LeadingAge Indiana PathWays Frequently Asked Questions

\*\* The following FAQs are in not necessarily in any particular order and represent an ongoing dialogue with members, regulators and MCEs. Accordingly, these FAQs will be updated routinely and re-posted.

Q: What are a good couple of resources to refer to for general information?

A: LeadingAge Indiana website dedicated to the Pathways program - <https://www.leadingageindiana.org/aws/LAIN/pt/sp/mmc>.

Pathways for Aging website - <https://www.in.gov/pathways/>

See also – this PowerPoint:



Q: If a Nursing Home (NH) resident (new potential Pathways enrollee) attempts to call into the Pathways number to select an MCE - what steps are being completed to verify the identity of the individual (or representatives on behalf of the individual) calling in?

A: FSSA has confirmed that its Pathways call center specialists have a series of questions that each asks to verify the identity of the potential new enrollee. Each MCE has confirmed that each has a similar process to also verify the identity (and / or authorization) of the individual(s) calling in.

Q: Some resident (or their representatives) are being told that they cannot be found in any of the 4 different state systems (to which customer service staff have access to in order to verify ID and eligibility).

A: FSSA conveyed that it appreciates any individual case-specific feedback and that such instances should be sent to [backhome.indiana@fssa.IN.gov](mailto:backhome.indiana@fssa.IN.gov), with a cc to [Eric Essley](mailto:Eric%20Essley%20%3ceessley@leadingageindiana.org%3e). FSSA is not aware of any widespread problems in this area generally but indicated it might be a re-determination process issue and is looking into that possibility.

Q: If providers have questions about eligibility/enrollment, is there an alternate number to call or email to use?  Providers have reported the PathWays customer service employees not being all that helpful generally outside a narrow scope of question.

A: FSSA conveyed that it appreciates any individual case-specific feedback and that such instances should be sent to [backhome.indiana@fssa.IN.gov](mailto:backhome.indiana@fssa.IN.gov), with a cc to [Eric Essley](mailto:Eric%20Essley%20%3ceessley@leadingageindiana.org%3e).

Q: Who will make Medicaid eligibility determinations?

A: The state (through its contractor, and never an MCE) will always make those determinations. All such determinations will be effective on the first of the following month (e.g. an April 17 eligibility determination will trigger coverage starting May 1).

Q: Who will be making initial outreach communications to residents /potential new covered persons?

A: All such initial contact will come from the state (FSSA). MCEs will make subsequent contact once a covered person has selected or been assigned to an MCE, roughly 60 days prior to July 1, 2024. MCE Service Coordinators will begin reaching out to their respective members the month prior to the start of the program.

See this PowerPoint for additional information:



Q: How will FSSA communicate with residents who have a power of attorney (POA) or other legal representative (and what of an individual has multiple representatives)?

A: Contact will be made to the individual(s) (up to three) who are already the authorized contact(s) in the FSSA-CORE system. This could be the resident and / or multiple other authorized persons.

Q: In the context of a healthcare POA holder and/or a financial POA holder, who gets to make MCE selection and other enrollment decisions?

A: Hopefully, any competing interests will be able to amicably work this out with the assistance of the SNF. If not, legal counsel might need to get involved.

Q: How will the MCE selection / assignment process work?

A: Most details are outlined on the state’s [Pathways website](https://www.in.gov/pathways/), but enrollees may select any one of the three MCEs. The state prefers that covered persons select an MCE that “aligns” with an existing Medicare Advantage (MA) plan if one exists. If no selection is made, the state will auto assign the selection, with an initial preference aligning with an existing MA plan, and if none exists then auto selection process will proceed in a round-robin fashion.

Q: How will MCEs address coordination of benefits between MA, VA, and /or other plans or payors?

A: Although not every scenario is addressed, FSSA has an FAQ on the [Pathways website](https://www.in.gov/pathways/) dedicated to coordination of benefits issues.

Q: Please explain enrollment details (including how a covered person might change an MCE)?

A: Please visit the state’s [Pathways website](https://www.in.gov/pathways/); and/or see previous LeadingAge Indiana PowerPoint.

