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

Utilization Management Discussion

2024 IHCP Works Annual Seminar

Anthem

Agenda Topics Presented by Kasey Reisman, RN

- Introduction of Utilization Management (UM) Team
- Anthem Health Plans
- Indiana PathWays for Aging (PathWays) Medical Benefit Covered Services
  - Dual Members
- Prior Authorization Differences
- Prior Authorization (PA) Look Up Tool
- Availity
  - UM Decision Letter Updates
- PathWays Home and Community Based Services (HCBS)
- Turnaround Times
- Clinical Hierarchy
- Case Denials
- Post Denial Options

Anthem Medicaid Health Plans Presented by Terrie Sproat, RN

- Healthy Indiana Plan
- Hoosier Healthwise
- Hoosier Care Connect
- Indiana PathWays for Aging

PathWays Covered Services (Not Limited To)

- Medical Benefits
  - Emergency Services
  - Primary Care
  - Acute Care
  - Home Health
  - Behavioral Health
  - Dental and Vision
- Waiver Benefits
  - Home and Community Based Support
  - Long-Term Services and Supports

Dually-Enrolled Members

- Dual aligned: Members that have Anthem Medicare Advantage and Anthem Medicaid

- Dual unaligned: Members that have traditional Medicare or Medicare Advantage with another MCE and Anthem Medicaid

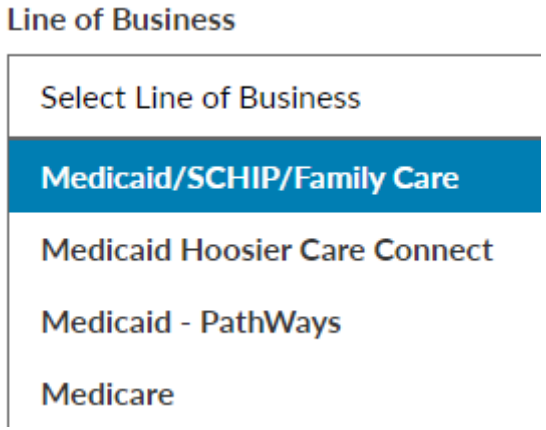
- HIDE SNP: Highly Integrated Dual Eligible Special Needs Plan
  - Anthem became a HIDE SNP on 7/1/24
  - A HIDE SNP is an integrated care plan that combines the benefits of Medicare Advantage and Medicaid from a managed care entity (MCE) into a more unified care plan.
- Physical health outpatient UM will review Medicaid PAs when Medicare denies
- Behavioral health UM will review Medicaid PAs when Medicare denies

Prior Authorization (PA) Differences

- Medical benefit
  - Service requests are submitted to Anthem via fax (866-406-2803) or Availity (Availity Essentials)
  - Indiana Health Coverage Program (IHCP) PA request form Indiana Health Coverage Programs Prior Authorization Request Form
  - PA required services receive a medical necessity review
  - No PA required services are not submitted
    - Hospice is a notification only service and submitted via fax or Availity
- Waiver services
  - Services are assessed by our care/service coordinators
  - Care/service coordinators enter the needed services via our internal platforms
  - PAs are not submitted
  - No medical necessity review

