

# ARTICLE 10. HEALTHY INDIANA PLAN

## Rule 1. General Provisions

### 405 IAC 10-1-1 Intent and purpose

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) Under IC 12-15-44.2, the office hereby adopts and promulgates this article to:

(1) ensure the:

- (A) efficient;
- (B) economical;
- (C) medically reasonable; and
- (D) quality;

operations of the plan;

(2) support:

- (A) healthy behaviors; and
- (B) personal responsibility; and

(3) safeguard against:

- (A) overutilization;
- (B) fraud;
- (C) abuse; and
- (D) the utilization of services and supplies that are not:
  - (i) covered under the plan; or
  - (ii) medically reasonable and necessary.

(b) This article implements the approved federal waiver and expenditure authorities and special terms and conditions established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (*Office of the Secretary of Family and Social Services; 405 IAC 10-1-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA*)

### 405 IAC 10-1-2 Approval of waiver; federal financial participation; hospital assessment fee

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5; IC 16-21-10

Sec. 2. The plan shall be conditioned upon the following:

(1) The continued approval of the Healthy Indiana Plan Section 1115 waiver application by the Centers for Medicare and Medicaid Services.

(2) The increased federal medical assistance percentage available to individuals defined in 42 CFR 435.119, as provided in 42 U.S.C. 1396d(y).

(3) The hospital assessment fee funds as set forth in IC 16-21-10, to support the plan beginning in calendar year 2017.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-1-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

### 405 IAC 10-1-3 References to the United States Code

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. Any reference to a provision of the United States Code (U.S.C.) shall mean that which was effective on February 20, 2015. (*Office of the Secretary of Family and Social Services; 405 IAC 10-1-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA*)

**405 IAC 10-1-4 References to the Code of Federal Regulations**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 4. Any reference to a provision of the Code of Federal Regulations (CFR) shall mean the October 1, 2017, edition. The provisions are incorporated by reference. Copies may be obtained from the Government Printing Office, 732 North Capitol Street NW, Washington, D.C. 20401 or are available for review and copying at the Indiana Family and Social Services Administration, Office of General Counsel, Indiana Government Center South, Room W451, 402 West Washington Street, Indianapolis, Indiana 46204. (*Office of the Secretary of Family and Social Services; 405 IAC 10-1-4; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**Rule 2. Definitions**

**405 IAC 10-2-1 Definitions**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.2; IC 12-15-44.5

Sec. 1. The following definitions in this rule apply throughout this article:

- (1) "Alternative benefit plan" means an alternative benefit plan approved by the Centers for Medicare and Medicaid Services.
- (2) "American Indian/Alaskan Native" means any individual defined in 25 U.S.C. 1603(13) or 25 U.S.C. 1603(28) or whom the division has determined eligible as an American Indian/Alaskan Native under 42 CFR 136.12.
- (3) "Applicant" means an individual for whom coverage under the plan is requested.
- (4) "Benefit period" means the annual period, from January 1 through December 31, in which an individual is enrolled with the same managed care organization, unless the individual meets the for cause standard defined in 405 IAC 10-8-2. Member benefits with limitations are subject to those limitations on a per benefit period basis. Member POWER accounts are also active for one (1) benefit period.
- (5) "Conditionally eligible" or "conditionally eligible individual" means a plan applicant who:
  - (A) has been determined eligible for the plan by the division; and
  - (B) is not yet able to receive coverage under HIP Basic, HIP Plus, HIP State Plan Basic, or HIP State Plan Plus.
- (6) "Copayment" means a fixed amount charged to a member by the provider for certain services at the time the services are provided.
- (7) "Covered service" means a service provided to a member for which payment is available under the plan, subject to the limitations set forth in this article.
- (8) "Deductible" means the amount of covered medical services for which the member is responsible. The amount of the deductible for the plan is two thousand five hundred dollars (\$2,500) for the benefit period.
- (9) "Designated enrollment center" means a center authorized by the division to:
  - (A) accept applications; and
  - (B) complete initial intake processing on applications.
- (10) "Division" means the division of family resources or its designee.
- (11) "Early and periodic screening, diagnostic, and treatment services" means those services defined in 42 U.S.C. 1396d(r).
- (12) "Eligibility period" means the continuous period of plan eligibility. Subject to any exceptions listed in this article, the period of plan eligibility is twelve (12) months.
- (13) "Emergency medical condition" means a medical condition as set forth in 42 U.S.C. 1395dd.
- (14) "Emergency services" means covered services, including inpatient and outpatient services, that are needed to evaluate or stabilize an emergency medical condition.
- (15) "Enrollment broker" means an entity that contracts with the state to:
  - (A) inform applicants and members about; and
  - (B) enroll applicants and members with;managed care organizations participating in the plan.

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- (16) "Family planning services" means services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills and nonoral contraceptives. The term also includes sexually transmitted disease testing. Elective abortions and abortifacients are excluded from the definition of family planning services.
- (17) "Fast track prepayment" means an optional ten dollar (\$10) POWER account contribution, which, upon the division's eligibility determination, is either:
- (A) refunded to a pending applicant determined ineligible for the plan; or
  - (B) applied toward the member's required POWER account contribution in the case of a pending applicant determined eligible for the plan.
- (18) "Federal income poverty level" or "FPL" means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).
- (19) "Federal marketplace" means an American health benefit exchange or online marketplace for health insurance operating in Indiana under 42 U.S.C. 18041.
- (20) "Healthy Indiana Plan Basic" or "HIP Basic" means the alternative benefit plan, subject to copayments as set forth in 405 IAC 10-10-3(c), that is provided to individuals with household income at or below one hundred percent (100%) of the FPL when such individuals do not make the required contributions to their POWER account as set forth in 405 IAC 10-10-3(a).
- (21) "Healthy Indiana Plan Maternity" or "HIP Maternity" refers to the Medicaid benefits category under the state plan for which a pregnant woman is eligible.
- (22) "Healthy Indiana Plan Plus" or "HIP Plus" means the enhanced alternative benefit plan available to individuals with countable household income up to and including one hundred thirty-three percent (133%) of the FPL, including those eligible for transitional medical assistance, who make the required POWER account contributions as set forth in 405 IAC 10-10-3(a).
- (23) "Healthy Indiana Plan State Plan" or "HIP State Plan" means the benefits that are, at a minimum, no less than the benefits offered in the Medicaid state plan or HIP Plus, and that are available to the following members who are enrolled in the plan:
- (A) Medically frail.
  - (B) Section 1931 parents and caretaker relatives.
- (24) "HIP State Plan Basic" means the benefits, subject to copayments as set forth in 405 IAC 10-10-3(c), available to HIP State Plan members with household income at or below one hundred percent (100%) of the FPL when such individuals do not make the required contributions to their POWER account as set forth in 405 IAC 10-10-3(a).
- (25) "HIP State Plan Plus" means the benefits available to HIP State Plan members with household income up to and including one hundred thirty-three percent (133%) of the FPL who make the required POWER account contributions as set forth in 405 IAC 10-10-3(a).
- (26) "Household" means the composition and family size of a household as set forth in 42 CFR 435.603(f).
- (27) "Household income" means the sum of the MAGI of every individual included in the individual's household as set forth in 42 CFR 435.603.
- (28) "Managed care organization" or "MCO" means a person that has a comprehensive risk contract with the office of Medicaid policy and planning under IC 12-15.
- (29) "MCO selection period" means the period of time in which a member can select the member's managed care organization for the following benefit period.
- (30) "Medically frail" means an individual who, in accordance with the process in 405 IAC 10-6-1, is determined to have any one (1) of the following:
- (A) A disabling mental disorder.
  - (B) A chronic substance abuse disorder.
  - (C) A serious and complex medical condition.
  - (D) A physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one (1) or more activities of daily living.
- (31) "Medically necessary service" means a covered service that, in a manner consistent with accepted standards of medical practice, is reasonably expected to:

- (A) prevent or diagnose the onset of:
    - (i) an illness;
    - (ii) an injury;
    - (iii) a condition;
    - (iv) a primary disability; or
    - (v) a secondary disability;
  - (B) cure, correct, reduce, or ameliorate the:
    - (i) physical;
    - (ii) mental;
    - (iii) cognitive; or
    - (iv) developmental;effects of an illness, an injury, or a disability; or
  - (C) reduce or ameliorate the pain or suffering caused by:
    - (i) an illness;
    - (ii) an injury;
    - (iii) a condition; or
    - (iv) a disability.
- (32) "Member" means an individual:
- (A) whom the division has determined to be eligible for the plan;
  - (B) who is able to receive coverage under HIP Basic, HIP Plus, HIP State Plan Basic, or HIP State Plan Plus; and
  - (C) who is not conditionally eligible.
- (33) "Modified adjusted gross income" or "MAGI" means MAGI-based income as calculated in accordance with 42 CFR 435.603(e).
- (34) "Nonemergency transportation services" means transportation services that are unrelated to an emergency medical condition as defined in subdivision (13).
- (35) "Office" means the Indiana family and social services administration, and its offices, divisions, or designee.
- (36) "Pending applicant" means an applicant whose application has been received by the division and who has not yet been determined eligible for the plan, but who has been determined by the division to meet the following initial criteria:
- (A) Be at least nineteen (19) years of age and less than sixty-five (65) years of age.
  - (B) Not be a pregnant woman.
  - (C) Not be enrolled in the federal Medicare program.
  - (D) Not be a former foster youth.
  - (E) Not be determined disabled.
  - (F) Not be an American Indian/Alaskan Native.
  - (G) Not be subject to a six (6) month plan lockout under 405 IAC 10-10-12.
- (37) "Plan" means the Healthy Indiana Plan or HIP as established by a U.S. Department of Health and Human Services approved Section 1115 demonstration waiver and IC 12-15-44.2 that provides health care benefit packages to eligible individuals through a high deductible health plan paired with a personal health spending account called a POWER account.
- (38) "Plan reimbursement rate" means the amount of reimbursement managed care organizations pay to providers participating in the plan. This amount shall be:
- (A) established by the office; and
  - (B) based on a Medicaid reimbursement formula that is:
    - (i) comparable to the federal Medicare reimbursement rate for the service provided; or
    - (ii) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.
- (39) "Potential plus" means a sixty (60) day period wherein a member who is in HIP Basic or HIP State Plan Basic may buy-up to HIP Plus or HIP State Plan Plus, as applicable, if the member makes the required initial contribution to the member's POWER account.
- (40) "POWER account" or "personal wellness and responsibility account" means a personal health spending account used

to pay a member's deductible for plan covered benefits and services.

(41) "Pregnant woman" means a woman who is pregnant and who otherwise meets the HIP eligibility criteria set forth in 405 IAC 10-4-1.

(42) "Presumptive eligibility" means the process established pursuant to 42 CFR 435, Subpart L by which individuals can be determined presumptively eligible for the plan and receive temporary health coverage until official eligibility for the plan is determined by the division.

(43) "Preventive care services" means care that is provided to a member to:

- (A) prevent disease;
- (B) diagnose disease; or
- (C) promote good health.

(44) "Prior authorization" or "PA" means the procedure for the managed care organization's prior review and authorization, modification, or denial of coverage for medical services and supplies within plan allowable limitations, based upon medical necessity and other criteria as established by one (1) of the following:

- (A) The office.
- (B) Managed care organizations, subject to approval by the office.

(45) "Provider" means:

- (A) an individual;
- (B) a state or local agency; or
- (C) a business entity;

that meets the requirements of 405 IAC 5-4-1. A provider enrolled as a Medicaid provider under 405 IAC 5-4 is eligible to participate in the plan.