Q: Do the Enhanced Benefits of each MCE apply equally to HCBS and NH residents?

A: All Enhanced Benefits will apply to all persons covered by that specific MCE, but as a matter of practice, some benefits will not be applicable or appropriate for some covered persons depending on the care setting, acuity level, overall health needs, etc.

Q: What are Care and Service coordinators?

A: Care and Service coordinators will be hired by each MCE and will serve a number of critical functions for residents and their providers. These roles, which might be two separate individuals, or could be one person, will be an ever-present resource in SNF buildings. Our partner, Probari, addresses these roles very well in this PowerPoint –



Q: Can NH communities have employees that become Care and/or Service Coordinators for residents under the Nursing Facility Level of Care?

A: No. Care and Service Coordinators will be separate employees of the MCE with whom they are attached.

Q: Will Care and Service Coordinators for NH residents only come from MCE’s or outside agencies, while residents needing HCBS services could have a Care and Service Coordinator from the NH facility?

A: See above FAQ relative to NH residents. For HCBS providers, it is likely that that the same process will apply. However, many of the HCBS Medicaid transition details have not yet been adequately discussed/released.

Q: Have regulators considered allowing NH communities to have their own Care and Service Coordinator for NH residents?

A: Yes. Care and Service Coordinators will be separate employees of the MCE with whom they are attached. They will not be employees of the individual NH facility.

Q: What will be prescribed caseload for Care and Service coordinators?

A: Care Coordinator ration are still TBD, but most likely will be 1-100; Service Coordinator ratios will be 1-50.

Q: Will there be a level of consistency of individuals (Care and Service coordinator roles) coming into the facility (i.e. – not a different person each time)?

A: Yes. That is the goal of each MCE now and over time – to the extent possible.

Q: Do the MCEs understand and appreciate the resource disruption that might be caused by a continuous flow of care and service coordinators (potentially 6 different individuals) in a facility?

A: Yes. The MCEs are aware and, while there might be some administrative burden on the facility staff, each MCE is committed to reducing that burden to the extent possible by working with staff to coordinate schedules, etc.

Q: How will care and service coordinators be scheduled in a facility?

A: This is still TBD, but each MCE is committed to working with every facility to cause as little disruption as is possible.

Q: With MCEs coming in the building (Care and Service Coordinators + possible other personnel), will they have their own Nurse Practitioners (NP) that will only see their MCE members?

A: That is not the intent. MCEs would like to contract with the NP or MD in the facility and some are working through this process already. The MCEs suggested that each facility contact the MCE to let them know the identity of the NP and MD to jump start that process.

Q: If the MCE-specific NP visits a facility, will this then result in a decreased caseload for that provider’s NP?   To what extent will there be a workload overlap?

A: These processes are still being developed.

Q: What does the acronym CHAT from the presentation mean?

A: Comprehensive Health Assessment Tool.

Q: Please explain the reintegration process following short-term nursing care?

A: Short-term nursing facility care is temporary medical aftercare following a surgery, injury, illness, or other medical condition that is expected to improve. Services are goal-oriented and typically last several weeks or a few months depending on the severity of the condition being treated. The contractor is responsible for obtaining services for its members in a skilled nursing facility setting on a short-term basis. The contractor is responsible for completing a clinical review for each admission. The contractor is responsible to start member discharge planning on the day of admission to the nursing facility. The contractor will complete concurrent reviews of a member’s short-term nursing facility care to assess medical necessity for continued stay. For authorizations originally approved by the Contractor, if the Contractor denies continuation of services with the skilled nursing facility, the Contractor must provide at least five (5) days of coverage for the services from the date of the notice of denial, to ensure the safe discharge of the member. This requirement does not apply for authorizations submitted untimely by the provider. This does not apply to an individual who loses Medicaid eligibility. *Cite – SOW 3.8.1 ... this is subject to change in the final version of the SOW.*

Q: Please explain long-term nursing care?

