PLEASE CIRCULATE TO ALL SATELLITE SITES, OFFICE STAFF, PRACTITIONERS, AND BILLING VENDORS

GATEWAY Review

A PROVIDER NEWSLETTER PUBLISHED BY GATEWAY HEALTH PLAN℠
Visit us at our website @ www.gatewayhealthplan.com
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COPAYMENTS

Gateway Health Plan℠ (Gateway) Pharmacy Services Department is committed to collaborating with our prescribers in providing high quality, cost effective care to our members. In order to do so, we are providing you with the necessary pharmacy information to assist in managing your Gateway patients.

The Gateway Medicaid Formulary is a list of FDA-approved medications reviewed and approved by our Pharmacy and Therapeutics (P&T) Committee and the Department of Public Welfare (DPW). The Gateway Pharmacy and Therapeutics Committee meets quarterly to review the Formulary, selecting medications on the basis of safety, efficacy, quality, and cost.

Gateway's Medicaid Formulary is available online at ***www.gateway-healthplan.com.*** The Formulary denotes which medications require step-therapy or prior authorizations. Availability or questions regarding the criteria for a prior authorization may be obtained by calling Pharmacy Services at 1-800-528-6738.

In addition, keep in mind the copayment structure when prescribing Formulary medications for Gateway members.

Copayments will apply to Gateway members on Medical Assistance who are 18 years of age and older and include $1 for generic medications and $3 for brand medications. Medications within the following ten specified therapeutic categories will be excluded from copay requirements: antipsychotics, antidiabetic agents, antineoplastic agents, antiparkinson agents, antiglaucoma agents, antihypertensive agents, anticonvulsants, HIV/AIDS medications, cardiovascular medications, and Family Planning medications.

NOMNC COMPLIANCE UPDATES

The Center for Medicare and Medicaid Services (CMS) has updated the Notice of Medicare Non-Coverage (NOMNC) template that skilled nursing facility, home health and comprehensive outpatient rehabilitative facility providers must deliver to patients at least two days prior to the end of care. The new template and provider instructions are available from the CMS website at www.cms.hhs.gov/MMCAG. Please ensure that your agency is using the most up-to-date CMS forms!

Individual audits of providers serving the highest volumes of *Medicare Assured*SM members were completed in October, and all results have been shared with those providers. Gateway Health Plan *Medicare Assured*SM thanks its providers for their cooperation with the audits. We look forward to collaborating with all our providers to increase provider compliance with the NOMNC delivery process and are continuing individual provider audits to attain the CMS compliance goal of 95%.

If you have questions on the NOMNC delivery process, the CMS website can help at www.cms.hhs.gov. The fax number for submitting signed NOMNC forms to Gateway Health Plan *Medicare Assured*SM is 1-800-685-5231.

