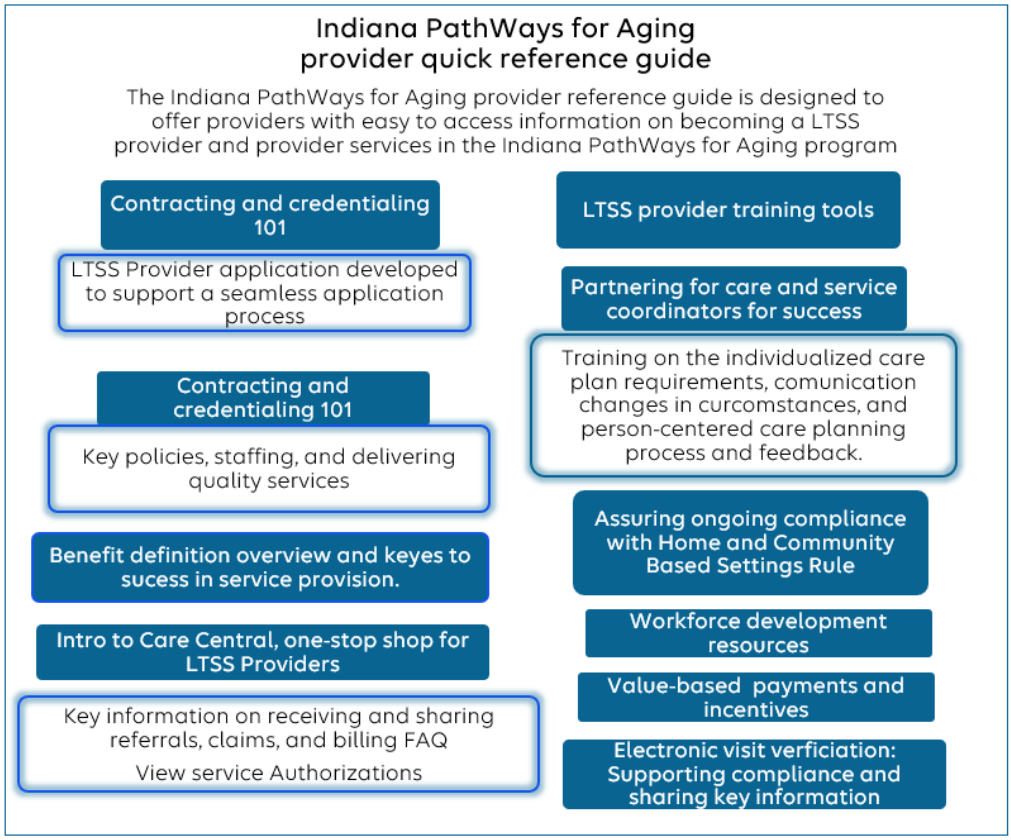
Long-term services and support provider reference guide for Indiana PathWays for Aging

Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect

Anthem recognizes the instrumental role that providers play in the Indiana PathWays for Aging program, and we are committed to partnering with you to support your success. We seek to listen and learn from providers, understand what is important to you, and offer resources to ensure you are prepared to provide services in the Indiana PathWays for Aging program.

This Quick Reference Guide (QRG) is intended to be a resource for long-term services & supports (LTSS) providers including HCBS and non-HCBS providers, developed based on state goals, provider feedback, and best practices in network development. This document offers information related to joining the provider network and providing services within the Indiana PathWays for Aging program for Anthem. Additional information on the Indiana PathWays for Aging program may be accessed in the provider policy manual – available on the Anthem provider website at https://providers.anthem.com/indiana-provider/patient-care/pathways-aging.



Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect 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-061869-24-A September 2024

