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Provider News Brief Gateway Health Plan Medicare Assured®

December 2009

The news brief was created to keep network providers informed of program information and federal and state requirements that impact Gateway Health Plan Medicare Assured®. This newsletter may be freely distributed throughout network provider agencies. Upon publication, a copy will be posted on our web site (www.cbhnp.org). You will find the following information in this edition:

CONFIDENTIALITY	2
OTR REQUESTS	3
PENNSYLVANIA SERVICE AREA	4
OHIO SERVICE AREA	5
CREDENTIALING	5
PROVIDER DATA UPDATES	6
RE-CREDENTIALING	6
BILLING MEMBERS	7
CONTINUED STAY REVIEWS	7
PROVIDER APPEAL OF PAYMENT DENIALS	8
MEDICAL RECORDS STANDARDS	10
ACCESSIBILITY AND AVAILABILITY OF MEDICAL RECORDS	10
RECORDKEEPING	10
RECORD RETENTION	12
CRITICAL INCIDENT REPORTING	13
FOLLOW-UP AFTER DISCHARGE: A QUALITY MEASURE AND OUTCOME	15
2010 MANUALS	16
TRANSPORTATION ASSISTANCE	17
SPECIAL NEEDS PLAN (SNP) MODEL OF CARE	17

CONFIDENTIALITY

Gateway Health Plan *Medicare Assured*[®] Providers will seek to assure that beneficiary personal and clinical information is kept secure and confidential, and that access will be permitted for treatment, payment or healthcare operations or as permitted or required by law. Additional access will be limited to those authorized persons as identified by valid releases signed by the beneficiary.

Providers are required to abide by all state and federal laws and regulations in regards to Member confidentiality, including HIPAA.

To guarantee Beneficiary confidentiality, Gateway Health Plan[®] and CBHNP comply with federal and state regulations governing the release of client information (disclosure of confidential information) and record retention. Gateway Health Plan[®] and CBHNP maintain strict policies concerning internal security, review processes, disposal of confidential documents and distribution of statistical information. Gateway Health Plan[®] and CBHNP also require all Providers to adhere to strict confidentiality measures including:

- Password protection of on-line Beneficiary information.
- Written consent from Beneficiary/guardian is required before disclosure of any information, except as allowed by law, (e.g., emergency treatment, under court-order, etc.). Drug and Alcohol services require Beneficiary consent regardless of age.
- Beneficiaries, 14 years and older, receiving mental health services shall control the release of their medical record. Any release of information forms needed shall be signed by the beneficiary, when the beneficiary is 14 years or older. Drug and Alcohol services require beneficiary consent regardless of age.
- Beneficiaries who are under the age of 14 years or who are incapacitated, except for Beneficiaries in drug and alcohol treatment, may not sign their own release of information forms. In these cases the parent or guardian shall sign the release of information forms.
- Beneficiaries of any age receiving drug and alcohol services shall control the release of their medical records, in accordance with state and federal laws.
- Gateway Health Plan *Medicare Assured*[®] Providers have the responsibility to make sure the release of information form is explained and understood by the beneficiary/guardian prior to being signed.
- A copy of the signed release of information form will be filed in the beneficiary's medical record and a signed copy given to the beneficiary/guardian.
- Gateway Health Plan *Medicare Assured*[®] Providers may release information when the beneficiary's condition is life threatening and it is impossible to obtain the beneficiary's/guardian's consent. All such occurrences must be thoroughly documented in the beneficiary's record.
- Verbal disclosure about a beneficiary can only be made if the beneficiary/guardian has a signed release of information form specifying the information to be released.
- Any documents released or exchanged between Gateway Health Plan[®], CBHNP and a Gateway Health Plan *Medicare Assured*[®] Provider must include a statement regarding the confidentiality of the information exchanged.
- Any Gateway Health Plan *Medicare Assured*[®] Provider violating any of the confidentiality policies and procedures will be subject to disciplinary action.
- Release of information forms should be signed by the beneficiary/guardian during the first session and retained in the Beneficiary's chart. If the beneficiary/guardian refuses

to allow the release of information, this must be clearly documented in the beneficiary's chart.

Providers may use their own consent form to release information in accordance with the federal and state laws that govern confidentiality for mental health, e.g. Federal Regulations 42 CFR, part 2; Pennsylvania stature D&A Control Act & State Regulations, 28 PA Code Subsection 255.5, PA Code Title 55, Subsection 5100.33-39, 5200.41, 5210.56, 5221.52; Health Care Financing Administration, 42 CFR Chapter IV, 10-1-93.

Through contractual agreements, all practitioners and providers participating with Gateway Health Plan *Medicare Assured*[®] have agreed to abide by all policies and procedures regarding beneficiary confidentiality. The performance goal is to secure and protect patient confidentiality and access to patient records.