(46) "Qualified presumptive eligibility provider" means a:

- (A) hospital;
- (B) federally qualified health center;
- (C) rural health center;
- (D) community mental health center; or
- (E) health department;

authorized by the office to determine presumptive eligibility subject to the requirements of 42 CFR 435.1103 and 42 CFR 435.1110.

(47) "Section 1931 parent and caretaker relative" means an individual defined in 42 CFR 435.4 who meets the following income criteria:

| <u>Family Size</u> | <u>Monthly Income Amount</u> |
|--------------------|------------------------------|
| 1                  | \$152                        |
| 2                  | \$247                        |
| 3                  | \$310                        |
| 4                  | \$373                        |
| 5                  | \$435                        |
| 6                  | \$498                        |
| 7                  | \$561                        |
| Each additional    | \$63                         |

(48) "State" means the executive branch of the state of Indiana.

(49) "Transitional medical assistance" means the extension of eligibility for medical assistance for Section 1931 parents and caretaker relatives in accordance with 42 U.S.C. 1396r-6 and as set forth in 405 IAC 10-4-5.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-2-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA; errata filed Apr 23, 2018, 11:30 a.m.: 20180502-IR-405180200ACA)*

**Rule 3. Applicants and Members**

**405 IAC 10-3-1 Application process**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) An applicant seeking coverage under the plan shall submit an application on the form approved or accepted by the office.

(b) An application may be submitted through:

- (1) the division;
- (2) a designated enrollment center;
- (3) an online method determined by the division; or
- (4) the federal marketplace.

(c) The following individuals may sign an application:

- (1) The applicant.
- (2) The applicant's next of kin.
- (3) The applicant's authorized representative.

(d) An enrollment broker may assist plan applicants in choosing a managed care organization.

(e) The office shall assign an applicant to a managed care organization if:

- (1) such applicant does not choose a managed care organization on the application; or
- (2) the applicant is within his or her current benefit period and not otherwise eligible to change managed care organizations in accordance with 405 IAC 10-8-2.

(f) A designated enrollment center that completes initial intake processing for an applicant shall forward the completed application and all required documentation materials to the division.

(g) The date of application shall be determined as follows:

- (1) In the case of an application filed with the division, the date a signed application is received by the division.
- (2) In the case of an application filed at a designated enrollment center, the date a signed application is received by the designated enrollment center.
- (3) In the case of an application filed via the federal marketplace, the date provided to the state by the federal marketplace.

(h) If an applicant fails or refuses to provide information or verification of information required to determine the applicant's eligibility for the plan, the applicant shall be ineligible and the division shall deny the application. Prior to denying an application under this section, the division shall provide the applicant written notice of the specific information or verification needed to determine eligibility. The division shall deny an application if the information or verification is not received by the division within thirteen (13) calendar days of the date of the notice. If a deadline falls on a weekend or holiday, the deadline for receiving the information shall be the next business day.

(i) The division shall send an eligibility determination notice to the applicant within forty-five (45) days of the date of the application. (*Office of the Secretary of Family and Social Services; 405 IAC 10-3-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-3-2 Standard enrollment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 2. (a) This section does not apply to a:

- (1) pending applicant; or
- (2) pregnant woman eligible for HIP Maternity.

(b) An applicant once determined eligible shall be considered conditionally eligible for HIP Plus unless such individual is eligible for HIP State Plan benefits.

(c) A conditionally eligible individual, in order to receive HIP Plus or HIP State Plan Plus benefits, shall make the initial contribution to a POWER account in the amount set forth in 405 IAC 10-10-3(a) within sixty (60) days of the division's eligibility

determination.

(d) A conditionally eligible individual with household income above one hundred percent (100%) of the FPL shall:

(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes an initial POWER account contribution; or

(2) in the event such individual does not make an initial POWER account contribution within the sixty (60) day payment period described in subsection (c), no longer be conditionally eligible.

(e) A conditionally eligible individual with household income at or below one hundred percent (100%) of the FPL shall:

(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes an initial POWER account contribution; or

(2) in the event such individual does not make an initial POWER account contribution within the sixty (60) day payment period described in subsection (c), begin HIP Basic or HIP State Plan Basic benefits, as applicable, the first day of the month in which the division determines nonpayment.

(f) Subsections (b) through (e) do not apply to an American Indian/Alaskan Native. An eligible American Indian/Alaskan Native shall begin receiving HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month of the eligible individual's date of application as determined in accordance with section 1(h) of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 10-3-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-3-3 Fast track enrollment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. (a) This section applies to a pending applicant.

(b) Upon receipt of an application but prior to determining eligibility, the office shall assign the pending applicant to either:

(1) the managed care organization selected on the application; or

(2) a managed care organization assigned to an individual in accordance with section 1(f) of this rule.

(c) The managed care organization shall send the pending applicant a ten dollar (\$10) fast track prepayment invoice that is due within sixty (60) calendar days of the date of the invoice, unless the pending applicant provides payment information on the application.

(d) A pending applicant shall remain in pending status until the division makes the final eligibility determination. If the individual is determined eligible but has not yet made the individual's fast track prepayment, the individual shall be considered conditionally eligible until the expiration of the sixty (60) day fast track prepayment period described in subsection (c).

(e) To begin receiving HIP Plus or HIP State Plan Plus benefits, a conditionally eligible individual shall make, at his or her option, either:

(1) the fast track prepayment described in subsection (c); or

(2) the initial monthly contribution to the individual's POWER account in the amount set forth in 405 IAC 10-10-3(a); within the sixty (60) day fast track prepayment period described in subsection (c).

(f) An individual with household income above one hundred percent (100%) of the FPL shall:

(1) begin receiving HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes either a fast track prepayment or initial POWER account contribution, as applicable, in accordance with subsection (e); or

(2) in the event such individual makes neither the initial fast track prepayment nor the initial POWER account contribution in accordance with subsection (e), no longer be a pending applicant or conditionally eligible, as applicable.

(g) An individual with household income at or below one hundred percent (100%) of the FPL shall:

(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes either a fast track prepayment or initial POWER account contribution, as applicable, in accordance with subsection (e); or

(2) in the event such individual makes neither the fast track prepayment nor the initial POWER account contribution in accordance with subsection (e), begin HIP Basic or HIP State Plan Basic benefits, as applicable, the first day of the month in which the sixty (60) day prepayment period described in subsection (c) expires.

(h) Subsections (b) through (g) do not apply to an American Indian/Alaskan Native. An eligible American Indian/Alaskan Native shall begin HIP Plus or HIP State Plan Plus benefits, as applicable, effective the first day of the month of the eligible individual's date of application, as determined in accordance with section 1(h) of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 10-3-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-3-4 Enrollment for pregnant women**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 4. (a) This section applies to a pending applicant who is also a pregnant woman.

(b) An applicant once determined eligible shall be considered conditionally eligible for HIP Plus unless such individual is eligible for HIP State Plan benefits.

(c) Pregnant members shall begin coverage in HIP Maternity benefits on the first day of the month following the eligibility determination on the application.

(d) Pregnant members shall be evaluated for coverage under traditional Medicaid for a period of up to ninety (90) days prior to the application submission in the following manner:

(1) The coverage shall be provided under the fee for service model.

(2) Members in HIP Maternity shall have no cost sharing obligations as provided for in 405 IAC 10-4-6.

(e) Eligible applicants under this section are not eligible for fast track enrollment in section 3 of this rule.

(f) Eligible applicants under this section shall not use the standard enrollment procedures in section 2 of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 10-3-4; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**Rule 4. Eligibility**

**405 IAC 10-4-1 Eligibility requirements**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5; IC 12-17.6; IC 27-8-14.1-1

Sec. 1. (a) The following individual shall be eligible for participation in the plan if the individual:

(1) Is at least nineteen (19) years of age and less than sixty-five (65) years of age, except as set forth in section 4(d) of this rule.

(2) Is an Indiana resident.

(3) Is not enrolled in or eligible for enrollment in the federal Medicare program.

(4) Is not eligible for another Medicaid assistance category, except for the following:

(A) Section 1931 parents and caretaker relatives.

(B) Transitional medical assistance.

(C) Members eligible for the HIP Maternity category in accordance with section 6 of this rule.

(5) Has household income at or below one hundred thirty-three percent (133%) of the FPL for the applicable family size.

(b) As a condition of eligibility, an individual living with a dependent child less than nineteen (19) years of age shall ensure that the child is enrolled in Medicaid, the Children's Health Insurance Program under IC 12-17.6, or otherwise receiving minimum essential coverage as defined in 26 U.S.C. 5000A(f). This condition does not apply to the following:

(1) Section 1931 parents and caretaker relatives.

(2) Transitional medical assistance.

(3) Pregnant women.

(c) There shall not be an asset or resource test for the plan.

(d) As a condition of eligibility for the receipt of benefits, a member may be required to participate in the Gateway to Work community engagement program pursuant to 405 IAC 10-12. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA;*)



*filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-4-2 HIP Plus; HIP Basic**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 2. (a) Except as otherwise provided in this article, a member in HIP Plus or HIP State Plan Plus shall make regular monthly POWER account contributions in the amount set forth in 405 IAC 10-10-3(a). A member who fails to make the member's POWER account contributions shall be subject to the actions set forth in 405 IAC 10-10-12, unless the individual is excepted under 405 IAC 10-10-13.

(b) A member who is either:

(1) enrolled in HIP Basic or HIP State Plan Basic in accordance with 405 IAC 10-3-2 or 405 IAC 10-3-3; or

(2) transferred to HIP Basic or HIP State Plan Basic in accordance with 405 IAC 10-10-12;

shall not be required to make POWER account contributions but may be required to pay copayments at the time of service delivery in accordance with 405 IAC 10-10-3(b).

(c) A member shall have the opportunity to transfer from HIP Basic to HIP Plus or HIP State Plan Basic to HIP State Plan Plus under the following circumstances:

(1) Upon annual renewal as set forth in section 9(g) of this rule.

(2) For a member with a balance remaining in the member's POWER account at the end of the benefit period, upon rollover in accordance with 405 IAC 10-10-5.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-4-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-4-3 Medically frail**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. (a) Subject to the eligibility requirements under subsection (b), a member who is determined to have one (1) or more of the conditions outlined under 405 IAC 10-2-1(30) shall be eligible to receive HIP State Plan services.

(b) An applicant who self identifies as medically frail under 405 IAC 10-6-1(b) shall be eligible for HIP State Plan Plus benefits and shall be enrolled in either HIP State Plan Plus or HIP State Plan Basic in accordance with 405 IAC 10-3-2 or 405 IAC 10-3-3, as applicable, effective the first of the month following the confirmation of his or her medically frail status by the managed care organization.

(c) A medically frail member who is enrolled in HIP State Plan Plus shall continue making the member's monthly POWER account contributions while the member's medically frail status is verified and, if confirmed as medically frail, during the benefit period. A member who does not continue making monthly POWER account contributions shall be subject to the nonpayment penalties set forth in 405 IAC 10-10-12, unless the individual is excepted under 405 IAC 10-10-13.

(d) A medically frail member in HIP State Plan Basic may choose to enroll in HIP State Plan Plus at annual renewal or prior to the rollover determination as provided in section 2(c) of this rule by making POWER account contributions in accordance with 405 IAC 10-10-3(a).

(e) A member's medically frail status shall be redetermined in accordance with 405 IAC 10-6-1. If the member is determined not to be medically frail, but still eligible under the plan, such member shall no longer receive HIP State Plan benefits and shall be transferred to:

(1) HIP Plus if the member is currently enrolled in HIP State Plan Plus; or

(2) HIP Basic if the member is currently enrolled in HIP State Plan Basic.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-4-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; errata filed Apr 23, 2018, 11:30 a.m.: 20180502-IR-405180200ACA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-4-4 Section 1931 parents and caretaker relatives**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 4. (a) An eligible applicant or member who meets the definition for Section 1931 parent and caretaker relative shall be enrolled in either HIP State Plan Plus or HIP State Plan Basic in accordance with 405 IAC 10-3-2 or 405 IAC 10-3-3, as applicable.

