Anthem

Indiana PathWays for Aging provider onboarding and orientation

[2024]

Anthem Blue Cross and Blue Shield's (Anthem) mission and values

Our mission:

- Improving lives and communities. Simplifying healthcare. Expecting more.

Our vision:

- Be the most innovative, valuable, and inclusive partner

Our values:

- Leadership — Redefine what's possible.
- Community — Committed, connected, invested.
- Integrity — Do the right thing, with a spirit of excellence.
- Agility — Deliver today; transform tomorrow.
- Diversity — Open your hearts and minds.

Agenda

- PathWays for Aging program overview
- Person-centered practices
- *HCBS Settings Rule* compliance
- LTSS Health Care Networks team
- Critical incidents
- Quality in LTSS service provision
- LTSS provider enrollment
- Member management tools for providers
- Billing and reimbursement
- Anthem LTSS VBP and incentives
- Member rights and responsibilities
- Workforce Development
- Provider resources

Long Term Services and Supports (LTSS)

LTSS encompasses a wide array of on-going services delivered over a long period of time, *paid and unpaid,* that are designed to meet the holistic needs of individuals of any age living with disabilities, chronic health conditions, or who need help with daily activities in home and community-based setting or institutional setting of choice. Minimum services provided through LTSS programs help people to maintain independence, quality of life, and dignity:

- LTSS is available to individuals that meet certain medical, function, and financial criteria determined by the state's eligibility guidelines.
- Medicaid is the primary payor.

Managed Long Term Services and Supports (MLTSS): When Managed Care Organizations provide the delivery of Medicaid health benefits, such as LTSS for individuals with disabilities and older adults, through contracted arrangements with state Medicaid agencies:

- Anthem, as the MLTSS, is responsible for working with you on the coordination of the services and supports for individuals receiving LTSS.

Pathways for Aging program overview

What is Indiana PathWays for Aging?

Indiana PathWays for Aging is an MLTSS program for Hoosiers over [60] on Medicaid.

Indiana PathWays for Aging member eligibility

Indiana PathWays for Aging is a statewide managed care program for Indiana's Medicaid enrollees. To be deemed eligible for enrollment into Indiana PathWays for Aging, a member must:

- Be [60] years of age or older.
- Be eligible for Medicaid based on age, blindness, or disability.
- Have limited income or resources.

They may also:

- Have full Medicare benefit (dually eligible).
- Reside in a nursing facility or receiving hospice services.
- Be receiving LTSS in a home- or community-based setting-including those on the *Aged and Disabled Waiver.*

PathWays for Aging benefits

Home- and community-based services (HCBS):

- Adult day
- Attendant care
- Home and community assistance
- Respite (skilled and unskilled)
- Adult family care (community home share)
- Assisted living facility
- Community transition
- Home delivered meals
- Home modification assessment
- Home modification
- Integrated health coordinator
- Nutritional supplements
- Personal emergency response systems (PERS)
- Pest control
- Specialized medical equipment
- Structured family caregiver
- Non-emergency, non-medical transportation
- Vehicle modification
- Caregiver coaching and behavior management

Facility-based providers:

- Nursing facilities
- Assisted living facilities
- Hospitals
- Community mental health centers

State plan providers:

- Home health
- Hospice
- Therapies:
  - Occupational therapy
  - Physical therapy
  - Supportive periodontal therapy

Key goals for Indiana PathWays for Aging program

The PathWays for Aging program is designed to ensure that aging Hoosiers are able to remain in their home or community settings of their choice.

Key program goals include:

- Comprehensive care coordination with an emphasis on ensuring that all older Hoosiers have access to quality care and can achieve similar health outcomes regardless of race, ethnicity, or geography.
- Seamless coordination of benefits regardless of program or setting.
- Enhanced benefits to help caregivers, care recipients, *and their families.*
- Increased access to services at home, with careful coordination and a responsive approach.
- Increased quality of care.

Care coordination and service coordination — roles

Care Coordinator	Service Coordinator
Primarily responsible for coordination of physical and behavioral health services within the *Individualized Care Plan (ICP)*.	Primarily responsible for coordination of LTSS within the service plan.

Care and Service Coordinator roles as related to LTSS providers:

- Provide information about member specific support needs and preferences to facilitate effective referral matches.
- Submit timely service authorization requests that align with care and service plans.
- Engage providers in the development and ongoing revisions of care plans and service plans.
- Keep providers informed about the status of care and service plan outcomes and changes.
- Facilitate resolution when a member/provider grievance occurs.

Care coordination and service coordination — provider role in the Interdisciplinary Care team

Care plans and service plans are the roadmap for how the member should be supported through service delivery. Providers are critical participants of Interdisciplinary Care teams to ensure services are delivered in alignment with the care and service plans.

Provider expectations as Interdisciplinary Care team participants:

- Participate in care and service planning and revisions.
- Deliver all services using a person-centered approach.
- Ensure all service delivery complies with the *HCBS Settings Rule*.
- Support each member to achieve their desired outcomes through service delivery as outlined in care and service plans and submit status updates according to the agreed upon schedule.
- Notify the Care/Service Coordinator immediately with any significant change, barrier to progress, social drivers of health (SDOH) needs, or any news that could impact the individual's service outcomes or health and safety.

LTSS program quality goals

Goal one: Person-centered services and supports — Develop service plans and deliver services in a manner that is person-centered, participant-driven, holistic, involves caregivers, and addresses SDOH.

Goal two: Ensuring smooth transitions — Ensure continuity of care and seamless experiences for participants as they transition into the PathWays for Aging program or among providers, settings, or coverage types.

Goal three: Access to services (member choice) — Assure timely access to appropriate services and supports to enable participants to live in their setting of choice and promote their well-being and quality of life.

Anthem's LTSS model

- Indiana PathWays for Aging LTSS program is a fully integrated model that begins with the foundational approach that provides high quality, culturally competent service coordination for seniors and people with disabilities reducing fragmentation, improving outcomes, all while maximizing member independence and choice:

Value to providers

- Advanced technologies, along with training and support on billing and other processes, ensuring timely and accurate claims processing.
- Value-based payment models support providers in driving improved health outcomes, improve efficacy, and enhance member safety and service performance.
- Training and TA delivered and designed to support providers in meeting evolving HCBS expectations.

Value to other stakeholders:

- Integrated service delivery that requires coordination and collaboration with other social/community entities, which leads to meaningful relationships with local schools, civic groups, public housing, transportation authorities, faith-based organizations, non-profit agencies, and other organizations.

Value to members and families:

- Care coordination and service coordination work to simplify systems access, integrate health, and supportive services tailored to member needs, and maximize member resources.
- Person-centered principles and practices delivered through innovative discovery processes leading to member-driven individualized support plans.
- Innovative network capabilities that improve access to care and increase awareness of quality and choice of providers.
- Meaningful participation in the community through integrated competitive employment and civic engagement.
- Supports for independence and exercise of self-direction that promotes self-determination and member self-actualization.
- Family and caregiver supports that strengthen the natural role of family and other member relationships to augment feelings of value and belonging leading to emotional well-being.