Under these policies, the practitioner or provider must meet the following:

1. Provide the highest level of protection and confidentiality of beneficiary's medical and personal information used for any purposes in accordance with federal and state laws or regulations including the following:
 - 42 USC 1296a(a)(7)
 - 42 CFR § 431,300
 - The Mental Health Procedures Act, 50 P.S. §§7111
 - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
2. Confirm that beneficiary records contain privileged information and, therefore, are protected by obligations of confidentiality.
3. Assure that beneficiary's identifiable Protected Health Information (PHI) as defined by HIPAA or other applicable regulations, necessary for treatment, payment or healthcare operations (TPO) is released to Gateway Health Plan *Medicare Assured*[®] without seeking the consent of a beneficiary. This information includes PHI used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues, and disease management. Gateway Health Plan *Medicare Assured*[®] follows the requirements of HIPAA and other applicable regulations and limits requests to the amount of PHI that is minimally necessary to meet the payment, treatment or operational function. All other requests for release of or access to PHI will be handled in accordance with federal and state regulations.
4. Environmental security of confidential information is conducted by all providers and practitioners treating Gateway Health Plan *Medicare Assured*[®] beneficiaries. This includes both internal and external monitoring of practice and provider sites. Provider and practitioner sites must comply with all Environmental Assessment standards.

OTR REQUESTS

Gateway Health Plan *Medicare Assured*[®] does not require outpatient services to be registered through CBHNP for par providers. Par providers are those individual providers who have signed an individual agreement; or the credentialed staff of a facility or group in which the group or facility holds the agreement. Providers may provide any medically necessary outpatient mental health service or substance abuse service on the rate schedule and bill Gateway Health Plan *Medicare Assured*[®] directly.

NOTE: CBHNP will pre-certify psychological and neuropsychological testing, acute mental health partial hospitalization and outpatient ECT. The following codes will need authorized or pre-certified before delivering the service.

H0035 96101 96102 96103 96116 96118 96119 96120 90870

Psychological Testing

Psychological testing requests require prior authorization using the Request for Psychological Testing form. The form is available on the Gateway Health Plan® website (www.gatewayhealthplan.com) or CBHNP website (www.cbhnp.org). Providers must complete the form and fax it to CBHNP at 1-717-540-1146.

Neuropsychological Testing

Neuropsychological testing requests require prior authorization using the Request for Neuropsychological Testing form. A copy of this form will be available on the Gateway Health Plan® website or CBHNP website. Providers must complete the form and fax to CBHNP at 1-717-540-1146.

ECT

Requests for ECT should not be submitted on a form. Requests for ECT services should be made by calling CBHNP at 1-866-755-7299 (PA Members) and requesting to speak with a Clinical Care Manager.

NOTE: All Services provided by non-par Gateway Health Plan *Medicare Assured*® Providers require authorization. If there is not an authorization for a service by a non-par provider, Gateway Health Plan® will deny the claim.

PENNSYLVANIA SERVICE AREA

Gateway Health Plan *Medicare Assured*® contracts with Community Behavioral HealthCare Network of Pennsylvania (CBHNP) to manage Gateway Health Plan *Medicare Assured*®'s behavioral health services in twenty-seven (27) counties in Pennsylvania. Those counties are:

Adams	Dauphin	Mercer
Allegheny	Erie	Northampton
Armstrong	Fayette	Northumberland
Beaver	Indiana	Perry
Berks	Lancaster	Schuylkill
Blair	Lackawanna	Somerset
Butler	Lawrence	Washington
Cambria	Lebanon	Westmoreland
Cumberland	Lehigh	York

OHIO SERVICE AREA

Effective January 1, 2010, Gateway is non-renewing its agreement with CMS to provide coverage under the Gateway Health Plan *Medicare Assured*[®]. Previous Gateway *Medicare Assured*[®] members will either choose another Medicare HMO or revert back to original Medicare.

Thank you to all providers who contracted with us during this campaign. We appreciated your support and the service you provided to our members.

CREDENTIALING

Each clinician in your organization with current Medicare enrollment must be individually credentialed. Staff not enrolled with Medicare but providing services "incident to" a physician do not need to be credentialed. The Medicare enrolled physician must be credentialed. Keep in mind that practitioners billing "incident to" MUST follow the documentation requirements outlined in the Medicare Benefit Policy Manual, Chapter 15 of the Medicare Benefit Policy Manual.

In order to be credentialed for the Gateway Health Plan *Medicare Assured*[®], CBHNP requires each individual behavioral health practitioner to have an active Medicare number. The practitioner must also complete a credentialing application. Practitioners interested in joining the Gateway Health Plan *Medicare Assured*[®] network must contact CBHNP Network Development or Credentialing staff and provide a representative with your name, address, date of birth and Medicare number. Before receiving the credentialing application, the provider will receive a Gateway Health Plan *Medicare Assured*[®] provider agreement. The provider must submit the signed agreement to CBHNP. After CBHNP receives the signed agreement, CBHNP credentialing staff will forward the information listed above to our primary source verification provider (Med Advantage CVO). Med Advantage CVO will forward a credentialing application to the provider for completion. The provider must complete the application and provide evidence such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc. Questions, please contact CBHNP Credentialing at 888-700-7370.

