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PATHWAYS PREVIEW

Presented by Elizabeth Eichhorn, IHCA/INCAL Director of Reimbursement Policy & Payor Affairs

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Today's Agenda

- Managed Care Basics
- Resident Enrollment
- Contracting
- Care and Service Coordination
- Claims Processing
- Upcoming Education

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What is managed care?

- In 2022, Family and Social Services Administration (FSSA) released a Request for Proposal (RFP) for Managed Long Term Services and Supports (MLTSS).
- Under managed care, a state pays a monthly capitation rate (per member, per month) to "manage" the care of its enrollees.
- In 2023, FSSA announced its bid award recommendations: Anthem, Humana, Molina and UnitedHealthcare.
- One of the RFP requirements is that each MCE also offer a Dual Eligible Special Needs (DSNP) plan by a certain date. CMS did not approve Molina's DSNP plan, and so Molina is no longer eligible to be PathWays MCE.

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Managed Care: today and tomorrow

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- In the current system, most residents are in Fee For Service(FFS)/traditional Medicaid

----The PASSR process determines need for and duration of skilled care

---*The state (via Gainwell) pays providers directly*

- In the new system, most residents will move to managed care (PathWays for Aging program)

----The PASSR process will determine the need for and duration of skilled care

----*The three Managed Care Entities (MCEs) will pay providers*

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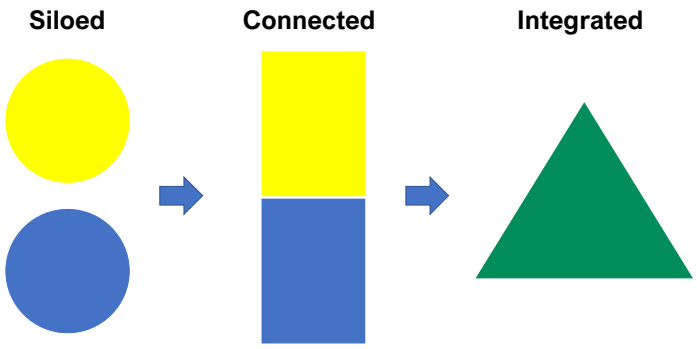
Medicaid & Medicare Dual-Eligible Population



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Resident Enrollment

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Who Is Eligible for PathWays?

Who is eligible for the Pathways program?

Indiana's Medicaid enrollees who meet the following requirements:

- 60 years of age and older
- Eligible for Medicaid based on age, blindness, or disability
- Also eligible for Medicare
- Have limited income/resources
- Can be in a nursing facility
- Can be receiving hospice services
- Can be receiving long-term services/supports in a home or community-based setting

Who is NOT eligible for the Pathways program?

- Anyone aged 59 and under
- Partial benefit dually-eligible (QMB-only, SLMB-only, QI, or QDWI) members
- DDRS waiver recipients
- Program of All Inclusive Care for the Elderly (PACE) members
- Room and Board (RCAP) members
- End Stage Renal Disease (ESRD) 1115 members
- Breast and cervical cancer (MA-12) eligible members
- Individuals who are TBI waiver recipients
- TBI out of state placements
- I/DD residents of intermediate care facilities (ICF) (i.e., group homes)
- Emergency services only (ESO) members
- Family planning only members
- Members with MAGI eligibility in HIP or HHW

PathWays is mandatory for most eligible populations (meaning the individual cannot be served in fee-for-services). However, the following individuals may opt-in to PathWays but are not required to participate:

- American Indians and Alaska Natives
- Individuals on hospice when entering the program

Additional Level of Care Eligibility is necessary to access the long-term services and supports in PathWays:

- This eligibility is conducted by State partners other than the MCEs (AAAs, Maximus/Ascend)
- Must be found eligible to have long-term nursing facility care or home-and-community-based services (HCBS)

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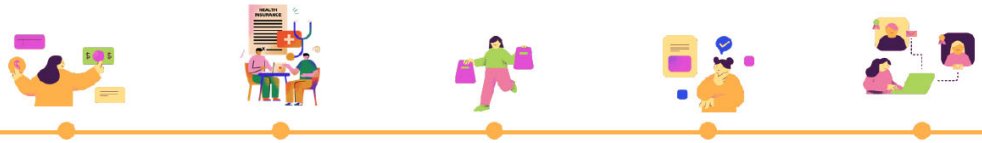
Member Enrollment Timeline