Person-centered practices

Person-centered practices

Person-centered language:

- Person-centered language recognizes the impact of language on thoughts and actions.
- It ensures language does not diminish the uniqueness and intrinsic value of each individual and allows a full range of thoughts, feelings, and experiences to be communicated.
- It is important to emphasize cultural preferences and communication style when training a direct support professional on the individual they will support.

Person-centered planning:

- Person-centered planning is a process whereby the needs and preferences of the person receiving services are described by that person (in collaboration with family, friends, and other circle-of-support individuals) to develop a support plan that ensures they receive the covered services they need in a manner they prefer.
- Planning is conducted to reflect what is important to the individual while balancing what is important for the individual so that delivery of services is in a manner reflecting personal preferences and ensuring health and welfare.

Person-centered practices (cont.)

The purpose of person-centered planning is:

- To emphasize the strengths of the individual.
- To assist a person in gaining control over the life of their choosing.
- To increase opportunities for participation in the community in order to achieve a full community life.
- To recognize individual desires, interests, and goals.
- Ultimately, through team effort, to develop a plan that turns their plans into reality.

Successful person-centered planning:

- Have a clear and shared appreciation of the skills, strengths, and capabilities of the person supported.
- Meet regularly with the person and their key supports to review methods used or to brainstorm different approaches.
- Make meaningful connections to the local community.
- Use the provided person-centered planning tools and create an individualized path to success.
- Support the person and their key supports to continue to be motivated to keep moving forward on their journey. Once initial goals are met, make new ones that support what is important to and for them as well as their full community life.
- This is an open process that continues throughout the individual's lifetime — It is not a product!

Care planning documents

The *ICP*:

- Is created based on the member's initial health screening and health risk assessments(s) to ensure that the member's care is appropriately coordinated and managed.
- Is a plan that reflects the individual's needs, preferences, and prioritized goals. It is developed by the individual, their care coordinator, and their team through a person-centered process that focuses on strengths, preferences, and goals.

Person-Centered Support Plan (PCSP):

- The member’s assigned Service Coordinator has primary responsibility for coordination of the member’s LTSS-specific *PCSP* (*Service Plan*), which must be integrated into the member’s overall individualized care plan.
- Focuses on the member’s LTSS needs and goals as well as housing, medical, social, educational, and a variety of services provided through the program or other funding sources.

Key components of the plan

Key components of the plan:

- It must be developed through a person-centered planning process, driven by the individual and including people chosen by the individual.
- It provides necessary information and support to the individual and ensures that they direct the process to the maximum possible extent.
- It is timely and occurs at times/locations of convenience to the individual.
- It reflects cultural considerations and uses plain language.
- It includes strategies for solving disagreements.
- It offers choices to the individual regarding services and supports they receive and from whom.
- It provides a method to request updates.

Key components of the plan (cont.)

It is conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare:

- It identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual.
- It may include whether and which services are self-directed.
- It includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, etc.
- It includes risk factors and plans to minimize them.
- The plan is signed by all individuals and providers responsible for its implementation.
- A copy of the plan must be provided to the individual and their representative.

Ongoing development of the PCSP

- The *PCSP* is always evolving just as the individual is also evolving.
- Interests and goals may change as the person integrates into the community and is exposed to more options.
- The *PCSP* will also change as a person's service needs change.
- Providers play an important role in the evolution of the *PCSP*.
- Collaboration/communication between the provider and care coordinator/support coordinator is key to ensuring services and supports reflect the current needs, goals, and interests of the person supported.
- As providers identify natural supports, and/or if fading of services occurs, the *PCSP* will need updating to reflect the person's current situation.
- Changes to a person's health must also be reflected in the *PCSP*.

The provider's role

You are an important member of the individual's support team.

When accepting referrals for HCBS, the provider must review the documentation provided in the referral and determine capacity to meet the person's specific needs. They must:

- Ensure qualified and trained staff are available and properly matched with the individual needing supports.
- Assess capacity to meet the person's transportation needs (if applicable).
- Review cultural preferences and communication needs.
- Participate in meet-and-greets with the person.
- Attest to and return the *PCSP* after receiving it to acknowledge they are ready to begin services.
- Accept and start services in a timely manner.
- Use the *PCSP* to develop an implementation plan.
- Ensure direct support professionals are trained on the *PCSP* and service implementation plan (if applicable).

HCBS Settings Rule

HCBS Settings Rule requirements*:*
HCBS Settings Rule 42 CFR 441.301

- OMPP is responsible for initial validation of *HCBS Settings Rule* compliance; however, Anthem is responsible to ensure that all contracted providers remain compliant with requirements on an ongoing basis.
- Applicable programs subject to the *HCBS Settings Rule*, operated by the Division of Aging (DA) within the Family and Social Services Administration (FSSA) includes the Indiana PathWays for Aging program.
- Ensures that member receive HCBS in settings fully integrated in the community, supporting full access to the community at large. This includes:
  - Opportunities to seek employment and work in competitive and integrated settings.
  - Engage in community life.
  - Control personal resources.
  - Receive services in the community to the same degree as those individuals who do not receive HCBS.
- Anthem does not contract with any provider who is not compliant with the *HCBS Settings Rule* requirement.

HCBS Settings Rule requirements

At a minimum, recredentialing/recertification of providers includes:

- Verification of continued licensure and/or certification (as applicable).
- Compliance with policies and procedures identified during credentialing/certification such as:
  - Background checks and training requirements.
  - Reportable event management.
  - Use of the electronic visit verification (EVV) system.
- Monitoring compliance with the *Settings Rule* using the HCBS site visit tool.
- Annual HCBS audits that include evaluating the physical location, policies, procedures, and other written documentation, employee training, and employee files (as appropriate).

