IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201780 DECEMBER 21, 2017

Nursing facilities have responsibilities associated with HIP member admissions and discharges

The Indiana Health Coverage Programs (IHCP) reminds nursing facility providers that **any admission or discharge** of an IHCP member enrolled in the Healthy Indiana Plan (HIP), must be reported to both the Division of Aging (DA) and the Division of Family Resources (DFR) within 10 days of the event. Providers should report the event to the DA through the Path Tracker tool. Reports should be made to the DFR via the online Benefits Portal, by fax or mail, or by calling 1-800-403-0864.

Extended nursing facility stays

Providers should understand that reporting admission of a HIP member to the nursing facility will not automatically change the coverage category and benefit plan for the member. A HIP member can be admitted to a nursing facility and remain enrolled in the HIP program; however, coverage of skilled nursing care for most HIP members is limited to 100 days.

Stays beyond this limit will require the member's enrollment to be transitioned from HIP to a fee-for-service (FFS) coverage category and benefit plan to continue Medicaid coverage. To transition, HIP members must qualify under the income and resource limits associated with FFS benefits. Specific steps must be taken by the nursing facility to facilitate the member's transition:

- All nursing facility stays for HIP members require prior authorization (PA). If a member's stay is expected to extend beyond the original PA time frame, the provider should request an extension of the PA from the enrolling managed care entity (MCE) before the original PA expires to allow time for assessment and possible transition to FFS coverage.
- The nursing facility must complete the Preadmission Screening and Resident Review (PASRR) process and report the member's level of care (LOC) to the DA using the Path Tracker tool. If appropriate, the nursing facility must notify the enrolling MCE of the intent to extend a member's stay and the need to transition the member to FFS coverage.
- The nursing facility must notify DFR of the need to move the member to FFS coverage. Notice should be made via the online Benefits Portal, by fax or mail, or by calling 1-800-403-0864. The following information must be provided:
  - Member's full name
  - Medicaid Member ID (also known as RID)
  - Social Security number
  - Date of birth
  - Admission date
  - Name and address of the nursing facility

The nursing facility is expected to complete the steps described on page 1 within the first 60 days of a HIP member's admission. After 60 calendar days, if the member remains in the facility, a member's assessment and LOC determination has not been initiated, and the member continues to be enrolled with the MCE, the nursing facility may be liable for any costs associated with the member's long-term stay. The time limit is established to ensure the appropriate reimbursement (managed care versus FFS) for services rendered without interrupting the care being delivered to the member.

Billing for extended nursing facility stays for HIP members

When a HIP member in a nursing facility is transitioning from HIP to FFS, it is the nursing facility's responsibility to meet the assessment and notice obligations in a timely manner. When completing this process, nursing facilities are reminded that coverage category changes are **prospective**; therefore, changes are effective on the first of the month following the date the request is made. Nursing facilities must work with the MCE on the submission of PA requests and claims for the dates of service during the transition period. If the facility has met the required notice and assessment obligations but a request for PA or a claim is denied by the MCE, the provider must exhaust all grievances and appeals processes with the MCE to resolve the issue.

If the nursing facility cannot resolve the issue with the MCE, the facility may request a retroactive transition date for the member's disenrollment from managed care and enrollment in FFS from DFR. Requests must include the following:

- A provider-generated claim (or copy of same) that clearly shows that the claim was denied by the enrolling MCE
- Verification that all grievances with the MCE have been exhausted
- An explanation of the situation

All requests will be reviewed on a case-by-case basis; approval of a retroactive transition date is not guaranteed. *Note: These requests should not be made to the Office of Medicaid Policy and Planning (OMPP) or to the IHCP provider representative.*

Questions about IHCP managed care member services should be directed to the MCE with which the member is enrolled.

QUESTIONS?

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