LeadingAge Indiana PathWays Frequently Asked Questions

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

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

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

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

See also – this PowerPoint:



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

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

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

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

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

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

Q: When calling in to the Pathways telephone number to enroll with an MCE, representatives have told the caller to submit the address, ID and other demographic info to [medicaidselect@maximus.com](mailto:medicaidselect@maximus.com). Will the submitter get a confirmation or other acknowledgment that this information was received, and the enrollment has been approved?

A: Yes, Maximus does reply with a confirmation regarding plan selection approval and/or a message explaining the requestor must be an authorized representative (AR) in order to enter the plan selection if Maximus does not have AR information on file.  Please note that an e-mail from a family member does not constitute an AR form.  A plan selection will not be accepted until an actual AR form is received. The AR form can be found at <https://www.in.gov/medicaid/members/member-resources/authorized-representative-form/> (IHCP Personal Representative Auth Form). It can be faxed directly to FSSA at 800-403-0864, or it can be sent to Maximus via email: [medicaidselect@maximus.com](mailto:medicaidselect@maximus.com); via FAX: 317-238-3120; or via mail: PathWays, P.O. Box 441410, Indianapolis, IN 46244-1410. Following submission, the individual should wait 24-48 hours to ensure the form has been received, before trying to reach out Maximus again.

Notably, this form is also an acceptable AR form:



Q: Who will make Medicaid eligibility determinations?

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

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

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

See this PowerPoint for additional information:



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

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

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

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

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

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

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

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

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

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

Q: Please confirm whether all current fee for service (FFS) benefits will be covered by all three MCEs, or will some be discretionarily covered in the future by different MCEs.

A: We are confirming that all currently covered services will continue to be covered by all three MCEs after the transition to managed care. Covered services are outlined in the PathWays Scope of Work found here: <https://www.in.gov/fssa/indiana-pathways-for-aging/files/RFP-23-72118-Att-P-Exhibit-3-Covered-Benefits.pdf>. For example, inpatient psychiatric treatment is a covered benefit under the FFS program and will be in the PathWays program by all MCEs.

Q: Will Hospice services be covered under managed care?

A: Hospice services are a part of the PathWays program and individuals eligible for PathWays that are currently receiving hospice services will have the option to opt-in to PathWays or remain on traditional FFS. FSSA has made this table with scenarios for a bit more clarification.

|  |  |  |
| --- | --- | --- |
| Scenario | PathWays | FFS |
| Receives hospice prior to PathWays enrollment. Includes individuals in current managed Medicaid programs such as HIP and HCC. | Will have an option to opt into PathWays. | If member does not opt into PathWays, they will remain in FFS. |
| Receives hospice after PathWays enrollment. | Will not have an opt in option and will remain in PathWays. | This is not an option for the member. |

Q: How will the Medicaid Bad Debt scenario work under managed care?

A: Medicare/Medicare Bad Debt will work in much the same manner as today. This issue will be part of the MCE-FSSA readiness review process and a claims workgroup as well.

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

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

Q: How is the AL waiver waitlist being handled?

A: Please look for a detailed FSSA Bulletin and /or list of updated PathWays FAQs the week of April 22 on this issue.

Q: What are Care and Service coordinators?

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q:           How will facilities know which MCE a resident chooses?

A:            Care and service coordinators of each MCE will have a roster of enrollees for the Plan.  However, Providers might want to periodically (or on a monthly basis) check the state’s eligibility / enrollment portal as well.

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

A: These processes are still being developed.

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

A: Comprehensive Health Assessment Tool.

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

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

Q: Please explain long-term nursing care?