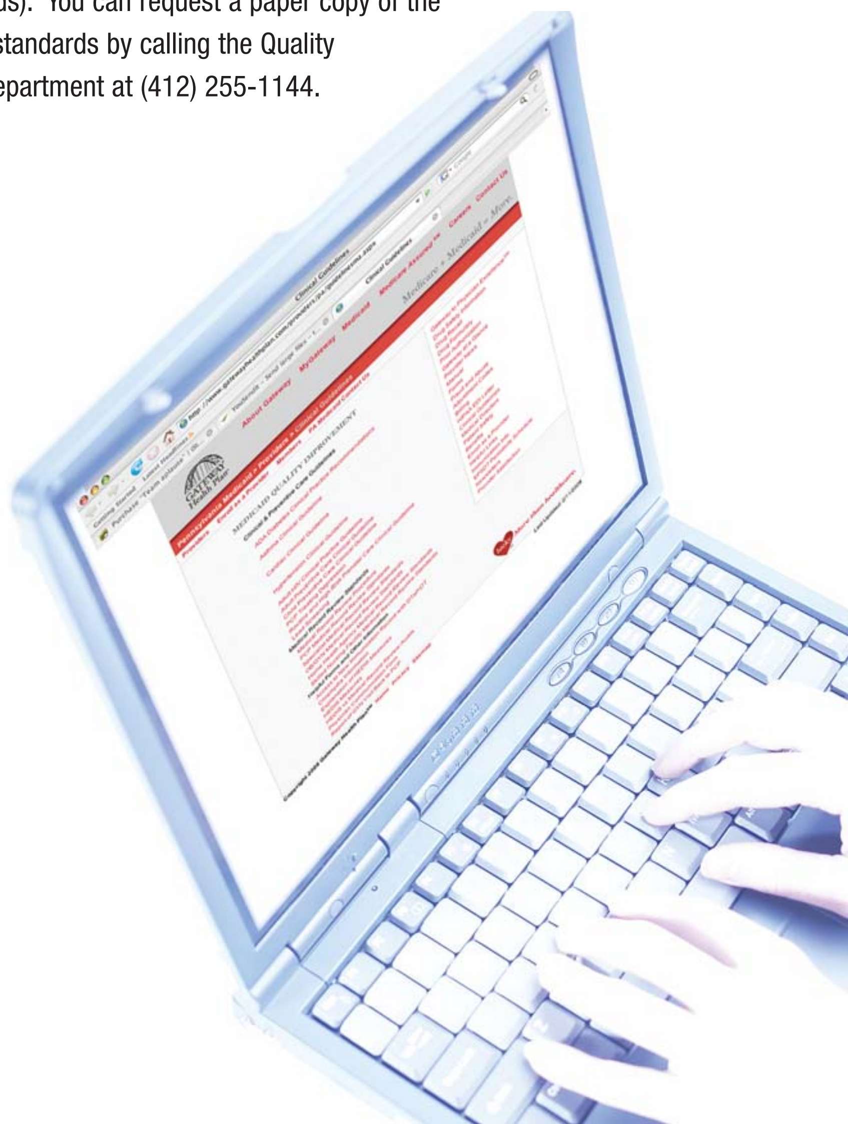
GUIDELINES ON GATEWAY'S WEBSITE

Gateway's Clinical and Preventive Care Guidelines can be viewed by accessing Gateway's website, www.gatewayhealthplan.com.

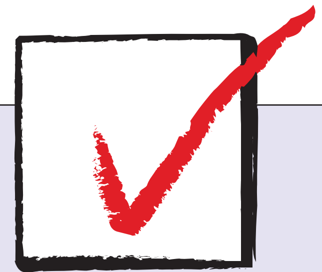
Those topics covered by our guidelines include:

- Adult with HIV
- Adult Preventive Care
- Asthma
- Cardiac Medical Management
- Child Preventive Care
- Diabetes 2007 ADA
- Hypertension
- Lead Screening
- Prenatal Care
- PCPs Treating Depression

To view these guidelines, select the Plan, then choose Providers, and Clinical Guidelines. Gateway's Medical Record Review standards for PCPs and Specialists are also located at this site (Providers, Medical Record Standards). You can request a paper copy of the guidelines and standards by calling the Quality Improvement Department at (412) 255-1144.



OVERVIEW OF 2007 CAHPS® MEMBER SATISFACTION SURVEY



Gateway Health Plan℠ (Gateway) contracted with The Myers Group, a NCQA certified vendor, for the 2007 CAHPS Member Satisfaction Survey.

The process utilized to conduct the survey was the NCQA defined methodology, which included attempting to contact the members by mail and then by phone.

There were a number of revisions in the questions asked, resulting in five of the composites not being trendable. Of the remaining composites, Gateway Health Plan's℠ scores improved in all but one of the measures, that being "Rating of Health Care". However, this decrease was not statistically significant.

For all of the effectiveness of care measures, scores were higher than last year. Once again, none of these increases were statistically significant.

Through the work of Gateway's CAHPS® task force, work groups, individual department efforts and collaboration with delegates, Gateway will continue to improve the level of member satisfaction with the care received and with Gateway Health Plan℠.

MEDICARE ASSURED℠ MEMBER RIGHTS AND RESPONSIBILITIES

Revisions have been made to Gateway Health Plan's (Gateway) *Medicare Assured℠* Member Rights and Responsibilities based upon CMS requirements. The revisions discuss the member's right to receive an explanation from Gateway in writing about any bills a member may get for services not covered by Gateway, and also about the plan's financial condition, network providers and pharmacies and how Gateway compares to other health plans.
For further clarification, please access this document on Gateway's website, ***www.gatewayhealthplan.com***, by choosing the *Medicare Assured℠* tab, then *Medicare Assured℠* 2008, and going to page 57 of the Explanation of Coverage under Information for Members.
To request a paper copy of this document, please call the Quality Improvement Department at 412-255-1144.

