

Provider | Update

PRODUCED FOR
GATEWAY HEALTH PLAN
PROVIDERS AND
CLINICIANS



GatewayHealthPlan.com



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GATEWAY'S PROVIDER UPDATE IS GOING GREEN IN 2011

Beginning with Gateway's March Provider Update newsletter, which delivers quality information and timely updates to help us deliver the best care for Gateway Health Plan® members, Gateway will discontinue printing paper copies and mailing the newsletter to Providers.

Gateway will notify Providers by e-mail or fax when a new issue of the newsletter is available on Gateway's website www.GatewayHealthPlan.com.

If you are unable to access the website, please contact your Provider

Relations Representative so they can make other arrangements to make sure you don't miss a single issue of the Provider Update.

We appreciate the positive feedback we have received in the decision to help the environment and Go Green!



OFFICE STAFF

SECURE YOUR FAXES

Gateway Health Plan® needs your help with ensuring your patient's protected health information (PHI) is secured. We've recently noticed an increase in the number of faxes received in our Care Management Department for members who have disenrolled from our Plan. Please be sure to verify eligibility for your patients before faxing any PHI to Gateway. Your office can verify eligibility by calling DIVA, our automated eligibility/referral system, at 1-800-642-3515 or by contacting our Provider Services Department at 1-800-392-1145 or 1-800-685-5205 for Medicare Assured®.



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HOW GATEWAY HEALTH PLAN® USES AND PROTECTS CONFIDENTIAL MEMBER INFORMATION

Gateway Health Plan® is committed to maintaining the privacy and security of its members' medical and non-public personal information in all formats (oral, written, and electronic). While member information must be made available to health care professionals to enable proper care, timely payment and reimbursement, Gateway employees follow strict guidelines to avoid disclosing more information than is needed.

Gateway seeks to assure that its employees follow the provisions of the Health Insurance Portability and Accountability Act (HIPAA), specifically guidance in 45 CFR 160, 164, and internal policies implemented to meet those regulations.

It is important to understand that HIPAA regulations also include guidance as to when healthcare providers can use or give out member information without the need for written authorization from the member. Examples include reporting

disease outbreaks or for judicial and administrative proceedings, such as a court order.

Gateway does not give out member non-public information (such as contact information provided on an enrollment application) except if required or permitted by law or if the member has given permission to release the non-public information.

In addition to following HIPAA regulations, Gateway demonstrates its commitment to protecting information by staying abreast of new regulations and privacy trends.

The American Recovery and Reinvestment Act (ARRA) is an example of a newer regulation that includes enhanced privacy protections. The ARRA regulation strengthens and improves enforcement of privacy and security under HIPAA. The ARRA regulation also expanded the definition of a breach, requires reporting of breaches, and includes tougher penalties for violations.

In order to help our employees understand their roles in protecting

confidential information, Gateway provides annual training and reference tools to its employees. We ask our employees to help identify and report potential security risks so they can be addressed before a breach occurs.

Not only do employees of Gateway sign a form annually reminding them about laws and regulations that protect information, they are also trained on ways to protect system security and privacy risks identified in the news or in the health care industry in general. All Gateway employees are expected to support Gateway's Code of Conduct and work with honesty and integrity.

To learn more about how Gateway uses or discloses member information, please visit us on-line at www.GatewayHealthPlan.com to view the "Notice of Privacy Practices". To request a paper copy, please contact Member Services at 1-800-392-1147 for PA Medicaid or 1-800-685-5209 for PA Medicare Assured® HMO SNP.



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AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Gateway's 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, 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.



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MEMBER RIGHTS & RESPONSIBILITIES

All Gateway Health Plan® (Gateway) members enrolled in Gateway's Medicare Assured® HMO SNP plan have certain "rights" concerning their care and treatment. They also have specific "responsibilities" as Gateway members.