A: Long-term nursing facility care is ideal for members with chronic or progressive medical conditions, such as Parkinson’s disease, permanent disabilities, dementia, or a debilitating stroke. This is a permanent placement for members who will permanently reside in the nursing facility and is not expected to return home. The contractor must have processes in place to monitor all long-term nursing facility stays. Contractor must assign a service coordinator to all its members residing in a long-term care facility. *Cite – SOW 3.8.1*

Q: What safeguards are in place for long-term nursing care?

A: It is the responsibility of the Contractor not to impose burdensome review criteria on nursing facility providers. This includes frequent requests for clinical documentation. Frequent requests are requests requiring providers to submit clinical documentation at a frequency of less than every seven (7) days. The state reserves the right to review the Contractor’s policies and procedures regarding medical necessity at any time.

Q: Please explain continuity of care as it relates to existing prior authorizations.

A: The MCE shall provide continuity of care for the authorization of services as well as choice of providers for ninety (90) days. For a member who meets HCBS Level of Care and has an existing care plan approved by FSSA or another MCE, that care plan will be honored for ninety (90) days from the date of enrollment. When receiving members from another MCE, fee-for-service, or commercial coverage, the MCE shall honor the previous care authorizations for one of the following durations, whichever comes first: ninety (90) calendar days from the member’s date of enrollment with the contractor, or the remainder of the prior authorized dates or service, or until the approved units of service are exhausted. The MCE shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member’s enrollment in their plan. MCEs must have a process to receive and transfer member information and the process must be managed by a transition coordinator. *Cite – SOW 3.22*

Q: Please describe how each MCE will create their own provider network and how the “any willing provider (AWP)” concept will apply to this question?

A: Each MCE has a robust provider-relations team that will be reaching out to most/every HCBS and LTCF provider in the state. If a provider does not hear from one of the MCEs by mid-April, they can contact the MCEs here:

* UnitedHealthcare: [IN\_providerservices@uhc.com](mailto:IN_providerservices@uhc.com)
* Humana: Denise Watson - [DWatson31@humana.com](mailto:DWatson31@humana.com); Terry King - [TKing58@humana.com](mailto:TKing58@humana.com)
* Anthem: [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com), Emma Badgley - [emma.badgley@anthem.com](mailto:emma.badgley@anthem.com); Taylor Blake - [taylor.blake@anthem.com](mailto:taylor.blake@anthem.com)

As for the AWP issues, the current Pathways program requires that each MCE must accept any willing provider (that generally meets the MCEs basis provider criteria) for three years post July 1, 2024. .

Q: How will contracting be done? Will this be though amendments, a new base contract, or through some other documentation?

A: It will depend on the extent of the existing provider relationship with any one of the MCEs and might be different for different MCEs.

Anthem example:

Providers that are currently contacted with Anthem for Medicaid received an Amendment by Notification (ABN) to add the IN PathWays for Aging program as a line of business to their contracts. Any provider adding HCBS services, or new to Anthem providing HCBS Services (Including 1-2 Star Nursing Facilities as Long-Term Care providers), will apply to the network through the Provider Enrollment application in Availity. For questions, please reach out to [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com)

Q: How will MCEs communicate to a provider as to which residents have enrolled in a particular plan (or has changed plans)?

A: Initial post-selection or assignment outreach to residents and their providers will begin by each MCE in June 2024. Subsequent outreach details will be part of the Provider Manual of each MCE.

Q: How will be billing proceed, and how will it be different than it is today?

A: Billing and claims payment matters will be addressed in the SOW ([Pathways website](https://www.in.gov/pathways/)) once it is finalized. Additionally, billing and claims will be a part of Provider Onboarding, outlined in the MCE Provider Manual, etc.

Q: Many providers currently bill (submit claims) to the fee for service payer on a weekly basis. Will this still be permitted in the new system or may claims only be submitted monthly?

A: Billing and claims payment matters will be addressed in the SOW once it is finalized, and that should be available on the state’s [Pathways website](https://www.in.gov/pathways/).

Q: From the perspective of the MCEs, does “processed” and “paid” mean the same thing, or are they different – and if so, how so?