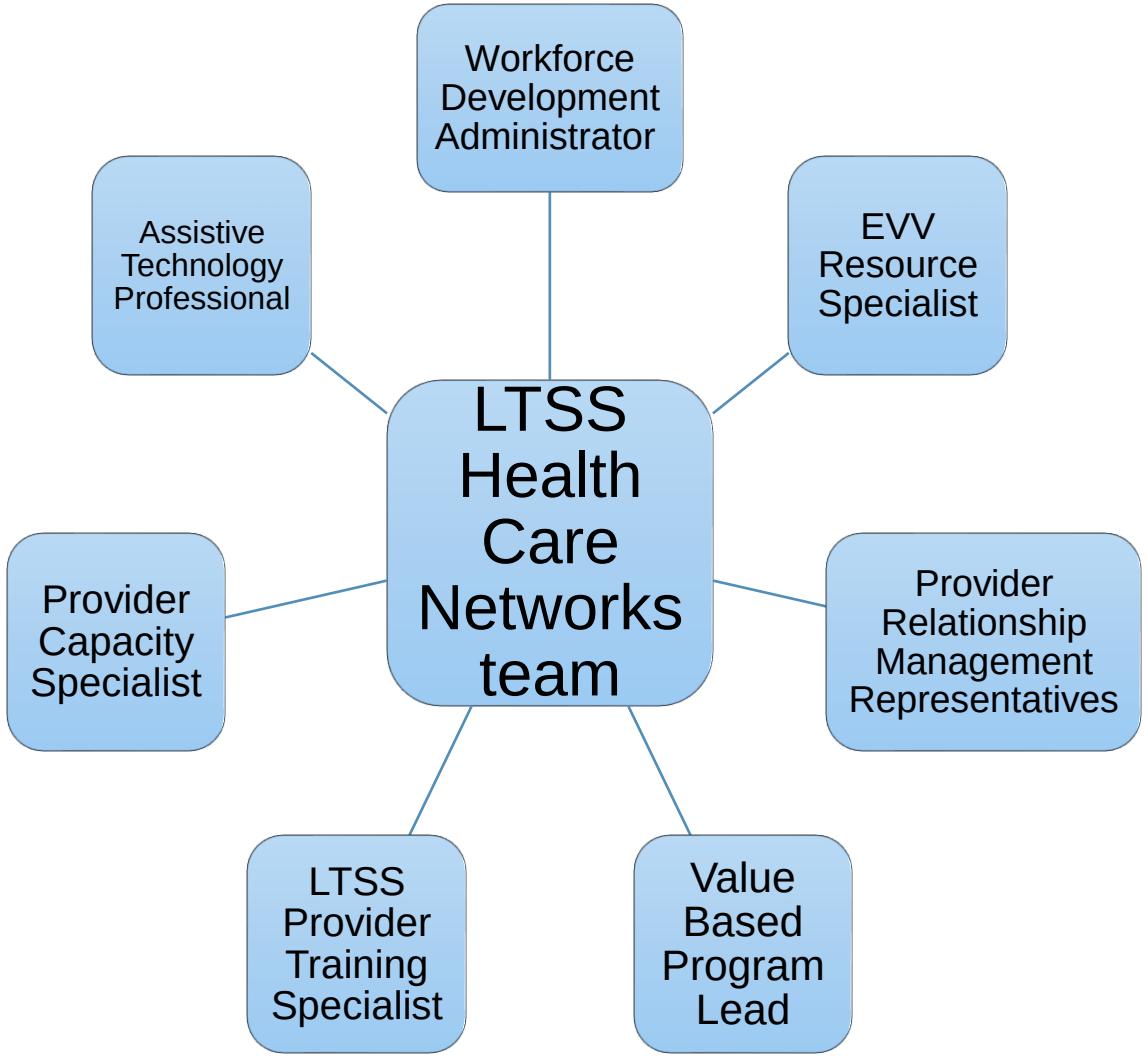
The *HCBS Settings Rule*, along with additional guidance and fact sheet, is available on the [CMS Home and Community-Based Services] website.

LTSS Health Care Networks team

We are here to support you

The cornerstone of Anthem's provider promise is to empower providers through education and training to serve the needs of Anthem members by delivering a superior provider network experience:

- Dedicated local team with diverse backgrounds to provide well-rounded provider support.
- Focuses on the Anthem and provider relationship, provider development opportunities, identify areas of expansion, and support provider growth.
- Key positions to ensure on-demand expertise to the issues most important to LTSS providers.



Dedicated LTSS Health Care Networks support

- All HCBS and nursing facility providers are assigned a dedicated LTSS Provider Relationship Management representative based on the organization’s geographic location.
- Your LTSS Provider Relationship Management representative will:
  - Ensure you receive comprehensive training and education on key requirements of LTSS both initial upon enrollment and on an ongoing basis.
  - Conduct support visits, including Implementation support, initial visits, onboarding, education and training, ongoing and technical assistance.
  - Provide 1:1 or group technical assistance as needed, either virtually or in-person.
  - Maintains regular and meaningful communication and training with the network.
  - Provides subject matter expertise in LTSS billing, direct services, and LTSS service provision.

Guided support — Dedicated LTSS Health Care Networks will actively engage providers to develop relationships, share the fundamentals of managed care, offer education, tools and resources needed to support their training and readiness needs.

Building a robust network — Anthem will work with all providers to build a robust network and comply with provider requirements.

Provider support visits

Types of support you can expect:

- ***Pre-Implementation Survey*:** This is a questionnaire where we can get to know your agency's mission, philosophy, expertise, approach, and what your biggest support needs are.
- **Implementation support visit:** We will provide additional support preparing for the PathWays for Aging implementation and may include verifying you meet all requirements and qualifications to become a PathWays for Aging provider. This will include topic such as: Service provision expectations, staff capacity and WFD needs, review of applicable policies and procedures, and ensuring you can access our systems.
- **Onboarding education and training:** This visit will focus on ensuring you feel confident in understanding all contractual, state, and federal requirements within your contract and *Provider Manual*, that you can access all needed training and billing platforms, and review of all Anthem related training.
- **Ad-hoc visits:** Technical assistance to the provider to support additional training and support needs or specialized focuses from Value-Based Program (VBP) Specialist, WFD Administrator, Technology Specialist, or Provider Capacity Specialist depending on needs.

Provider support visits (cont.)

Ongoing annual provider support visits: This visit will be annual, and your provider representative will either come onsite or virtually check in with you. They will review anything from your initial support visits to ensure accuracy, conduct any re-training that is needed, as well as evaluate your overall performance since the last meeting. We will talk through referral process and acceptance, billing/claims denials and needed assistance, ensure you have all provider updates and resources, and that you remain HCBS compliant, etc.

Provider preparation

Review any documentation sent to you by your Provider Relationship Management representative prior to the visit and ensure you have made them aware of things you'd like to review:

- Arrange for key people within the agency you'd like to attend, based on type.
- Ensure policies and procedures are up to date.
- Prepare properly to limit how long it takes to conduct the visit.
- Prepare any question you'd like addressed.

Critical incidents

Critical incidents/unusual occurrences

PathWays for Aging critical incidents may also be referred to as *unusual occurrences*.

These fall into [three] categories:

- HCBS critical incidents
- Abuse, neglect, and exploitation (ANE) critical incidents
- All other critical incidents

Critical incidents/unusual occurrences (cont.)

The following are examples of HCBS critical incidents:

- Significant injuries requiring emergent medical intervention, including but not limited to, a fracture, burn greater than first degree, choking that requires intervention, contusions, or lacerations
- Injuries of unknown origin
- Any threat or attempt of suicide
- Any unusual hospitalization due to significant change in health and/or mental status that may require a change in service provision *or* admission of an individual to a nursing facility, excluding respite stays
- Member elopement or missing person
- Inadequate formal or informal support for a member, including inadequate supervision that endangers the member

Critical incidents/unusual occurrences (cont.)

- Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs
- A residence that compromises the health and safety of a member
- Environmental or structural problems with a dwelling
- A residential fire resulting in relocation, personal injury, property loss
- Suspected or observed criminal activity by staff, family member
- Police arrest of a member or any person responsible for the care of the member
- A major disturbance or threat to public safety created by the member
- Any instance of restrictive intervention (including chemical or physical restrains or seclusion)
- Falls with injury

ANE critical incidents

Definition:

- Alleged, suspected, reported, observed, or actual abuse/battery, assault, neglect, or exploitation of a member
- Unexpected death of a member

Adult Protective Services (APS)

Responsible for defining, receiving reports of, and investigating suspected neglect, battery, or exploitation of an endangered adult. The pertinent definitions can be found at: [in.gov/fssa/da/adult-protective-services]

It is **mandatory** for providers to report **all instances of ANE to APS.**

Providers are to report any suspected abuse neglect or exploitation of the member, even in cases that the member does not explicitly state abuse is happening.

All other critical incidents

All other critical incidents include those not experienced by a member receiving HCBS or involving ANE.

If a critical incident does not meet the definition of an HCBS or ANE critical incident, it falls in the category of *all other critical incidents*.

When in doubt report the unusual occurrence so it can be reviewed and any issues resolved.

Reporting for Non-HCBS settings

ANE: APS is responsible for defining, receiving reports of and investigation suspected neglect, battery, or exploitation of an endangered adult. Any incident that meets APS's definition of a critical incident must be reported to APS. Instructions for reporting can be found [in.gov/fssa/da/provider-resources/provider-information/incident-reporting/].

Hospitals and other acute care facilities: IDOH receives reports for critical incidents that occur at acute care facilities. Any incident that meets the IDOH's definition of a critical incident must be reported by staff and personnel of acute care facilities licensed by IDOH. The definition and reporting form can be found [in.gov/health/cshcr/acute-and-continuing-care/report-an-incident-regarding-an-acute-care-facility/].

Reporting critical incidents

Anthem and providers are expected to report any critical incident of which they have knowledge. If the provider perceives an immediate threat to the participant's life or safety, follow emergency procedures which may include calling [**911].**

Other options to submit reports:

- HCBS critical incidents:
  - Submit a report via FSSA's DDRS/DA Incident and Follow-Up Reporting Tool (IFUR) link: [ddrsprovider.fssa.in.gov/IFUR/]. The provider must submit these reports within [48] hours of the time of the incident or becoming aware of it, whichever is sooner.
- ANE critical incidents:
  - Report to local APS office within [24] hours, including interventions underway or anticipated intervention. Link: [ddrsprovider.fssa.in.gov/APSOnlineReporting]. APS is not an emergency responder. If you believe someone is in immediate danger, call [**911**] immediately.

Reporting for non-HCBS settings

Nursing facilities: Comprehensive care and licensed residential facilities are required to report to the IDOH Division of Long Term Care any allegations of abuse and any unusual occurrence that directly threatens the welfare, safety, or health of a resident of the licensed facility. The *IDOH Long Term Care Abuse and Incident Reporting Policy* may be found at [in.gov/health/ltc/incident/].

Mental healthcare settings: The Indiana Division of Mental Health and Addiction (DMHA) receives reports for critical incidents that occur during the provision of mental health and addiction services. Applicable provider types include: DMHA contracted providers, private mental health institutions, state psychiatric hospitals, opioid treatment programs, and other residential reporting agencies. The definition and reporting form can be found at [in.gov/health/ltc/incident/].

Preventing and reporting critical incidents/unusual occurrences

- Providers are expected to have a policy in place that describes how critical incidents will be prevented, reported, mitigated, and tracked over time. Providers should utilize critical incident data to determine opportunities for improvement.
- Reports submitted are tracked by the state and MCE, late reports and repeat issues are noted. The state expects the MCE to provide oversight of critical incident reporting, management and mitigation.
- Providers agreements include provisions to ensure providers understand the requirements to:
  - Submit an incident report.
  - Notify the member's service coordinator for any reportable HCBS critical incident within [48] hours of the time of the incident or becoming aware of the incident, whichever is sooner.
  - Requirements to comply with critical incident reporting requirements.
  - Potential action to protect health and welfare.
  - Consequences for non-compliance.

Quality in LTSS service provision

Quality program goals

Providers are responsible to ensure service delivery supports FSSAs quality goals:

- **Person-centered services and supports:** Develop service plans and deliver services in a manner that is person-centered, participant-driven, holistic, involves caregivers, and addresses SDOH.
- **Ensuring smooth transitions:** Ensure continuity of care and seamless experiences for participants as they transition into the Indiana PathWays for Aging program or among providers, settings, or coverage types.
- **Access to services (member choice):** Assure timely access to appropriate services and supports to enable participants to live in their setting of choice and promote their well-being and quality of life.

PathWays for Aging quality management

There are multiple elements used to measure, monitor, and improve quality of LTSS service provision, such as, but not limited to:

- NCQA distinction standards
- HEDIS® measures
- Care plan audits and service plan reporting
- Member surveys
- Complaints
- Critical incidents/unusual occurrences
- Member and provider incentives
- EVV
- Referral management tracking
- Utilization management data

Pathways for Aging — Surveys

- The **Consumer Assessment of Healthcare Providers (CAHPS®) and *Systems Home and Community Based Survey*** is for adults receiving LTSS from state Medicaid HCBS programs. This survey includes core questions cover topics such as: getting needed services, communication with providers, case managers, choice of services, medical transportation, and personal safety, as well as community inclusion and empowerment. This is completed annually.
- **CAHPS nursing home** surveys are conducted annually and include the following:
  - *Long-Stay Resident Survey* asks about the experiences of long-stary residents currently living in nursing facilities.
  - *Discharged Resident Survey* asks about the experiences of residents recently discharged from nursing facilities after short stays.
  - *Family Member Survey* asks respondents to report their own experiences with the nursing home and their perceptions of the quality of care provided to a family member living in a nursing home.
- ***National Core Indicators Survey Client Sample Report (NCI-AD)*** will be conducted by the State. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families.

Anthem will develop and implement action plans based on results and in accordance with state requirements.

LTSS quality service provision

What are some ways providers can contribute to quality service provision?

- **Person-centered services and supports:** Communicate clearly and timely with care and service coordinators, support in development of the service plan, and deliver services in a manner that is person-centered, participant-driven, holistic, and involves caregivers. Look for opportunities to identify and address SDOH needs, communicating any needs to the care/service coordinator.
- **Ensuring smooth transitions:** Be proactive in planning for transitions to ensure continuity of care and seamless experiences for participants. Communicate clearly and often with the member, family, care and service coordinators and share concerns and mitigate concerns.
- **Access to services (member choice):** Provide services timely. Engage members in selecting staff that meet their preferences and enable participants to live in their setting of choice and promote their well-being and quality of life.