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

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

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

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

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

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

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

* UnitedHealthcare: [IN\_providerservices@uhc.com](mailto:IN_providerservices@uhc.com)
* Humana: Denise Watson - [DWatson31@humana.com](mailto:DWatson31@humana.com); Terry King - [TKing58@humana.com](mailto:TKing58@humana.com);
  + For those already contracted with Humana, but have not received any outreach - [INProviderUpdates@humana.com](mailto:INProviderUpdates@humana.com)
  + For additional general inquires at Humana - <https://humana-6853.quickbase.com/db/btnam42he> - Humana Healthy Horizons.
* Anthem: [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com), Emma Badgley - [emma.badgley@anthem.com](mailto:emma.badgley@anthem.com); Taylor Blake - [taylor.blake@anthem.com](mailto:taylor.blake@anthem.com)
* IHSN members:  As an IHSN member you have a consultant at your fingertips to help with MCE contracting and credentialing.  Please contact Dawn Miller ([*dawn.miller@shcare.net*](mailto:dawn.miller@shcare.net)) if you haven’t heard from the MCEs noted above or if you have any questions.

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

Also – providers will want to familiarize themselves with the Provider Manual of each MCE. For example, UHC’s is:

* [UnitedHealthcare Community Plan of Indiana Care Provider Manual - PathWays for Aging Provider Manual (uhcprovider.com)](https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/IN-PathWays-Aging-Provider-Manual.pdf);
* UHC Indiana Provider Web Page [UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com](https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home.html).

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

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

Anthem example:

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

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

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

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

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

Q: How frequently will reimbursement rates be re-calculated in the new system?

A: Rates will be re-calculated every six (6) months – July 1 and January 1.

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

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

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

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

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

A: Such outreach efforts and notifications are ongoing.

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

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

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

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

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

A: FSSA has an ID versification process. Also, generally speaking, potential enrollees will work with Maximus, the state’s Enrollment Broker to confirm their MCE selection and ask questions about the MCEs to make an informed decision on which MCE to select; ID verification will be part of that process.

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

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

Q:           How will the community spouse benefit be addressed in the future, and will those benefits changes depending on which MCE is selected?  What if one spouses selects a different plan than the other?

A:            Changes to the Community Spouse rules have been in motion for a few years; these are nt related to the Pathways transition. There is no relationship between the ultimate Community Spouse rules and Pathways program or the MCEs of administering that program. Furthermore, it is acceptable for two spouses to select different MCEs in Pathways.

Q:           How does a provider contact each MCE for claims testing purposes (i.e in order to trigger potential access to the Temp. Emergency Fund)?

A:           Detailed information should be coming out the week of April 22. Please be on the lookout for an FSSA Bulletin soon.

Q:           How will AL and HCBS contracting be done.

A:            Each MCE’s process is slightly different.  Please contact the email addresses provided by the MCEs.  However, sperate AL credentialing will not be required.  The state’s AL certification will typically be sufficient for contracting purposes.

Q: Please explain the HCBS provider contracting process?

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

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



Additional information relevant to Anthem is as follows:

**Anthem Enrollment for Existing Medicaid Providers:**

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

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

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

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

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

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

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

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

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

New as of April 29, 2024 ...

Q: Does a provider need to have a contract in place with one or more of the MCEs to participate in the claims testing program windows coming up?

A: No. Please refer to FSSA’s **Claims Testing informational Bulletin (**[BT202451](https://www.in.gov/medicaid/providers/files/bulletins/BT202451.pdf)) for detailed information.

Q: Does a provider need to participate with all three MCEs (or just 1 or just 2?) to satisfy the qualification requirement to participate in the temp. emergency fund program post July 1?

A: Providers should submit claims to every MCE with whom they will partner in the Pathways program - which should be all of them. Accordingly, providers should engage each of the three MCEs in the claims testing program. Failure to engage one or more of the MCEs could negate the ability to seek redress with respect to that MCE.

Q: Is there any sort of cap on how many providers participate in either of the client testing windows?  That is, are the MCE systems ready for the anticipated volume from the jump?

A: There is no cap – the MCEs claim they are ready.

Q: Does a provider need to participate in any part of the window ... first day, last day, any of the 10 days - all of the days?

A: Any part of the window should be sufficient. Please refer to FSSA’s **Claims Testing informational Bulletin (**[BT202451](https://www.in.gov/medicaid/providers/files/bulletins/BT202451.pdf)) for detailed information.

New as of May 17, 2024

Q: Are LTC providers required to check eligibility and MCE-enrollment status for every resident each time they submit a claim?