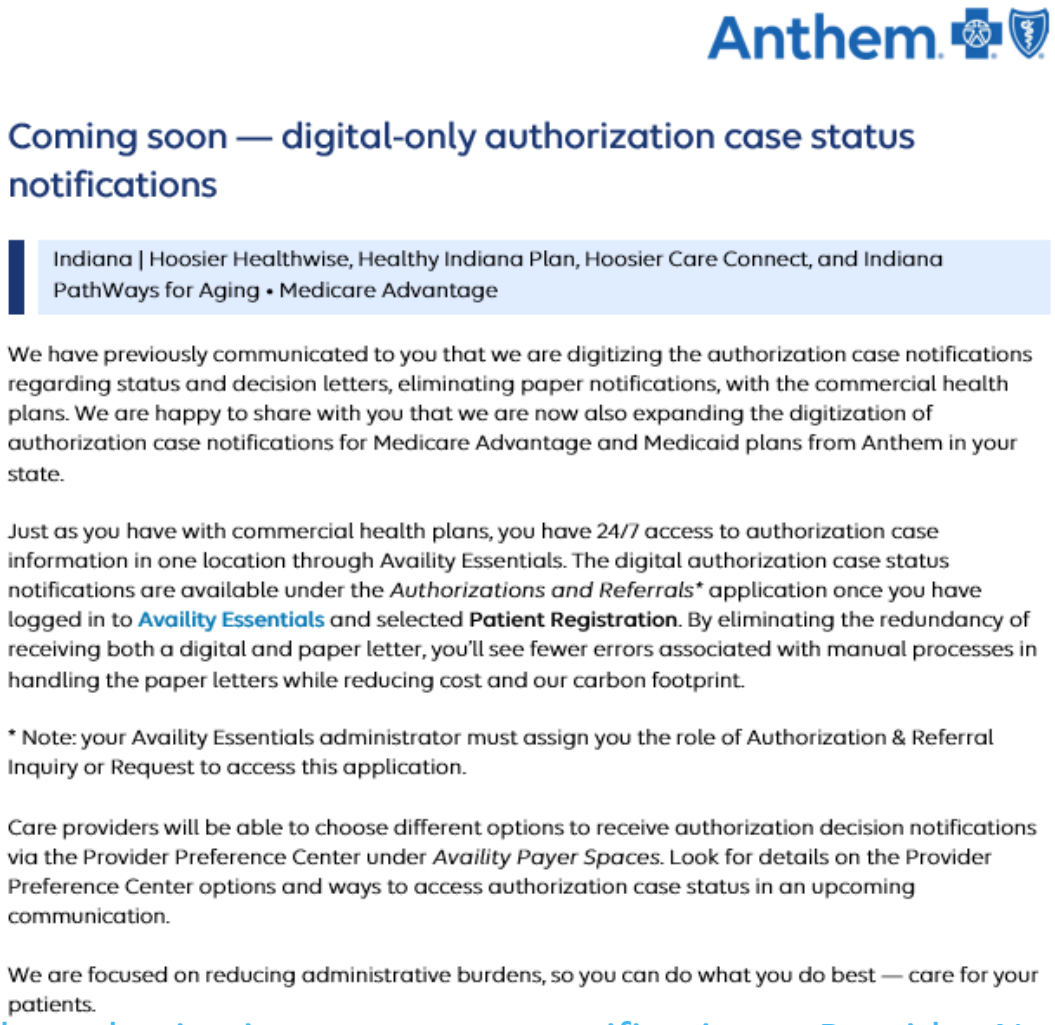
Prior Authorization Lookup Tool

- Allows providers to search codes to determine if prior authorization (PA) is required
- Search by the specific line of business (Medicaid/SCHIP/Family Care, Medicaid Hoosier Care Connect, Medicaid PathWays)



- Directs the user on which guideline is utilized for the case review
- Prior authorization lookup tool is available at [https://providers.anthem.com/in] > claims > [Precertification lookup tool]

Availity Letter Update Coming Soon



Anthem

Coming soon — digital-only authorization case status notifications

Indiana | Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging • Medicare Advantage

We have previously communicated to you that we are digitizing the authorization case notifications regarding status and decision letters, eliminating paper notifications, with the commercial health plans. We are happy to share with you that we are now also expanding the digitization of authorization case notifications for Medicare Advantage and Medicaid plans from Anthem in your state.

Just as you have with commercial health plans, you have 24/7 access to authorization case information in one location through Availity Essentials. The digital authorization case status notifications are available under the *Authorizations and Referrals** application once you have logged in to **Availity Essentials** and selected **Patient Registration**. By eliminating the redundancy of receiving both a digital and paper letter, you'll see fewer errors associated with manual processes in handling the paper letters while reducing cost and our carbon footprint.

* Note: your Availity Essentials administrator must assign you the role of Authorization & Referral Inquiry or Request to access this application.

Care providers will be able to choose different options to receive authorization decision notifications via the Provider Preference Center under *Availity Payer Spaces*. Look for details on the Provider Preference Center options and ways to access authorization case status in an upcoming communication.

We are focused on reducing administrative burdens, so you can do what you do best — care for your patients.

[Coming soon — digital-only authorization case status notifications - Provider News (anthem.com)]

Availity provider call assistance number: 800-282-4548

Indiana PathWays for Aging Presented by Cindy Stokes, RN

- New plan went live on July 1, 2024:
  - PathWays is a long-term services and supports (LTSS) program that provides home and community based services (HCBS) with a vision to empower members to achieve their optimal whole-person health and to live a life where they choose either in their home or a long-term care facility
  - The program is designed to ensure that aging Hoosiers can remain in the home or community setting of their choice, achieving this through person-centered services and supports, smooth transitions, and access to services
  - PathWays is the overarching health plan with HCBS/LTSS services
  - The HCBS/LTSS UM team will review for a subset of enhanced services for these members such as home or community-based services (HCBS) and long-term care such as residing in an assisted living or nursing facility

Who Is Eligible for PathWays?

- Medicaid eligible
- 60 years of age or older
  Are eligible for a full-coverage aged, blind or disabled category (with or without Medicare)
- Can be receiving long-term support services including:
  - Resides in a nursing or long-term care facility
  - Can be on Behavioral and Primary Health Coordination program
- https://www.in.gov/pathways/who-is-eligible-for-the-pathways-program/

How Are HCBS Requests Received and Authorized?