(b) If a member under this section is determined to no longer meet the Section 1931 parent and caretaker relative definition but is still eligible under the plan, the member shall be transferred to:

(1) HIP Plus if the member is currently enrolled in HIP State Plan Plus; or

(2) HIP Basic if the member is currently enrolled in HIP State Plan Basic.

(c) A member who has received coverage as a Section 1931 parent and caretaker relative for three (3) of the past six (6) months and who no longer meets the Section 1931 parent and caretaker relative definition because of increased income from employment that results in household income greater than allowed under this rule shall be eligible to receive transitional medical assistance in accordance with section 5 of this rule. Any member who is enrolled at a HIP Basic level of coverage when Section 1931 qualification is lost due to increased employment income shall be given the opportunity to buy-up to HIP Plus coverage.

(d) A member who meets the Section 1931 parent and caretaker relative definition and is at least sixty-five (65) years of age while enrolled in the plan shall remain eligible for the plan for so long as the member continues to meet the Section 1931 parent and caretaker relative definition under 405 IAC 10-2-1(47). (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-4; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-4-5 Transitional medical assistance category**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 5. (a) The transitional medical assistance category under the plan is available only to those members listed in section 4(c) of this rule.

(b) The transitional medical assistance category under the plan provides for continued HIP eligibility for Section 1931 parent and caretaker relatives whose income from employment increases to above one hundred thirty-three percent (133%) of the FPL. If all other requirements of the program are met, these members may receive HIP coverage for an additional six (6) months regardless of the amount of increased income. If the increase does not equal more than one hundred eighty-five percent (185%) of the FPL, the coverage may last up to twelve (12) months as provided in this section. Actual childcare expenses due to employment shall be deducted from countable income during the transitional medical assistance period.

(c) A member in the transitional medical assistance category shall make the POWER account contributions in accordance with 405 IAC 10-10-3(a). A member who fails to make the member's POWER account contributions, regardless of household income, shall lose eligibility under transitional medical assistance, and if income has not decreased to below one hundred percent (100%) of the FPL, shall lose eligibility for the plan altogether.

(d) A member who is eligible for the transitional medical assistance category shall respond to requests to resolve discrepant information, and must comply with annual redetermination if it comes due during the transitional medical assistance period in order to maintain eligibility for such assistance category under the plan, but there shall not be any additional reporting required from these members.

(e) A member who no longer meets the parent/caretaker requirement due to having no remaining dependents in the home, or who does not maintain employment and shows no good cause for the job loss, shall no longer be eligible for the transitional medical assistance category. If the member is not eligible without the protection of the transitional medical assistance category, the member shall be terminated from the plan. A member whose income increases to over one hundred eighty-five percent (185%) of the FPL shall no longer be eligible for the transitional medical assistance category and shall be terminated from the plan at the end of month six (6) or at the time of the increase, whichever is later. Members terminated for reasons other than nonpayment of required POWER account may reapply to the plan at any time.

(f) A member shall be ineligible to receive coverage under this section at the end of the transitional medical assistance

coverage period and shall be terminated from the plan altogether if countable household income remains in excess of one hundred and thirty-three percent (133%) of the FPL at the expiration of the maximum twelve (12) months of transitional medical assistance. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-5; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

**405 IAC 10-4-6 HIP Maternity**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 6. (a) A member who becomes pregnant during the member's benefit period shall remain enrolled in the plan.

(b) A pregnant member shall be exempt from cost sharing, including, but not limited to, the following:

(1) HIP Plus monthly contributions set forth in 405 IAC 10-10-3(a).

(2) HIP Basic copayments set forth in 405 IAC 10-10-3(c).

(3) Copayments for nonemergent use of a hospital emergency department set forth in 405 IAC 10-7-9.

(4) Deductible amounts funded through the member's POWER account.

(c) A pregnant member who remains in the plan as described in subsection (a) shall receive enhanced benefits, starting the first day of the month following the pregnancy notification, throughout the member's pregnancy and for a postpartum period equal to sixty (60) days commencing on the date such individual's pregnancy ends.

(d) Beginning the first day of the month following the end of the postpartum period described in subsection (c), a woman who remains enrolled in the plan shall:

(1) be enrolled in HIP Basic with the opportunity to buy-up to HIP Plus;

(2) be subject to any applicable copayment or POWER account contribution requirements under 405 IAC 10-10-3; and

(3) be subject to the nonpayment penalties described in 405 IAC 10-10-12.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-4-6; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

**405 IAC 10-4-7 American Indian/Alaskan Native**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 7. (a) An American Indian/Alaskan Native who meets the eligibility requirements for the plan shall not be subject to any cost sharing requirements under this article.

(b) An American Indian/Alaskan Native applicant who applies for benefits and who has been determined eligible for the plan shall be enrolled in HIP Plus or HIP State Plan Plus benefits in accordance with 405 IAC 10-3-2(f). Such an individual may either:

(1) elect to enroll or remain enrolled with a managed care organization; or

(2) elect to opt-out of the plan to receive fee-for-service coverage by submitting a form provided by the office at any time following the date of application.

(c) For an American Indian/Alaskan Native member enrolled with a managed care organization, if such member submits the form provided by the office to elect to opt-out of the plan pursuant to subsection (b)(2), the member's fee-for-service coverage shall begin the first day of the month following the month in which the office received the request to opt-out.

(d) An American Indian/Alaskan Native's eligibility for the plan shall not impact the American Indian/Alaskan Native's ability to receive services at a qualified Indian Health Service facility.

(e) An American Indian/Alaskan Native who chooses to opt-out of the plan and receive fee-for-service benefits under this section may reenroll in the plan and begin receiving HIP Plus benefits at the member's annual renewal. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-7; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-4-8 Household; household income; as applied**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 8. The division shall determine the applicant's or member's:

- (1) eligibility under the plan; and
- (2) POWER account contribution requirements;

by considering the applicant's or member's household and household income as defined in 405 IAC 10-2-1(26) and 405 IAC 10-2-1(27). (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-8; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; errata filed Apr 23, 2018, 11:30 a.m.: 20180502-IR-405180200ACA*)

**405 IAC 10-4-9 Eligibility period; renewal**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 9. (a) A member shall be eligible for a twelve (12) month period from the date such individual becomes a member unless the member:

- (1) is terminated from the plan in accordance with 405 IAC 10-10-12; or
- (2) becomes ineligible under the rules established under section 10 of this rule.

(b) A member shall be subject to an annual renewal process at the end of the eligibility period to determine continued eligibility for participation in the plan. A member may be asked to submit documentation necessary for the division to determine eligibility.

(c) If a member does not provide the requested documentation under subsection (b) before the end of the member's twelve (12) month eligibility period, the member shall be disenrolled from the plan. However, within ninety (90) days of the end of the expired eligibility period, such individual may submit the requested information to the division without having to reapply for the plan. Such individual shall not be eligible to receive services during this ninety (90) day period until documentation is received and payment has been made.

(d) An individual who loses coverage under subsection (c) shall not be permitted to reapply for the plan for a period of at least six (6) months from the date of disenrollment unless the individual is:

- (1) medically frail;
- (2) a Section 1931 parent and caretaker relative;
- (3) eligible for transitional medical assistance; or
- (4) eligible for an exception under 405 IAC 10-10-13.

The process set forth in 405 IAC 10-10-6(c) shall apply to a member disenrolled under this subsection.

(e) At the time of a positive eligibility renewal, a member who is enrolled in:

- (1) HIP Plus shall remain in HIP Plus unless circumstances have changed that require the member to be transferred to HIP State Plan Plus;
- (2) HIP Basic shall remain in HIP Basic unless:
  - (A) the member's household income has increased above one hundred percent (100%) of the FPL and the member is only eligible for HIP Plus;
  - (B) the member chooses to transfer to HIP Plus in accordance with subsection (h); or
  - (C) circumstances have changed such that the member is eligible for HIP State Plan Basic;
- (3) HIP State Plan Plus shall remain in HIP State Plan Plus unless circumstances have changed that require the member to be transferred to HIP Plus; or
- (4) HIP State Plan Basic shall remain in HIP State Plan Basic unless:
  - (A) the member's household income has increased above one hundred percent (100%) of the FPL and the member is only eligible for HIP State Plan Plus;
  - (B) the member chooses to transfer to HIP State Plan Plus in accordance with subsection (h); or
  - (C) circumstances have changed such that the member is required to be transferred to HIP Plus or HIP Basic.

(f) During renewal, the office shall recalculate a member's monthly POWER account contribution for HIP Plus or HIP State Plan Plus.

(g) A member who must transfer to HIP Plus or HIP State Plan Plus, as applicable, because the member's household income has increased above one hundred percent (100%) of the FPL shall make the required initial contribution to the member's POWER account within sixty (60) days of the renewal effective date. If the member fails to make the initial POWER account contribution within sixty (60) days of the renewal effective date, the member shall be terminated from participation in the plan unless the individual is excepted under 405 IAC 10-10-13.

(h) A member who is in HIP Basic or HIP State Plan Basic and has household income at or below one hundred percent (100%) of the FPL shall have the opportunity at the time of the member's annual renewal to transfer to HIP Plus or HIP State Plan Plus, as applicable, if the member makes the required initial contribution to the member's POWER account within sixty (60) days of the renewal effective date. If the member fails to make the initial POWER account contribution within sixty (60) days of the renewal date, the member shall remain in HIP Basic or HIP State Plan Basic, as applicable. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-9; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

#### **405 IAC 10-4-10 Loss of eligibility**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 10. (a) During the twelve (12) month eligibility period, an individual shall become ineligible to participate in the plan under the following circumstances:

- (1) The member is no longer an Indiana resident.
- (2) The member is enrolled or is otherwise eligible for enrollment in the federal Medicare program.
- (3) The member becomes eligible for another Medicaid assistance category, except for:
  - (A) Section 1931 parents and caretaker relatives;
  - (B) transitional medical assistance; or
  - (C) HIP Maternity.
- (4) The member has household income above one hundred percent (100%) of the FPL and is terminated under 405 IAC 10-10-12 for failure to make the required POWER account contributions, unless the member is excepted under 405 IAC 10-10-13.
- (5) The member or the member's duly authorized representative requests in writing that coverage be terminated.
- (6) The member falsifies information on the application.
- (7) The member is at least sixty-five (65) years of age unless the member is:
  - (A) a Section 1931 parent and caretaker relative; or
  - (B) eligible for transitional medical assistance.
- (8) Except for a member eligible for transitional medical assistance, the member's household income exceeds one hundred thirty-three percent (133%) of the FPL.

(b) Coverage shall be terminated for a member who loses eligibility under this section. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-10; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-4-11 Presumptive eligibility**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 11. (a) An individual may apply for presumptive eligibility under the plan. A qualified presumptive eligibility provider shall determine whether an individual is eligible for a presumptive eligibility period.

(b) An individual who is determined presumptively eligible for the plan shall receive coverage under the fee-for-service

model comparable to HIP Basic, including applicable copayments.

(c) A presumptively eligible individual who does not file an Indiana application for health coverage shall receive the presumptive eligibility benefits described in subsection (b) until the last day of the month following the month in which the determination of presumptive eligibility was made.

