy Department
P&T Committee, Floor 19
Pittsburgh, PA 15222

The Pharmacy Department Help Line: We are Committed to Quality

Gateway's Pharmacy Department is focused on providing a first-class customer service experience for our providers. Designated staff is available to address provider questions related to the drug benefit or other pharmacy processes.

If you are a provider or calling on behalf of a provider, please contact the Pharmacy Technical Help Desk at:

Pennsylvania Medicaid
1-800-392-1147

Medicare Assured℠
1-855-847-6380 (KY)
1-855-847-6430 (NC)
1-888-447-4505 (OH)
1-800-685-5209 (PA)

A trained representative is ready to help with all of your questions related to the drug benefit or other pharmacy processes. A representative can help you locate important pharmacy forms (e.g. prior authorization forms), assist you in the pharmacy prior authorization process, and provide you with formulary alternatives to non-formulary medications. You can find this valuable information on our website under the provider section at http://www.gatewayhealthplan.com/providers/pharmacy-tools.

2016 GPE® INCENTIVES

Gateway Health is proud to present a redesigned GPE® program that includes multiple opportunities for practitioners to earn incentives! Eligibility to participate is still limited to practices with greater than 50 members in Medicaid or Medicare by December 31, 2015. Widget based payments, patient centered medical home, practice-based end of year performance improvement payout, and multipliers are the program components. Gateway Health is also improving the scorecards and dashboards in an effort to provide real-time, actionable data to practitioners to enhance quality improvement and the Provider Engagement team is available to support practices at individual offices and at an entity-level.

2016 eligibility and enhancements are noted below.

- FQHC modifications
- Widget payments for gap closure
- End of Year overall practice improvement bonus
- Redesigned dashboard and scorecard reports
- PCMH per member, per month incentive
- Payment multipliers for completion of SOAP notes and readmission rates <8.5%
- Profile measures
- HEDIS reference and CPTII guides
- Ongoing support from the Provider Engagement team

Who is eligible for the program?

- Primary care physician practices (family practice, internal medicine and pediatrics) with panel size of 50 or more Medicaid or Medicare members
- Obstetrical care providers (panel size not required)/Medicaid only
- Dentists (panel size not required)/Medicaid only

We encourage you to visit our website for a detailed explanation of the program. When you log onto our website you will see the following links which take you through the program.

GPE Resources:

- 2016 GPE® presentation
- CPTII coding guide
- HEDIS reference guide

For more information regarding the Gateway to Practitioner Excellence® Program, please visit our website. To schedule a visit with someone from Provider Engagement, contact ProviderPay-for-Performance@gatewayhealthplan.com

COMMUNICATING CARE TRANSITIONS BETWEEN SKILLED NURSING FACILITIES AND PCPS

Since Medicare patients are especially vulnerable to receiving fragmented and unsafe care as a result of poorly coordinated care transitions, Gateway Health's Medicare SNP plans make special efforts to help providers manage the care transition process.

Planned and unplanned care transitions occur when a patient's health care needs to change from one setting to another setting, including when the patient is discharged from a skilled facility to home. When discharged home, the patient's care transitions back to the member's primary care physician (PCP).

When patients experience a planned or unplanned care transition, the sending setting must provide a patient care plan to the receiving setting within one business day of the transition notification. This can be accomplished by providing a copy of the patient's discharge instructions. For planned transitions from an inpatient skilled facility to home, the member care plan should be sent to the treating practitioner, which is the member's PCP. It is also important to review the care plan in detail with the patient or caregiver to ensure they understand diagnoses, treatments, medications and follow-up medical appointments.

Sharing a comprehensive care plan increases continuity and coordination of care across settings and helps prevent patient risks. The patient care plan is often referred to as a transfer summary, discharge summary or patient discharge instructions. A patient care plan includes patient-specific information that is relevant to the member's clinical condition and health status, such as a current problem list, allergies/sensitivities, medication regimen, baseline physical, and cognitive functioning and advance directives. Patients will be more likely to follow the care plan when they or their caregiver take an active role in the care transition and have the opportunity to ask questions. It may be beneficial to list medications by both brand and generic names and to assist patients in making follow up physician appointments in advance of the transition to home. Since Medicare patients are especially vulnerable to receiving fragmented and unsafe care as a result of poorly coordinated care transitions, Gateway Health's Medicare SNP plans make special efforts to help providers manage the care transition process.