Table of Contents

Section 1: Contracting 101

1.1 Provider Application and Contracting:

- All Home and community-based service (HCBS) providers must be certified as providers with the Office of Medicaid Policy and Planning (OMPP) and enrolled with the Indiana Health Coverage Programs (IHCP) to begin the application and contracting process.
- Submit the required documentation with the Anthem application:
  - Copy of current *W-9* form
  - Copy of current *Certificate of Insurance (COI)* – see property and personal liability insurance as required by *455 IAC 2-11-1, 455 IAC 2-6-2, and 455 IAC 2-12-1(4)* where applicable.
- The Provider Enrollment tool is available through Availity Essentials. If you are not currently registered as a provider in Availity Essentials, you will be prompted to register at Availity.com prior to completing the application process.
- If your organization is not currently registered for Availity Essentials, the person in your organization designated as the Availity administrator should go to **Availity.com** and select **New to Availity? Get Started** to begin registering their organization.
- **Note:** Atypical providers who want to register their organization will come to the section of the application asking, "Does this organization have an NPI?". Providers can select the option, "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." This will allow providers to continue their registration as atypical providers.
- 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.
- For organizations already using the Availity Essentials, your organization's Availity administrator should go to *My Account* dashboard from the Availity homepage to register new users and update or unlock accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of provider enrollment. (Availity administrators and user administrators will automatically be granted access to provider enrollment.)
- If you are using Availity today and need access to provider enrollment, work with your organization's administrator to update your Availity role. Go to **My Account Dashboard > My Administrators** to determine who your administrator is.
- Need assistance with registering or using Availity Essentials? Contact Availity Client Services at **800-282-4548**.

Accessing the provider enrollment tool:

- Providers can log in to Availity Essentials and from the dashboard page, select the **Payer Spaces** tab > Anthem tile > Provider Enrollment.

Provider enrollment dashboard page:

- Providers can select **Begin New Application** on the top of the dashboard to begin the enrollment. The Dashboard page will also have three options to review the status of submitted applications — recent applications, incomplete applications, and submitted applications.
- Anthem will process all applications within 30 calendar days of receipt of a complete application. A member of our network development team will reach out if additional information is needed or in the case of application errors. In addition, providers can email INLTSSProviderRelations@anthem.com for application inquiries.

Availity help and resources

Availity offers many trainings and resources for navigating the portal and using the many tools available to providers:

- *Help and Training Tab*. From the Availity dashboard select, *Help and Training* and then choose one of the following options:
- Find Help — Use the search bar to search for guides and resources for specific materials.
- Payer Help — Search for specific Anthem or payer-related resource materials.
- Get Trained — Use the search and filter tabs to view training recordings or sign up for live Availity webinar training.

Availity Client Learning Center

The Client Learning Center is available by logging in to Availity and selecting Payer Spaces > Custom Learning Center.

Available training in the Client Learning Center includes:

- Navigating the Availity Essentials for administration and users.
- Authorizations.
- Claims.
- Provider onboarding presentation.
- Guide for the digital provider enrollment tool.
- Care Central application guide.

Section 2: IN LTSS Program Readiness: Key Contacts, and Policies

2.1 Your LTSS Provider Relations Team

Long-term services and support (LTSS) providers have a local and dedicated provider relationship management representative who is equipped with subject matter expertise to support you and to be your ongoing resource.

IN LTSS Provider Relations Manager	Email:
Wendy Dragoo	Wendy.Dragoo@anthem.com
LTSS Provider Relations Team and Supports	
For general inquiries, contact the Provider Relations Network Team email at:	INMLTSSProviderRelations@anthem.com
For contracting questions:	INLTSSProviderContracting@anthem.com
To Connect with a Provider Network Relations and Supports Team member:	The Network Relations Map and Supports document is available through the provider web portal here: Indiana PathWays for Aging's Network Relations Map and Supports
For training questions or inquiries	Ryan.Fennessy@anthem.com
For claim questions or training inquiries	Cortnee.Montgomery@anthem.com Or INLTSSClaims@anthem.com

2.2 Preparing for Virtual and Onsite Support Visits

In addition to training, the LTSS provider relations team will offer an array of individual provider virtual and onsite visits to support your readiness to provide services in the Indiana PathWays for Aging program.

Pre-Implementation Surveys will be completed by the LTSS provider relationship management representatives following a care provider's network participation submission to conduct a readiness meet and greet. This will include a questionnaire to determine the provider's level of readiness and understanding of the program, population, biggest support needs, and the provider's strengths, experience, and mission.

Implementation support visits will provide additional support in preparing for the Indiana PathWays for Aging implementation and may include verifying they meet all requirements and qualifications to become an Indiana PathWays for Aging provider with Anthem. The dedicated LTSS Provider Relations associate will walk through the requirements and qualifications that include, but are not limited to:

- Assisting with the LTSS-specific enrollment application
- Reviewing service provision expectations including ensuring the care provider has staff capacity and appropriate licensure or training/certification to provide those services
- Reviewing applicable policies and procedures documented in accordance with FSSA-specific requirements, NCQA, and licensing bodies, if applicable, based on provider type
- Review FSSA HCBS Settings Rule status

- Reviewing accessing Anthem systems

To ensure providers have the tools and resources needed to meet member needs, the onboarding training will occur within 30 days of an executed contract/SCA through specific training for LTSS for Indiana PathWays for Aging providers related to service provision expectations, VBP enrollment, workforce development supports, billing, and other processes including LTSS referrals and authorizations.