FEB - MAR 2024	MAR – APR 2024	MAY 2024	JUNE 2024	JULY 1, 2024
• Member receives Plan Selection Notice from Enrollment Broker for PathWays (2/2024) and members can begin calling. • Members in a Nursing Facility or receiving HCBS via waiver will receive phone call(s) from the Enrollment Broker to select a plan (2/2024 to 3/2024)	• Member continue to make plan selection.	• If no plan is selected before May 1, 2024, the member will be auto-assigned to an MCE. • Members receive 60-day notice of PathWays Enrollment with plan benefit and contact information (May 2024)	• Member receives Welcome Packet from assigned Plan (June 2024)	• PathWays coverage becomes effective (and changes from FFS or HCC)

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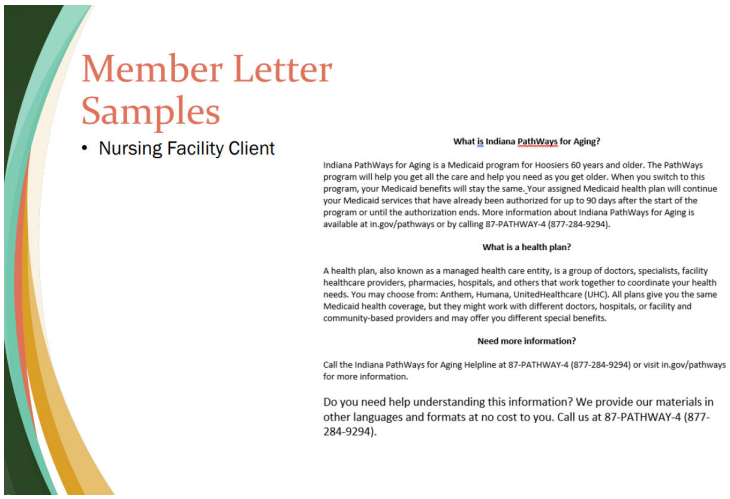
Sample Letter to your Residents

Member Letter Samples

- Nursing Facility Client



What is Indiana PathWays for Aging?

Indiana PathWays for Aging is a Medicaid program for Hoosiers 60 years and older. The PathWays program will help you get all the care and help you need as you get older. When you switch to this program, your Medicaid benefits will stay the same, Your assigned Medicaid health plan will continue your Medicaid services that have already been authorized for up to 90 days after the start of the program or until the authorization ends. More information about Indiana PathWays for Aging is available at in.gov/pathways or by calling 87-PATHWAY-4 (877-284-9294).

What is a health plan?

A health plan, also known as a managed health care entity, is a group of doctors, specialists, facility healthcare providers, pharmacies, hospitals, and others that work together to coordinate your health needs. You may choose from: Anthem, Humana, UnitedHealthcare (UHC). All plans give you the same Medicaid health coverage, but they might work with different doctors, hospitals, or facility and community-based providers and may offer you different special benefits.

Need more information?

Call the Indiana PathWays for Aging Helpline at 87-PATHWAY-4 (877-284-9294) or visit in.gov/pathways for more information.

Do you need help understanding this information? We provide our materials in other languages and formats at no cost to you. Call us at 87-PATHWAY-4 (877-284-9294).

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What is an Aligned Plan?

- An aligned plan in PathWays is an enrollment with an MCE that also operates a Dual-Eligible Special Needs Plan (D-SNP) to provide Medicare benefits
- It is available for people who have both Medicaid and Medicare (aka a dual-eligible individual)
- PathWays members who have decided to join a D-SNP run by Anthem, Humana or UHC for their Medicare benefits will automatically be enrolled in the same PathWays MCE, but will have the choice to enroll with another MCE if they feel that is a better fit for their care.

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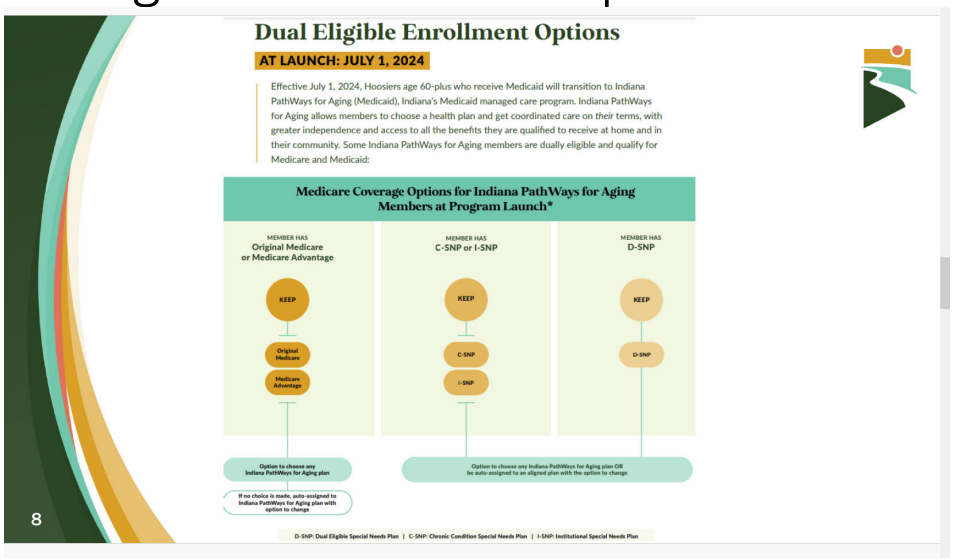
Dual Eligible Enrollment Options