(d) A presumptively eligible individual whose application for health coverage has been filed and approved by the division shall receive the presumptive eligibility benefits described in subsection (b), until one (1) of the following occurs, as applicable:

(1) Presumptively eligible adult members are enrolled in HIP Basic effective the first day of the month following approval of the members full Indiana health coverage program application. These members continue to have the potential to buy in to HIP Plus benefits by making a POWER account contribution within sixty (60) days of HIP enrollment.

(2) Presumptively eligible adult members who make a POWER account payment within sixty (60) days from the date of determination shall be enrolled in HIP Plus effective the first day of the month after payment is received.

(3) Presumptively eligible adult members who do not make a POWER account payment within sixty (60) days and have household income equal to or less than one hundred percent (100%) of the FPL, shall be enrolled in HIP Basic effective the first day of the month following approval of the members full Indiana health coverage program application. These members are not eligible to buy in to HIP Plus until eligibility redetermination.

(e) A presumptively eligible individual whose Indiana application for health coverage has been filed, but not approved by the division, shall receive the presumptive eligibility benefits described in subsection (b), until the day on which a decision is made on that application.

(f) An individual whose presumptive eligibility period ends in accordance with subsections (c), (d)(2), and (e) shall not be enrolled in the plan and may reapply.

(g) An individual shall only be approved for one (1) period of presumptive eligibility within a twelve (12) month period beginning on the date that a qualified presumptive eligibility provider makes an affirmative presumptive eligibility determination. (*Office of the Secretary of Family and Social Services; 405 IAC 10-4-11; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

## **Rule 5. Member Appeals**

### **405 IAC 10-5-1 Appeals of determinations by the office or division**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) For purposes of this rule, the term action means any of the following:

(1) A termination of benefits.

(2) A suspension of benefits.

(3) A change in benefits.

(4) A denial of covered services.

(5) A reduction of covered services.

(b) In the event that the office or the division takes an action that the applicant, pending applicant, conditionally eligible individual, or member believes was undertaken erroneously, such person or entity may request an administrative hearing under 405 IAC 1.1.

(c) Appeals under this rule shall be governed by the procedures and time limits set out in 405 IAC 1.1. (*Office of the Secretary of Family and Social Services; 405 IAC 10-5-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA*)

### **405 IAC 10-5-2 Member appeals; managed care organizations**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 2. (a) A pending applicant, conditionally eligible individual, or plan member dissatisfied with the action of a managed

care organization must first exhaust the managed care organization's internal appeals procedure prior to requesting a hearing with the state.

(b) After exhausting the managed care organization's internal appeals procedures, a pending applicant, conditionally eligible individual, or member may request an administrative hearing with the state no later than thirty-three (33) days from the date of the managed care organization's resolution of appeal.

(c) The state's hearing process shall be governed by the procedures and time limits set forth in 405 IAC 1.1. (*Office of the Secretary of Family and Social Services; 405 IAC 10-5-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-5-3 Maintaining services**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. (a) This subsection applies to an aggrieved member requesting an administrative appeal under section 1 or 2 of this rule as follows:

(1) If an aggrieved member requests an administrative hearing as provided in the notice of adverse action, prior to the effective date of the adverse action, plan coverage shall continue without change until an administrative law judge issues a decision after the hearing under 405 IAC 1.1-1-6. If POWER account contributions were required for that member to receive services, the member shall continue to make contributions to the member's POWER account during the appeal in order to continue coverage.

(2) If the administrative law judge sustains the action, the member shall be responsible for repaying the cost of any services furnished by reason of this section, minus any POWER account contributions made for coverage during the pendency of the appeal.

(3) If the action under appeal is overturned, the state or the managed care organization shall make coverage available effective to the date the overturned action was taken. However, unless the member is not required to make POWER account payments to maintain coverage, the individual shall make any POWER account payments that became due during the appeal within sixty (60) days of the managed care organization's date of invoice in order to continue participating in the plan.

(4) A member shall not receive continued benefits pending the outcome of an administrative hearing if:

(A) the action is the result of the member's nonpayment of POWER account contributions; or

(B) the member requests in writing that plan benefits not be maintained pending the administrative appeal.

(b) This subsection applies to an applicant requesting an administrative appeal under section 1 or 2 of this rule. If an applicant was determined ineligible but receives a favorable decision on appeal, coverage begins as follows:

(1) For an applicant who made either a fast track prepayment as provided under 405 IAC 10-3-3(c) or initial POWER account contribution, the first day of the month in which the individual made either the fast track prepayment or the initial POWER account contribution.

(2) For an applicant who made neither a fast track prepayment nor an initial POWER account contribution prior to the date of the appealable action, such individual shall be given a period of time to make either a fast track prepayment or an initial POWER account contribution. This period of time shall be equal to the amount of time remaining in the applicant's payment period from the date of the office's erroneous action. Such period begins on the date of the managed care organization's new invoice issued after the favorable decision on appeal. If the individual makes either a fast track prepayment or POWER account contribution within this period, the individual shall receive a coverage start date intended to put such individual in the position the applicant would have been in but for the office's erroneous determination.

(c) An aggrieved applicant requesting an administrative appeal under section 1 or 2 of this rule who receives a favorable determination and is enrolled in either HIP Plus or HIP State Plan Plus in accordance with subsection (b) shall make the required POWER account contributions that accrued during the appeal within sixty (60) days of the date of the invoice in order to continue to be eligible to receive HIP Plus or HIP State Plan Plus coverage. An individual who does not make the required contributions within sixty (60) days of the date of invoice shall:

(1) be transferred to HIP Basic or HIP State Plan Basic if the individual is at or below one hundred percent (100%) of the FPL; or

(2) become ineligible for participation in the plan if such individual is above one hundred percent (100%) of the FPL.  
(Office of the Secretary of Family and Social Services; 405 IAC 10-5-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)

## **Rule 6. Medically Frail**

### **405 IAC 10-6-1 Medically frail screening**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) An applicant or member shall be reviewed for medically frail status at any of the following times:

- (1) During the verification period if such member's responses on the initial health screening indicate the potential existence of a medically frail condition.
- (2) At any time during the benefit period if documentation, such as claims data or provider identification, demonstrates that the member may have a medically frail condition.
- (3) At any time if documentation demonstrates that the member may no longer have a medically frail condition.
- (4) At any time upon member request.
- (5) For a medically frail member, at least annually by the managed care organization for continued medically frail eligibility.
- (6) For an applicant that has been locked out pursuant to 405 IAC 10-10-12, a request for a lockout exemption based on a medically frail condition.

(b) During calendar year 2015, beginning upon the date an individual identified as potentially medically frail in accordance with subsection (b) becomes a member, the managed care organization shall have a period of sixty (60) days to verify the member's medically frail status. For purposes of this section, this period is referred to as the verification period. Beginning in calendar year 2016, and for each subsequent year of the plan, the verification period shall be thirty (30) days.

(c) A member identified as potentially medically frail in accordance with subsection (b) shall be enrolled in either HIP Plus or HIP Basic in accordance with 405 IAC 10-3-2 or 405 IAC 10-3-3, as applicable, until the medically frail verification is completed.

(d) In order to verify a member's medically frail condition, the managed care organization shall consider one (1) or more of the following using a process approved by the office:

- (1) The member's initial health screen.
- (2) The member's health assessment.
- (3) The member's medical records.
- (4) The member's present or historical medical claims data.
- (5) Any other information relevant to the member's health condition.

(e) If the managed care organization determines that a member is not medically frail or the managed care organization is unable to verify the member's medically frail status during the verification period, the member shall remain enrolled in either HIP Plus or HIP Basic in accordance with 405 IAC 10-3-2 or 405 IAC 10-3-3, as applicable.

(f) An individual wishing to appeal a managed care organization's determination under this section shall first appeal to the managed care organization making the determination in accordance with 405 IAC 10-5-2. If, on appeal to the managed care organization, the managed care organization finds that the member is not medically frail, the member may appeal the finding to the state in accordance with 405 IAC 10-5-1.

(g) The office may review the placement of a member who has been determined to be medically frail to determine whether the member meets the medically frail definition under 405 IAC 10-2-1(30) by considering any of the following:

- (1) The member's medical records.
  - (2) Communication with or other outreach to the managed care organization, the member, or the member's provider or providers.
  - (3) The member's past claims history, if available and accessible.
  - (4) Other processes, as determined by the office.
- (h) If, under subsection (g), the office determines that a member is not medically frail, the member shall no longer receive



HIP State Plan benefits and shall be transferred to:

- (1) HIP Plus if the member is currently enrolled in HIP State Plan Plus; or
- (2) HIP Basic if the member is currently enrolled in HIP State Plan Basic.

An individual determined not medically frail under this subsection may appeal the determination directly to the state in accordance with 405 IAC 10-5-1. (*Office of the Secretary of Family and Social Services; 405 IAC 10-6-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

## **Rule 7. Benefits and Medical Policy**

### **405 IAC 10-7-1 Coverage requirements; medically necessary service**

Authority: IC 12-15-44.5-9  
Affected: IC 12-15-44.5

Sec. 1. For a service to be covered under the plan, it shall be medically necessary as defined in 405 IAC 10-2-1(31). (*Office of the Secretary of Family and Social Services; 405 IAC 10-7-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; errata filed Apr 23, 2018, 11:30 a.m.: 20180502-IR-405180200ACA*)

### **405 IAC 10-7-2 HIP Basic covered benefits and services; noncovered services**

Authority: IC 12-15-44.5  
Affected: IC 12-15-44.5

Sec. 2. (a) This section outlines the services available to an individual enrolled in HIP Basic. The covered services provided under HIP Basic are in accordance with the essential health benefit requirements under 42 CFR 440.347 for alternative benefit plans.

(b) HIP Basic shall include covered services in each of the following categories:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity services.
- (5) Mental health and substance abuse services.
- (6) Prescription drugs.
- (7) Rehabilitative and habilitative services and devices.
- (8) Laboratory services.
- (9) Preventive care services.
- (10) Early and periodic screening, diagnostic, and treatment services for members nineteen (19) and twenty (20) years of age.
- (11) Any other services approved by the Centers for Medicare and Medicaid Services in the HIP Basic alternative benefit plan.

(c) The following services shall not be covered under HIP Basic:

- (1) Services that are not medically necessary.
- (2) Dental services.
- (3) Vision services.
- (4) Nonemergency transportation services.
- (5) Any other services not approved by the Centers for Medicare and Medicaid Services in the HIP Basic alternative benefit plan.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-7-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-7-3 HIP Plus covered benefits and services; noncovered services**

Authority: IC 12-15-44.5

Affected: IC 12-15-44.5

Sec. 3. (a) This section outlines the services available to an individual enrolled in HIP Plus. The covered services provided under HIP Plus are in accordance with the essential health benefit requirements under 42 CFR 440.347 for alternative benefit plans.

(b) HIP Plus shall include covered services in each of the following categories:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity services.
- (5) Mental health and substance abuse services.
- (6) Prescription drugs.
- (7) Rehabilitative and habilitative services and devices.
- (8) Laboratory services.
- (9) Preventive care services.
- (10) Vision services.
- (11) Dental services.
- (12) Early and periodic screening, diagnostic, and treatment services for members nineteen (19) and twenty (20) years of age.
- (13) Any other services approved by the Centers for Medicare and Medicaid Services in the HIP Plus alternative benefit plan.

(c) The following services shall not be covered under HIP Plus:

- (1) Services that are not medically necessary.
- (2) Nonemergency transportation services.
- (3) Any other services not approved by the Centers for Medicare and Medicaid Services in the HIP Plus alternative benefit plan.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-7-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)*

**405 IAC 10-7-4 HIP State Plan**

Authority: IC 12-15-44.5

Affected: IC 12-15-44.5

Sec. 4. (a) This section outlines services available to a member enrolled in HIP State Plan. All covered services under HIP State Plan are subject to the coverage criteria, limitations, and procedures specified in this article as well as those services specified in the Centers for Medicare and Medicaid Services approved Medicaid State Plan.