HCBS onboarding education and training visits will be conducted by the LTSS provider relationship management team within 30 days of a provider being contracted. This visit will focus on ensuring providers are educated and feel confident in understanding all contractual, state, and federal requirements, as described in their contract and provider manual before providing services to Indiana PathWays for Aging members.

Ongoing provider support visits will be done annually at a minimum to support ongoing education, contract, and procedural issues, and to ensure a smooth re-credentialing cycle. During the visit, the Provider Relations Associate will re-verify anything from the initial visit as well as evaluate their overall performance since the last meeting. This time is also used to conduct re-training or discussions on topics like billing, claims denials or trends, EVV, outstanding service needs, process updates and communications, newsletters, memos, training offerings, QRG, and resources.

Section 3: Benefit Definition Overview and Keys to Success in Service Provision

Indiana PathWays for Aging Benefit Overview

Indiana PathWays for Aging covered LTSS benefits:

- 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 healthcare coordination
- 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
- Nursing facilities
- Home health
- Hospice

Eligibility, claims submission, and claims status are found within the Availity Essentials/Care Central site.
*The most up-to-date billing guidance on billing codes, modifiers, and lifetime caps can be found in the Provider Reference Module.

Anthem recognizes the needs of HCBS providers and actively engages in understanding the outcomes and quality goals associated with services for our in-home providers, assisted living, adult day providers, and nursing facilities. We will offer training specific to the individualized care plan (ICP) and partner with the care/service coordinator through ongoing communication on service progress, goal achievement, and changes in circumstances to support behavioral health/physical health needs.

The dedicated provider relationship management team will engage with providers to offer value-based programs (VBPs) and incentives to enhance provider quality and support the overarching goal of improved health for all Indiana PathWays for Aging members.

Additionally, Anthem provides education and training opportunities to in-home providers to support EVV compliance. They also support ongoing review and assessment for Assisted Living and Adult Day providers for HCBS Settings Rule and heightened scrutiny to ensure the setting does not possess characteristics of an institution and provide collaborative care planning and transition planning to support quality oversight with Nursing Facility providers. Anthem provides education and training opportunities to in-home providers to support EVV compliance. They also support ongoing review and assessment for Assisted Living and Adult Day providers for HCBS Settings Rule and heightened scrutiny to ensure the setting does not possess characteristics of an institution, and they provide collaborative care planning and transition planning to support quality oversight with Nursing Facility providers.

Section 4: LTSS Authorizations, Billing, and Reimbursement

4.1 Billing and Systems

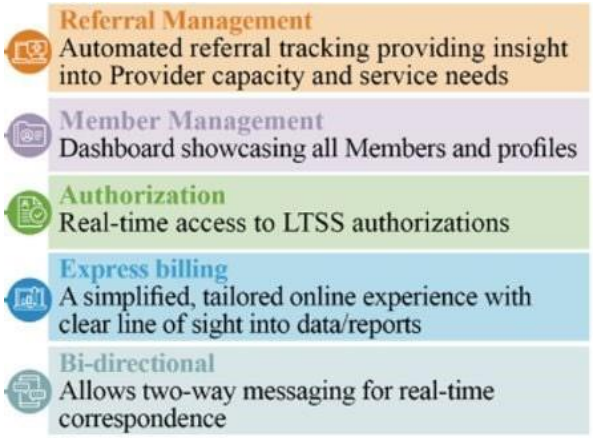
Availity Essentials offers secure access to manage daily transactions with payers.
Availity features:

- Electronic transactions provide 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 the Care Central application for Anthem, the one-stop shop for LTSS providers.

Care Central offers a streamlined process for HCBS providers, offering a tailored billing, referral, and member management solution within Availity:

- Enables a simplified, seamless, and tailored online experience which reduces administrative burden
- Reduces errors and manual processes
- Provides quick access to information
- Provides a clear line of sight into critical data and reporting
- Member Care Plan Accessibility and Digital Provider Attestation
- Streamlined claims submission and tracking
- Ability to view authorization details for all LTSS members for which care is provided



Care Central referral management tool:

- Digital referral processing wherein the care coordination team can generate a detailed referral that is instantly distributed through Care Central 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
- Allows 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

Authorization dashboard:

- This dashboard showcases all a provider's authorizations for the past 365 days. 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 provider's authorization dashboard for one year after expiration.
- Ability to export authorization dashboard views to Excel.

