

IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS

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IHCP updates policy for HIP members transitioning to FFS when moving into a nursing facility

The Indiana Health Coverage Programs (IHCP) updated its eligibility policy so that when an IHCP Healthy Indiana Plan (HIP) member moves into a nursing facility, it is now a reported change (also referred to as verified or positive change). This policy update is effective for reported dates of admission on or after **October 1, 2019**. This update has been made in the [Indiana Health Coverage Program Policy Manual \(IHCPPM\)](#).

After the Social Security Administration (SSA) or Medical Review Team (MRT) completes a disability determination, this policy change allows a member's coverage to transition from the managed care delivery system to the fee-for-service (FFS) delivery system, on the first day of the month following the reported change.

The IHCP reminds nursing facility providers that any admission or discharge of an IHCP member enrolled in the HIP must be reported to both the Division of Aging (DA) and the Division of Family Resources (DFR) within 10 days of the event (see [Contact process](#) section).

The IHCP recommends that members or authorized representatives write the request to transition from the HIP to the FFS benefit coverage category and request an eligibility interview at the same time that the provider reports the admission to a nursing facility.

When the transition to the FFS benefit coverage category is completed, the member and authorized representatives may receive a benefit award letter indicating that FFS coverage will begin the month *following* the disability determination. The nursing facility provider must contact the DFR to request the FFS coverage start date be backdated to the month following the report of the admission to the nursing facility. After the start date has been backdated, the DFR will send a second benefit award letter indicating the new FFS coverage start date.

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 an 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 and be determined as disabled per the definition used by the SSA.



Contact process

Providers, members, and authorized representatives should complete the following contact process steps to transition a member from HIP to FFS coverage:

1. The provider should submit written notice of the nursing facility admission within 10 days of the admission to both of the following agencies:
 - To the DA through the [Path Tracker tool](#) at assessmentpro.com.
 - To the DFR via the online [Benefits Portal](#) at fssabenefits.in.gov or by fax or mail. To find your DFR office contact information, visit the [DFR Benefits Information](#) page at in.gov/fssa/dfr.
- Simultaneously, the member or authorized representative should request the transition to FFS coverage and request an eligibility interview.
2. After the transition process has been completed and the member has been awarded FFS coverage for the month following the disability determination, the provider may need to call the DFR to request the FFS coverage start date to be backdated.
3. If step 2 is not completed within 3 weeks, the provider should email the appropriate DFR regional mailbox to escalate the issue.
4. If the coverage is not appropriately backdated after an additional 3 weeks, the provider can contact the Office of Medicaid Policy and Planning (OMPP) Provider Relations team at OMPPPProviderRelations@fssa.in.gov.



Addressing previous cases

For any member that has transitioned from HIP to FFS coverage on or after October 1, 2019, the IHCP can assist in reviewing the member's FFS start date. Providers should review the contact process in this bulletin and start with step 2. If a member's admission to a nursing facility was not reported within 10 days, the FFS start date cannot be backdated.

Backdating deceased members' coverage

Continued action for a member who has passed away requires court-ordered representation. The DFR terminates authorized representation on the date of death.

Appeal process

To preserve a member's rights, an appeal must be filed if the member or authorized representative disagrees with the decision that the DFR makes, including the start date of a new category of coverage. The appeal request must be received within 33 days from the effective date of the action; or 33 days from the mailing date of the eligibility notice regarding the change (whichever is later). The eligibility notice itself will contain more details on how to file an appeal.

After the appeal request is received, the DFR will reach out to the member and/or authorized representative by phone for a prehearing conference to discuss the decision that was made on the case. If a correction to the case is needed, it can be made at that time and the appeal can be avoided. The member or authorized representative will have the choice to withdraw the appeal (in writing) or to continue to the hearing.

QUESTIONS?

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