Medicare members can find their Rights and Responsibilities in their Evidence of Coverage booklet. They can also be viewed on Gateway's website at www.GatewayHealthPlan.com by clicking on For Members and Medicare Assured® HMO SNP Members. Medicare Assured® HMO SNP members should then click on Evidence of Coverage in the list on the left under the Benefits section and check the index for the page number. Offices may also access these documents and print them out for posting.



OFFICE STAFF

MEMBER OUTREACH PROGRAM

Gateway Health Plan® has a Member Outreach Program staffed by Outreach Representatives that assist your practice in outreaching to members who are in need of our services.

When members are referred the Gateway Health Plan® Outreach Representatives telephonically contact members and provide education, aid in scheduling appointments, proactively direct the member to the Care Management Department for specific disease state information and much more. Additionally, the Member Outreach Program can provide and discuss:

- Member education on available programs and resources specific to their health care needs
- Preventive Health care screenings; mammogram, colon cancer, immunizations, dental, well child visits, etc.
- Education for head of household on importance of compliance for pediatric members on target and/or behind in EPSDT screens and immunizations

- Contact those who are in need of follow-up for blood lead testing or need coordination of care
- Outreach to adult and pediatric members who are chronic "no show" for appointments. It is important to provide the dates of the missed appointments, reason for the appointment and current phone number
- Transportation needs members may have to access care

Please refer members by faxing or mailing a Member Outreach Form to the Preventive Health Department. To facilitate outreach, please ensure you provide the member's most current telephone number. A copy of this form can be found in the Provider Manual in the Forms and Reference Material Section or by calling the Preventive Health Department at 1-800-642-3550, Ext. 4.



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REMINDER FOR PRACTITIONERS COMMUNICATING WITH PATIENTS WITH LIMITED ENGLISH PROFICIENCY

Practitioners are expected to comply with Title VI of the Civil Rights Act of 1964 that prohibits race, color or national origin discrimination in programs receiving Federal funds. Practitioners are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Access and Interpreters for Disabled Members

Practitioner offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to

arrange and coordinate interpreter services to assist members who are hearing impaired. Gateway will assist practitioners in locating resources upon request. For our visually impaired members, Gateway offers the Member Handbook and other Gateway information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct Medicaid members to call Member Services at 1-800-392-1147 or *Medicare Assured*[®] members to call 1-800-685-5209 to ask for these other formats.

Practitioner offices are required to adhere to the Americans with

Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Gateway's Provider Services Department at 1-800-392-1145 or 1-800-685-5205 for *Medicare Assured*[®].

For interpreter services, please contact a qualified medical interpretation service such as Language Line Services. Language Line Services can be reached at 1-800-752-6096.



OFFICE STAFF

ENVIRONMENTAL ASSESSMENT STANDARDS FOR GATEWAY OFFICE SITES

Gateway has established specific guidelines for evaluating both the external and internal aspects of a practitioner's office. This Environmental Assessment (EA) of the office is conducted as part of the initial credentialing process for all Primary Care Practitioners, Dental and high volume Behavioral Health office sites.

The standards reviewed address the following areas:

- Physical Accessibility
- Physical Appearance
- Adequacy of waiting and examining room space
- Availability of Appointments
- Adequacy of treatment record keeping

The following performance standards have been established:

- 80% compliance for site visit standards
- 80% compliance for medical record keeping standards

Any office found to have deficiencies will be required to develop an action plan and bring the office into compliance within 90 days. A Provider Relations Representative will re-review the physician office to assure ongoing compliance

with the standards has been obtained. Gateway also reviews member complaints on a monthly basis to determine if there are issues with the practice site regarding EA standards. If deficiencies are noted the Provider Relations Representative will schedule another site visit to bring the office back into compliance.

The same process is followed when a QI Nurse notifies Provider Relations of an office deficiency.

If you have any questions regarding the EA Standards or site visit process, please contact your Provider Relations Representative. A copy of Gateway's EA Standards is also available on Gateway's website at www.GatewayHealthPlan.com in the Provider Manual under Policies and Procedures.



