Michael R. Pence, Governor
State of Indiana

Division of Family Resources
402 W. WASHINGTON STREET, ROOM W392
INDIANAPOLIS, IN 46204-2747

MEMORANDUM

TO: **All Staff**

FROM:

RE: **Requests to Transition from Managed Care to FFS**

DATE: **2/14/17**

Switching from HCC to FFS

Med 1 categories, MA A/B/D and MASI, can all be covered either through Hoosier Care Connect (HCC) or in traditional Medicaid (also known as fee-for-service, or FFS). FFS coverage is the best benefit type for aged, blind, or disabled members who are institutionalized for more than 30 days because in addition to paying for medical care, it pays for the most expensive part of care in a nursing facility: the room and board charges.

The change to FFS must occur in the Medicaid Management Information System. This is done by the Division of Aging entering a level of care into the system. There is nothing that a DFR worker can do to correctly make the switch to FFS coverage when they are already in the correct aid category. The managed care disenrollment is triggered by the entry of a nursing facility level of care in the MMIS. The DA does this when appropriate PASRR screenings are completed in the AssessmentPro system and when an admit date is recorded in PathTracker by the nursing facility. It takes approximately 10 business days for that entry to be made in the MMIS. If an authorized representative contacts a DFR worker with a request to move to FFS, it should be requested that they check with the nursing facility that appropriate PASRR screenings were completed. If and only if all appropriate PASRR screenings were completed and an admission date was recorded AND at least 10 business days have passed since the time these activities were completed, then the manager can email the Division of Aging at PASRR@fssa.IN.gov (PASRR= Preadmission Screening and Resident Review**)**. The nursing facility may be the only one that can verify that is all complete. The nursing facility should be advised to contact the PASRR@fssa.in.gov email on their own if all PASSR screenings are completed. That email is widely distributed to them for the resolution of PASRR issues. The subject line of the email should be **Managed Care Switch**, and the body of the email should contain:

- Individual's name

- RID number
- Facility name
- Facility provider number (LPI)
- Admission date
- LOC end date

If any PASRR screenings are missing or the LOC is missing or the admit date has not been entered, the DA will NOT be able to enter the LOC segment in the MMIS and the individual will remain in managed care.

HIP 2.0 Hospice, and Nursing Home Care

HIP 2.0 covers hospice services provided as home health visits, hospice in a facility, and nursing home care.

Discovering that a HIP 2.0 member is in a nursing/rehabilitation facility or receiving hospice services does not mean that a member should automatically be moved into a Med 1 category or closed if they do not pass for Med 1. Members may choose to stay in HIP as long as they continue to pass eligibility. For non-hospice nursing facility care, the number of days covered is dependent on the category of HIP. MARB/MARP have limited days of nursing facility coverage, but MASB/MAPC/MASP (State Plan) members do not have a set limitation.

While we cannot force a member to change categories, members who anticipate a nursing facility stay that is ***greater than 30 days*** should be encouraged to assist DFR in reviewing eligibility for an appropriate Med 1 category. It is important to make sure the member is aware that a large portion of room and board expense will not be covered through the HIP 2.0 program, and that in most cases retroactive coverage in a Med 1 category will not be allowed for months where the member was fully open in HIP 2.0.

DFR staff can send questions to fssa.DAWaiverUnit@fssa.in.gov email for Aged and Disabled and Traumatic Brain Injury waiver member issues. The PASSR mailbox should only be used for nursing facility issues.