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IHCA Resident Enrollment Webinar Materials

- Managed Care Resources – IHCA

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Contracting

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MCE Provider Contracting

- Any willing provider (AWP) applies for at least three years. AWP means that each MCE must offer a contract to any provider who is willing to accept the MCE contract terms.
- Providers are not required to contract with all three MCEs.
- FSSA will set the reimbursement rate for at least the first five years of the program.
- MCEs are required to reimburse out of network providers the same as in network providers for the first several years.

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Pathways MCE Provider Relations Contacts

- Anthem—Emma Badgley emma.badgley@elevancehealth.com
- Humana—Denise Watson DWatson31@humana.com
- UnitedHealthcare—Amanda Wilson amanda_wilson@uhc.com

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Care and Service Coordination

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Care Coordinator & Service Coordinator Roles Overview

Care Coordinator	Service Coordinator
Available to all Indiana PathWays members	Available only to Indiana PathWays for Aging members who are determined NFLOC and are receiving LTSS
Members are able to opt-out	Required for members who are determined NFLOC and are receiving HCBS
Primary responsibility for coordination of the member's physical and behavioral health	Supplements, but does not supplant, the roles and responsibilities of the Care Coordinator. Collaborates heavily with the Care Coordinator and focuses primarily on waiver-specific services available to the member.
Primary writer of the ICP	Primary writer of the Service Plan, which must be incorporated into the ICP
For members in NFs, assesses at least annually the member's potential for an interest in transition to the community.	Conducts the monthly loneliness assessment, quarterly needs assessment, annual informal caregiver assessment, and nursing facility assessments (if applicable).

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Slide 18

ML0 [@Tower, Darcy E] Revised this bullet, since it previously read that the LCAR would conduct a reassessment THEN the CC and SC would conduct the CHAT (which have the same LOC components). My understanding is that in most instances the MCE will be forwarding the CHAT results to the LCAR for determination. This is only different for long-term NF residents who will be reassessed directly by the LCAR, rather than the MCE.
Morrell, Lucy, 2023-08-18T19:20:56.296

MLO

Scope Requirements - Service Coordinator & Care Coordinator

Care Coordinator (CC)

SoW 4.11.2 Complex Case Management –Member Outreach and Contact

- Non-NFLOC members shall be contacted by their Care Coordinator **monthly** either face to face or by telephone **unless the member specifically requests to opt out** or otherwise reduce the frequency of these contacts.
- For NFLOC members who *also* receive monthly Service Coordination contacts, Care Coordinators may contact such members **less frequently**, but no less than **once every three months** or according to the members' preferences.
- Choice of contact frequency must be captured in **ICP**.
- Leads the Interdisciplinary Care Team.

Service Coordinator (SC)

SoW 4.11.3 Service Coordination – HCBS Minimum Contacts

- HCBS members shall be contacted by their Service Coordinator **at least monthly** either in person or by telephone **unless the member specifically requests to opt out** or otherwise reduce the frequency of these monthly contacts.
- The Service Coordinator may also meet **more frequently with the member** when appropriate **based on the member's needs and/or request.**
  - Choice of contact frequency captured in the **Service Plan**
  - Responsible for **documenting** evidence of any-and-all **communications.**

The expectation is the Care and Service Coordinators are communicating. The Care Coordinator shall be **responsible for communicating and coordinating with the member's Service Coordinator between Care Coordination contacts** regarding any updates to member's status, needs, and/or preferences that are discovered during Service Coordination contacts.