Gateway Health collaborates with members, PCPs and participating skilled nursing facilities to improve transition communication. One of the ways that Gateway helps to facilitate safe care transitions is by mailing an approval letter to the member. This letter helps to educate members about care transitions and informs members of how to reach Gateway for help with transition needs. In an effort to encourage communication of the care transition being sent to the member's PCP, the inpatient approval letter also identifies the member's PCP name, address and phone number.

If you have questions or suggestions regarding care transition management, please contact Gateway's Care Management Department at one of the following phone numbers:

1-855-847-6380 (KY)
1-855-847-6430 (NC)
1-888-447-4505 (OH)
1-800-685-5209 (PA)

BEHAVIORAL HEALTH CARE MANAGEMENT INTRODUCES READMISSION PROCESS

Psychiatric readmissions present hospitals with unique treatment challenges. To better support hospital treatment teams with these cases, Gateway Health's Behavioral Health team is here to support your efforts. We have introduced a readmission process to support members who have experienced a 30-day readmission. This comprehensive process delivers timely concurrent contact with both our behavioral health utilization management and clinical care coordination staff. During initial telephonic concurrent reviews, the integrated Behavioral Health team will support all hospital utilization management, discharge planning and social work efforts by offering clinically-focused and patient-relevant information and assistance. Members are managed under the readmission process if an inpatient behavioral health admission occurs within 30 days of discharge from a previous hospitalization. Please call the Behavioral Health Department with questions and to obtain a 30 Day Readmission Provider Guide at 1-800-685-5209.

CMS PRESCRIBER ENROLLMENT REMINDER

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.

MODEL OF CARE OVERVIEW

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

- **Medicare Assured Diamond**℠ is a Dual Eligible Special Needs Plan (DSNP) and 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).

- **Medicare Assured Ruby**℠ is a Dual Eligible Special Needs Plan (DSNP) and 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).

- **Medicare Assured Gold**℠ and **Medicare Assured Platinum**℠ are Chronic Condition Special Needs Plans (CSNP), and cover those who have both Medicare Parts 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 Model of Care Plan is the architecture for care management policy, procedures and operational systems.

In accordance with CMS, the SNP MOC must provide the structure for care management processes and systems that will enable 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 SNP 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.

SNP MOC 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

How the MOC 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 who is asked to complete all questions on the form. The member can return the assessment by mail, or if they prefer, 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 ICP 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.

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MODEL OF CARE OVERVIEW (CONTINUED)

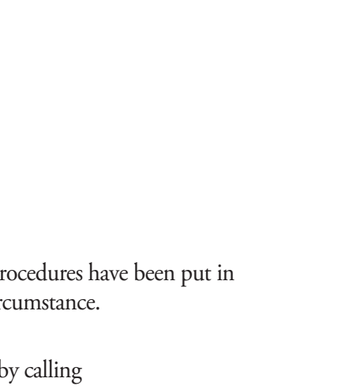
Other Important Information about Gateway's MOC

- Gateway recognizes that members' care needs are varied and 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 1-800-685-5209, option 1
  - Ohio (OH) Providers may call 1-888-447-4505, option 1
  - Kentucky (KY) Providers may call 1-855-847-6380, option 1
  - North Carolina (NC) Providers may call 1-855-847-6430, option 1
  - PA Members may self-refer by calling 1-800-685-5209, option 1
  - OH Members may self-refer by calling 1-888-447-4505, option 1
  - KY Members may self-refer by calling 1-855-847-6380, option 1
  - NC Members may self-refer by calling 1-855-847-6430, option 1
  - Gateway employee via an internal process

- Oversight of the MOC Plan is handled by the Quality Improvement Department. Specific questions with regard to the MOC Plan should be addressed with your Gateway Provider Representative.

*Action Required – Please visit www.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.