(b) HIP State Plan shall include covered services in the following categories that are equivalent to the Medicaid State Plan:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity services.
- (5) Mental health and substance abuse services.
- (6) Prescription drugs.
- (7) Rehabilitative and habilitative services and devices.
- (8) Laboratory services.
- (9) Preventive care services.
- (10) Vision services.
- (11) Dental services.
- (12) Early and periodic screening, diagnostic, and treatment services for members nineteen (19) and twenty (20) years of

age.

(c) The following services shall not be covered under HIP State Plan:

(1) Services that are not medically necessary.

(2) Any other services not covered by the Centers for Medicare and Medicaid Services approved Medicaid State Plan.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-7-4; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-7-5 Mental health parity**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 5. Coverage of mental health care services shall be subject to the same treatment limitations or financial requirements as coverage of services for physical illness. *(Office of the Secretary of Family and Social Services; 405 IAC 10-7-5; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-7-6 Prescription drug benefits**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 6. (a) For purposes of prescription drug benefits, HIP Basic and HIP Plus shall cover, at a minimum:

(1) one (1) drug in every United States Pharmacopeia category and class; or

(2) the same number of prescription drugs in each category and class of the essential health benefits benchmark plan.

(b) A HIP Basic member may only access a brand name prescription drug if either:

(1) the managed care organization approves a prior authorization request for the brand name drug; or

(2) the individual accesses the drug through step therapy.

(c) Subject to subsection (d), HIP State Plan Plus and HIP State Plan Basic health plans shall provide prescription drug benefits in accordance with the requirements of legend drugs in the Medicaid fee-for-service program as set forth in 405 IAC 5-24-3.

(d) HIP Basic and HIP State Plan Basic prescription drug coverage shall be:

(1) limited to no more than a thirty (30) day prescription drug supply; and

(2) subject to a copayment in accordance with 405 IAC 10-10-3(c).

(e) HIP Plus and HIP State Plan Plus pharmacy benefits include:

(1) up to a ninety (90) day prescription supply;

(2) mail order pharmacy benefit; and

(3) medication therapy management services.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-7-6; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA)*

**405 IAC 10-7-7 Laboratory services**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 7. Covered laboratory services include only laboratory services provided by laboratories or providers certified by Clinical Laboratory Improvement Amendments. *(Office of the Secretary of Family and Social Services; 405 IAC 10-7-7; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-7-8 Preventive care services**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 8. (a) Preventive care services as set forth in 42 U.S.C. 300gg-13 shall be covered, regardless of whether the member has met the member's deductible, and shall not be reimbursed using the member's POWER account.

(b) Preventive care services not set forth in 42 U.S.C. 300gg-13 shall be covered up to five hundred dollars (\$500) during the member's benefit period, regardless of whether the member has met the member's deductible, and shall not be reimbursed using the member's POWER account. Any such services in excess of five hundred dollars (\$500) shall be covered but shall be subject to the member's deductible and shall be reimbursed using the member's POWER account.

(c) A member's failure to receive preventive care services applicable to the member during the benefit period may impact the rollover of POWER account funds as outlined in 405 IAC 10-10-5(c) and 405 IAC 10-10-5(d).

(d) If a managed care organization determines that a member has not met the member's preventive care requirements during the benefit period, such member may submit documentation to the managed care organization showing that the member received the required preventive care services. (*Office of the Secretary of Family and Social Services; 405 IAC 10-7-8; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-7-9 Emergency room visits; copayments**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 9. (a) A member shall be subject to an eight dollar (\$8) copayment for the member's nonemergency use of a hospital emergency department.

(b) The following members shall be exempt from paying the copayments described under subsection (a):

(1) Pregnant women.

(2) American Indians/Alaskan Natives.

(3) Individuals who meet the requirements of 405 IAC 10-10-3(g).

(c) The copayments described under subsection (a) shall not apply if:

(1) the member is found to have an emergency medical condition;

(2) the member is admitted to the hospital within twenty-four (24) hours of the emergency department visit; or

(3) the member contacted the member's managed care organization's twenty-four (24) hour nurse hotline prior to seeking services from a hospital emergency department regarding the emergency medical condition for which the member is seeking emergency department services.

(d) A hospital provider shall conduct an appropriate medical screening examination as provided under 42 U.S.C. 1395dd prior to rendering any medical services. If the provider determines that the member does not have an emergency medical condition, the provider shall inform the member of the informational requirements under 42 U.S.C. 1396o-1(e) prior to rendering any medical services.

(e) Hospital providers shall be responsible for collecting emergency room copayments incurred under this section.

(f) A member may not use the member's POWER account to pay for emergency room copayments incurred under this section. (*Office of the Secretary of Family and Social Services; 405 IAC 10-7-9; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

**405 IAC 10-7-10 Out-of-network services**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 10. The following services shall be covered under the plan, even if provided out-of-network:

(1) Family planning services.

- (2) Emergency services.
- (3) Medically necessary covered services if the member's managed care organization is unable to provide the services in network within:
  - (A) thirty (30) miles of the member's residence for primary care; and
  - (B) sixty (60) miles of the member's residence for specialty care.
- (4) Nurse practitioner services that are medically necessary covered services provided within the scope of the nurse practitioner's applicable license and certification.
- (5) Medically necessary covered services provided at a federally qualified health center or rural health clinic.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-7-10; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)*

**405 IAC 10-7-11 Self-referral services**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-11; IC 12-15-44.5; IC 27-8-14.5-6

Sec. 11. (a) A member may receive the following covered services without a referral from the member's primary medical provider or prior authorization or precertification from the member's managed care organization:

- (1) Family planning services.
- (2) Emergency services.

(b) A member may receive the following services without a referral from the member's primary medical provider, provided the service is a covered service under such member's benefits package and subject to any requirements established by the managed care organization regarding the use of in-network providers:

- (1) Psychiatric services provided by a provider licensed under IC 12-15-11.
- (2) Behavioral health services.
- (3) Immunization services.
- (4) Diabetes self-management training services, as set forth in IC 27-8-14.5-6.
- (5) Chiropractic services.
- (6) Eye care services, except for surgical services on the eye.
- (7) Podiatric services.
- (8) Urgent care services.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-7-11; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)*

**405 IAC 10-7-12 Prior authorization**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 12. (a) A managed care organization may implement utilization control procedures, including prior authorization or precertification of services as provided under 42 CFR 438.210. The following services shall be exempt from prior authorization:

- (1) Emergency services, subject to the requirements of section 9 of this rule.
- (2) Family planning services.
- (3) Urgent care.
- (b) A provider that:
  - (1) has an agreement with the office; and
  - (2) renders services to a member;

shall follow the utilization control procedures implemented by the member's managed care organization under subsection (a) regardless of whether that provider has a contract with the member's managed care organization.

(c) Managed care organizations shall make decisions regarding prior authorization and precertification in accordance with the requirements of 405 IAC 5-3-14. *(Office of the Secretary of Family and Social Services; 405 IAC 10-7-12; filed May 18, 2015,*

12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)

## **Rule 8. Managed Care Organizations and Administrators**

### **405 IAC 10-8-1 Unauthorized cost sharing**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) Managed care organizations and providers shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance, to plan members for covered services, except in the following circumstances:

- (1) Deductible amounts paid for with funds out of a member's POWER account.
- (2) Emergency room copayments, as set forth in 405 IAC 10-7-9.
- (3) Copayments, as set forth in 405 IAC 10-10-3(c).

(b) In those instances where the managed care organization pays for a service at the Medicare rate, any cost sharing that would typically be applicable in the Medicare program:

- (1) shall not be applicable; and
- (2) shall be included in the rate paid by the managed care organization.

(c) Notwithstanding subsection (a), managed care organizations and providers shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance, for any covered service to a member who is:

- (1) pregnant; or
- (2) an American Indian/Alaskan Native.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-8-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA)*

### **405 IAC 10-8-2 Changing managed care organizations**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 2. (a) A member shall remain enrolled with the same managed care organization during the member's benefit period. If a member leaves the program and returns during the same benefit period, the member shall remain enrolled in the same MCO. A member may change managed care organizations upon request only in the following circumstances:

- (1) Without cause for new conditional or fast track members, before making the member's fast track prepayment or initial POWER account contribution or within sixty (60) days of being assigned to a managed care organization, whichever comes first.
- (2) For cause at any time. A member under this subsection may request to change managed care organizations at any time by submitting a grievance to the managed care organization and receiving the managed care organization's or the division's approval.
- (b) For purposes of subsection (a)(2), "for cause" includes any of the following:
  - (1) The causes for disenrollment set forth in 42 CFR 438.56(d)(2)(i) – (iii).
  - (2) Receiving poor quality care.
  - (3) Failure of the managed care organization to provide covered services.
  - (4) Failure of the managed care organization to comply with established standards of medical care administration.
  - (5) Lack of access to providers experienced in dealing with the member's health care needs.
  - (6) Significant language or cultural barriers.
  - (7) Corrective action levied against the managed care organization by the office.
  - (8) Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence.
  - (9) A determination that another managed care organization's formulary is more consistent with a new member's existing health care needs.

(10) Member was unable to select a managed care organization in the MCO selection period due to the member's eligibility status during the MCO selection period.

(11) Other circumstances determined by the office to constitute poor quality of health care coverage.

(c) A member who receives an unfavorable decision from the managed care organization under subsection (a)(2) may submit a request for reconsideration pursuant to the instructions in the managed care organization's notice of decision. A request for reconsideration shall be deemed approved if official action is not taken on the request by the first day of the second month following the month in which the individual submits the request. A member who files a grievance with the managed care organization and completes the reconsideration process shall be considered to have met the requirements of 405 IAC 10-5-2 for purposes of filing an appeal with the state. (*Office of the Secretary of Family and Social Services; 405 IAC 10-8-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

#### **405 IAC 10-8-3 Network**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. The managed care organization shall maintain and monitor an adequate network of providers in accordance with 42 CFR 438.206. The managed care organization shall not maintain network differentiation between its HIP Plus and HIP Basic benefit plans. (*Office of the Secretary of Family and Social Services; 405 IAC 10-8-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

### **Rule 9. Providers**

#### **405 IAC 10-9-1 Provider enrollment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) With the exception of emergency services providers, a provider rendering covered services to a member shall be enrolled in the Indiana Medicaid program at the time of service in order to receive reimbursement. An emergency services provider who is not enrolled in the Indiana Medicaid program at the time of service shall enroll in the Indiana Medicaid program retroactive to the date of service in order to receive reimbursement.

(b) In order to enroll as a provider as required under subsection (a), the provider shall comply with the procedures set forth in 405 IAC 5-4-1.

(c) A provider providing covered services to members shall provide the services under a contract with a managed care organization except in the following circumstances:

(1) If the service provided is listed in 405 IAC 10-7-10.

(2) If the managed care organization:

(A) has designed an out-of-network benefit for its members; or

(B) otherwise approves the out-of-network service.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-9-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-9-2 Provider grievances and appeals; managed care organizations**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 2. (a) The right of providers contracting with managed care organizations to dispute any actions taken by the managed care organization shall be governed by the provider's contract with the managed care organization.

(b) The reimbursement dispute resolution procedure set forth at 405 IAC 1-1.6 shall apply to providers who do not have a

contract with a managed care organization for services provided under the plan.

(c) Any provider disputes involving prior authorization determinations made by the managed care organizations shall be governed by the managed care organization's procedures for provider grievances and appeals.