OFFICE STAFF

REFERRALS ARE NECESSARY IN ORDER TO PRESERVE THE PRIMARY CARE PRACTITIONER'S GATEKEEPER RELATIONSHIP WITH THE PATIENT.

Referrals allow the primary care practitioner to approve specialty services for members on their panel.

To determine which services require a referral or authorization, please refer to Gateway's Quick Reference Guide for Referrals and Authorizations in the *Forms and Reference Materials Section* of this Manual or visit our website at www.GatewayHealthPlan.com and view the quick reference guides in our forms and reference material section for Practitioners.

When a primary care practitioner determines that a member requires medical services or treatment outside of the primary care practitioner's office, the primary care practitioner must issue a referral to a participating facility or specialty care practitioner. If services are performed in a hospital setting, the referral should be issued to the hospital's provider identification number.

Primary care practitioners may not issue referrals to other primary care practitioners.

OFFICE STAFF



CONTINUITY AND COORDINATION OF CARE

Patient safety is important to each of us as healthcare professionals. One area where PCPs and specialists can have an impact is in the communication to other providers of care rendered and prescriptions written. Although PCPs are to provide first-line care, there is an even greater responsibility to oversee all care provided to each of their patients. Communication of patient care information from care providers back to the member's PCP and then shared with appropriate consultants is very important to help ensure patient safety. Failure to share information about the care of a patient can result in suboptimal outcomes, increased costs, and medical errors.

This communication process is made more difficult and more important since Gateway's Medicaid members are permitted to self-refer for OB/Gyn and behavioral health care and our Medicare members may self-refer to any specialist. Even if a referral is made, the PCP may not be aware that the provider was seen if a consultation report isn't sent. Receiving reports of therapies provided and concerns identified by other care providers is essential to ensure that the patient's care is safe, proper, and unduplicated.

Gateway monitors continuity and coordination of care through medical record review (MRR) of high-volume specialists and OB/Gyns, skilled nursing facilities, and home health agencies every two years. The provider satisfaction survey and focus studies are also utilized for this purpose.

To improve the communication process, help from all providers is needed in the following areas:

PCPs

- File all documentation received from other care providers and facilities in the patient's chart.
- Ask your patients if they are receiving any other medical services.
- Document any verbal communications with other care providers in the patient's chart.

Specialists & OB/Gyn offices

- Verify the member's PCP and send a consultation report as listed on their ID card. Addresses are located on Gateway's website, www.GatewayHealthPlan.com, (Find a Provider and plan).
- Utilize the "Physician Communication Form" and the "Gynecology Patient Visit Summary" located on Gateway's website (Providers, choose the plan, Quality Improvement, Clinical Guidelines, Helpful Forms).
- Use a stamp to note that documentation has been faxed to the PCP

Good communication will help to ensure safe and proper patient care.

OFFICE STAFF



ELECTRONIC CLAIMS SUBMISSION

Gateway accepts electronic claims through Emdeon and RelayHealth. To submit claims to Gateway, please refer to information below for Emdeon Payer IDs and RelayHealth CPIDs:

CPID PAYER NAME PAYER ID CLAIM TYPE

- 8472 Gateway Health Plan® - Medicaid PA 25169 Professional
- 4569 Gateway Health Plan® - Medicaid PA 25169 Institutional
- 2298 Gateway Health Plan® - PA Medicare Assured® 60550 Professional
- 2912 Gateway Health Plan® - PA Medicare Assured® 60550 Institutional

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GATEWAY HEALTH PLAN®

HIPAA 5010 AND ICD-10 STRATEGY AND TIMELINE

The 5010 version of the HIPAA electronic transactions is required in order to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Currently, Gateway is conducting internal testing of the 5010 maps and loading of test scenarios in its claims system. External testing with Gateway's three EDI clearinghouses/direct submitters will be initiated prior to March 31, 2011 to ensure version 5010 format and data compliance. Contact your Practice Management System vendor and/or EDI vendor/clearinghouse to confirm preparedness for January 1, 2012.