INTEGRATING PHYSICAL AND BEHAVIORAL HEALTHCARE



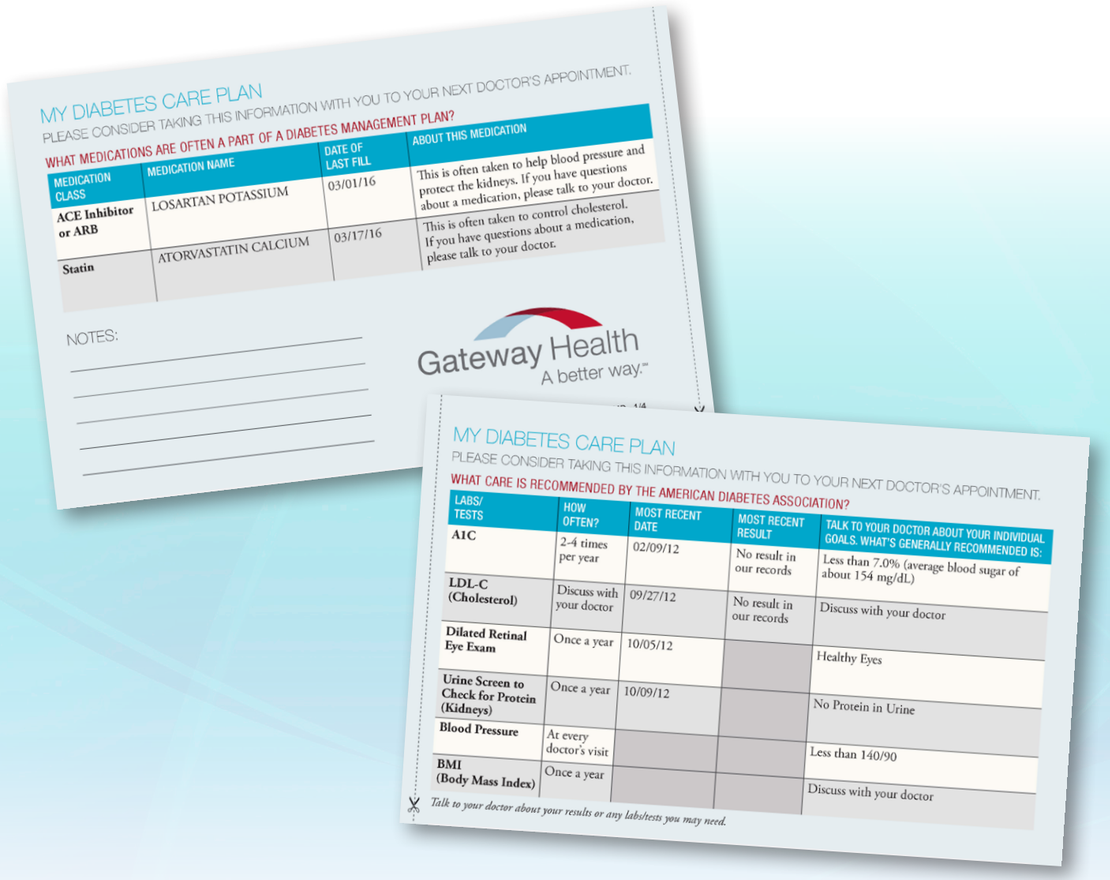
The Pennsylvania Department of Health and Human Services (DHS) introduced an Integrated Care Plan (ICP) initiative in January 2016. The ICP involves collaboration with the Physical Health MCOs such as Gateway, and the Behavioral Health MCOs overseeing HealthChoices members' behavioral health care. The ICP targets members with specific diagnosis of severe and persistent mental illness, with schizophrenic disorders, mood disorders, nonorganic psychoses and borderline personality disorder targeted for the initiative. Pay for performance monies are available to both the PH and BH MCO based upon progress in improving various quality metrics including reducing emergency department visits when care could be met at the community-level, reducing all-cause admission and all-cause readmission, and increasing medication compliance related to antipsychotic medications, and improving access to treatment for substance use disorders. Key strategies include combined PH and BH stratification of the members to identify members who would benefit from ICP efforts. Other strategies include timely exchange of acute hospital admission and exchange of care plan information. Gateway fully supports this initiative and will use this innovative approach to support quality healthcare treatment of our members. If you are a provider who would like to learn more about efforts to integrate physical and behavioral health care for Gateway members, please call the Gateway Case Management Department at 1-800-392-1147, option 1.

MANAGING DIABETES

Gateway Health recognizes the important role that medical practices play in providing quality health care to our members. We also know the critical role members play in managing their own health. For that reason, we want to empower them with the best tools and resources to increase the likelihood of healthy outcomes.

With this in mind, Gateway would like to notify you that **My Diabetes Care Plan** will be mailed to members within the upcoming months.

My Diabetes Care Plan is an educational tool that provides information on medications, as well as dates and results for diabetes-related labs/exams. It is being sent to adult diabetic members 18 to 75 years old. Below is a sample of the **My Diabetes Care Plan**.