Addressing SDOH

LTSS providers are often the first to encounter a member's SDOH needs because they are visiting the member in their home to provide support and may identify, without the member voicing a problem, that a concern exists. Providers may notice challenges almost immediately upon entering a member's home, such as:

- Issues with cleanliness or disrepair to the home.
- Physical barriers for the person to navigate their home environment (may cause fall and other risks).
- Lack of transportation.
- Lack of basic resources such as food, water, electricity, or clothing.
- Safety issues, both interior and exterior, including exposure to crime.

Providers can support addressing SDOH by developing community partnerships and linking members to resources, communicating SDOH needs to the member's service coordinator, and training direct service workers on how to identify and respond when issues are discovered. Timely identification of needs and closed loop referrals are key to ensuring the member is connected to the appropriate resources.

Provider feedback and technical assistance

- Anthem is committed to ensuring members are receiving quality services, and that our contracted providers are successful. Our Health Care Networks team will work directly with providers through technical assistance and training to help providers improve the quality of services delivered:
  - Support providers to understand reports that include feedback around quality and utilization, supporting providers to build capabilities to improve and meet performance targets.
  - Provide training to help providers understand and assess SDOH and how to connect members with social services providers to address member and informal caregiver SDOH needs.
  - Partner with FSSA and the other MCEs to provide training and technical assistance to help with engagement in VBP programs and to establish a core set of measures that will be standardized across all MCEs.
  - Targeted training around specific quality improvement initiatives, establishing a HCBS learning network preparing for VBP adoption.
  - Support workforce development efforts in coordination with the state and other MCEs.

LTSS provider enrollment

Provider enrollment

- LTSS providers must meet specific eligibility criteria in order to enroll in Anthem's LTSS provider network. The following requirements are necessary in order to submit an application with Anthem:
  - Enrolled with IHCP at the beginning of the network process.
  - Must be certified by the appropriate State division (Division of Aging or Office of Medicaid Policy and Planning).
  - Must meet all provider qualification requirements as listed *in 455 IAC 1-3* and *IHCP Provider Manual*.
- Once enrolled as a PathWays for Aging LTSS provider, you must continue to meet the defined provider qualifications:
  - Provider qualifications are dependent upon the service for which you are certified to provide and are outlined within the Division of Aging's HCBS [*HCBS Waiver Provider Manual, Section 7]*.

Credentialing vs. certification

- **Credentialing:** All contracted providers, *excluding HCBS providers*, must meet the National Committee for Quality Assurance (NCQA) guidelines to ensure quality of care if maintained or improved and assuring that all contracted providers hold current State licensure and enrollment with the IHCP. This process is called **credentialing:**
  - Anthem will not be able to offer an executed contract to any provider that does not meet credentialing standards.
  - Re-credentialing for appliable providers occurs every three years.
- **Certification:** For HCBS providers, NCQA credentialing does not apply. Rather, Anthem ensures that the provider is enrolled with IHCP at the beginning of the network participation process, is certified by the appropriate State division (Division of Aging or Office of Medicaid Policy and Planning) and meets all provider qualifications established in [*455 IAC 1-3*]. This process is called **certification:**
  - Anthem will not be able to offer or extend a contract to any HCBS provider who does not meet the certification standards.
  - Verification of certification occurs annually.

Provider demographic updates

- For waiver providers, many types of updates must first be submitted to the Division of Aging and may require a new *Waiver Certification Letter* before they can be submitted to IHCP and communicated to Anthem, including:
  - Name changes.
  - Tax identification changes.
  - Additional service location addresses.
  - Changes to counties served.
  - Specialty changes.
  - Changes in ownership (CHOW).
- Revalidations and profile updates, including demographic changes, are completed through the [IHCP Provider Healthcare Portal].
- Existing Anthem providers wishing to make a demographic change, such as updating an address or telephone number, can also do so by submitting a [*Provider Maintenance Form*].
- Promptly notify your LTSS provider relations associate for any changes related to your IHCP waiver provider certification.

Provider disenrollment

- **Anthem will provide written notice to members upon provider termination/ disenrollment:**
  - **PMP** — immediate written notice
  - **Physical/behavioral health providers** — written notice as soon as possible but no less than [30] calendar days prior to the effective date of the termination and no more than [15] calendar days after receipt or issuance of the termination notice.
  - **Non-PMP** — No less than [30] days prior to the effective date of the termination.
  - **LTSS provider** — written notice as soon as possible but no less than [30] calendar days prior to the effective date of the termination and no more than [15] calendar days after receipt or issuance of the termination notice.
  - **Hospital termination** — Must be reported by Anthem to the State no less than [30] calendar days prior to the effective date of the termination.

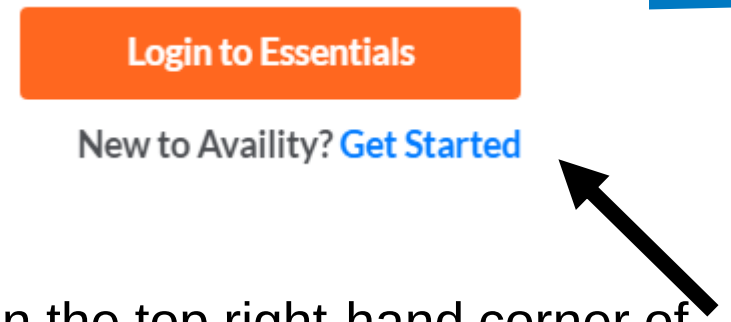
Member management tools for providers

Systems: Availity Essentials,* Care Central, Electronic Visit Verification

Availity Essentials

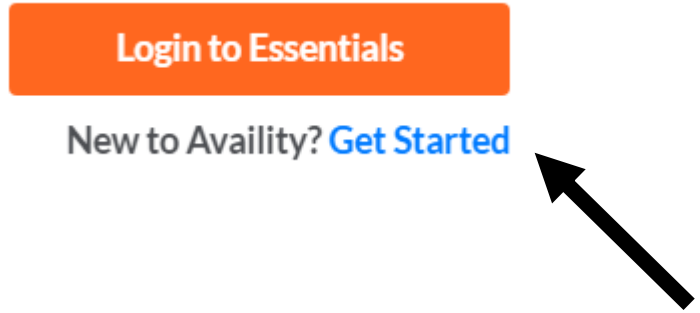
- Availity Essentials offers secure access to manage daily transactions with payers.
- Availity Essentials does not require special software, and is accessible with high-speed internet, using Google Chrome/Microsoft Edge/Firefox browsers.
- Availity Essentials features:
  - **Electronic transactions** provides a secure platform where providers can perform eligibility and benefit inquiries, check claim status, and track remittance.
  - **Multi-payer portal** ensures a consistent workflow for all participating health plans, allowing providers the same user experience.
  - Through this multi-payer portal, providers can access several Anthem's **Care Central** application, the one-stop shop for LTSS providers.
- Availity Essentials can be found at [availity.com].
- Availity can be contacted directly at **[800-AVAILITY** (**800-282-4548**)].