(d) A contracted or noncontracted provider shall have no right to appeal a managed care organization's action to the state. (*Office of the Secretary of Family and Social Services; 405 IAC 10-9-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-9-3 Provision of covered services; verification of enrollment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 3. (a) Except as provided in subsection (b), before providing any nonemergency service covered under the plan, a provider shall verify all of the following:

- (1) The individual is eligible for the plan.
- (2) The individual is enrolled with a managed care organization.
- (3) The individual is enrolled in the plan at the time the service is being provided.
- (4) The individual whose name appears on the card is the same individual for whom the service is being performed.
- (5) The service is covered under the member's benefit plan.

Failure to do so may result in denial of the provider's claim if the individual is not enrolled in the plan or the service is not authorized.

(b) Hospitals providing services to individuals during the presumptive eligibility period in accordance with 405 IAC 10-4-11(c), 405 IAC 10-4-11(d), or 405 IAC 10-4-11(e) shall be exempt from the requirements of subsection (a)(1) and (a)(2). Such hospitals shall verify that the individual is eligible for presumptive eligibility under 405 IAC 10-4-11.

(c) If an individual is disenrolled from a managed care organization while receiving inpatient hospital services covered under the plan, the managed care organization shall pay any claims related to the covered inpatient hospital services provided to the member through the date of discharge. (*Office of the Secretary of Family and Social Services; 405 IAC 10-9-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-9-4 Provider reimbursement; managed care organizations**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5-5

Sec. 4. (a) Reimbursement matters including:

- (1) the time limit for filing claims; and
- (2) rates paid to providers contracting with managed care organizations;

shall be governed by the contract between the provider and the managed care organization.

(b) Reimbursement rates paid by managed care organizations to providers without contracts who render services to plan members shall be at plan reimbursement rates governed by IC 12-15-44.5-5.

(c) No provider retains any independent or duplicative right for reimbursement from the office in addition to or in lieu of reimbursement received from the managed care organization. (*Office of the Secretary of Family and Social Services; 405 IAC 10-9-4; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-9-5 Reimbursement process; provider reimbursement rates; POWER account**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 5. (a) A provider shall be reimbursed for covered services as follows:

- (1) Until the member's deductible is met, with POWER account funds accessed through the member's POWER account and paid by the managed care organization. If the member lacks sufficient POWER account funds at the time of service, the



managed care organization shall pay for any portion of the plan reimbursement rate that cannot be paid with POWER account funds but shall reconcile these prepaid amounts as additional POWER account funds are received from the member.

(2) For all covered preventive care services, which are not subject to the member's deductible, by the managed care organization.

(3) For covered services under the member's health plan after the deductible has been met, by the managed care organization.

The provider shall be reimbursed at the plan reimbursement rate.

(b) Reimbursement shall not be available for services provided to individuals who are not enrolled in the plan on the date the service is provided except as provided under the following:

(1) To those individuals whose coverage dates back to the first of the month as outlined in 405 IAC 10-3-2 or 405 IAC 10-3-3.

(2) To an individual in accordance with section 3(b) and 3(c) of this rule.

(c) The plan reimbursement rate defined in 405 IAC 10-2-1(38) does not include:

(1) critical access hospital payments;

(2) graduate medical education payments; or

(3) disproportionate share hospital payments.

(d) Managed care organizations shall reimburse federally qualified health centers and rural health clinics for covered services at the Medicare all-inclusive rate for each visit. In the event the amount paid by managed care organizations is less than the amount set forth in 42 U.S.C. 1396a(bb), the office shall make a supplemental payment in accordance with 42 U.S.C. 1396a(bb)(5). (*Office of the Secretary of Family and Social Services; 405 IAC 10-9-5; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

#### **405 IAC 10-9-6 Member payment liability**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 6. A provider shall accept plan reimbursement as payment in full. A provider cannot collect from a member any portion of the provider's charge for a covered service that is not reimbursed by the managed care organization, with the exception of the following:

(1) Emergency room copayments authorized under this article.

(2) Payments made with POWER account funds before the deductible of the member's health plan is met.

(3) Copayments authorized under 405 IAC 10-10-3(c).

(*Office of the Secretary of Family and Social Services; 405 IAC 10-9-6; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

### **Rule 10. POWER Accounts and Copayments**

#### **405 IAC 10-10-1 Establishment of POWER account; noninterest bearing account**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 1. (a) The managed care organizations shall establish and administer a POWER account in the name of each individual enrolled in the plan. The maximum amount that may be contributed to the POWER account is two thousand five hundred dollars (\$2,500) per year, contributed as specified under section 4 of this rule.

(b) POWER account funds shall be used to pay the member's deductible for health care services covered under the plan.

(c) A member shall not keep interest earned on the member's POWER account. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-1; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-10-2 Uses of POWER account funds**

Authority: IC 12-15-44.5-9  
 Affected: IC 12-15-44.5

Sec. 2. (a) Each member shall be responsible for the member's use of funds in the member's POWER account until the deductible is met. A member's POWER account funds shall only be used to pay for covered services and shall not be used to pay the following:

- (1) The emergency room services copayment described in 405 IAC 10-7-9.
- (2) HIP Basic copayments as set forth in section 3(b) of this rule.
- (3) Any other cost not covered in the member's specific benefit package as listed in 405 IAC 10-7-2, 405 IAC 10-7-3, or 405 IAC 10-7-4.

(b) Members may use POWER account funds to pay for covered out-of-network services described in 405 IAC 10-7-10. *(Office of the Secretary of Family and Social Services; 405 IAC 10-10-2; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-10-3 POWER account contributions; copayments**

Authority: IC 12-15-44.5-9  
 Affected: IC 12-15-44.5

Sec. 3. (a) A member enrolled in either HIP Plus or HIP State Plan Plus shall be required to contribute a monthly amount to the member's POWER account. Except as provided in subsection (h), a member's monthly POWER account contribution (PAC) shall be determined in accordance with the following criteria:

| Percent of FPL | Monthly PAC Single Individual | Monthly PAC Spouses |
|----------------|-------------------------------|---------------------|
| <22%           | \$1.00                        | \$1.00              |
| 23-50%         | \$5.00                        | \$2.50              |
| 51-75%         | \$10.00                       | \$5.00              |
| 76-100%        | \$15.00                       | \$7.50              |
| 101-138%       | \$20.00                       | \$10.00             |

In no event shall the member's monthly POWER account payment exceed one hundred dollars (\$100) per month or be less than one dollar (\$1) per month or one dollar and fifty cents (\$1.50) per month for a tobacco user as set forth in section 15 of this rule.

(b) All tobacco users shall be subject to a fifty percent (50%) surcharge for each monthly POWER account payment.

(c) Except as provided under subsection (d), a member enrolled in HIP Basic or HIP State Plan Basic shall not be required to make monthly contributions to the member's POWER account but shall be charged a copayment at the time services are rendered, as follows:

- (1) Four dollars (\$4) for outpatient services.
- (2) Seventy-five dollars (\$75) for inpatient services.
- (3) Four dollars (\$4) for preferred drugs.
- (4) Eight dollars (\$8) for nonpreferred drugs.
- (d) The following members shall not be subject to cost sharing under this section:

- (1) An American Indian/Alaskan Native.
- (2) A pregnant woman.
- (3) Any individual who meets the requirements in subsection (g).

(e) No copayment shall be required for the following services:

- (1) Preventive care services.
- (2) Family planning services.
- (3) Maternity services.

(f) A provider shall be responsible for collecting the required copayments at the time services are provided. A provider may not deny a service to a member if such member is unable to pay the copayment at the time of service delivery. If a member does not pay the copayment at the time services are provided, the member shall still be responsible for paying the copayment and the

provider may bill the member for the copayment amount owed.

(g) A member's out-of-pocket cost sharing amount shall not exceed five percent (5%) of the member's annual household income, except that all HIP Plus or HIP State Plan Plus members whose household income is at or below five percent (5%) of the FPL shall be required to contribute, at a minimum, monthly one dollar (\$1) POWER account contributions or one dollar and fifty cents (\$1.50) if the member is a tobacco user set forth in section 15 of this rule.

(h) In a family with two (2) or more members, each member shall have a POWER account established in accordance with section 1 of this rule. In the case where two (2) members are married, the combined total of both spouses' required POWER account contributions cannot exceed two percent (2%) of the monthly household income subject to the one dollar (\$1) minimum contribution amount set forth in subsection (g) or one dollar and fifty cents (\$1.50) if the member is a tobacco user set forth in section 15 of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-3; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; errata filed Feb 22, 2018, 9:36 a.m.: 20180307-IR-405180114ACA*)

**405 IAC 10-10-4 POWER account contributions; state contributions; employer contributions**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 4. (a) The state shall contribute the difference between:

- (1) the member's annual contribution; and
- (2) two thousand five hundred dollars (\$2,500).

(b) Amounts may be contributed to a member's POWER account by:

- (1) a member, including the use of incentive funds earned through a managed care organization if the member elects to do so;
- (2) a member's employer, if the contribution is not from funds payable by the employer to the employee;
- (3) any third party, subject to the restrictions in subsection (d); or
- (4) the managed care organization, under which the member is enrolled, if the payment:
  - (A) is to provide a health incentive to the member; and
  - (B) does not count toward the member's required contributions as set forth in section 3(a) of this rule.

(c) In no event shall a member's POWER account balance exceed two thousand five hundred dollars (\$2,500).

(d) A health care provider or provider-related entity may make a contribution to a member's POWER account in accordance with subsection (b)(3), provided:

- (1) the provider or provider-related entity establishes criteria for providing assistance that do not distinguish between individuals based on whether they receive or will receive services from the contributing provider or providers or class of providers; and
- (2) the provider or provider-related entity does not include the cost of such payments in either the cost of care for purposes of Medicare and Medicaid cost reporting or included as part of a Medicaid shortfall or uncompensated care for any purpose.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-10-4; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-10-5 Annual recalculation of POWER account contribution; rollover; copayment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 5. (a) A member enrolled in the Healthy Indiana Plan by December 31 may be eligible to rollover part of the member's POWER account to the new benefit period beginning January 1 of each year.

(b) A member enrolled in HIP Plus or HIP State Plan Plus with a balance remaining in the member's POWER account at the end of the benefit period may be eligible to roll over a portion of the account balance to reduce such member's POWER account contributions for the new benefit period in accordance with subsection (c) or (d), as applicable.

(c) If a member enrolled in HIP Plus or HIP State Plan Plus has met the member's preventive care services goals as set by the office for the expiring benefit period as set forth in 405 IAC 10-7-8, the member's final rollover amount shall be calculated as follows:

- (1) The member's pro-rata share is determined by adding the member's required monthly contributions owed for all enrolled months in the expiring benefit period dividing that sum by two thousand five hundred dollars (\$2,500).
- (2) The member's portion is determined by multiplying the member's pro-rata share as determined in subdivision (1) by the amount spent from the POWER account.
- (3) The base rollover amount is determined by subtracting the member's portion determined under subdivision (2) by the sum of the member's paid contributions for the benefit period.
- (4) The final rollover amount is determined by multiplying the base rollover amount as determined in subdivision (2) by two (2).

(d) If a member enrolled in HIP Plus or HIP State Plan Plus has not met the member's preventive care services goals as set by the office for the expiring benefit period as set forth in 405 IAC 10-7-8, the member's final rollover amount shall be calculated only in accordance with the base rollover amount in subsection (c)(3). Such member's base rollover amount shall not be multiplied by two (2).