MY DIABETES CARE PLAN

PLEASE CONSIDER TAKING THIS INFORMATION WITH YOU TO YOUR NEXT DOCTOR'S APPOINTMENT.

WHAT MEDICATIONS ARE OFTEN A PART OF A DIABETES MANAGEMENT PLAN?

MEDICATION CLASS	MEDICATION NAME	DATE OF LAST FILL	ABOUT THIS MEDICATION
ACE Inhibitor or ARB	LOSARTAN POTASSIUM	03/01/16	This is often taken to help blood pressure and protect the kidneys. If you have questions about a medication, please talk to your doctor.
Statin	ATORVASTATIN CALCIUM	03/17/16	This is often taken to control cholesterol. If you have questions about a medication, please talk to your doctor.

NOTES:

Gateway Health
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MY DIABETES CARE PLAN

PLEASE CONSIDER TAKING THIS INFORMATION WITH YOU TO YOUR NEXT DOCTOR'S APPOINTMENT.

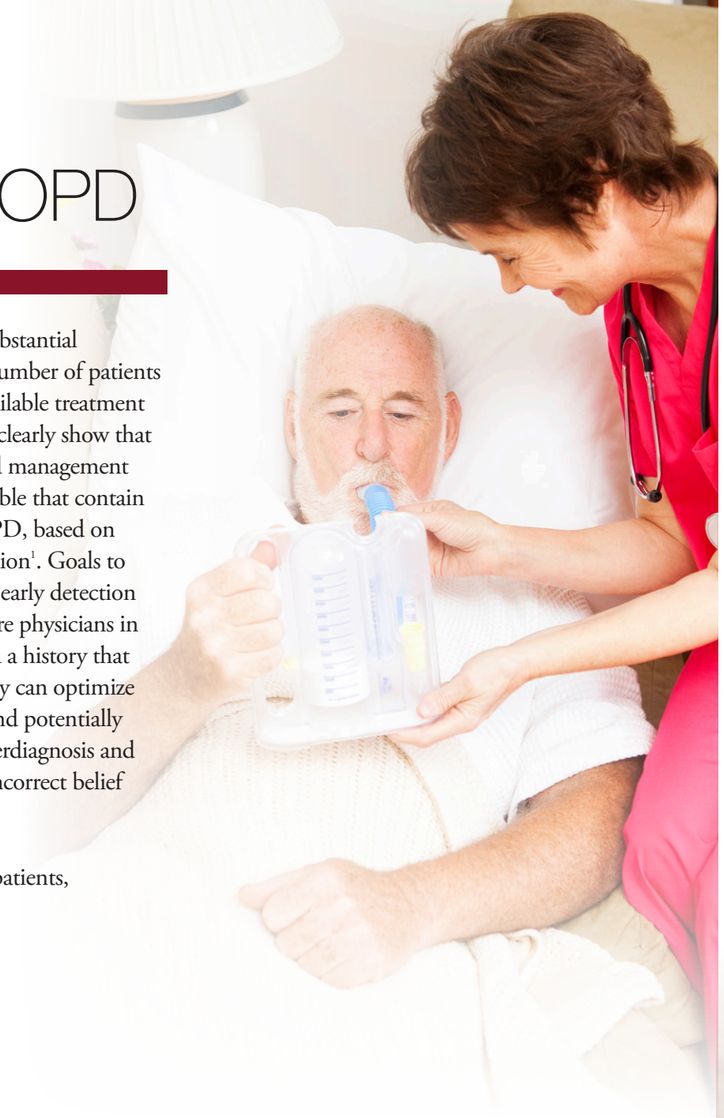
WHAT CARE IS RECOMMENDED BY THE AMERICAN DIABETES ASSOCIATION?

LABS/ TESTS	HOW OFTEN?	MOST RECENT DATE	MOST RECENT RESULT	TALK TO YOUR DOCTOR ABOUT YOUR INDIVIDUAL GOALS. WHAT'S GENERALLY RECOMMENDED IS:
A1C	2-4 times per year	02/09/12	No result in our records	Less than 7.0% (average blood sugar of about 154 mg/dL)
LDL-C (Cholesterol)	Discuss with your doctor	09/27/12	No result in our records	Discuss with your doctor
Dilated Retinal Eye Exam	Once a year	10/05/12		Healthy Eyes
Urine Screen to Check for Protein (Kidneys)	Once a year	10/09/12		No Protein in Urine
Blood Pressure	At every doctor's visit			Less than 140/90
BMI (Body Mass Index)	Once a year			Discuss with your doctor

Talk to your doctor about your results or any labs/tests you may need.