Availity Essentials — getting started



- To initiate registration, navigate to [Availity Essentials Registration] on the top right-hand corner of the screen, clicking on **New to Availity? Get Started**.
- Providers must first register with Availity, specific to the option that best describes the situation:
  - **Healthcare Provider** — Providers who are part of a physician's practice, mental health provider, or non-physician provider. These providers typically have a national provider identifier (NPI) and are also known as medical providers.
  - **Caregiver or atypical provider** — This category would include PathWays for Aging's HCBS providers. This provider type is often referred to *atypical* or *non-medical* providers.
- **Need help?** Join Availity for a live webinar or explore options on Availity's [training site].

Availity Essentials — getting started (cont.)



- What's needed to get started?
  - All organization types — Only the person who will be designated as the administrator needs to register. The following information is needed:
    - Physical and billing addresses
    - Tax ID (EIN or SSN)
    - NPI (if you have one)
    - Primary specialty/taxonomy
  - **Atypical providers** — Some provider types are not required to have an NPI. If you are an atypical provider, in the **Organization Setup** step, look for this verbiage and the associated button: **This organization does NOT have an NPI. This organization is an atypical provider and does not provide healthcare, as defined in *45 Code of Federal Regulations (CFR) section 160.103*.**

Availity Essentials — getting started (cont.)

- Once the Availity registration form is complete and sent, the submitter will receive an application ID used for tracking the status of registration:
  - Keep this ID in a safe place if you need to follow up on the status of your registration.
  - Visit the **Manage my Organization** page to check the status of the registration:
    - **Approved** — you are ready to submit transactions on Availity Essentials.
    - **Pending** — you are not quite ready to submit transactions. Be sure to stay updated on your application by visiting the **Manage My Organization** page and follow-up on any actions needed.
    - **Rejected** — be sure to review the **Organization Activity** section to review the notes on why the application was rejected and next steps. Registrations might get rejected when the organization with duplicate information already exists on Availity Essentials.

Availity Essentials — getting started (cont.)

- Once the organization's administrator has registered and verified their identify, the administrator can:
  - **Add users** — add users one at a time, use a spreadsheet to upload multiple users at once, and copy a user from one organization to another.
  - **Explore roles and permissions** — assign roles to users in the organization based on each user's job function.
  - **Assign a backup Administrator** to help manage users and roles.
  - **Enroll for additional features.**
  - **Add additional tax IDs** to the business details, as applicable.
- Once all registered and ready to get started, *Availity's Reference Guide for Users and Reference Guide for Administrators* is available through the Availity Notification Center.

Care Central

- Accessible through Availity Essential's **Payer Spaces**, Care Central is a one-stop shop for LTSS/atypical providers, with tailored billing, referral and multiple dashboards to support member management, which:
  - Enables a simplified, seamless and tailored online experience reducing administrative burden.
  - Reduces errors, manual processes, and obsolete technology.
  - Empowers the provider with quick access to information necessary to initiate and maintain member care.
  - Provides clear line of site into critical data and reporting.

Member Care Plan accessibility and *Digital Provider Attestation.*

Streamlined claims submission and tracking.

Receive service referrals from care coordinators with detailed information to support the referral management process.

Ability to view authorization details for all LTSS member for which care is provided.

Care Central: Automated Referral Management Dashboard

Care Central- Referral Management tool:

- Digital referral processing wherein the care coordination team can generate a detailed referral, delivered to providers via the Care Central application for instant distribution to preferred or all applicable providers, tracking from receipt through acceptance.
- Detailed insight into overall member needs and provider gaps, supporting quicker service initiation and targeted provider expansion and recruitment.
- Bidirectional allowing two-way messaging for real-time correspondence.
- Data tracking, trending, and reporting: Referral acceptance/decline rates, provider capacity by county and service, service initiation timeframes.

Care Central: Authorization Dashboard features

- **Authorization Dashboard**: This dashboard showcases all a provider's authorizations for the past [365] days, with the ability to view real-time authorization details for all LTSS members for which care is provided:
  - Ability to sort, filter, and search authorizations by the authorization number, member name, member ID, authorization start and end date, and authorization status.
  - Ability to view authorization details for a selected authorization including:
    - Member details (member name, member ID, and DoB).
    - Authorization details (diagnosis code, request date and type, service, and plan).
    - Service details (procedure code, modifiers, description, units, start and end dates).
  - Authorizations will stay on the providers authorization dashboard for [one] year after expiration.
  - Ability to export Authorization Dashboard views to Excel.

Care Central: Value Based Programs Dashboard

- **Value Based Programs Dashboard**: This dashboard allow providers to manage their VBP program enrollment, through a variety of features, including:
  - Ability to complete and submit different VBP attestation forms and/or templates necessary for program participation
  - Ability to view what VBP offerings the organization may be eligible for based on the services they provide
  - Quick access to all program eligibility requirements, responsibilities, and descriptions for VBP programs the organization is enrolled in and eligible for
  - Easily contact Anthem's LTSS Health Care Networks team, specifically the VBP lead, for any questions related to program participation
  - Track and trend performance based on provider-specific VBP reporting

Care Central: Claims Dashboard features

- **Claims Dashboard:** Streamlined claims submission and tracking, reducing administrative burden, and billing errors:
  - Create and submit claims — allows for submission of claims for one or more members (with same service)
  - Allows for the upload of supporting documentation of a claim
  - Can save claims settings for streamlining
  - Can review claims and make changes prior to submission
  - Confirmation of submission
  - The ability to sort, filter, and search by member and claims information
  - The ability for the provider to see the dollar amount of claims that have been billed
  - Allow providers to see fee schedule/contracted rates.

- View Claims Dashboard with claims status reasons:
  - **Submitted:** The claim is submitted, awaiting claim number
  - **Pending:** The claim is pending review, may take up to [30] days
  - **Finalized:** The claim has been paid
  - **Denied:** This claim has been denied

EVV requirements

- EVV is the use of technology to record the time and location of paid caregivers during a scheduled visit check-in and check-out.
- This method of verification has been proven to provide an accurate account of provider's time while minimizing or eliminating inappropriate claims.
- EVV is required for providers that deliver care to Medicaid members in HCBS settings.
- Required for personal care services (PCS) and home health care services (HHCS) through the *21st Century Cures Act*.