Other than Hospitals and Partial Hospitalization Programs, facility and professional provider organizations do not need to complete a Facility Application or be credentialed. All Medicare approved practitioners within these organizations must be credentialed. The facility or provider organization must complete a Provider Payee Form, Provider Assignment Form and Provider Acceptance form in order to receive payment for those practitioners who are practicing under that facility or group.

CBHNP accepts the Pennsylvania Standard Credentialing Application for all Medicare enrolled clinicians. Please forward the application to:

Michelle Smith, Credentialing Supervisor
CBHNP, P.O. Box 6600
Harrisburg, PA 17112

If you need an individual application mailed to you, please call Michelle at 717-671-6518 or email to msmith@cbhnp.org.

PROVIDER DATA UPDATES

It is critical that Providers notify their Provider Relations Representative immediately if anything has changed that will affect our ability to refer Members to your organization or practice. Notification must also be provided in writing to avoid any miscommunication. The CBHNP "Provider Data Update Form" may be used for this communication, but communications in other formats are acceptable. Information can be faxed to Provider Relations at 717-671-6522.

Regular reporting benefits Providers by ensuring that the Provider Directory will be updated appropriately.

RE-CREDENTIALING

CBHNP's review of network providers' performance is an ongoing process; however all providers (both independent practitioners and facilities) are formally re-credentialed at least every **three (3) years**. CBHNP reviews the provider's licensure, malpractice insurance, and membership in their respective national organizations, compliance with CBHNP standards, accessibility to Members, clinical and administrative outcomes, accreditation status and the results of satisfaction surveys mailed to all treated Members, when available. The re-credentialing process also includes review of the provider's performance since the last credentialing decision.

We have seen increasing numbers of providers who failed to complete the re-credentialing package when it was sent to them.

Our process is as follows:

1. Med-Advantage automatically sends out the individual re-credential application to the provider 6 months before the provider is due for Credentialing.
2. We verify that the individual providers have received their applications from Med-Advantage. Six months before the provider is due for re-credentialing, a Credentialing Specialist will call the provider to inform them the provider is due for re-credentialing and an application will be sent by MedAdvantage. At this time, the Specialist will also discuss with the provider if he/she wishes to be re-credentialed.
3. Specialists check on a regular basis to verify that the provider received his/her application and the application has been returned to Med-Advantage in order for the provider to be re-credentialed on time. All providers that have not returned their application beyond 30 days of the mailing date are contacted to confirm receipt of the application and instructed to return the application to MedAdvantage as soon as possible.

If the provider fails to complete and submit the re-credentialing application, the provider will be listed as a non-par provider in Gateway Health Plan *Medicare Assured*[®]. The provider will remain non-par until he/she submits a complete the application and obtain approval through the Credentialing Committee.

As a non-par provider, Gateway will require you to obtain prior approval of services. Failure to obtain authorization will result in denial of your claim.

BILLING MEMBERS

The Centers for Medicare and Medicaid Services (“CMS”) recently revised its regulations for Medicare Advantage plans. Members of these advantage plans may not be liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

In order to comply with CMS regulations, Gateway Health Plan is amending its contracts with providers to assure that Members are not liable for Medicare Parts A and B cost-sharing. Providers will agree that upon receiving payment from Gateway under the Gateway Health Plan *Medicare Assured*[®] line of business, Providers will either:

1. Accept the Gateway Health Plan *Medicare Assured*[®] payment as payment in full; or
2. Bill the appropriate State Medicaid source.

This change will take effect January 1, 2010. If you had an older contract, you would have received an Amendment to your contract prior to December 1, 2009. If you did not receive the Amendment, please contact:

CBHNP
Rick Madey
Network Development Manager
P.O. Box 6600
Harrisburg, PA 17112
717-540-1141

CONTINUED STAY REVIEWS

CBHNP conducts continued stay reviews (CSR) or concurrent reviews for managed care members based upon site of service. Continued stay reviews for IP and PHP shall be conducted telephonically with CBHNP Clinical Care Managers (CCM's). During the review, please be prepared to provide current psychotropic medications, any changes in patient condition that have occurred since the last review, updated diagnoses and GAF scores and current symptoms. CBHNP makes review decisions are based solely upon the medical information obtained at the time of the review determination.