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 the 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
- Use the Claim Status tool to get detailed information on claims and begin a claim dispute
- 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

Billing and reimbursement overview:

- Anthem accepts electronic and paper claim submissions but encourages providers to submit electronic claims.
- Clean electronic claims will be processed within seven business days of receipt.
- Paper claims will be processed within 30 calendar days of receipt.
- Submit claims on an original claim form (*CMS-1500*) or UB-04 form for Institutional claims with dropout red ink, printed or typed (not handwritten) in a large, dark font.

Mail paper claims to:

Anthem
Mailstop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

Timely filing is within 90 days from the date of service and corrected claims are filed within 90 days of the date of remittance notice.

Providers should verify a member's eligibility prior to rendering a service or submitting a claim. Providers can view real-time eligibility information and details through Care Central via Availity including eligibility dates, ID numbers, member's demographics, and other important information.

Providers can enroll in the electronic funds transfer (EFT) solution. Electronic claims payment through EFT is secure and the fastest way to receive payment reducing administrative processes.
Use EnrollSafe (https://enrollsafe.payeehub.org/) to register and manage EFT account changes.

Checking member eligibility

Here are two easy ways to check a member's eligibility and assignment to Anthem:

- Care Central: As a one-stop shop for LTSS providers, member eligibility information is available on the Member Management Dashboard within the Care Central portal. Providers can also select the eligibility and benefits link from the member dashboard page to be taken to the eligibility and benefits tool in Availity to check member benefits and eligibility.
- Indiana's secure website, Provider Healthcare Portal:
  - Log in and use the member's Medicaid ID: IHCP Provider Portal > Home.
  - https://portal.indianamedicaid.com. Review the member's enrollment and verify they are assigned to Anthem.

Providers can also call **800-457-4584** and select **option two** followed by **option five**.

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 obligations and balances in the Care Central Portal. FSSA Eligibility is determined by the state of Indiana's FSSA Division of Family Resources (DFR).

Waiver Liability (HCBS)

This term refers to the monetary amount that a member will contribute to their monthly care and applies to members who receive home and community-based services.

Patient liability (NF):

- 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: Social Security benefits 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:
  - 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.
  - EnrollSafe at enrollsafe.payeehub.org.
- EnrollSafe is the only option for providers to enroll or make changes for EFT payment.

Submitting your first claim:
- Your provider relationship management representative will do the following to support you in submitting your first claim:
  - Confirm registration with Availity/Care Central and ensure you are properly set up across.
  - Anthem systems, including registering through EnrollSafe for reimbursement.
  - Walk you step-by-step through your first claim submission.
  - Review the dashboard within Care Central to check the claim status for successful submission.

Care Central — submitting a claim

Filling out the Claims Form: Easy!
Fill out the required fields marked with a red asterisk, and then select **Submit**. You may have to open sections on the claim form to fill out additional necessary information.

Tips and helpful advice:
- Use Frequency Type 1 — Admit through discharge when submitting a new claim for services that have not yet been billed or when submitting a new claim to replace a claim that received a rejection.
- Located in the Claim Information section, the units field on the claim form is interchangeable with quantity amount. defaults to the unit. Only use minutes when billing for services involving anesthesia. Enter the correct charge amount for the quantity entered. For example, if you charge $100 for one unit, the charge amount for two units should be $200.
- Check the claim status after submission to confirm 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

Phone	Provider Services 833-569-4739
Online	Use the secure Provider Availity Payment Appeal Tool at Availity.com
Mail	Mail to: Anthem 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.

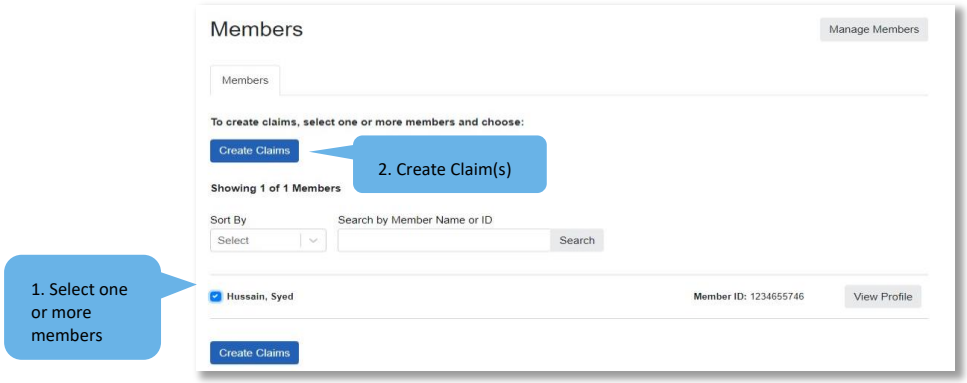
Member appeals
Members have the right to file a medical appeal regarding an adverse action taken by Anthem.
Refer to your provider manual and/or the denial letter for the correct appeals process.