(e) A HIP Basic or HIP State Plan Basic member with a POWER account balance remaining at the end of the expiring benefit period shall be eligible to receive a discount on the POWER account contribution such member would need to make in order to be enrolled in the HIP Plus or HIP State Plan Plus plan for the new benefit period. The HIP Plus discount for a HIP Basic or HIP State Plan Basic member with a POWER account balance shall be calculated as follows:

- (1) Divide the remaining balance in the POWER account by two thousand five hundred dollars (\$2,500). If the resulting percentage is less than or equal to fifty percent (50%), then that percentage shall be used in subdivision (2). However, if the resulting percentage is greater than fifty percent (50%), then the percentage shall be capped at fifty percent (50%) for purposes of subdivision (2).
- (2) Multiply the required monthly POWER account contribution by the percentage calculated in subdivision (1).
- (3) Subtract the product calculated in subdivision (2) from the POWER account contribution for the current benefit period.

(f) The managed care organizations may collect member debt, if any, as calculated under section 7 of this rule, from the member portion of rollover funds calculated in either subsection (c), (d), or (e). The resulting amount shall reduce the member's annual POWER account contribution for the new benefit period. No rollover funds contributed by the state may be used to pay member debt.

(g) The managed care organization shall reconcile a member's POWER account for the rollover process described in this section no later than one hundred twenty (120) days after the end of the benefit period. A member who remains enrolled in HIP Basic or HIP State Plan Basic at the time the member receives notice of the amount of the discount set forth in subsection (e) shall have a period of sixty (60) days from the date of such notice to transfer to HIP Plus or HIP State Plan Plus by making a POWER account contribution at the new discounted rate.

(h) In the event the amount of the member's POWER account balance that is rolled over at the end of the benefit period exceeds the amount of the member's annual POWER account contribution for the new benefit period, the member shall not receive a refund of the excess amount. The excess funds shall be returned to the office. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-5; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-10-6 POWER account balance; termination and disenrollment**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5; IC 32-34-1

Sec. 6. (a) If a member loses plan eligibility due to nonpayment of POWER account contributions as specified in section 12 of this rule, the member shall be paid only a portion of the balance remaining in the member's POWER account as calculated in subsection (b).

- (b) If a member loses plan eligibility for reasons set forth in subsection (a), the member refund shall be calculated as follows:
  - (1) Divide the sum of total contributions owed by the member for enrolled months during the benefit period by two thousand

five hundred dollars (\$2,500).

(2) Multiply the ratio calculated in subdivision (1) by the total amount spent from the individual's POWER account.

(3) Sum total contributions made towards the member's required monthly contributions and subtract the member share calculated in subdivision (2). Where the result is positive the member shall be due a refund. Where the result is negative the member may have debt as calculated under section 7 of this rule.

(4) Multiply the amount calculated in subdivision (3) by seventy-five hundredths (.75) to determine the amount to be returned to the individual.

(c) If a member loses plan eligibility for reasons other than those set forth in subsection (a), the member shall be paid a portion of the balance remaining in the member's POWER account, calculated as follows:

(1) Divide the sum of total contributions owed by the member for enrolled months during the benefit period by two thousand five hundred dollars (\$2,500).

(2) Multiply the ratio calculated in subdivision (1) by the total amount spent from the individual's POWER account.

(3) Sum total contributions made towards the member's required monthly contributions and subtract the member share calculated in subdivision (2). Where the result is positive the member may be due a refund. Where the result is negative the member may have debt, as calculated under section 7 of this rule.

(d) The managed care organization shall return the amount calculated in subsection (b) or (c) to the member within one hundred and twenty (120) days of the last date of the plan benefit period. The former member shall be liable for the POWER account portion of any claims for covered services with dates of service occurring during the prior benefit period but after the POWER account balance has been paid to the former member. The former member shall not be liable for claims originally denied but overturned on appeal if the appealed claim is paid more than one hundred twenty (120) days following the member's last date of participation in the plan.

(e) After payment to the member of the amount calculated in subsection (b) or (c), the state shall retain any remaining POWER account balance.

(f) In the event that a member:

(1) cannot be located; or

(2) otherwise does not claim the amount calculated in subsection (b) or (c);

such amount shall be treated as unclaimed property and shall be subject to the Unclaimed Property Act, IC 32-34-1. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-6; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

#### **405 IAC 10-10-7 Member debt**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 7. (a) For purposes of this section, "debt" means amounts that accrue as a result of:

(1) a managed care organization's advance payment of the member's portion of the deductible as provided under 405 IAC 10-9-5(a)(1) that has not been repaid through the member's POWER account contributions; or

(2) any nonsufficient funds check charges resulting from a member's payments to a managed care organization as a result of payment processing.

(b) A member's debt under subsection (a)(1) shall be calculated as follows:

(1) Divide the member's annual POWER account contribution amount by two thousand five hundred dollars (\$2,500).

(2) Multiply the amount of claims paid up to two thousand five hundred dollars (\$2,500) during the benefit period by the amount determined in subdivision (1).

(3) Subtract the total monthly individual contributions paid by the member during the benefit period by the amount determined under subdivision (2).

(c) A member's debt under this section shall not exceed the sum of the unpaid monthly contributions that accrued during the months in which the member received HIP Plus coverage.

(d) If a member has debt, the managed care organization may collect from the individual. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-7; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42*

*a.m.: 20180214-IR-405170484FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-10-8 Reporting changes**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 8. A member shall promptly report any change that may affect the member's continued eligibility in the plan, including any of the following qualifying events:

(1) A change in family status that results in an increase or decrease in the number of individuals in the member's household.

(2) Any change in employment status or household income.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-10-8; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-10-9 POWER account contributions; billing; payment options**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 9. A member shall, at a minimum, make the required POWER account contribution within sixty (60) days from the first day of the coverage month for which the POWER account contribution is owed each month to remain eligible. Any excess payments a member pays in a given month shall offset the following months' payments. *(Office of the Secretary of Family and Social Services; 405 IAC 10-10-9; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-10-10 Third party contributions**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 10. (a) An employer or other third party defined in section 4(b)(3) of this rule may contribute up to one hundred percent (100%) of a member's annual POWER account obligation. If such an entity contributes less than a member's annual POWER account obligation, such amount shall be applied to the member's next due POWER account payment. Any excess amount shall be carried over from month to month until it is exhausted. A member shall be responsible for paying any balance in a given month.

(b) Any contribution received from an employer or other third party defined in section 4(b)(3) of this rule shall be used to offset the member's required POWER account contribution only, and shall not be used to offset the state's contribution to the POWER account set forth in section 4(a) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 10-10-10; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA)*

**405 IAC 10-10-11 Billing; prior year contribution amount**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 11. (a) If a member's first POWER account contribution for a new benefit period becomes due before the division calculates the member's new POWER account contribution, the managed care organization may bill the member in the amount of the POWER account contribution for the previous benefit period.

(b) Any overpayments or underpayments a member makes as a result of subsection (a) shall be reconciled within thirty (30) days of notification by the state of the member's recalculated POWER account contribution amount for the new benefit period. An overpayment or underpayment may impact a member's future POWER account obligations as a result of subsection (a). *(Office of the Secretary of Family and Social Services; 405 IAC 10-10-11; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA)*

**405 IAC 10-10-12 Nonpayment of monthly POWER account contribution; termination**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 12. (a) A HIP Plus or HIP State Plan Plus member who does not make a required monthly POWER account contribution within the time frame established in section 9 of this rule shall receive a notice of nonpayment. Upon receiving a notice of nonpayment:

(1) except as provided in section 13 of this rule, a member with household income above one hundred percent (100%) of the FPL shall:

(A) be terminated from participation in the plan; and

(B) not be allowed to reapply for a period of six (6) months from the notice of nonpayment; or

(2) a member with household income at or below one hundred percent (100%) of the FPL shall be:

(A) transferred to HIP Basic, if previously enrolled in HIP Plus; or

(B) transferred to HIP State Plan Basic, if previously enrolled in HIP State Plan Plus.

(b) Any funds remaining in the POWER account of a member terminated pursuant to subsection (a)(1) shall be credited to the state and returned to the individual as provided in section 6(b) of this rule.

(c) A member who voluntarily withdraws from the plan shall be subject to subsection (b). (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-12; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-10-13 Exceptions to nonpayment penalties and plan lockout periods**

Authority: IC 12-15-44.5-9

Affected: IC 10-14-3-12; IC 12-15-44.5

Sec. 13. (a) A member exempt from cost sharing pursuant to section 3(d) of this rule shall not be subject to any of the nonpayment penalties set forth in section 12(a) of this rule.

(b) A medically frail individual with household income over one hundred percent (100%) of the FPL shall not be subject to disenrollment for nonpayment under section 12(a)(1) of this rule, but shall:

(1) remain in HIP State Plan Plus;

(2) be required to pay copayments as set forth in section 3(c) of this rule; and

(3) continue to be billed for monthly POWER account contributions and accrue debt to the managed care organization.

Such member shall no longer be subject to the copayment requirement under subsection (b)(2) if, at the member's annual renewal, the member pays the first month POWER account contribution in the new benefit period.

(c) A member disenrolled under section 12(a) of this rule or 405 IAC 10-4-9 may reenroll in the plan prior to the expiration of the six (6) month lockout period if such individual is determined to be medically frail during the lockout period. Such individual shall reapply for the plan and be verified as medically frail in accordance with 405 IAC 10-6-1(e) before the individual may be reenrolled in the plan under this subsection.

(d) A member disenrolled under section 12(a) of this rule or 405 IAC 10-4-9 shall not be subject to the six (6) month lockout period but may be reinstated to the plan prior to the expiration of the six (6) month lockout, if a new application is filed and the individual can provide verification that one (1) of the following qualifying events caused the disenrollment:

(1) Obtained and subsequently lost private insurance coverage.

(2) Had a loss of income after disqualification due to increased income.

(3) Took up residence in another state and later returned.

(4) Was a victim of domestic violence.

(5) Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-10-13; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-10-14 Member identification cards**

Authority: IC 12-15-44.5-9  
Affected: IC 12-15-44.5

Sec. 14. Each member shall receive a membership identification card upon enrollment in the plan. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-14; filed May 18, 2015, 12:34 p.m.: 20150617-IR-405140339FRA; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**405 IAC 10-10-15 Tobacco surcharge**

Authority: IC 12-15-44.5-9  
Affected: IC 12-15-44.5

Sec. 15. HIP Plus members who are tobacco users shall be required to pay a surcharge to the member's monthly contributions. The surcharge shall be waived for the first year of enrollment in order to provide the individual the opportunity to take advantage of the smoking cessation programs offered through the Healthy Indiana Plan. If after a year the member continues to be a tobacco user, the member's monthly contributions shall increase beginning in the first month of the member's renewed benefit period. The tobacco surcharge is not applicable to the excluded groups listed in section 3(d) of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 10-10-15; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**Rule 11. HIP Employer Benefit Link (Repealed)**

(*Repealed by Office of the Secretary of Family and Social Services; filed Jan 19, 2018, 8:42 a.m.: 20180214-IR-405170484FRA*)

**Rule 12. Gateway to Work**

**405 IAC 10-12-1 Definitions**

Authority: IC 12-15-44.5-9  
Affected: IC 12-15-44.5; IC 20-18-2-18; IC 20-33-2; IC 21-7-13-6; IC 21-17-1-15

Sec. 1. The following definitions apply throughout this rule:

- (1) "Certified temporary illness or incapacity" means either of the following:
  - (A) An inpatient or observation hospital stay covered under the plan.
  - (B) An illness or injury certified by a provider, via a face-to-face interaction, within the first seven (7) days of incapacity, that leaves a member incapacitated for more than three (3) consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also involves either:
    - (i) treatment by a health care provider two (2) or more times within thirty (30) days of the first day of incapacity, unless extenuating circumstances exist (i.e., the health care provider does not have any available appointments during that timeframe); or
    - (ii) treatment by a health care provider on at least one (1) occasion that results in a regimen of continuing treatment under the supervision of the healthcare provider.
- (2) "Disabled dependent" means a qualifying child or relative, as defined by the Internal Revenue Service, determined to be disabled, or who has a pending determination, by:
  - (A) the Social Security Administration as set forth in 20 CFR 416 Subpart I; or
  - (B) the Indiana Medicaid medical review team (MMRT).
- (3) "Family and Medical Leave Act" or "FMLA" means the federal law set forth in 29 U.S.C. 28.
- (4) "Gateway to Work" or "GTW" means the community engagement program of the Healthy Indiana Plan (HIP) to encourage and support members to engage in educational opportunities, secure employment, and engage in community service.
- (5) "Gateway to Work eligibility period" means the annual period, from January 1 through December 31, in which a member's Gateway to Work compliance is determined.