The continued stay review should be initiated on or before the last covered day in order to allow sufficient time for the concurrent review process to be completed, and to provide sufficient notice of the determination to the provider. **Reviews should occur prior to 4 p.m. on the last day of coverage.**

The frequency of concurrent reviews is contingent upon the member's clinical condition and response to the prescribed plan of treatment or based upon arrangements with specific facilities.

The CCM will collect relevant clinical information and evaluate the medical necessity of the request using McKesson's InterQual or ASAM criteria as appropriate. The clinical information collected includes, but is not limited to:

- Diagnosis/co-morbidities
- Age
- Complications
- Progress of treatment
- Medical history
- Current medications
- Psychosocial situation
- Home environment/social situation, when applicable
- Treatment plan

Please have the above information available when you call!

If the CCM is able to authorize the request for service, the requesting practitioner/provider will be notified, and a reference number provided either telephonically or by return fax within designated timeframes. Confirmation of certification will include the number of extended days, units of service and the next anticipated review date.

Certification for services is based upon the information available at the time the certification is issued (including information regarding the member's eligibility for coverage and/or the availability of benefits). If additional information is needed to authorize or continue services, you will be advised during the request for services.

If the CCM is unable to certify the care that has been requested, the CCM must consult with a Physician Advisor/Medical Director for physician review. The Physician Reviewer will attempt to contact the treating provider to discuss the member's clinical condition prior to rendering a determination.

PROVIDER APPEAL of PAYMENT DENIALS

Clinical Care Managers are not permitted to backdate any request for authorization. Such requests must be submitted through the provider payment denial appeal process. The process for appeal requests is outlined below.

Providers are expected to follow all prior authorization requirements as defined in the Provider Manual and Provider Infos. This policy is intended to address claims denial only. Any denial that occurs after the service has been rendered is subject to review under the provider appeal or reconsideration processes, but not both types of reviews. For services not yet provided, the Gateway Health Plan[®] Member reconsideration policy and procedure will apply.

Reversal of payment denials should be regarded as an exception and will not be routinely approved without compelling evidence that the Provider did not follow protocol due to legitimate special circumstances as determined by CBHNP. CBHNP will evaluate all requests and take into consideration factors that caused the procedural error as well as remedies in place to prevent future occurrences.

CBHNP will be responsible for all first and second level internal review appeals. The provider must initiate the formal Provider Payment Denials Appeal process through a written appeal request. All requests must go to:

Gateway Health Plan®
Attention: Medicare Complaint Administrator
U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704

Providers requesting review of a payment denial will be instructed to send a letter stating the following:

- Plan Name (Gateway Health Plan *Medicare Assured*®)
- Member name
- Members Gateway Health Plan *Medicare Assured*® ID Number
- Documentation of Members seen/dates, services provided and billable amount(s)
- The service that was delivered
- Reason for the delay or failure to get authorization
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Desired action from CBHNP
- Documentation relevant to the request (i.e.... Eligibility slips verifying that eligibility was checked and wrongly indicated enrollment status, fax confirmation page, etc...)
- ALL relevant information should be included with your appeal.

Appropriate reasons for approval (reversal of the non-authorization decision) include but are not limited to:

1. Documentation of eligibility verification issues beyond the control of the provider
2. Documentation of processing errors by CBHNP or Gateway Health Plan®
3. Documentation of continued stay review issues beyond the control of the provider
4. Unavoidable delays caused by another provider.
5. Timely notification and resolution of the issue.
6. Any other reason as decided by the review committee.

Reasons to uphold a non-authorization decision include but are not limited to:

1. Failure in authorization management by the provider.
2. Submission of the request for review beyond 90 days of the initial notice or service delivery date.
3. Failure to check eligibility prior to service delivery.
4. Failure in claims or billing management by provider.
5. This was a MNC denial when services have already been provided.
6. Any other reason as decided by the review committee.

A decision will be made and written notice issued to the provider within 30 days of receipt of the documentation. If the request is **approved** and the claim is in the Gateway Health Plan® claims

processing system, **CBHNP will contact Gateway Health Plan® to adjudicate the claim.** The approval letter serves as authorization and you should retain it in your records.

Second Level Review

A provider may request a second level internal review. The provider must request the second level review in writing and the request must be received at Gateway within 30 days of the date of the first level internal review decision letter. All second level appeal requests must set forth the specific reason why the provider feels that the first level decision was in error.

A second level determination will be completed and a written decision notice issued within 45 days of receiving the payment denial appeal. The provider may elect to participate in the review by telephone or in person to present information. The provider's written appeal request must indicate the provider's intention to participate in these proceedings.

You should direct questions on this process to CBHNP Provider Relations at 888-700-7370.

All relevant information must be submitted with the appeal, as the decision of the Second Level Committee review is final.