A: Member MCE enrollment changes happen on the first of the month. IHCP requires providers to verify member eligibility on the date of service, using the Eligibility Verification on the IHCP Portal, or through Interactive Voice Response system, or through approved vendor software for 270/271 batch. At a minimum LTSS providers should verify member eligibility at the beginning of each calendar month.

Q: Must a facility medical officers (CMO) be a Medicaid/IHCP approved provider (and potentially contracted with each MCE) for claims to be paid by an MCE?

A: CMOs only need to be IHCP attested if the CMO plan to bill the MCE for their services. If they do not bill Medicaid for their services than they do not need to be IHCP attested. 80% of the PathWays population has Medicare as their primary health plan and professional services would be billed through the Medicare benefit.

Q: Please explain any updates as to the issue of “bed holds” in the PathWays program.

A: In the MCE scope of work for PathWays under section 3.8.1 Nursing Facility it states the following:

The Contractor must not cover Nursing Facility services in a facility located outside of the state of Indiana. The Contractor shall not reimburse for bed-hold days in a nursing facility as a member benefit unless the member is under the care of hospice. All members residing in a nursing facility are directed to talk with their MCE and individual provider regarding any type of “bed-hold” or leave-day policy that may exist in that facility. The Contractor must assure that a nursing facility makes members aware of the facility bed-hold policies and the Contractor must assure that a member cannot be charged for services the member does not request. The Contractor cannot require that a nursing facility hold beds. The Contractor must assure that the facility informs a resident in writing prior to a hospital transfer or departure for therapeutic leave that Medicaid does not pay for bed holds; the facility must also communicate its policies regarding bed-hold periods. The Contractor must assure that the nursing facility has a written policy under which a resident, whose hospital or therapeutic leave exceeds Medicaid coverage limitations, is readmitted to the facility upon the first Long-Term Care availability of a bed in a semiprivate room if the resident requires nursing facility-level services and is eligible for Medicaid nursing facility services. Regardless of the length of leave, if the individual remains eligible for nursing facility level of care and Medicaid, the individual may choose to be readmitted to the facility to the first available bed or be provided with care in a home or community setting at the member’s discretion.

 Q: For providers who frequently incur less than $25,000 Medicaid claims - over some period of time, does that mean they will not be eligible for the Temporary Emergency Assistance Fund?

* This might be small providers, home health, hospice providers, etc.  They might be will be particularly vulnerable if claims payment goes awry - and SB 132 seems to exclude them based on the $25K threshold?

A: A “financial emergency” is defined as one of the following:

* A provider’s denied claims during one billing period are greater than 15% of claims submitted “appropriately” by the provider. For example, if a provider submits 100 claims “appropriately” during a billing period, and more than 15 of those claims deny, this would be considered a financial emergency.
* A provider “appropriately” submits claims to a PathWays MCE and by 21 days after claims submission, that provider has not received at least $25,000 in total claims payment from the MCE.  For example, a provider has received $10,000 in payments from a Pathways MCE as of a date, such as 10/1/24. On 10/1/24, the provider “appropriately” submits claims totaling $5,000. If by 10/22/24, the provider hasn’t received payment for the $5,000 in appropriately submitted claims, this would be considered a financial emergency.
* The Indiana Medicaid Director determines that a Pathways MCE’s claim submission system with which a provider is contracted experiences failure or overload. This would be considered a financial emergency.
* The Indiana Medicaid Director makes a determination that a provider is experiencing a financial emergency.

Q: Will there be any training seminars/webinars specific to AL waiver claims submission/payment matters (providers think there might be/are differences between this group and SNF claims issues?)?

A: AL claims are under HCBS waiver services so all trainings that pertain to HCBS would pertain to AL as well.

Q: Will the current Medicaid number assigned to a current enrollee stay the same after MCE selection or assignment - or will it change / be updated when assigned to an MCE?

A: Medicaid Number will not change.

Q: Will each enrollee will get a new Medicaid card with the selected/assigned MCE prominently displayed on it in the welcome packet - correct?

A: Yes.

Q: What happens post July 1 (or really anytime) when a resident selects an MCE but that provider (where he or she lives/receives services) does not yet have a contract with that particular MCE?