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Claims Payment

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Slide 19

ML0 [@Tower, Darcy E] You're right about the potential for member abrasion if members are getting contacted by the Care Coordinator and Service Coordinator on a monthly cadence. The design team thought about this, and in section 4.11.2 of the SOW, there is specific language allowing for less frequent Care Coordinator contacts for those NFLOC members who are already receiving monthly Service Coordinator contacts. I've added the bullet here that reflects that language.
Morrell, Lucy, 2023-08-18T19:16:03.182

MCE Claims Processing Requirements

- MCE must pay or deny "clean" electronically filed claims within twenty-one (21) calendar days of receipt.
- MCE must pay or deny clean paper claims within thirty (30) calendar days of receipt.
- MCE shall ensure that provider submission requirements are not burdensome and align with standard billing practices and IHCP guidance.
- MCE shall employ a local Provider Claims Educator to work collaboratively to educate LTSS providers transitioning from fee-for-service reimbursement to managed care.

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Senate Bill 132 Provisions

- Establishes an emergency fund for first six months of PathWays
- Providers are required to participate in claims testing to have access to the fund
- OMPP must convene a workgroup to develop a uniform billing format, seek feedback on claims testing and advise on claims submission education

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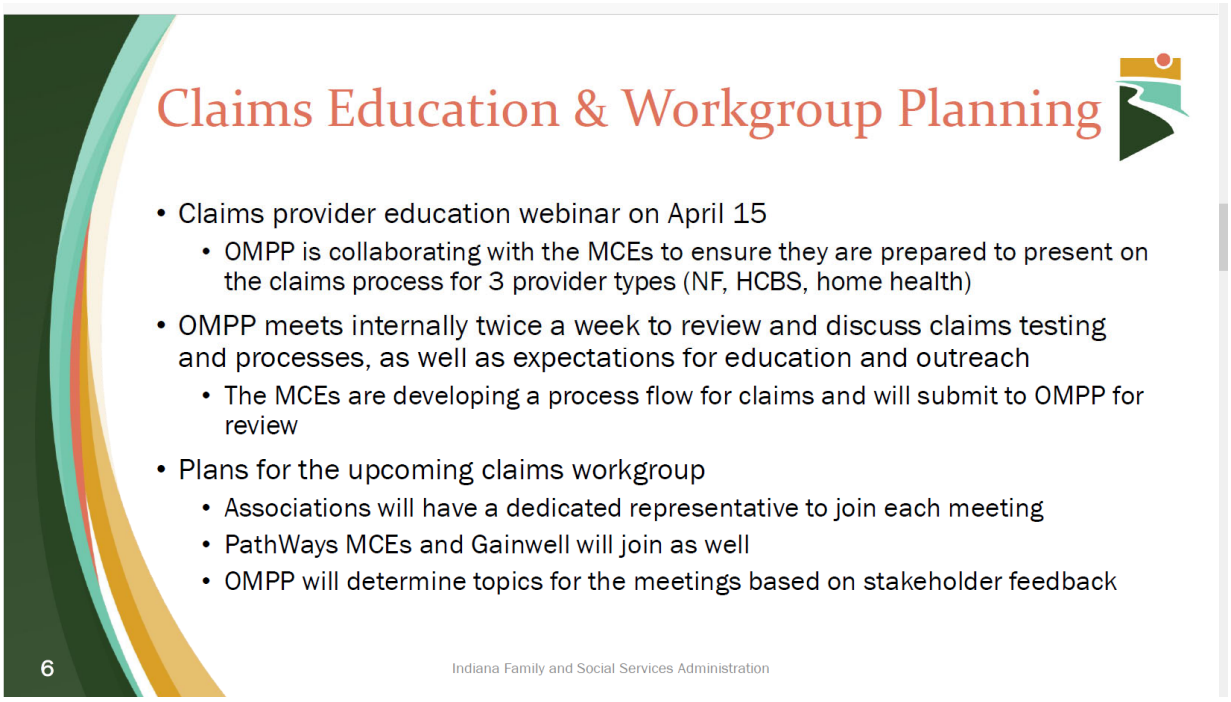

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FSSA Claims Webinar

- April 15,2024 at 10:30 am
- Register here: https://nasuad.zoom.us/webinar/register/WN_9OSA4CpETSGPZUjV_xujZg#/registration

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Additional MLTSS Education

- April 3, 2024 at 2 pm FSSA PathWays webinar for 60+ and their caregivers. Register here.
- April 4, 2024 at 11 am FSSA PathWays webinar for 60+ and their caregivers. Register here.
- Upcoming IHCA monthly webinar topics:

  April—MLTSS update by FSSA

  May—Care and Service Coordination by Probari

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Questions?
Future Webinar Topic Ideas?

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