MEDICAL RECORDS STANDARDS

The Quality Improvement Program provides guidelines for medical record documentation for Gateway Health Plan *Medicare Assured*® Providers. These guidelines are consistent with the standards of national accrediting organizations. Gateway Health Plan *Medicare Assured*® Medical Records standards for behavioral health providers are as follows:

Accessibility and Availability of Medical Records

Provider contracts include provisions to permit Gateway Health Plan® and CBHNP Quality Improvement staff, and appropriate/required agencies access to the medical records of Gateway Health Plan *Medicare Assured*® Members. Records may be reviewed to monitor quality, medical necessity, coordination of care, and continuing care planning.

Gateway Health Plan *Medicare Assured*® Providers are contractually obligated to maintaining medical record documentation of each encounter with Gateway Health Plan *Medicare Assured*® Members.

Recordkeeping

Standards are established for organization, content, and readability of the Gateway Health Plan *Medicare Assured*® Member's medical records. The Member medical record documentation may be either paper based or electronic. Documentation must be current, detailed, organized, comprehensive, and legible, promote effective care, and facilitate quality review. Providers must adhere to all applicable federal and state confidentiality regulations for treatment records. By provider contract, treatment records must be made available for review by Gateway Health Plan®, CBHNP and appropriate/required agencies for quality improvement purposes. Data elements for Member medical records include:

- The Member's name and/or client number on each page of paper documentation and on every entry of electronic records.
- The Member's identifying information and demographics to include:
 - Name
 - Age and Date of Birth (DOB)
 - Address and County of residence
 - Home, work telephone number and/or method of contact
 - Employer or school
 - Marital status
 - Legal status
 - Parent/Guardian Name (for children and non-adjudicated adolescents)
- Name and contact information of Primary Care Physician (PCP)
- All entries are dated; author of documentation is identified by name, title, credential and signature (paper) or key identifier (electronic).
- Written documentation is legible to someone other than writer or affiliated staff colleagues. Legibility is determined through review by CBHNP Staff.
- Allergies to include medication allergies and adverse reactions. Absence of allergies is noted as "no known allergies – NKA".
- Risk factors/Risk assessments
- Past Medical History/Treatment History to include:
 - Significant Health Events – accidents, operations, hospitalizations
 - Developmental History (for children and adolescents)
 - History of past behavioral health interventions/treatment to include dates and duration of services and level of care
 - DSM-IV diagnoses for all axes I through V
- Medication Information to include medication name, frequency, dosage, effectiveness of treatment regime and any known side effects for:
 - Past medications for physical conditions
 - Past psychotropic medications
 - All current medications
 - Evidence that current medication has been consistently provided as prescribed and reevaluated as necessary; changes in medication, dosage and reason for change
- Past history and current use of alcohol/drugs to include kind, type, frequency and amount
- Consultations, Referrals and Specialists' Reports to include laboratory results and review psychological evaluations, summaries and review as applicable
- Record of all emergency care, how directed and emergencies' surveys
- Discharge summaries
- Individualized Treatment Plan to include:
 - Goals and objectives
 - Discharge criteria to move to lesser level of care
 - Therapeutic interventions/modalities
 - Client's response to treatment/client progress towards goal achievement
 - Documentation of evidence and results of any behavioral health screening
 - Documentation of all treatment/interventions provided and results of treatment/interventions
 - Documentation of team Members involved in the multi-disciplinary team of Gateway Health Plan *Medicare Assured*[®] Member needing specialty care

- Documentation of behavioral health and medical surgical integration to include:
 - Screening for behavioral health conditions which may be affecting physical health
 - Screening for physical health conditions which may be affecting behavioral health
 - Screening and referral to Gateway Health Plan *Medicare Assured*[®] Primary Care physician when appropriate
 - Documentation of Gateway Health Plan *Medicare Assured*[®] Primary Care Physician referral to Gateway Health Plan *Medicare Assured*[®] Provider.
 - Quarterly summary of the Gateway Health Plan *Medicare Assured*[®] Member's progress in behavioral health treatment, prepared by the Gateway Health Plan *Medicare Assured*[®] Provider(s) for the Gateway Health Plan *Medicare Assured*[®] Member's Primary Care Physician.
 - Summary is prepared more frequently when clinically appropriate.
 - Documentation that behavioral health professionals are included in the primary and specialty care service teams when a Gateway Health Plan *Medicare Assured*[®] Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- Documentation of GAF scores at initiation of treatment and delineated treatment intervals through episode of care/illness but at a minimum at termination of treatment for all Gateway Health Plan *Medicare Assured*[®] Members.
- Documentation of reason for termination of treatment.
- Documentation of date(s) of family, therapy/intervention/visits for any Gateway Health Plan *Medicare Assured*[®] Member under the age of 18.

RECORD RETENTION

The Center for Medicare and Medicaid Services (CMS) guidelines require retention of records for ten (10) years. All Gateway Health Plan *Medicare Assured*[®] Providers credentialed through CBHNP have had their contracts amended to read as follows:

- Records, Reports and Inspections.