We appreciate your continued support of Gateway's mission to deliver quality programs that positively impact the health and wellness of our members. If you have any questions or suggestions, please contact your provider relations representative directly.

SPIROMETRY/COPD



COPD is a common disease that is associated with substantial mortality and uncomfortable symptoms, yet a large number of patients with COPD remain underdiagnosed and without available treatment to ease their symptoms[3]. Together, these observations clearly show that a paradigm shift is needed in diagnosis, treatment and management of patients with COPD[2]. GOLD guidelines are available that contain well defined recommendations for patients with COPD, based on their risk for exacerbation and level of airway obstruction[1]. Goals to improve COPD outcomes should include enhancing early detection through the required use of spirometry by primary care physicians in outpatient clinics among patients with symptoms and a history that suggests the possibility of COPD. Utilizing spirometry can optimize the usage of short- and long-acting bronchodilators and potentially decrease the use of inhaled corticosteriods[2,3]. The underdiagnosis and undertreatment of COPD may be attributed to the incorrect belief that treatments are not effective[2].

If you would like support in managing your COPD patients, please call our Care Management Department:

Pennsylvania Medicaid: 1-800-392-1147

Pennsylvania Medicare: 1-800-685-5209

Ohio Medicare: 1-888-447-4505

Kentucky Medicare: 1-855-847-6380

North Carolina Medicare: 1-855-847-6430

Reference:

1. Global Initiative for Chronic Obstructive Lung Disease. (2016). Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease. Retrieved from http://www.goldcopd.org/guidelines-global-strategy-for-diagnosis-management.html on March 30, 2016.

2. Johnson, J. (2013, Jan). Conference Report: Chronic Obstructive Pulmonary Disease from a Payer and Provider Lens. The American Journal of Managed Care. Retrieved from https://ajmc.s3.amazonaws.com/_media/_pdf/A434_13Jan_COPD_nwsltr_Final.pdf on March 30, 2016.

3. Johnson, J. (2013, June). COPD from a Managed Care Lens: Emerging Trends and Treatment Choices in Diagnosis and Treatment. Journal of Managed Care Medicine. 16,3. p 7-10.

ARTHRITIS HELP FOR PATIENTS: Rheumatoid Arthritis is a Condition Affecting Many Gateways Members

The American College of Rheumatology guidelines recommend the use of a disease modifying anti-rheumatic drug (DMARD) in patients diagnosed with rheumatoid arthritis (RA), unless contraindicated, to lower disease activity as much as possible or achieve remission. Unfortunately, too many Gateway members are not filling a DMARD.

If your patient is not already on a DMARD for their rheumatoid arthritis, please consider the benefits this treatment can provide. Before initiating treatment, please ensure the patient is appropriately vaccinated and tested for tuberculosis if a biologic DMARD is prescribed.

* Refer to www.gatewayhealthplan.com to view the formulary. Formulary DMARDs include hydroxychloroquine, leflunomide and sulfasalazine. Additional formulary DMARDs include methotrexate, Humira, Remicade and Cimzia all with prior authorizations.

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1. Clinical Practice Guidelines, American College of Rheumatology

2. Singh, J. A., Furst, D. E., Bharat, A., Curtis, J. R., Kavanaugh, A. F., Kremer, J. M., ... & Saag, K. G. (2012). 2012 Update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. Arthritis care & research, 64(5), 625-639.

ZIKA VIRUS AND PREGNANCY

What is Zika virus?

Zika virus is spread to people through the bite of the Aedes mosquito species. These mosquitoes tend to bite during the daytime unlike the mosquitos causing malaria that bite at night. The Aedes mosquitoes also carry other types of infections such as dengue fever, chikungunya fever and yellow fever.

Symptoms

- Mild to no symptoms
- Fever
- Rash
- Joint pain
- Conjunctivitis

History of Zika virus

- First identified in Africa in 1947 in rhesus monkeys.
- It was later identified in humans in 1952 in Uganda.
- It was noted to be spreading across the world in the past two to three years and there have been many outbreaks in South America (Brazil), the Pacific and Caribbean islands.
- Zika virus patients have spread to the Americas and been identified in the United States in the past two to three years in most states. As of April 13, 2016, there have been 358 cases of Zika virus in the United States and 31 of those were pregnant.
  - Pennsylvania had 12 cases of Zika virus
  - West Virginia had five cases of Zika virus
  - Delaware had three cases of Zika virus

How could a patient become infected?