A: Providers can submit out of network claims but will not have access to the MCE provider portal which could affect the claims process. Also, out of network providers will not be on the provider list to receive new referrals from the MCE.

New as of June 3, 2024

Q: Relative to Medicaid pending residents will payments be retroactively paid (as is the current process) for care delivered pre-July1? That is, for residents accepted (to a facility) while in Medicaid-pending status prior to 7/1, will the facility bear that cost, or will the facility still be able to bill the MCE or FFS?

A: If pending, the resident will remain fee for service until the month their application is approved.  They will be expected to select an MCE in that month and the MCE will cover them back to the first day of the month. Providers should not be exposed to any periods of non-payment. As an example, a resident enters the facility and applies for Medicaid on February 10 and application is approved April 13.  The patient is potentially Medicaid eligible 90 days prior to date of application; FFS coverage would be November 10 – March 31.  MCE coverage would begin April 1.

Q: Regarding therapy services for PathWays recipients, will prior authorization be required, and will there be caps in place?

A: If the recipient is in a skilled nursing facility and the coverage is Medicaid primary, there should be no additional prior authorization for therapy services.  The MCE’s have said the only prior authorization is the Level of Care determination.

New as of June 6, 2024

Q: How will the Care Coordinators prepare their Service Plans as outlined in the State Rules for Residential Care Facilities (Assisted Living)?

A: Service Plan will align the state's requirements and will be posted in HealthEdge for providers to be able to review.

Q: How will the Integrated Health Care Coordination units be billed through the MCE’s?

A: Provider can bill IHCC units with HCPC code T2022 and modifiers U7 and U1.

Q: What are the filing limitations for billing claims*?*

A: 90 days for par (contracted) and non-par providers.

Q: For Assisted Living Facilities- will anything replace the Notice of Action for billing?

A: MCEs are in the process of creating a document that will replace the NOA that are used to today, but providers will get something similar informing them of the auth verification and current services being rendered.

Q: What will the role of the Care Coordinator be regarding billing?

A: Determining the level of care that the member qualifies that can then be reimbursed for.

Q: When billing claims- will additional coding be required for Assisted Living facilities?

A: No, providers will bill the code and modifiers based on the service level that is referenced in the [DAHCBS](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiPtO24-cSGAxWTFVkFHRugAfcQFnoECBsQAQ&url=https%3A%2F%2Fwww.in.gov%2Fmedicaid%2Fproviders%2Ffiles%2Fmodules%2Fda-hcbs-waivers.pdf&usg=AOvVaw2BdB9ryp-vel83m9w-Qt1E&opi=89978449) module.

Q: Will Assisted Living Facilities be billing by Levels based on resident care?

A: Yes, level 1-3 can be billed for Assisted Living Facilities depending on the modifiers used.

Q: With respect to prospective residents, how are they going to transition through the process from inquiry to move-in? What will be the interaction between residents, AAAs, MCEs, and Providers?

A: MCE Care Coordinators will assess members using the CHAT, we can request an NFLOC determination through the AAA (same process as today) and the AAA will submit information to Maximus (state vendor) for Level of Care determination.  The MCEs will submit annual CHAT information to Maximus for Level of Care redeterminations.

Q: Please explain the process and timeline relative hiring clinical staff (care and staff coordinators).

A: Care Coordinator will be assigned to each facility as a point of contact with the facility staff.  The Care Coordinator will outreach (phone or face to face) to determine when member’s annual assessment is due.  E.G. - Humana’s Care Coordinator will conduct the CHAT assessment with the member and the facility staff, review the Care Plan, make suggestions if needed, and conduct quarterly in-person follow up with the member and staff. Probari/Humana will be providing a Welcome Packet to help prepare the facilities for July 1.

Q: Can an MCE’s Care or Service Coordinator’s ever suggest that a resident be discharged out (from SNF - to AL or AL to home) based on a LOC determination?

A: A third party vendor makes LOC determinations, not the MCE. If a LOC determination came back that the member no longer Nursing Facility Level Of Care (NFLOC), we would work with the member and facility on a discharge plan that all parties are satisfied with. The AAAs make LOC determinations until 7/2025 when Maximus (state vendor) takes over.