As of January 1, 2012, version 4010 transactions will be accepted for dates of service prior to 1/1/2012. Only version 5010 transactions will be accepted for dates of service on or after 1/1/2012.

Prior to January 1, 2013, Gateway will begin ICD-10 testing with its 3 clearinghouses/direct submitters. Contact your Practice Management System vendor and/or EDI vendor/clearinghouse to confirm preparedness for ICD-10 implementation.

Remember: ICD-10 Compliance Date for Implementation

October 1, 2013 – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)

1. ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013
2. ICD-10 codes will not be accepted for services prior to October 1, 2013

Providers must begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on **all paper and electronic claims** with dates of service on or after October 1, 2013, and for all diagnoses on **all paper and electronic claims** for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, hospitals must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on **paper and electronic claims** with dates of discharge that occur on or after October 1, 2013.

Gateway will continue to provide updates and further details as these initiatives progress.

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WINNERS OF THE PRACTITIONER SATISFACTION SURVEY DRAWING

Congratulations to the winners of the 2010 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. The lucky winners were:

MICHEL TORET M.D.
 MOHAN M. PATEL, M.D., P.C.
 R. B. CARRUTHERS, M.D.
 RICHARD S. CRUMRINE, M.D.
 WATERDAM SURGICAL ASSOCIATES, P.C.
 WOMENS HEALTH AND LASER CARE, P.C.

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!

You can view the 2009 results of the Practitioner and Provider Satisfaction survey on the Gateway website at www.GatewayHealthPlan.com. Results of the 2010 Practitioner and Provider Satisfaction survey will be available soon.

CLINICAL

COLORECTAL CANCER (CRC) SCREENING

The U.S. Preventive Services Task Force recommends CRC screening 1 for adults age 50 to 75 as follows:

- Annually with high sensitivity fecal occult blood testing (FOBT)
- Every 5 years with a sigmoidoscopy along with FOBT every 3 years
- Every 10 years with a colonoscopy

1. FOCUS on strategies that MAXIMIZE the number of individuals who get screened!
2. TALK about BARRIERS with patients.

¹ Please note: A single test of a stool sample in the clinical setting (as, for instance, is done with a stool collected on the fingertip during a digital rectal exam) is not an adequate substitute for an FOBT collection protocol.

PATIENT SAYS	YOUR RESPONSE
"I'm not at risk."	Discuss basic information about risk factors and symptoms of CRC
"Why do I need to be screened if no one in my family has had CRC?"	Discuss the benefits of detecting CRC early by screening
"I don't think my benefits cover this kind of screening."	Encourage patient to call Gateway's Member Services and confirm CRC screening as a covered benefit
"I don't want to talk about such private matters!"	Make it standard practice to discuss and recommend preventive screening at every annual exam and non-emergent visit
"I couldn't handle the prep for the screening – limiting what I eat or drinking that bad tasting stuff."	Explain the characteristics of each test so patients can choose a type they feel they could do
"I don't want to get my hands dirty touching a stool sample!"	Explain CRC screening options other than FOBT for patients with limited dexterity or visual ability
"I don't speak English. I need Spanish information."	Talk to your Gateway Provider Relations representative to see what educational materials Gateway can supply in languages other than English
"The doctor/specialist is not on the bus line so I would have a hard time getting there."	Encourage patients to call Gateway to ask what transportation assistance might be available
"I get confused when I hear so many different recommendations about 'necessary tests'."	Provide basic information about why screening is so important to prevention
"It really has been a long time since my last screening, like 10 years ago, but that one was fine so I will just keep on assuming everything is ok."	Provide basic information about screening test intervals and why its important to keep up with prevention and screenings

CLINICAL

VACCINE AND FLU REMINDER:

It is important to have children of all ages vaccinated and to make sure parents:

- understand the need, importance, and the schedule for the vaccinations
- comply with the vaccine schedules as soon as the child is born to foster better health care
- assure children continue to receive age appropriate vaccinations in a timely manner
- know that vaccinations are required for school; starting at birth helps to better insure the need for continuity of care and compliance

Here are some things to remember for the upcoming flu season:

- all people older than 6 months of age (except those who have a severe allergy to chicken eggs, had a severe reaction to an influenza vaccination, or developed Guillian-Barré syndrome within 6 weeks of getting an influenza vaccine) should receive a flu shot
- people between the ages of 2 and 49 can receive the flu vaccine via nasal mist if they are in good health.
- Fluzone is 4 times more potent than the regular vaccine and is approved for use in people age 65 and older



CLINICAL

PHARMACY FORMULARY UPDATES

The Gateway Health Plan® (Gateway) formulary is updated on a regular basis. The listed medication changes reflect the decisions made by Gateway's Pharmacy and Therapeutics Committee.

Please review the changes and update your Gateway formulary book as necessary. Please note that Gateway's formulary can be accessed online at www.GatewayHealthPlan.com. The website also provides additional information regarding prior authorization or step therapy requirements as applicable.

Additional copies of the formulary may be printed directly from our formulary website, or requested through Provider Services by calling 1-800-392-1145 for Medicaid members or 1-800-685-5205 for Medicare Assured® HMO SNP members.



Medicaid Formulary Additions

Drug Name	Effective Date	Notes
Flomax (tamsulosin)	12/1/2010	GC, QL

Medicaid Formulary Deletions

Drug Name	Effective Date
Uroxatral (alfuzosin)	1/1/2011

Medicare Assured® HMO SNP Formulary Changes from 2010

Drug Name	Effective Date	Addition or Deletion	Notes
Concerta (methylphenidate extended release tablet)	1/1/2011	Deletion	
Diovan (valsartan)	1/1/2011	Deletion	
Diovan HCT (valsartan HCT)	1/1/2011	Deletion	
Enblex (darifenacin)	1/1/2011	Deletion	
Exforge (amlodipine/valsartan)	1/1/2011	Deletion	
Exforge HCT (amlodipine/valsartan/HCT)	1/1/2011	Deletion	
Lexapro (escitalopram)	1/1/2011	Deletion	
Metadate CD (methylphenidate extended release capsule)	1/1/2011	Deletion	
Novolin	1/1/2011	Deletion	
Nasonex (mometasone furoate)	1/1/2011	Deletion	
Novolog	1/1/2011	Deletion	
Novolog Mix 70/30	1/1/2011	Deletion	
Proprantheline	1/1/2011	Deletion	
Revatio (sildenafil citrate)	1/1/2011	Deletion	
Zenpep (lipase/protease/amylase)	1/1/2011	Addition	
Adcirca (tadalafil)	1/1/2011	Addition	PA, QL
Cervarix (human papillomavirus vaccine)	1/1/2011	Addition	PA
Amitiza (lubiprostone)	1/1/2011	Addition	QL
Colcrys (colchicine)	1/1/2011	Addition	QL
Alimta (premetered disodium)	1/1/2011	Addition	PA
Xenazine (tetraabenazine)	1/1/2011	Addition	PA, SPN
Avastin (bevacizumab)	1/1/2011	Addition	PA
Amifostine	1/1/2011	Addition	
Arcalyst (rilonacept)	1/1/2011	Addition	PA, QL
Promacta (eltrombopag olamine)	1/1/2011	Addition	PA, QL, SPN
Increlex (mecasermin)	1/1/2011	Addition	PA
Dronabinol	1/1/2011	Addition	PA, QL
Zometa (zoledronic acid)	1/1/2011	Addition	PA
Tamsulosin	1/1/2011	Addition	GC
Torsemide	1/1/2011	Addition	
Losartan-HCT	1/1/2011	Addition	GC, QL, ST
Losartan	1/1/2011	Addition	GC, QL, ST