1. CBHNP Provider shall maintain financial reports and source records that include any revenues from, expenditures for, or other financial activity related to services rendered under this Agreement for the period required by law, at a minimum of **ten (10) years** or any longer period as may be required by CMS from time-to-time, following the termination or expiration of this Agreement or from the date of completion of any audit, whichever is later. Provider may keep such records in an original paper state or preserved on micro media or electronic format. Provider will develop and maintain written policies and procedures for the storing of these records.

CBHNP Provider further agrees to provide to Gateway Health Plan[®] and CBHNP all medical, financial and administrative information and reports as may be necessary for (1) compliance by Gateway Health Plan[®] with State and Federal law; (2) Gateway Health Plan[®] Medicare Advantage Plan program management purposes; (3) Gateway Health Plan[®] compliance with the reporting and quality assurance requirements of any contract between a government agency and Gateway Health Plan[®] to provide healthcare services to a specified category of

Members; and (4) such other legal purposes as determined by Gateway Health Plan[®] from time-to-time.

Any and all references to a required financial report or source record retention of less than **ten (10) years** contained in provider's current participation agreement or any amendment thereto are hereby omitted and replaced with the requirement herein.

4. CBHNP Providers agree to reasonably cooperate with and participate in such review and service programs related to the Gateway Health Plan[®] Medicare Advantage Plan as may be established by Gateway Health Plan[®] and CBHNP, including Utilization Review/Management, quality assurance programs, credentialing, sanctioning, external audit systems, and administrative and provider appeals, grievance and reconsideration procedures. CBHNP Provider further agrees to reasonably cooperate with HHS, the Comptroller General or their designees' inspection or evaluation of records for a period of **ten (10) years**, or for any longer period as may be required by CMS from time-to-time, from the termination of this Agreement or from the completion of a then-pending audit. CBHNP Provider acknowledges that CMS may inspect, evaluate and audit Gateway Health Plan[®], CBHNP and CBHNP Provider at any time if CMS determines that there is a reasonable possibility of fraud. CBHNP Provider will comply with all final determinations rendered through the above programs.

Any and all references to a required period of cooperation with an audit conducted by HHS, the Comptroller General or their designees of less than ten (10) years contained in provider's current participation agreement or any amendment thereto are hereby omitted and replaced with the requirement herein.

5. Medical Records. To the extent applicable to the provision of Covered Behavioral Health Services to Members, CBHNP Providers agree to maintain an appropriate and accurate medical and clinical record for each Member who has received Covered Behavioral Health Services, for a period of at least **ten (10) years** or any longer period as may be required by CMS from time-to-time, from the date of the last encounter, in accordance with State and Federal laws and regulations, and CBHNP standards and accepted medical and clinical practice. In the event CMS determines there is a need to retain records beyond the normal retention period, CBHNP Provider shall comply with written notice of such extended retention period.

Any and all references to a required medical record retention of less than ten (10) years contained in provider's current participation agreement or any amendment thereto are hereby omitted and replaced with the requirement herein.

CRITICAL INCIDENT REPORTING

The following information on Critical Incident Reports is targeted for implementation in the near future. It is being provided here to assist you with any planning for implementation of this future requirement.

Gateway Health Plan *Medicare Assured*[®] providers are expected and required to develop written policies and procedures for an incident management process, take strong measures to prevent the occurrence of critical incidents, investigate and report on those that occur, and to take reasonable corrective action to prevent reoccurrence.

All Gateway Health Plan *Medicare Assured*[®] providers will be required to report critical incidents within 24 hours of the time at which the provider becomes aware of the occurrence.

The following incidents must be reported immediately:

1. Death of a Member.
2. Suicide attempt.
3. Medication error.
4. Any event requiring the services of the fire department, or law enforcement agency.
5. Abuse or alleged abuse involving a Member.
6. Any injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid.
7. A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time.
8. Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents.
9. Seclusion or restraint.
10. Other incident identified by Providers as Critical, Adverse or Unusual.

Some definitions:

Medication Error:

Any missed medication, incorrect medication or incorrect dosage, where a Member requires treatment greater than first aid for adverse effects of the medication.

Abuse:

Any act of alleged or suspected abuse, neglect of a consumer which could include physical, verbal, psychological or sexual abuse, exploitation, neglect and misuse of a Member's funds.

Injury or Illness of a Member:

Any injury or illness where the Member requires medical treatment more intensive than first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a band aid, etc. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room. This incident type includes:

- Diseases reportable to the Department of Health, defined as any disease reportable on the Pennsylvania Department of Health List of Reportable Diseases. Report is only required when disease is initially diagnosed.
- Emergency Room Visits are defined as the use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to a primary care physician (PCP) or as a

result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of a physician's office is not reportable.