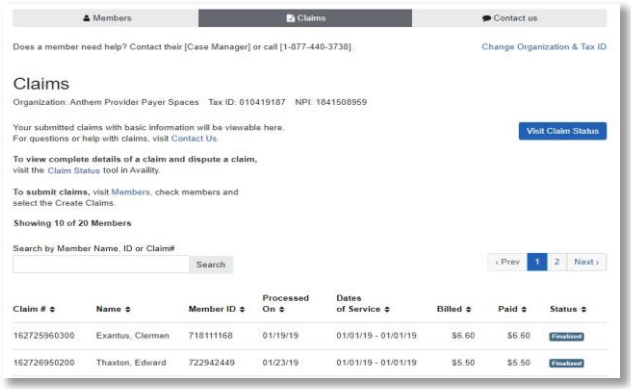
Filing a provider grievance
Providers wanting to file a grievance can do so by navigating to the following link on our website at https://providers.anthem.com/IN> Resources> Forms.

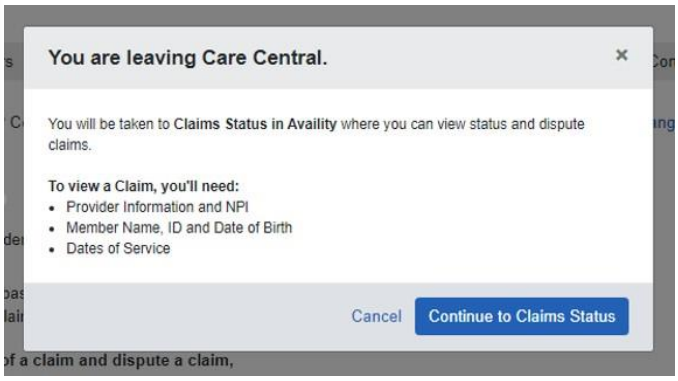
Provider Grievance Form

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

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







Section 5: LTSS Provider Training Tools for Anthem

5.1 Elsevier

Elsevier is the world's leading health sciences publisher, bringing a wealth of technology and content expertise to today's human services organizations. This guide:

- Gives you step-by-step help to access the Elsevier Performance Manager.
- Explains how to select a course.
- Explains how to review your educational transcript.
- Provides contact information if you need help.

Accessing the Elsevier Performance

Manager Elsevier can be accessed:

- Directly at https://login.elsevierperformancemanager.com
- From our provider website at http://www.anthem.com/inmedicaiddoc > Provider Support > Indiana Medicaid Academy for Anthem > Elsevier Performance Manager.

Logging into Elsevier Login

information:

- Prior to logging in to Elsevier, all providers must be registered. You can register through your agency administrator at indianamedicaidacademy@anthem.com. Once registered, your credentials will be as follows:
  - **Login:** Username — This will be the first letter of your first name and full last name.

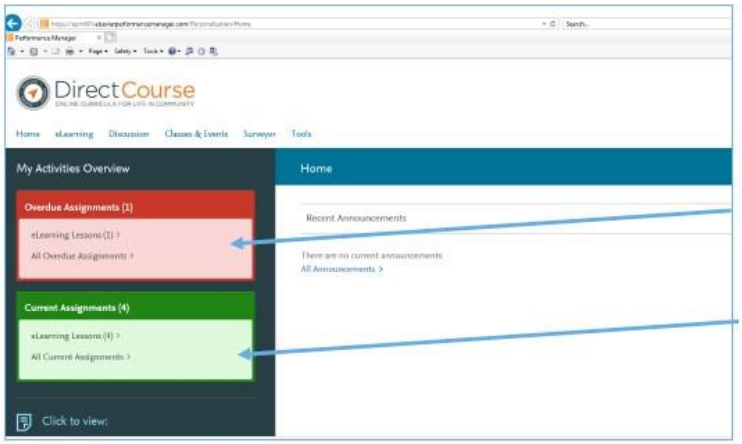
- **Password:** Your initial password will be *hello* (all lowercase). You will be instructed to immediately create a unique password for your account.