Billing and reimbursement

Claims submission

Claims can be submitted via Availity Essentials, the Care Central application, or a clearinghouse:

- **Availity Essentials:**
  - Availity Essentials offers secure access to manage daily transactions with payers.
  - Essentials does not require special software.
  - Within Essentials, eligibility can be verified, claims can be submitted, and claims status can be checked.
- **Care Central:**
  - Accessible through Availity's *Payer Spaces*, an Anthem application designed specifically for LTSS providers.
  - Reduces the fields within an LTSS claim to only those required for the type of service being provided.
  - Claims can be submitted for one or more members receiving the same service.
  - Within Care Central, real-time visibility into claim status.
- **Clearinghouse**:
  - An institution that electronically transmits different types of medical claims data on behalf of a provider.
  - Typically includes fees charged to the provider for the submissions.

Billing and reimbursement — tips

- Anthem accepts **electronic** and **paper** claim submissions but encourages providers to submit electronic claims:
  - Clean electronic claims will process within [seven] business days of receipt.
  - Paper claims will be processed within [30] calendar days of receipt
- **Timely filing** is within [90] days from the date of service and **corrected claims** filed within [90] days of the date of remittance notice.
- Providers should verify a **member's eligibility** prior to submitting a claim. Providers can view real-time eligibility information and details through Care Central via Availity Essentials, including eligibility dates, ID numbers, members demographics and other important information.

What is the difference between a rejected and a denied claim?

Rejected:

- A rejected claim does not enter the adjudication system due to missing or incorrect information.

Denied:

- A denied claim goes through the adjudication process but is denied for payment.

Waiver and patient liability

Long-term care claims are not reimbursable until waiver or patient liability has been met. Providers will be able to see liability obligation and balance in the Care Central Portal. FSSA determines the amounts for waiver liability and patient liability.

Waiver liability (HCBS):

- This term refers to the monetary amount that a member will contribute to their monthly care.

Patient liability (nursing facilities):

- Applies to members in a nursing home or intermediate care facility for [30] days or more.
- For liabilities for members related to rule *42 C.F.R 435.725*, the amount of the liability will be deducted from the total reimbursement of monthly claims to the facility.
- Providers must apply current income to current needs.
- Example given social security benefit check received in [October] must be applied to [October] charges.

Electronic payment services

If you sign up for electronic remittance advice (ERA)/electronic funds transfer (EFT), you can:

- Start receiving ERAs and import information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create custom reports within your office.
- Access reports [24] hours a day, [seven] days a week.

Beginning [November 1, 2021], EFT enrollments are through EnrollSafe:*

- EnrollSafe at **[**enrollsafe.payeehub.org].
- EnrollSafe is the only option for providers to enroll or make changes for EFT payment.

Submitting your first claim

Whatever your chosen method of claims submission, your Anthem LTSS Provider Relationship Management representative will do the following to support you in submitting your first claim:

- Confirm registration with Availity Essentials/Care Central and ensure you are properly set up across Anthem systems, including registered through EnrollSafe for reimbursement.
- Walk you step-by-step through your first claim submission.
- Review the dashboard within Care Central to check claim status for successful submission.

Claim disputes

A claim payment dispute may be submitted for multiple reasons including:

- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Contractual payment issues.
- Timely filing issues.

How to submit	
Verbal	Provider Services: • Hoosier Healthwise: [**866-408-6132]** • Healthy Indiana Plan: [**844-533-1995**] • Hoosier Care Connect: [**844-284-1798]** • PathWays for Aging: [**883-310-3775]**
Online	Use the secure Provider Availity Payment Appeal Tool at [availity.com]
Written	Mail to: [Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599]

Grievances and appeals

There are separate and distinct appeals processes for members and providers depending on the services denied or terminated.

Provider appeals:

- To appeal a claim, please complete a claims dispute in Availity by logging on to [availity.com].
- Refer to your provider manual and/or the denial letter for the correct appeals process.

Member appeals:

- Members have the right to file an authorization determination appeal regarding an adverse action taken by Anthem.
- Refer to your provider manual and/or the denial letter for the correct appeals process.

Filing a provider grievance

Providers wanting to file a grievance can do so by navigating to the following link on our website at [providers.anthem.com/IN] > Resources> Forms > Provider Grievance Form.

Provider grievances must be submitted in writing and include the following information:

- Provider’s name
- Date of the incident
- Description of the incident

Anthem LTSS VBP and incentives

PathWays for Aging outcome-based programs

We have developed a broad array of incentive programs to support providers across the PathWays for Aging delivery system in achieving positive outcomes and delivery of high-quality care supports. These programs promote person-centered care, continuity of care, training, and certifications, as well as reward providers who prioritize workforce development strategies and *HCBS Settings Rule* compliance.

Programs available for PathWays for Aging provider enrollment
Nursing Facility Transition Incentive Program
Nursing Facility Transition Incentive Program
Attendant Care Quality Incentive Program
Assisted Living Facility Transition Incentive Program

How to enroll?

Enrolling in our provider incentives programs is easy! In the coming weeks, your Provider Relationship Management representative will be reaching out to you regarding enrollment in the PathWays Provider Incentive programs. Review the enrollment process below to ensure you are prepared for the [2025] Provider Incentive Program participation.

Provider Incentive Program enrollment:

1. Your Provider Relationship Management representative will reach out to gather interest in participating in the PathWays provider incentive programs.
2. If interested, you will connect with the Anthem VBP lead. The VBP lead is a dedicated resource that will provide program specific training and support you in achieving success in your enrolled provider incentive programs. This resource will also solicit feedback for program enhancements.
3. Once you have reviewed the program with the Anthem VBP Lead, you will complete the *Letter of Agreement (LOA)* for each program that you would like to participate in. Once the *LOA* is complete, you are enrolled.

Member rights and responsibilities

Member rights and responsibilities

These rights include:

- The right to receive information, which relates to the managed care program and plan in which the member is enrolled.
- The right to be treated with respect and with due consideration for the member’s dignity and privacy.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- The right to participate in decisions regarding the member’s healthcare, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- The right to request and receive a copy of the member’s medical records, and request that they be amended or corrected, as specified in the *HIPAA Privacy Rule,* which address security and privacy of individually identifiable health information.

Member rights and responsibilities (cont.)

- The right to be furnished healthcare services that relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- The right to review their care plan
- For those members who are receiving home and community based long-term services and supports:
  - The right to have and review their service plan (of care)
  - The right to request a fair hearing when an individual is:
    - Not given the choice of HCBS waiver services as an alternative to institutional level of care.
    - Denied the services of their choice or the providers of their choice.
    - Denied, suspended, reduced, or terminated from services.

Workforce Development

Workforce Development — What is it?