A: Paid and processed are not interchangeable terms. “Paid” reflects the status of a claim when it has been fully processed to completion.

Q: Have the MCEs or the Pathways teams been communicating with pharmacies, therapy providers, and other ancillary service providers about Pathways transition matters?

A: Such outreach efforts and notifications are ongoing.

Q: If a SNF resident (or a new potential Pathways enrollee) recently received an enrollment notice letter from FSSA and would like to go ahead and select an MCE - what should they do?

A: The resident or their representative(s) should call the Pathways number [87-PATHWAY-4 (1-877-284-9294)] and select an MCE).

Q: What if the resident wants to select an MCE that has not yet signed a contract with the current or prospective place or residence

A: There is a continuity of care period to allow the member to make their choice and receive services. Further, Service Coordinators will work with the member, and LTSS Provider Relations partner to bring the NF in network to ensure no disruption to the member’s care.

Q: If a resident (or new potential Pathways enrollee) attempts to call into the Pathways number to select an MCE - what steps are being completed to verify the identity of the individual.

A: Still TBD – but this is a FSSA question/answer. However, generally speaking, potential enrollees would work with Maximus, the state’s Enrollment Broker to confirm their MCE selection and ask questions about the MCEs to make an informed decision on which MCE to select.

Q: What is the MCE process for verifying the identify of potential enrollees / enrollees generally when they or their representatives call in?

A: After MCE selection, the MCEs receive an enrollment file from the state to notify them of their membership. After a member has chosen their MCE, when contacting the MCE customer service department will likely require the caller to provide the member’s full name, MCE ID and date of birth. Additional HIPAA validation points, such as address, or phone number will be required of the MCE ID is not available.

Q: Please explain the HCBS provider contracting process?

A: Ancillary Medicaid providers are contracted at the TIN level. For skilled providers that also provide an HCBS service, they would have an Ancillary Contract for the skilled service, with an HCBS Amendment (by notification) to add the PathWays for Aging line of business to their skilled contract. These providers should also receive a HCBS Contract for the waiver services.

General provider enrollment / claim submission information can be found here:



Additional information relevant to Anthem is as follows:

**Anthem Enrollment for Existing Medicaid Providers:**

For Skilled providers that are contracted with Anthem as a Medicaid provider, an Amendment by Notification (ABN) was sent via USPS (United States Postal Service) certified mail to the existing network of providers, adding Indiana PathWays for Aging Medicaid line of business to their contracts. The ABNs were sent out, one per Tax ID, to the address we have on file.

* For skilled providers needing to add HCBS services, those providers will need to go to our Digital Provider Enrollment application within Availity to enroll for those LTSS services and receive an HCBS contract.
* For skilled providers that received an ABN that are not adding an HCBS service, no further action is needed

**Anthem Enrollment for New Home-and-Community Based (HCBS) Providers:**

Home-and-Community Based (HCBS) providers wishing to join the Anthem network for the Indiana PathWays for Aging Program must complete the online application through our Digital Provider Enrollment (DPE) Tool.

* If the organization is not currently registered for Availity, the designated Administrator in the organization should go to [Availity.com](https://www.availity.com/) and select “Register Organization”
* Once the organization is registered in Availity, complete the online application through DPE by following these steps. Availity.com --> Payer Spaces --> Anthem Blue Cross and Blue Shield 🡪 Provider Enrollment

Is there a specific contact that they may reach out to directly to ask additional pointed questions like this one?

* For HCBS provider enrollment questions, please contact [INLTSSProviderContracting@anthem.com](mailto:INLTSSProviderContracting@anthem.com)
* For questions specific to Skilled Nursing Facility, Skilled Home Health and/or Hospice contracts, please contact [alina.cruz@anthem.com](mailto:alina.cruz@anthem.com)

Anthem, Page 2 of the Amendment by Notification (ABN) that was sent to Skilled providers with existing Anthem Medicaid contracts, which outlines next steps for those providers adding an HCBS Service:

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Additionally, Anthem hold Virtual Office Hours every other week dedicated to what we would call “Hybrid Provider”- those skilled providers that also provide HCBS Services.