PAPER CLAIMS SUBMISSION

If you submit your claims on CMS-1500 and UB-04 paper forms, please be sure that your forms are aligned correctly when printing so that all procedure codes, diagnosis codes, # of units and pricing information is legible. This helps Gateway Health Plan℠ ensure that your claims are processed accurately the first time. Any claims processed incorrectly due to illegible information on the claim form will be required to be resubmitted as corrected claims. All corrected claims must be submitted within 120 days from the date of the initial remittance advice.

AFFIRMATIVE STATEMENT ABOUT INCENTIVES AND OVER-UNDER UTILIZATION STATEMENT

Gateway's Utilization Management (UM) decisions are based only on the appropriateness of care and services and existence of coverage.

Gateway does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Gateway monitors for both over and under utilization of care to prevent inappropriate decision-making, to identify causes and corrective action, and to indicate inadequate coordination of care or inappropriate use of services. Gateway is particularly concerned about underutilization and monitors utilization activities to assure members receive all appropriate and necessary care.

WINNERS OF THE *MEDICARE ASSURED*SM PRACTITIONER SATISFACTION SURVEY DRAWING

Congratulations to the winners of the 2007 *Medicare Assured*SM Practitioner Satisfaction Survey Drawing. The winners returned their surveys to The Myers Group, an independent survey vendor, by the date specified and qualified for the random drawing. All surveys were blinded, therefore Gateway received no specific results.

- Kramer & Maehrer, LLC
- George M. Joseph, M.D. & Associates
- Tony J. Albertelli, D.P.M.
- Chris T. O'Donnell, M.D.
- Baycity Associates in Podiatry, Inc.
- H. Martin Wrigley, M.D.

The winners received a Harry & David Gift Basket for their staff. Gateway appreciates your response to the survey and will work to improve our processes and policies to better serve your needs!

2007 PRACTITIONER AND PROVIDER SATISFACTION SURVEY RESULTS

The results of the 2007 *Medicare Assured*℠ Practitioner and Provider Satisfaction Survey are in! The practitioner survey was mailed to a random sample of primary care practitioners and high-volume specialty care practitioners, and the provider survey was mailed to all Gateway participating hospitals and ancillary providers in March 2007. An overview of the results is to the right.

Gateway utilized a survey vendor, The Myers Group, to conduct this first *Medicare Assured*℠ survey in 2007.

Gateway has developed an action plan based on the 2007 results that focuses on areas for improvement. Gateway will continue to take great strides to meet the needs of the practitioner and provider populations through education and assessment of internal policy.

If you would like to receive additional information regarding the survey results, action plan or goals, please contact Gateway's Provider Services Department at 1-800-685-5205.

Question	Primary Care Practitioner Rate	Special Care Practitioner Rate	Hospital Rate	Ancillary Rate
Knowledge of which services require an authorization	89.1%	87.3%	84.6%	83.4%
Timeliness of UM Staff	86.4%	88.6%	82.6%	81.5%
Clinical knowledge of UM Staff	88.6%	91.0%	95.5%	85.1%
Consistency of UM Staff	87.9%	91.5%	90.9%	86.1%
Medical appropriateness of Gateway's Physician Reviewer	81.1%	82.3%	88.9%	80.9%
Professionalism/ courtesy of UM Staff	93.1%	95.1%	95.0%	91.5%
Overall Satisfaction with the UM Process	88.7%	89.0%	90.5%	85.8%
Hours of availability for UM Dept. meet needs	95.7%	96.5%	85.7%	92.5%
Satisfaction with clean claims being processed consistently	86.7%	80.6%	76.9%	78.7%
Overall satisfaction with the claims review process	80.0%	77.5%	80.0%	74.3%
Ease of using Gateway's Web-based and PDA Drug Formulary	86.4%	73.6%	NA	82.4%
Variety of drugs available on Gateway's Drug Formulary	63.6%	59.0%	NA	52.2%
Overall Satisfaction with the Pharmacy Authorization Process	78.6%	80.4%	NA	79.2%
Overall Satisfaction with Gateway Health Plan℠	81.1%	82.3%	73.9%	85.5%