CLINICAL

REFERRING MEMBERS TO THE COMPLEX CASE MANAGEMENT PROGRAM

Gateway Health Plan® provides Complex Case Management to eligible members based on specific disease or medical condition criteria. Care Managers at Gateway Health Plan® provide education about disease or condition processes, provide support, identify resources to better serve the member and help coordinate care with providers. Members with the following diseases and conditions are considered for services under the Complex Case Management program:

For Pennsylvania Medicaid:

- Cancers with metastasis
- Symptomatic HIV/AIDS
- Chronic Obstructive Pulmonary Disease
- New Traumatic Brain Injury with significant cognitive deficits
- New spinal cord injury with paralysis

For Medicare Assured®:

- Stage IV Heart Disease
- Symptomatic HIV/AIDS
- Chronic Obstructive Pulmonary Disease
- Cancers with metastasis

The role of the practitioner in the Complex Case Management program is extremely important. Practitioners who have identified a member that may benefit from this program may make a referral by contacting the Care Management department to speak with a Care Manager at the following numbers:

- Pennsylvania Medicaid: 1-800-642-3550, Option 1
- Pennsylvania *Medicare Assured*®: 1-800-685-5212, Option 1

Gateway Health Plan® 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.

Notes Key:

PA = Prior Authorization required

QL = Quantity Limit applies

ST = Step Therapy applies

SPN = Obtain through Specialty Pharmacy Network

GC = Generic covered

OTC=Over the Counter

To avoid a lapse in your patient's care, please work with your patient to transition him or her to a formulary alternative before the effective January 1, 2011 deletion date. If the formulary alternatives available are not appropriate for your patient, or it is medically necessary to override certain requirements placed on specific drugs (e.g. step therapy, quantity limits), you can request a formulary exception by faxing a Drug Exception Form to 888-245-2049 (Medicaid) or 888-447-4369 (Medicare), Attn: Pharmacy Department. The Drug Exception Form is available online at www.GatewayHealthPlan.com

Please contact Gateway's Pharmacy Department with all formulary questions, and other pharmacy benefit concerns at 1-800-528-6738 for Medicaid members or 1-800-685-5215 for *Medicare Assured*® HMO SNP members.

CLINICAL

GUIDELINES & REVIEW STANDARDS ON GATEWAY'S WEBSITE

Throughout the year, Gateway Health Plan® reviews and revises its clinical guidelines, and presents them to our Physician Advisory Workgroups and/or QI/UM Committee for approval. A Chronic Obstructive Pulmonary Disease (COPD) guideline has been recently added.

Our clinical and preventive care guidelines can be viewed by accessing Gateway's website,

www.GatewayHealthPlan.com, then selecting Pennsylvania Medicaid or *Medicare Assured*® HMO SNP, Providers, and Clinical Guidelines. Gateway's Medical Record Review standards for PCPs, Specialists, Skilled Nursing Facilities and Home Health Agencies are also located here. You can request a copy of the guidelines and standards by calling the QI Department at (412) 255-1144.

OFFICE STAFF

2011 ACCESSIBILITY STANDARDS FOR PRACTITIONERS

Gateway Health Plan® follows CMS, DPW, DOH, and NCQA guidelines for accessibility standards. Practitioners are required to comply with these standards. We encourage you to review the standards closely to ensure that they are being followed. Practice access standards are assessed annually through member complaints related to access as well as our Provider Accessibility and Appointment Standard Study. Gateway will share the results of this year's survey in the *Gateway Review* in early 2011.