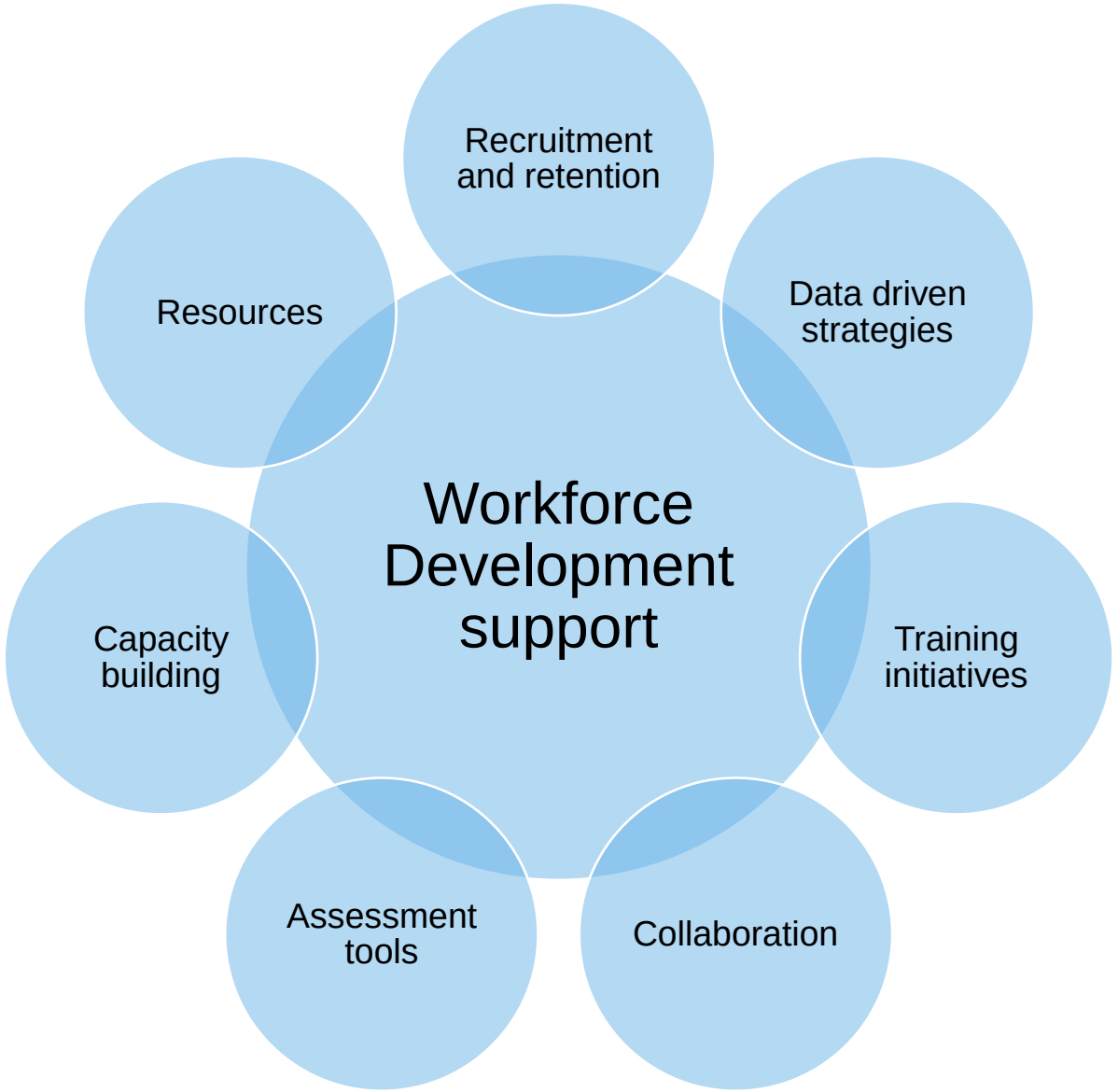
- A diverse, stable, and well-trained workforce is crucial to providing quality person-centered services and supports.
- Investment in direct service workers (DSWs) is essential to serving more Hoosiers in the homes and communities.
- DSWs include:
  - Certified nursing assistants.
  - Home health aides.
  - Direct support professionals.
  - Personal care aides.
  - Other non-licensed personnel.

Workforce challenges

What has contributed to this workforce to be understaffed?

- Low wages
- Feeling unappreciated
- Feeling unprepared and unsupported
- Lack of opportunities for career advancement
- Lack of professional development/training
- Intense demands of the job

What you can expect



Workforce initiatives

Pathways	Online training through Elsevier* that provides training pathways for frontline supervisors
	Partnership with Indiana Association of Home and Hospice Care that provides standardized train the trainer curriculum
Value-based incentives	Performance-based payment strategies that ties payments for care delivery to the quality of care provided
	These programs reward providers that prioritize workforce development strategies and *HCBS Settings Rule* compliance.
Ongoing support	Monthly DSW collaborative conversations to give DSWs opportunities to share their experiences, challenges, and effective interventions
	Monthly provider workforce conversations to discuss challenges, provide resources, strategies, and best practices in the WFD space

Policies and Procedures Manual

- The *Provider Manual* is designed for network physicians, hospitals, and ancillary providers. We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a system that includes a wide array of healthcare topics.
- Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed healthcare plan to find the most reliable, responsible, timely, and cost-effective ways to deliver quality healthcare to our members.
- The *Policies and Procedures Manual* will outline important topics like:
  - Billing procedures and instructions on using the provider website.
  - Credentialing and enrollment with IHCP and Anthem.
  - Claims and payment.

Provider resources

Your support system

- LTSS Health Care Networks team, including specialty roles such as:
  - Workforce Development and Provider Capacity Specialists
  - Provider Trainer, Claims Educator
  - HCBS Contract Specialist
  - Assistive Technology Specialist
- Care and service coordination
- Electronic Data Interchange (EDI)
- *LTSS Provider Manual*
- Anthem provider website
- Anthem *Provider News*
- FSSA website

Contact information

Team	How to contact
[Provider Services: member eligibility, claims information, and general inquiries	Hoosier Healthwise: **866-408-6132** Healthy Indiana Plan: **844-533-1995** Hoosier Care Connect: **844-284-1798** PathWays for Aging: **883-310-3775**
LTSS Provider Relations Email	INMLTSSProviderRelations@anthem.com
Provider Services at the National Contact Center fax	**844-765-5156**
Dedicated Service Unit	**844-533-1995**
Electronic Data Interchange (EDI) Hotline	**800-457-4584**, option **3**
Electronic Visit Verification (EVV) Help Desk	**800-457-4584**, option **5**
Fraud Hotline	**800-403-0864** or reportfraud@fssa.in.gov
Availity Client Services	**800-AVAILITY (800-282-4548)**
Division of Aging (FSSA)	**888-673-0002**

Provider website

Our provider website, [**providers.anthem.com/in**], offers you a full complement of online tools, including:

- *Provider Directory*
- Provider training tools:
  - Provider Pathways
  - Elsevier
  - Availity Essentials
- *LTSS Provider Manual*
- Provider resources
- Provider forms
- Provider newsletters

Thank you for teaming up with Anthem!

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan. EnrollSafe is a tool developed by Zelis Payments, an independent organization offering electronic fund transfer services on behalf of the health plan. Elsevier is an independent company providing training support services on behalf of the health plan.

https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

INBCBS-CD-036915-23 [rdate]