- Bite by the Aedes mosquito species
- Having sex with an infected male person that has an active Zika virus infection
- Through blood donations from infected persons with Zika virus
- Mothers to babies before or after delivery

Testing for Zika virus if your patient is pregnant

- Blood test
- Urine test
- Amniocentesis (test amniotic fluid)
- Frequent prental appointments
- Follow-up tests as needed
- No vaccines to prevent Zika virus

Birth defects identified with Zika virus

- Microcephaly – A rare nervous system disorder that causes an abnormally small head and the brain does not develop properly
- Other fetal brain defects and other poor pregnancy outcomes such as eye, hearing and growth defects

Other complications

- Guillain-Barré Syndrome – A disorder in which the body's immune system attacks part of the peripheral nervous system. The symptoms start out as weakness or tingling sensations in the legs and spread to the arms and upper body. Eventually the disorder can be life threatening until the patient is totally paralyzed.
- Viral meningitis – Infection of the tissue that covers the brain and the spinal cord (meninges). This is the most common type of meningitis and the patients usually get better on their own without treatment.

Discuss how to prevent mosquito bites while your patients are traveling to countries where Zika virus is known

- Pregnant women should postpone travel to known areas where Zika virus exists.
- Avoid mosquito bites.
  - Wear light colored long sleeved shirts and long pants
  - Stay in an air conditioned area when possible
  - Use physical barriers such as screens, closed doors and windows
  - Do not be around open windows or screens
  - Wear insect repellents per label instructions and reapply as needed
  - Environmental Protection Agency (EPA) containing DEET, picaridin, oil of lemon eucalyptus and para-menthane-diol products
- Sleep under a mosquito bed net if you are outside or in areas where there are open windows.
- Get rid of stagnant water from places where mosquitos breed.

Prevention

- Abstinence
- Condom use when having sex with a male partner that has an active Zika virus infection
- For couples trying to conceive, the CDC recommends waiting eight weeks after a possible Zika exposure before getting pregnant to ensure a healthy pregnancy

CDC Recommendations

The CDC is updating information regarding Zika virus often. Please check with the CDC website for any updates since the writing of this article.

References:

1. CDC – Centers for Disease Control and Prevention website article: "Zika and Pregnancy", Updated 4/15/2016, http://www.cdc.gov/zika/resources/index.html, http://www.cdc.gov/zika/
2. Website article: Pan American Health Organization: "Zika Virus infection and Zika fever: Frequently asked questions, March 25, 2016 http://www.paho.org/hq/index.php?option=com_content&view=article&id=9183:2015-preguntas-frecuentes-virus-fiebre-zika&Itemid=41711&lang=en
3. Website article: World Health Organization: "Zika virus" Fact Sheet, 4/15/2016, http://www.who.int/mediacentre/factsheets/zika/en/
4. The New England Journal of medicine article: "Zika Virus and Birth Defects – Reviewing the Evidence for Causality" April 13, 2016, DOI: 10.1056/NEJM sr1604338.
5. National Institute of Neurological Disorders and Stroke, "Guillain-Barre Syndrome Fact Sheet" and "NINDS Meningitis and Encephalitis Information page"

MEDICAID REQUIREMENTS FOR PERINATAL CARE

Offices who administer maternity care on a regular basis are very familiar with the HEDIS clinical guidelines that recommend:

- A prenatal visit in the first trimester visit
- Regular visits throughout the pregnancy
- A postpartum visit 21 to 56 days after delivery

Below is a brief list of additional perinatal screenings that are required for Medicaid recipients as recommended by the Department of Health and Human Services (DHS).

- Prenatal and postpartum depression with documentation of referral when applicable with notation of the depression scale used
- Tobacco, alcohol and illicit drug use screening with documentation of counseling or referral when applicable
- Exposure to environmental smoke
- Intimate partner violence
- Medication review (prescribed and over the counter)

Please complete and document these important perinatal screenings when caring for Gateway Health members.

ANNUAL DENTAL VISIT
HEDIS HIGHLIGHT

Prevention is the foundation of good overall health for members. This is also true for dental health. In fact, for the first time, in the year 2000, a surgeon general released an oral health guide as a way to link together dental health and general well-being.[1] This document is still as important today as it was 16 years ago because the need to improve utilization of preventive dental services remains.