- Hospitalization, defined as an inpatient admission to an acute care facility for the purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

Restraint:

Any chemical, mechanical, or manual technique used for the purpose of restricting movement. A chemical restraint is a medication used to control acute or episodic behavior that is not the standard treatment for the Member's medical or psychiatric condition, and is intended to significantly lower the individual's level of consciousness and restricts the movement of a Member. A medication ordered by a physician as part of the ongoing individualized treatment plan for treating the symptoms of mental, emotional, or behavioral disorders is not a chemical restraint. A mechanical restraint is a device used to control acute or episodic behavior that restricts movement or function of a Member or portion of a Member's body. Examples of mechanical restraints are handcuffs that are locked around the wrists, elbow restraints, foot restraints, cloth harnesses applied to any portion of the body, and blanket wraps. Mechanical restraints do not include measures to promote body positioning to protect the Member and others from injury, or to prevent the worsening of a physical condition. Devices also used for medical treatment such as helmets for prevention of injury during seizure activity, mitts, and muffs to prevent self-injury are not considered restraints. A manual restraint is a physical hands-on technique that restricts the movement or function of a Member's body or portion of a Member's body. Prompting, escorting, or guiding a Member who does not resist to assist in the activities of daily living is not a manual restraint.

Seclusion:

Restriction of a Member in a locked room, and isolating the person from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

Time-out Room:

An unlocked room used to remove an individual from the individual's immediate environment to reduce stimulation and assist the individual to regain self-control. Use of a time-out room constitutes a potential alternative to the use of seclusion and restraint.

FOLLOW-UP AFTER DISCHARGE: A QUALITY MEASURE AND OUTCOME

Timely follow-up after a mental health inpatient stay is an important part of the service continuum. Among managed care plan members more than half in private plans received follow-up care within 7 days but only two of five managed care members in Medicare plans received follow up within 7 days. By 30 days, three-quarters of private managed care plan member receive care but only about 3 of 5 Medicare managed care plan members had received follow up care. The likelihood of readmission is decreased for members who receive follow-up care and those who do require readmission are less likely to be in crisis. For purposes of outcomes and quality initiatives, NCQA and HEDIS measures include follow-up at two intervals – 7 days and 30 days.

Follow-up measures for 7 and 30 days after discharge from mental health services impact quality of service in multiple ways. A member's risk for re-hospitalization is doubled if not seen within the 7 -30 day period. Follow-up care efforts can offer the opportunity to monitor member medication checks, identify possible regression that can lead to readmissions as well as develop and implement interventions to avoid or minimize the intensity of readmission and monitor how Members are doing. This best practice helps Members more easily transition from mental health inpatient settings to community settings. The 7 and 30 day measure is selected because it has been found that members and families who set and keep outpatient appointments following inpatient care tend to have fewer readmissions compared with persons who do not have or keep aftercare appointments. These timeframes are able to be compared to the National Medicare Performance Assessments.

Interventions to improve follow-up readmissions include the use of follow-up specialists who conduct outreach prior to appointments as well as post-appointment dates to confirm appointments are kept and if not, identify the reasons and possible barriers. In addition, identification of high risk members who require special attention helps avoid readmissions. Providers who offer mobile psychiatric / outpatient services can have a positive impact as well.

Current data shows reasons members in general do not keep appointments include the following, providing the opportunity to address specific barriers to receiving these important services.

1. Active substance abuse issues that may complicate or interfere with follow up
2. Transportation issues
3. Child care needs that interfere with keeping appointments
4. Chronic psychosis which interferes with making good judgments about follow-up appointments

Other barriers include:

1. Backlog of appointments for psychiatrists and therapists
2. Inadequate discharge planning and lack of specific appointments in some cases by hospitals. Discharge plans not specific enough or do not include specific appointments.
3. Waiting lists for case management
4. Patient refusal and Member noncompliance; Member lack of understanding of discharge planning
5. Poor coordination of care or reluctance of providers to work with high-risk Members with substance abuse needs.

CBHNP and Gateway Health Plan[®] recognize the importance of the aftercare follow-up efforts as they relate to best practice and positive Member outcomes. Providers are encouraged to assist in ensuring Members receive proper follow-up services in order to limit readmissions. Reporting on these NCQA / HEDIS measures will be completed in the coming months.

2010 MANUALS

The 2010 Gateway Health Plan *Medicare Assured*[®] Provider Manual for Behavioral Health Care is available online at www.cbhnp.org.

TRANSPORTATION ASSISTANCE

Gateway Health Plan *Medicare Assured*[®] provides its members with a non-emergency transportation benefit. Members may receive up to 36 one-way (18 round) non-emergent trips to plan-approved locations, within 50 miles one-way, per calendar year. This includes non-emergency transportation to doctor visits, covered dental, vision, hearing, and behavioral health services; and to pharmacies and fitness centers.