OFFICE MANAGER INCENTIVE PROGRAM WINNERS

Congratulations to the winners of the 3rd Quarter 2007 Primary Care Office Manager Incentive Program!
The winners are as follows:

- Health Care Partners
- Sterling Medical Associates
- McMurray Pediatric and Adolescent Medicine
- RFP/Millvale Division
- LGH-Family Health Services
- St. Joseph Family and Womens Care/PCP

As a reminder, the criteria for participation includes the following:

1. Submission of claims electronically.
2. Submission of greater than or equal to the peer average of encounters per member per year.
3. Maintenance of a member transfer rate that is equal to or less than the peer average.
4. Submission of EPSDT forms and preventive health encounter forms.

The winners received a plaque to display in their office and a gift basket. The winners of the 4th Quarter will be announced in the next issue of the *Gateway Review*. Good Luck!

2007 PRACTITIONER ACCESSIBILITY STANDARDS

Results of the 2007 Practitioner Accessibility Study will be presented in the first issue of the Gateway Review in 2008.

The following standards are relevant to all **Pennsylvania Medicaid Primary Care Practitioners**:

REQUIREMENT	STANDARD
Wait time for an Emergent Appointment	Immediately, and not inappropriately referred to the ER
Wait time for Urgent Care Appointment	Within 24 hours
Wait time for Regular or Routine Appointments	Within 10 business days
Wait time for a Preventive Care Appointment	Within 3 weeks of enrollment
After-hours Care Accessibility	Access to a practitioner 24 hrs/ 7 days a week
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

The following standards are relevant to all **Pennsylvania Medicaid Specialty Care Practitioners:**

REQUIREMENT	STANDARD
Wait Time for Emergent Appointment	Immediately from the date of referral
Wait time for an Urgent Care Appointment	Within twenty-four (24) hours from the date of referral
Wait time Asymptomatic Regular/Routine Appointment	Within ten (10) business days from the date of referral
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

The following standards are relevant to all ***Medicare Assured℠*** **Primary Care Practitioners:**

REQUIREMENT	STANDARD
Wait time for Urgent, but Non-Emergent Care Appointment	Within 24 hours
Wait time for Non-Urgent Care, but in need of Attention Appointments	Within 1 week
Wait time for a Routine or Preventive Care Appointment	Within 30 days
After Hours Care Accessibility	Access to a practitioner 24 hrs/ 7 days a week
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

The following standards are relevant to all **Pennsylvania Medicaid OB/GYNs and Certified Nurse Midwives:**

REQUIREMENT	STANDARD
First Trimester	Within (10) business days of the member being identified as being pregnant
Second Trimester	Within (5) business days of the member being identified as being pregnant
Third Trimester	Within (4) business days of the member being identified as being pregnant
High-Risk Pregnancies	Within twenty-four (24) hours of identification of high-risk by Gateway or the maternity care provider, or immediately if an emergency exits

The following standards are relevant to all ***Medicare Assured℠*** **OB/GYNs and Certified Nurse Midwives:**

REQUIREMENT	STANDARD
Wait time for an Urgent, but Non-Emergent Care	Within twenty-four (24) hours from Appointment the date of referral
Wait time for a Non-Urgent, but in need of Attention Appointment	Within 1 week from the date of referral
Wait time for a Routine Care Appointment	Within 30 days from the date of referral
Waiting Time in the Waiting Room	No more than fifteen (15) minutes or up to one (1) hour when the MD encounters an unanticipated urgent visit or is treating a member with a difficult need.

US Steel Tower, Floor 41; 600 Grant Street; Pittsburgh, PA 15219

www.gatewayhealthplan.com

Important Phone Numbers

PROVIDER SERVICES
Medicaid 1-800-392-1145
Medicare 1-800-685-5205

MEDICAL MANAGEMENT
Medicaid 1-800-392-1146
Medicare (PA) 1-800-685-5207
Medicare (Ohio) 1-800-447-4375

MEMBER ELIGIBILITY/DIVA VERIFICATION LINE
Medicaid and Medicare 1-800-642-3515

EPSDT
Medicaid 1-800-642-3550, Option 4

PHARMACY
Medicaid 1-800-528-6738
Medicare 1-800-685-5215

NATIONAL IMAGING ASSOCIATES
Medicaid and Medicare 1-888-879-5922

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