Most dental health issues such as dental caries are largely preventable. However, dental caries are still the most common chronic condition that children in the United States face.[2] They can become more serious if they are left untreated, which can result in pain that leads to changes in eating habits or possibly more serious infections. These issues can cause systemic issues and the pain even leads patients to seek unnecessary emergency care.

Pediatricians and other primary care providers can make a significant difference in the oral health of their patients. Oral examinations on young children can spot abnormalities in the mouth and physician offices can be trained to apply topical fluoride varnish. Topical fluoride varnish application has been shown to reduce cavities in baby teeth by 37 percent and permanent teeth by 43 percent,[3] and it is a reimbursable service that each member under age five can receive once per quarter. It is such a valuable service that the American Academy of Pediatrics has issued guidance around fluoride varnish application[4] and even offers training (resources below).

The HEDIS measure, Annual Dental Visit, looks at the eligible members ages two to 20 years who receive at least one preventive dental visit per year. Primary care providers can play a large role in increasing the number of patients who visit a dentist by having a list of dentists to refer their patients to while they are at the office. This helps the patient create a dental home similar to their primary care office. These regular dental visits can prevent tooth decay or other serious oral health problems and improve your HEDIS scores. The Annual Dental Visit measure is also included in Gateway Health's GPE® program for those providers who qualify, so recommendations to visit the dentist benefit both you and your patients.

Fluoride Varnish Resources

1. On-site training offered by AAP – PA Chapter's Healthy Teeth Healthy Children Collaboration. Visit www.healthyteethhealthychildren.org for more information.
2. Online training offered by Smiles for Life. Visit www.smilesforlifeoralhealth.org to access the training. Course 6 – Caries Risk Assessment, Fluoride Varnish, and Counseling provides information on applying fluoride varnish.

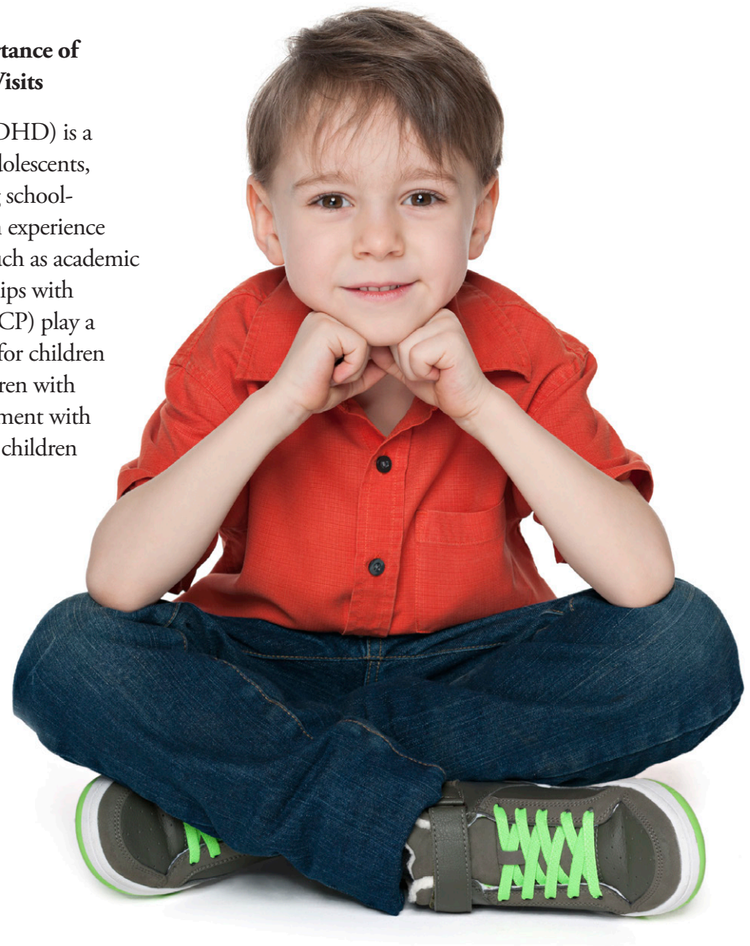
References

1. U.S. Department of Health and Human Services. "Oral Health in America: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
2. National Center for Health Statistics. "Health, United States, 2014: With Special Feature on Adults Aged 55–64." Hyattsville, MD. 2015.
3. Marinho VCC, Worthington HV, Walsh T, Clarkson JE. "Fluoride varnishes for preventing dental caries in children and adolescents." Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279.pub2
4. Clark, M. B., and R. L. Slayton. "Fluoride Use in Caries Prevention in the Primary Care Setting." Pediatrics 134.3 (2014): 626-33. Web.