Members should call 1-866-670-3063 (TTY Users 1-800-855-2880) three (3) business days before their appointment. Hours to call are 8 a.m. – 5 p.m., Monday thru Friday and 9 a.m. - 1 p.m., Saturday.

SPECIAL NEEDS PLAN (SNP) MODEL OF CARE

Overview

Gateway Health Plan[®] (Gateway) offers a Special Needs Plan (SNP), *Medicare Assured*[®], for individuals who have Medicare Parts A and B, and Full or Qualified Medicare Beneficiary (QMB) Medicaid eligibility. These individuals are referred to as “dual-eligibles”.

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

SNP Model of Care Elements

1. Staff Structure and Care Management Roles

- There are three essential care management roles within Gateway’s Model of Care:
 - **Administrative Roles** – These roles involve the day-to-day operations of the plan such as processing enrollments, paying claims, and handling appeals and grievances.
 - **Service Delivery Roles** – These roles involve providing care to the beneficiary, including such things as Advocating, Informing and Educating Beneficiaries, Identifying and Facilitating Access to Community Resources, and ensuring that the member receives the care he/she needs.
 - **Oversight Roles** – These include oversight of both Administrative and Clinical functions. Some examples include Monitoring Model of Care Compliance, Assuring Statutory and Regulatory Compliance, and Evaluating the Model of Care Effectiveness; And, Monitoring the Interdisciplinary Care Team (see below), Assuring Timely and Appropriate Delivery of Services and Assuring Seamless Transitions and Timely Follow-up to care, and Conducting Chart Reviews.

2. Provider Network Having Specialized Expertise and Use of Clinical Guidelines

- Gateway contracts with a network of providers with the clinical expertise pertinent to the *Medicare Assured*[®] population. The providers go through appropriate credentialing processes and are expected to use appropriate clinical guidelines in the care of Gateway's members.

3. Health Risk Assessment (HRA)

- Health Risk Assessments are a set of questions designed to provide Gateway with an overview of a member's health status and risks. Shortly after enrolling, each member is asked to complete a Health Risk Assessment, either by paper or over the phone. Reassessments are performed at least annually thereafter.

4. Interdisciplinary Care Team (ICT)

- EACH member of *Medicare Assured*[®] is assigned to an Interdisciplinary Care Team base upon his/her level of need as indicated by the assessment of the HRA. The composition of the team varies based on the needs of the member. Under most circumstances, the member's Primary Care Physician (PCP) is included on the ICT. Whenever possible, the member or member's caregiver is included as part of the team.

5. Individualized Care Plan (ICP)

- An individualized care plan contains goals, objectives and plan of care for the member. The ICP is developed by the ICT based on needs identified by the Health Risk Assessment.

6. Communication Network

- Gateway has a communication network to facilitate communication between the Plan, the member, providers, and when necessary the ICT. Communication is primarily handled via printed materials / reports, faxes, and telephone calls.

7. Performance and Health Outcomes

- Performance and health outcomes are measured in a variety of ways within Gateway. Some of these include the Medicare Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Healthcare Effectiveness Data and Information Set (HEDIS) measures, various member surveys, and analysis of encounter data.

8. Measurable Goals.

- Using CMS guidelines, Gateway has established Model of Care goals that measure, and attempt to improve outcomes for things such as Access to Medical, Mental Health, and Social Services; Access to Preventable Health Services; and Cost-effective Service Delivery.

9. Model of Care Training

- Model of Care Training is provided to Gateway *Medicare Assured*[®] employees, sub-contractors, and providers at time of hire / contract, and annually thereafter.

How the Model of Care Works for a Member

- Shortly after a member enrolls with *Medicare Assured*[®], the member is given a Health Risk Assessment. The assessment is mailed to the member as part of the member's new member packet. The member is asked to complete and return the form. If the form is not returned within a specified period of time, Care Management outreaches to that member by telephone.
- The completed Health Risk Assessment is reviewed, and based on that review, the member is assigned to an Interdisciplinary Care Team (ICT).
- The ICT develops the member's Individualized Care Plan (ICP). Input is gathered from the primary care physician (PCP) whenever applicable.
- The ICP is communicated to the member, the member's primary care physician (PCP), and other ICT members as appropriate; normally by mail.
- The member receives care 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.

Other Important Information about Gateway's Model of Care

- Gateway recognizes that member's care needs are varied and are subject to change. Policies and procedures have been put in place to allow members to receive the level of care management needed for their particular circumstance.
- Members may be referred for Care Management in a variety of ways:
 - Providers may call 1-800-685-5212, option 1
 - Members may self-refer by calling 1-800-685-5212, option 1.
 - Gateway employee via an internal process.
- Oversight of the Model of Care Plan is handled by the Medicare Administration Department. Specific questions with regard to the Model of Care Plan should be addressed with your Gateway Provider Representative.