Resetting your password

If you forget your password, please contact your agency administrator at indianamedicaidacademy@anthem.com.

Accessing assigned training

On the *Home* page, you will see *My Activities Overview*. These will be the courses that are currently assigned to you. The items in the green box are current course assignments. If you have assigned courses that are past due, a red box will appear with the past due courses.



To begin an assigned course, select the eLearning Lessons in either the green or red box. The list of individual courses will appear. Select the course name to start the course.

*Additional resources are available under the "Indiana PathWays for Aging provider resources and forms" section, located on the Anthem provider website at providers.anthem.com/in

5.2 Provider Pathways — Introduction to Long-Term Support & Services

Provider Pathways – Introduction to LTSS is a 24/7 educational resource on the provider website that offers a foundation for doing business with Anthem in Indiana. It is designed to be user-friendly and gives you flexibility when scheduling training for yourself and your staff.

5.3 Availity Essentials Training for Providers

Access the Custom Learning Center for training on Anthem-specific functions, through Payer Spaces on Availity.com:

- Log in to Availity.com and select **Anthem** from the *Payer Spaces* drop-down.
- From the *Payer Spaces* applications tab, select **Custom Learning Center**.
- From the *Custom Learning Center* landing page, use the Catalog drop-down box to select **Resources**.
- Additional training materials are available under the *Help and Training* tab on the Availity Dashboard page.

Section 6: Partnering with Care and Service Coordinators for Success

Care and Service Coordinators are part of the care planning team for individuals in the Indiana PathWays for Aging program. These coordinators work with individuals enrolled in the program to create person-centered service plans that reflect the physical, behavioral, and LTSS needs and goals of each person enrolled in the program. The care planning team will partner with LTSS providers to send referrals and ensure services continue to align with the needs of the person supported.

Care/service coordinator information is noted in the person-centered service plan and may be accessed through Care Central (via Availity).

Providers will receive referrals digitally through our Care Central platform in accordance with the counties and services they are contracted for.

Providers must review the documentation provided in the referral when accepting referrals for HCBS services and determine the capacity to meet the person's individual needs.

6.1 Eligibility and Authorizations

How do I know if a member is eligible?

You can view real-time eligibility information and details through our Care Central platform (via Availity), including eligibility dates, ID numbers, member demographics, and other important information.

- Providers do not have to request authorizations for HCBS services. Service needs are determined through the person-centered planning process. Upon accepting referrals, Anthem will document and create an authorization for providers.
- Providers can view authorization details and check real-time authorization status through our Care Central platform at any time.
- The length of authorization is based on assessed needs through the person-centered service planning process.

- At the onset of the Indiana PathWays for Aging program, there is a continuity of care provision that will keep current authorization/service levels in place for 90 days from the date of enrollment for a member who meets HCBS level of care and has an existing service plan approved by FSSA or another MCE. After this, Anthem service coordinators will reassess to determine the appropriate level of need. New authorizations will be sent to align with the level of need.

Indiana Family Caregiver Support Program

- The Family Caregiver Program, part of the Older Americans Act, acknowledges and encourages the role caregivers play in the nation's home- and community-based services system. These services are provided through Indiana's Area Agencies on Aging. These 15 Area Agencies on Aging (serving 16 planning and service areas) comprise the INconnect Alliance. Additional resources on this program can be found at https://www.in.gov/fssa/da/older-americans-actfamily-caregiver-support/.

6.2 Critical Incident Management

Providers are expected to take an active role in the prevention, detection, reporting, tracking, and trending of critical incidents. Critical incidents are categorized as 1) HCBS critical incidents, 2) Abuse, Neglect, and Exploitation (ANE) critical incidents, and 3) all other critical incidents.

Critical incident: An occurrence involving the care, supervision, or actions involving a member that is **adverse in nature** or has the **potential** to have an adverse impact on the **health, safety, and welfare of the member or others**.