- Requests received from the Care Coordinator or Service Coordinator through the ICP submission in our Healthy Innovations Platform (HIP) computer system

- The Care Coordinator or Service Coordinator meets with the members and completes assessments that then become the members Individualized Care Plan (ICP). The ICP outlines which providers the member wants to provide the needed services
  - If additional services/units are necessary members/providers will need to collaborate with the care/service coordinator

- HCBS/LTSS UM team receives the request automated from our Healthy Innovations Platform (HIP) to our computer system Anthem Care Management Platform (ACMP)

- UM processes the request within 5 business days

- Authorization letters are sent to the member and provider via surface mail

HCBS/LTSS Services

- Adult Day Services
- Adult Family Care
- Assisted Living
- Attendant Care
- Care Coordination/Care Management
- Caregiver Coaching and Behavior Management
- Home Modification Assessment
- Home Modifications
- Integrated Health Care Coordination (IHCC)
- Nonmedical Transportation
- Nutritional Supplements
- Personal Emergency Response System (PERS)
- Pest Control
- Respite Services
- Specialized Medical Equipment and Supplies
- Structured Family Caregiving
- Vehicle Modifications

PA Turnaround Time (TAT) Presented by Kasey Reisman, RN

- Standard pre-service (non-urgent): 5 business days from the received date
  - Post-acute reviews (Skilled nursing facility, Acute Inpatient Rehabilitation, Long Term Acute Care Hospital) are completed in 3 calendar days from the received date
- Urgent/expedite pre-service: 48 hours from the received date
- Emergent admissions and concurrent review: 48 hours from the received date
- Retrospective review: 30 calendar days from the received date:
  - This applies to requests for admission that are received on or after the date the member has been discharged from inpatient care

Peer-to-Peer Timeframe Changes for PathWays

- Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect:
  - Peer-to-peer review request must be requested within 7 business days from the date the request was denied
- PathWays:
  - Peer-to-peer must be requested within 15 business days from the date the request was denied
- The member's provider (MD, DO, nurse practitioners) can request to speak to the clinician who made the denial decision by calling the peer-to-peer direct number: 866-902-4628, option 1 and leaving a voicemail 24 hours a day/ 7 days a week
- This information is located on all denial letters

Clinical Criteria Hierarchy Presented by Dr. Amy McConnell, DBH, LCSW

- Clinical criteria hierarchy for medical benefit services (excludes waivers services)
  - Behavioral Health
    - Milliman Care Guidelines (MCG) criteria is utilized to make medical necessity decisions for psychiatric requests
    - MCG and American Society of Addiction Medicine (ASAM) criteria is utilized to make medical necessity decisions for substance use disorder requests
    - State approved Anthem clinical UM guidelines and medical polices
  - Physical Health:
    - MCG criteria utilized to make medical necessity decisions for each request
    - State approved Anthem clinical UM guidelines and medical polices
  - Criteria is used to determine that the member is receiving medical necessity treatment and at an appropriate level of care

Types of Case Denials for Medical Benefits

- Medical necessity denials:
  - The PA request will result in a not medically necessary denial when criteria is not met

- Administrative Denial Reasons:
  - Late notification
  - Benefit exhaust
  - Failure to prior authorize
  - Non-covered service
  - Ineligible on date of service

Post-Denial Options Presented by Ben Pfeiffer, LCSW

- Reconsideration:
  - Request within 7 business days of denial date via fax or Availity portal (Availity Essentials)
  - Submit additional clinical information to the health plan and indicate Reconsideration on the fax coversheet or in the Availity note
  - A decision will be rendered within 7 business days of the reconsideration request
  - Reconsideration determinations are sent via surface mail notification letters
- Peer-to-peer:
  - Request within 7 business days of denial date (initial or reconsideration) for Healthy Indiana Plan, Hoosier Healthwise and Hoosier Care Connect
  - Request within 15 business days of denial date (initial or reconsideration) for PathWays
  - Peer-to-peer determinations are sent via notification letter with fax confirmation
- Appeal:
  - Request within 60 calendar days of the denial date
  - Fax clinical to 855-535-7445
  - A decision will be rendered within 30 calendar days unless the request is expedited, in which the request will be responded to within 48 hours

Reconsiderations and peer-to-peers are suggested to occur first. Once an appeal is made, reconsiderations and peer-to-peers cannot occur

UM Contacts for Anthem

- Physical health UM:
  - Inpatient/Continued Stay Review:
    - Kasey Reisman, RN Manager
    - kasey.reisman@anthem.com
  - Outpatient:
    - Terrie Sproat, RN Manager
    - terrie.sproat@anthem.com

- Behavioral health UM:
  - Inpatient/Outpatient/Continued Stay:
    - Amy McConnell, DBH, LCSW Manager
    - amy.mcconnell@carelon.com
    - Ben Pfeiffer, LCSW Manager
    - benjamin.pfeiffer@carelon.com

- HCBS/LTSS UM:
  - Cynthia Stokes, RN Manager
  - Cynthia.Stokes@anthem.com

Questions

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

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