GATEWAY HEALTH PLAN® MEDICAID

Practitioner Type	Requirement	Standard
PCP Specialist	Wait time for an Emergent Appointment	Immediately seen or referred to an emergency facility
PCP Specialist	Wait time for Urgent Care Appointment	Within 24 hours
Specialty Types: Dermatology, Dentist, Orthopedic Surgery, Otolaryngology, Pediatric Allergy & Immunology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric General Surgery, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Pediatric Neurology, Pediatric Oncology, Pediatric Pulmonology, Pediatric Rehab Medicine, Pediatric Rheumatology, Pediatric Urology	Wait time for Asymptomatic Regular/ Routine Appointment	Within fifteen (15) business days from the date of referral
PCPs and Specialties not listed above	Wait time for Routine Appointments	Within 10 business days
PCP	Wait time for a Health Assessment/ General Physical Examinations and First Examinations	Within 3 weeks of enrollment
PCP	After-hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
PCP Specialist	Wait Time in the Waiting Room for routine care	Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical condition need.
PCPs who treat members under the age of twenty-one (21)	Wait time for new member EPSDT screens	Within forty-five (45) days from the effective date of enrollment unless the child is already under the care of a PCP and is current with screens and immunizations.
PCP Specialist	Wait time for first time appointment with Persons known to be HIV positive or diagnosed with AIDS	Within seven (7) days from the effective date of enrollment, unless member is already in active care with a PCP or specialist
PCP Specialist	Wait time for first time appointment with member who is a Supplemental Security Income (SSI) or SSI-related consumer	Within forty-five (45) days of enrollment unless the Member is already in active care with a PCP or specialist.
PCPs or Specialists who provide prenatal	Wait time for first trimester visit	Within ten (10) Business Days of the Member being identified as being pregnant
PCPs or Specialists who provide prenatal	Wait time for second trimester visit	Within five (5) Business Days of the Member being identified as being pregnant
PCPs or Specialists who provide prenatal	Wait time for third trimester visit	Within four (4) Business Days of the Member being identified as being pregnant
PCPs or Specialists who provide prenatal	Wait time for high-risk pregnancies	Within twenty-four (24) hours of identification of high risk
PCP Specialist	Missed Appointment	Conduct outreach whenever a member misses an appointment and document in the medical record. Three attempts with at least one attempt to include a telephone call.



GATEWAY HEALTH PLAN MEDICARE ASSURED® HMO SNP

Practitioner Type	Requirement	Standard
PCP Specialist	Wait time for Urgent, but Non-Emergent Care Appointment	Within 24 hours
PCP Specialist	Wait time for Non-Urgent, but in need of Attention Appointments	Within 1 week
PCP Specialist	Wait time for a Routine or Preventive Care Appointment	Within 30 days
PCP	After-hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
PCP Specialist	Waiting Time in the Waiting Room for routine care	Average office waiting time no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical condition need.

2011 PCP MEDICAID AND MEDICARE ASSURED® HMO SNP AFTER HOURS ACCESSIBILITY STANDARDS

- A live person, recording or auto attendant will direct patients in the case of a true emergency as follows:
 - Hang-up and dial 911 or go to the nearest emergency room
- If a patient is immediately placed on hold, hold time will not exceed one minute.
- After-hours access to an on-call physician.

OFFICE STAFF

REMINDER

Obstetrical Ultrasounds do not require a referral, only a script. Gynecological ultrasounds still require a referral.

OFFICE STAFF



GATEWAY PRACTITIONER E-LEARNING RESOURCE TOOLKIT FOR CULTURAL AND LINGUISTIC GAPS IN HEALTHCARE

Gateway Health Plan® understands that in order to best improve the quality of life of our members, we must be cognizant of their cultural and linguistic differences. For this reason we have made a commitment to address racial and ethnic disparities. A collaborative and trusting patient-provider relationship is the key to reducing the gaps in health care access and outcomes.

Gateway has assembled a list of resources and web-based tools to assist you and your office staff in providing care that is sensitive to the cultural and linguistic differences of your patients.