A critical incident, also known as an unusual occurrence, includes but is not limited to:

- Significant injuries to the member requiring emergent medical intervention, including, but not limited to, the following:
  - A fracture
  - A burn greater than first-degree
  - Choking that requires intervention
  - Contusions or lacerations
  - Injuries of unknown origin
  - Any threat or attempt of suicide made by the member
  - Any unusual hospitalization due to a 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 which endangers the member
  - 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 due to any of the following:

    - A significant interruption of a major utility
    - An environmental, structural, or other significant problem
  - Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals
  - A residential fire resulting in any of the following:
    - Relocation
    - Personal injury
    - Property loss
  - Suspected or observed criminal activity by:
    - Provider's staff when it affects or has the potential to affect the member's care
    - A family member of a member receiving services when it affects or has the potential to affect the member's care or services
    - The member receiving services
  - 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. The threat can be:
    - Toward anyone, including staff
    - In an internal setting
    - Need not be outside the individual's residence
  - Any instance of restrictive intervention (including chemical or physical restraints, or seclusion)
  - Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

Abuse, Neglect, and Exploitation (ANE) are categorized as **ANE Critical Incidents** and include:

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

Critical incident reporting
All contracted providers are considered mandatory reporters and are responsible for critical incident reporting.

Abuse, Neglect, Exploitation (ANE) Reporting	Report to the local Adult Protective Services APS office within 24 hours, including interventions underway or anticipated intervention. Link: Online reporting. APS is not an emergency responder. If you believe someone is in immediate danger, call 911 immediately.
HCBS Critical Incident Reporting	Submit a report via FSSA's Division of Disability and Rehabilitation Services (DDRS) and Division of Aging (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.

Providers may also use FSSA's DDRS/DA Incident and Follow-Up Tool (IFUR) through the following link at https://ddrsprovider.fssa.in.gov/IFUR/ to submit a critical incident report or call Provider Services at **833-412-4405** to initiate a report.

Anthem will track and investigate HCBS critical incidents fully and take immediate steps to ensure member safety and prevent future risks as necessary. Anthem will track incidents to review and analyze the information to identify patterns, trends, indicators of quality of care, and/or health and safety concerns. This information will be provided to FSSA'S Division of Disability and Rehabilitation Services and Division of Aging along with proposed strategies to address critical incidents so that further actions for improvement can be identified.

6.3 Eligibility Redetermination Process

Anthem will prioritize efforts in assisting members in navigating the Medicaid eligibility redetermination process, directing them to the right resources within the allowable limits on appropriate activities. Anthem aids members who are allowed under Medicaid regulations and those who are not SSI members. Eligibility is determined by FSSA Division of Family Resources and members with eligibility questions can be referred to the DRF for further assistance. The approach of Anthem to redetermination is to achieve no gaps in coverage, and we will maintain this approach for Indiana PathWays for Aging program members by leveraging multiple channels to remind members. Reminders (calls, texts, and emails) begin approximately 60 days prior to the member's effective date with Anthem. For members not automatically re-enrolled in Medicaid, Anthem will follow the Family and Social Services Administration-approved redetermination policy and procedures, as well as the requirements outlined in Indiana PathWays for Aging's *SOW Section 5.9* Redetermination Assistance.

6.4 LTSS Health Plan Contacts

	Phone #	Fax	Hours
LTSS Provider Services	**833-569-4739**		M-F 8 a.m. to 5 p.m.
Grievance and Appeals	**833-569-4739**	**855-535-7445** Expedited fax: **855-516-1083**	
Member Services	**833-569-4739**		
Pharmacy Member Experience	**844-691-2486**		
Pharmacy Help Desk	**844-691-2487**		24 hours a day, 7 days a week
Durable Medical Equipment	**833-412-4405**	**844-765-5157**	
24-hr Nurse Helpline	**833-412-4405**		
Vision Services	**866-866-5641**		
Dental Services	**888-291-3762**		
Fraud, Waste or Abuse Reporting	**877-283-1524** www.fighthealthcarefraud.com		
Translation & Interpreter Services	For assistance with translation services for your patients, please contact Provider Services **at 833-412-4405.**		
Indiana Relay Service	Available 24 hours a day by calling **800-743-3333** or **711**.		
IN LTSS Provider Website: https://providers.anthem.com/Indiana-Anthem provider web portal-care/mltss			

Section 7: Assuring Ongoing Compliance with Home and Community-Based Settings Rule

Anthem is aligning our network development plan to FSSA's guiding documents to support Indiana PathWays for Aging providers' transition to managed care. Anthem receives information from the state on provider-specific transition plans and as part of the implementation readiness visits. We are using the LTSS Provider Relations Site Visit tool for Anthem to ensure HCBS Settings Rule compliance and discuss with Indiana PathWays for Aging providers any related documents. The designated Provider Relations Representative will support ongoing meetings with care providers to discuss processes in place, and potential barriers, and collaborate to build best practices and promote helpful tools like the Advancing States Business Acumen tool kit and training courses. Providers may access the tool at HCBS Business Acumen Tool Kit-Advancingstates.org.