ADHD MEDICATION ADHERENCE GUIDELINES

Treating ADHD in Children: The Importance of Medication Monitoring and Follow-up Visits

Attention deficit/hyperactivity disorder (ADHD) is a common condition among children and adolescents, with estimates at four to 12 percent among school-aged children. Children with ADHD often experience behavioral problems, problems in school such as academic underachievement, and troubled relationships with peers and family. Primary care providers (PCP) play a critical role in the diagnosis and treatment for children with ADHD. It is very important for children with ADHD to maintain pharmacological treatment with their ADHD medications. In the summer, children are more likely to be non-compliant with their meds, necessitating greater PCP follow-up to ensure ongoing successful treatment. All children diagnosed with ADHD that initiate treatment with an ADHD medication should have at least two follow-up visits with a practitioner within nine months of diagnosis to ensure effective treatment.[1]



A summary of the American Academy of Pediatrics' Clinical Practice Guideline for the diagnosis, evaluation and treatment of Attention-Deficit/Hyperactivity Disorder is below. The full guideline is available at: http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/14/peds.2011-2654.full.pdf

Evaluation	Perform a thorough assessment of children ages four to 18. a. Standard history and physical examination: The clinician should consider ADHD in a child presenting with any of the following concerns: (1.) Can't sit still, (2.) Lack of attention/ poor concentration/doesn't seem to listen/daydreams, (3.) Impulsivity, (4.) Academic underachievement b. Neurological examination c. Family assessment d. School assessment
Diagnosis	1. Accurately establish a diagnosis. The significant components of diagnosis include the following: (1.) The use of the DSM-IV, (2.) The importance of obtaining information about the child's symptoms in more than 1 setting, (3.) The search for coexisting conditions that may make diagnosis difficult, **including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g. learning and language disorders or other neurodevelopmental disorders), and physical (e.g., tics, sleep apnea) conditions** 2. Does the child meet the DSM-IV criteria for ADHD? Meeting the ADHD criteria using the DSM-IV must include whether symptoms began before the age of seven and interfere with functioning and performance in more than one setting and last longer than six months
Treatment	1. **Discuss treatment alternatives, benefits and risks with the patient and family** 2. Determine and implement a treatment plan a. Medication with patient management b. Behavioral interventions **for preschool aged children (four to five years of age), the primary care clinician should prescribe evidence-based parent and/or teacher-administered behavior therapy as the first line treatment.** c. Integrated behavioral therapy with medication management d. Consultation (psychiatrist or mental health professional) e. Secure support services
Follow-Up and Re-Evaluation	1. Practitioners are encouraged to work with appropriate educators, mental health professionals and dietitians that specialize in ADHD in the treatment of school-aged children with ADHD. 2. Ongoing communication with parents, teacher and other school-based professionals is necessary to monitor the progress and effectiveness of specific interventions. 3. Consider ADHD a chronic condition, thus practitioners should follow the principles of the Chronic Care Model and Medical Home. 4. Integration of services with psychologists, child psychiatrists, neurologists, educational specialists, developmental-behavioral pediatricians and other mental health professionals is appropriate for children with ADHD who have coexisting conditions and may continue to have problems in functioning despite treatment. 5. Children who do not respond as expected should be referred to behavioral health specialists for consultation. 6. **Once the child is stable, three or more office visits yearly are necessary for assessment of:** a. **Medication response and side effects** b. **Height and weight** c. **Learning and school performance** d. **Behavior at home and in social settings**
Resources	• Reference the National Resource Center on ADHD at http://www.HELP4ADHD.ORG/ • National Initiative for Children's Healthcare Quality (NICHQ) ADHD Practitioners' Toolkit (Contains ADHD Vanderbilt Assessment Scales): • http://www.nichq.org/childrens-health/adhd/resources

1. Agency for Healthcare Research and Quality. *Follow-up care for children prescribed ADHD medication.* Available at: https://www.qualitymeasures.ahrq.gov/content.aspx?id=48840

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Pittsburgh, PA 15222-1222
www.gatewayhealthplan.com

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)
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SATURDAY 9 A.M. – 1 P.M.
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1-866-670-3063 (PA)
TTY is 1-800-855-2880

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CALL TO INQUIRE ABOUT:

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1-800-392-1147
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- 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