Please visit Gateway’s provider website to find links to:

- Current articles and events**
- Facts about Health Care Disparities**
- Learn more and find out what you can do**
 - Assessment tools for evaluating your practice**
 - Communication regulations and resources**
 - Health literacy**
 - Learn more about the cultures you serve**
 - Web-based models for continuing education**
 - Disease specific interventions**



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

www.GatewayHealthPlan.com

PROVIDER SERVICES

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

MEDICAL MANAGEMENT

Medicaid 1-800-392-1146
Medicare 1-800-685-5207

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

OFFICE STAFF

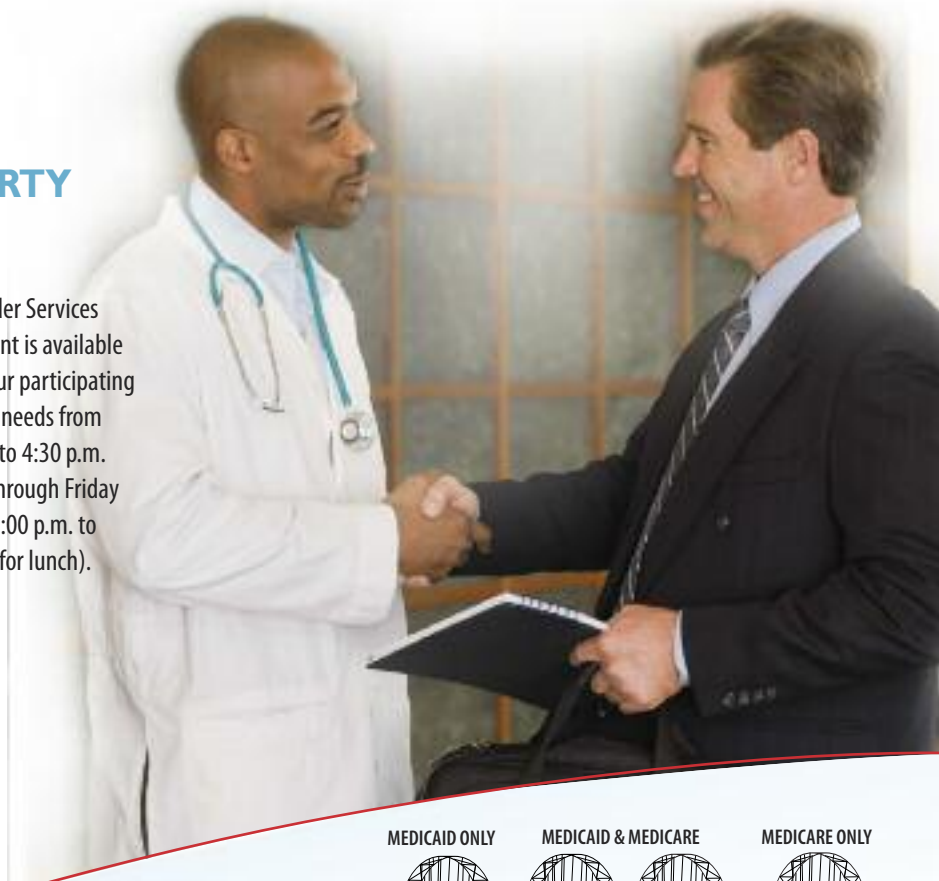


**GATEWAY HEALTH PLAN®
PROVIDER SERVICES THIRD PARTY
ORGANIZATION EDUCATION**

Gateway Health Plan® is committed to keeping our member's protected health information (PHI) secure; therefore, our Provider Services Representatives are not permitted to disclose information to third party organizations without permission from our members. There are no exceptions to this practice. Examples of third party organizations include: pharmaceutical companies; collection agencies; medical equipment vendors; etc.

We encourage our participating providers to limit the release and use of our member's PHI as required by HIPAA regulations.

Our Provider Services Department is available to meet our participating provider's needs from 8:30 a.m. to 4:30 p.m. Monday through Friday (closed 12:00 p.m. to 1:00 p.m. for lunch).



ICON KEY

MEDICAID ONLY



MEDICAID & MEDICARE



MEDICARE ONLY