Home and Community-Based Services Final Rule
The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services.

To support compliance with state requirements, Anthem has developed training programs to include robust Person-Centered Thinking training sessions made available in person or virtually and Elsevier modules to support ongoing training compliance. Anthem will provide announcements of upcoming training schedules once trainings are available. Additional resources and trainings can be found on the Anthem provider web portal and through the Anthem training academy.

The final rule addresses several sections of Medicaid law under which states may use federal funds to pay for HCBS. The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services. In addition, this rule reflects the Centers for Medicare and Medicaid Services' (CMS) intent to ensure that individuals receiving services and support through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. In addition, the final rule, as part of the HCBS setting rules, addresses:

- Setting sets standards to ensure Medicaid-funded HCBS are provided in settings that are noninstitutional in nature.
- Establishes an outcome-oriented setting focused on the nature and quality of the member's experience
- Ensures members receiving HCBS have:
  - Access to benefits of community living
  - Services that are selected by the person, based on their needs and goals
  - Full opportunity to be integrated into their communities
- Services support access to care by ensuring the person receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Additional information/resources for Indiana Home-and Community-Based Service can be found at https://www.in.gov/fssa/da/medicaid-hcbs/.

Section 8: Workforce Development Resources

The Workforce Development team will consist of a dedicated Workforce Development Manager and a Provider Capacity Specialist working to support providers to increase capacity and implement impactful workforce strategies. The Workforce Development team will assess workforce barriers, identify financial incentives, and provide training opportunities and other tools for providers to increase capacity through recruitment, retention, and training The Workforce Development team will collaborate with members, Care Coordination and Service Coordination teams, LTSS providers, and direct service workers to support members and implement impactful workforce strategies.

The Workforce Development Manager is responsible for ensuring a qualified, competent, and sufficient workforce is established to consistently deliver needed services in a timely manner. The Workforce Development Manager will serve as a liaison and collaborate with state partners, MCEs, and providers to implement statewide workforce development initiatives and activities as outlined in the Indiana Direct Service Workforce Plan.

The Workforce Development Manager and Provider Capacity Specialists will meet with providers and direct service workers monthly to discuss training opportunities, best practices, and resources related to the workforce development space.

Section 9: Value-Based Payments and Incentives

Value-based payments (VBP) refer to a broad set of performance-based payment strategies that tie payments for care delivery to the quality of care provided and reward providers for both efficiency and effectiveness to individuals by increasing the quality of care while lowering healthcare costs. VBP programs for Indiana PathWays for Aging are tailored to the unique needs of the specialty providers that serve our members. They include quality indicators such as HEDIS®, requirements for providers to meet the minimum Medicare Stars rating, and other quality-related performance measures that ensure our members receive the highest quality of care.

Indiana PathWays for Aging provider incentive programs

Anthem has developed a broad array of incentive programs to support providers across the Indiana 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 that prioritize workforce development strategies and HCBS Settings Rule compliance.

Programs available for Pathways Provider Enrollment	
Nursing Facility Quality Incentive Program	Participant Directed Services Quality Incentive Program
Nursing Facility Transition Incentive Program	Workforce Development Provider 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 2025 provider incentive program participation.

Provider Incentive Program enrollment:
- Your provider relationship management representative will reach out to gather interest in participating in the PathWays provider incentive programs.
- If interested, you will be connected with the VBP lead for Anthem. 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.
- Once you have reviewed the program with the VBP lead for Anthem, 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!

Section 10: Electronic Visit Verification (EVV)

The *21st Century Cures Act* directs state Medicaid programs to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered. Federal law requires that providers use the EVV system to document the following information:
- Date of service
- Location of service
- Individual providing service
- Type of service
- Individual receiving service
- Time the service begins and ends

Electronic Visit Verification is required as of July 1, 2024 with the launch of the Indiana PathWays for Aging program. The Anthem adjudication system is integrated with the state-sponsored EVV aggregator, Sandata. When a provider submits a claim through Availity and/or CareCentral with a procedure code requiring EVV data elements, the Anthem claims system will place the claim in a pending status and perform a check with the Sandata aggregator.

If there is a match (all EVV data elements are present) the claim will continue to payment. If no match is found (no corresponding EVV visit), the claim will be denied if EVV elements are not present. continue to payment with the following codes on the *Explanation of Payment (EOP)*:

For additional information on EVV and claims, please reference the Indiana Medicaid Provider Manual starting on page 181 on the Anthem provider web portal.