- (6) "Gateway to Work exempt" or "exempt" means the Gateway to Work status of a member who meets any of the listed exemptions in section 3 of this rule and is not required to report activities.
- (7) "Gateway to Work required" means the Gateway to Work status of a member who is determined not to meet any of the exemptions in section 3 of this rule.
- (8) "Half-time" means at least six (6) credit hours per semester or equivalent time period as defined by the institution.
- (9) "Homeless" means an individual who lacks a fixed, regular, and adequate nighttime residence or who has a primary nighttime residence that is a supervised temporary shelter, an institution that provides a temporary residence, or a place not designed or ordinarily used as a regular sleeping accommodation.
- (10) "Homeschooling" means a nonaccredited and nonpublic education provided by a member to the member's own child or children. Homeschooling must meet all applicable legal requirements in IC 20-33-2.
- (11) "Institutionalized" means a member who is:
  - (A) an inpatient in a nursing facility;
  - (B) an inpatient in a medical institution for whom payment is made based on a level of care provided in a nursing facility; or
  - (C) receiving home and community based waiver services.
- (12) "Phase-in period" means the period from January 1, 2019, through June 30, 2020, when the community engagement minimum hour requirements shall be less than twenty (20) hours per week.
- (13) "Recently incarcerated" means a member who has been imprisoned for at least thirty (30) days and has since been released. Incarceration shall include imprisonment in a county, state, or federal facility.
- (14) "Student" means a member enrolled and attending one (1) of the following:
  - (A) A secondary school as set forth in IC 20-18-2-18.
  - (B) A postsecondary educational institution as set forth in IC 21-7-13-6.
  - (C) A vocational school as set forth in IC 21-17-1-15.
- (15) "Substance use disorder treatment" means active participation during the month in any covered treatment that includes:
  - (A) individual and group counseling (including Medicaid Rehabilitation Option services);
  - (B) inpatient treatment;
  - (C) residential treatment;
  - (D) intensive outpatient treatment;
  - (E) partial hospitalization;
  - (F) case or care management after completing an inpatient or residential stay; or
  - (G) medication assisted treatment.

*(Office of the Secretary of Family and Social Services; 405 IAC 10-12-1; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-12-2 Eligibility**

Authority: IC 12-15-44.5-9  
Affected: IC 12-15-44.5

- Sec. 2. (a) Participation in the Gateway to Work community engagement program shall be a condition of eligibility for all HIP members who are between the ages of nineteen (19) and fifty-nine (59) years of age.
- (b) HIP members shall be reviewed on January 1, 2019, to determine if the member meets a GTW exemption, based on the member's eligibility information, in order to be declared exempt from participating in GTW.
  - (c) HIP applicants shall be reviewed at the time of the application to determine if the applicant meets a GTW exemption, based on the applicant's eligibility information, in order to be declared exempt from participating in GTW.
  - (d) All HIP members without an exemption shall be considered Gateway to Work required. Gateway to Work required members shall complete and report activities in at least one (1) of fifteen (15) qualifying activities for twenty (20) hours per week, or eighty (80) hours per month, for eight (8) out of twelve (12) months in a calendar year, subject to the phase-in period of section 5 of this rule.
  - (e) If a member meets one (1) of the exemptions in section 3 of this rule but is not determined exempt at the time of

enrollment, the member may claim an exemption by contacting the member's MCO. (*Office of the Secretary of Family and Social Services; 405 IAC 10-12-2; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-12-3 Exemptions to Gateway to Work requirements**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5; IC 20-33-2-6

Sec. 3. (a) HIP members meeting one (1) or more of the following exemptions shall not be required to complete GTW community engagement related activities in order to maintain continued coverage during the month or months the exemption applies:

- (1) Pregnant women.
  - (2) Students enrolled at least half-time as defined in section 1 of this rule.
  - (3) Primary caregiver of:
    - (A) a dependent child below the compulsory education age, as set forth in IC 20-33-2-6;
    - (B) a dependent that has been designated by the department of child services as children in need of services (CHINS) cases; or
    - (C) a disabled dependent.
  - (4) Members determined to be medically frail pursuant to 405 IAC 10-6.
  - (5) Those members with a certified temporary illness or incapacity (includes individuals on FMLA) as defined in section 1 of this rule.
  - (6) Members actively participating in substance use disorder treatment as defined in section 1 of this rule.
  - (7) Anyone sixty (60) years of age or above.
  - (8) Homeless or institutionalized members as defined in section 1 of this rule.
  - (9) Members who have been recently incarcerated, as defined in section 1 of this rule, within the previous six (6) months.
  - (10) Current Temporary Assistance for Needy Families (TANF) recipients or Supplemental Nutrition Assistance Program (SNAP) recipients.
- (b) A member must report any change in circumstances related to his or her exemption status within ten (10) days of the date of the change. An additional ten (10) days shall be allowed to provide any necessary verification. (*Office of the Secretary of Family and Social Services; 405 IAC 10-12-3; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-12-4 Qualifying activities**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 4. (a) HIP members may satisfy their GTW community engagement requirements through a variety of activities, including:

- (1) employment;
- (2) educational activities as a student enrolled in less than half-time;
- (3) MCO employment initiatives;
- (4) job skills training;
- (5) job search activities;
- (6) education related to employment;
- (7) general education (i.e., high school equivalency);
- (8) attending English as a second language education program taught by a licensed or certified professional;
- (9) vocational education or training;
- (10) community work experience;
- (11) community service or public service;
- (12) caregiving services for a nondependent relative or other person with a chronic, disabling health condition, including individuals receiving FMLA to provide caregiving;

(13) homeschooling;  
 (14) volunteer work; or  
 (15) members of the Pokagon Band of Potawatomi who participate in the tribe's comprehensive Pathways program.  
*(Office of the Secretary of Family and Social Services; 405 IAC 10-12-4; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-12-5 Community engagement minimum requirements**

Authority: IC 12-15-44.5-9  
 Affected: IC 12-15-44.5

Sec. 5. (a) All members not meeting an exemption in section 3 of this rule shall be required to meet the GTW community engagement hours as outlined in subsection (b).

(b) HIP members entering the program any time during the phase-in period shall be required to meet the minimum hours per week using the following criteria:

| Gateway to Work Phase-in Period Requirements |  |
|--|--|
| Gateway to Work Phase-in Period              | Required Community Engagement Hours Per Week |
| January 1, 2019 - June 30, 2019              | 0  |
| July 1, 2019 - September 30, 2019            | 5  |
| October 1, 2019 - December 31, 2019          | 10   |
| January 1, 2020 - June 30, 2020              | 15   |
| July 1, 2020, and beyond                     | 20   |

*(Office of the Secretary of Family and Social Services; 405 IAC 10-12-5; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-12-6 Compliance**

Authority: IC 12-15-44.5-9  
 Affected: IC 12-15-44.5

Sec. 6. (a) Members required to participate in Gateway to Work shall be required to engage in qualifying activities pursuant to section 4 of this rule or provide documentation of an exemption pursuant to section 3 of this rule.

(b) Compliance shall be assessed annually in December for all members by reviewing the Gateway to Work eligibility period for that year.

(c) A member with Gateway to Work required status shall engage in any combination of the Gateway to Work qualifying activities to meet all weekly hour requirements for eight (8) of the twelve (12) months during the Gateway to Work eligibility period.

(d) Members shall report their qualifying activities and may be required to provide further verification to document the member's community engagement.

(e) Any member who is employed and working more than the minimum required hours in section 5 of this rule shall not be required to report their activities if the member's employment status has been reported to the office as required in 405 IAC 10-10-8.

(f) Reported activities may be subject to auditing to verify compliance. *(Office of the Secretary of Family and Social Services; 405 IAC 10-12-6; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA)*

**405 IAC 10-12-7 Noncompliance**

Authority: IC 12-15-44.5-9  
 Affected: IC 12-15-44.5

Sec. 7. (a) Subject to subsection (b), coverage shall be suspended effective the first day of the new benefit period for HIP members who fail to meet required community engagement hours for eight (8) out of the twelve (12) months in the previous Gateway to Work eligibility period.

(b) A member shall not be suspended in January of the following benefit period if the member:

(1) has an exemption in place during the month of December; or

(2) appeals the suspension prior to its effective date pursuant to section 10 of this rule, and the appeal is still pending.

(c) A member shall remain in a suspended state for one (1) benefit period or until one (1) of the following occurs:

(1) The member completes one (1) month of required community engagement hours with a qualifying activity.

(2) The member becomes eligible for Medicaid under a group not subject to the community engagement requirements of this rule.

(3) The member obtains an exempt status.

(d) A member may remain enrolled in HIP if suspended for noncompliance with Gateway to Work. However, the member shall not receive any benefits while suspended.

(e) A member who is suspended shall have the member's annual renewal date changed to December 31.

(f) If a member does not come into compliance during the member's suspension period, the member shall be disenrolled from the plan at the member's annual eligibility determination. The member may reapply to regain HIP coverage. (*Office of the Secretary of Family and Social Services; 405 IAC 10-12-7; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

#### **405 IAC 10-12-8 Reactivation following noncompliance**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 8. (a) Reactivation shall occur based on the following specific member eligibility criteria:

(1) If a member becomes eligible under another eligibility category in Medicaid, the member's coverage shall be reactivated based on established policy for that group.

(2) If a member meets an exemption, the member's coverage shall reactivate in the concurrent month of notification of exemption.

(3) If a member becomes pregnant, the member's coverage may be retroactive to a prior month pursuant to 405 IAC 10-3-4.

(4) If a member completes one (1) month of required community engagement hours, the member's coverage shall reactivate in the month following notification to the office that the member has come into compliance.

(b) When a member's benefits are reactivated following noncompliance, the member's annual renewal date shall be set at twelve (12) months after reactivation. (*Office of the Secretary of Family and Social Services; 405 IAC 10-12-8; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

#### **405 IAC 10-12-9 Good cause exemptions**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 9. (a) A member may present evidence of a good cause exemption at any point to either the office or the member's MCO.

(b) A good cause exemption may apply to a member's eligibility in section 2 of this rule, a member's exemption in section 3 of this rule, or a member's qualifying activity in section 4 of this rule.

(c) A good cause exemption may be first presented during the member's appeal process as set forth in section 10 of this rule.

(d) Recognized good cause exemptions include the following verified circumstances:

(1) The member has a disability as defined by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, or Section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability.

(2) The member is a recent victim, within the previous six (6) months, of domestic violence.

(3) Severe inclement weather or other natural disaster.

(4) Other circumstances that would impose a severe burden on participating in community engagement activities.

(*Office of the Secretary of Family and Social Services; 405 IAC 10-12-9; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

**405 IAC 10-12-10 Appeals**

Authority: IC 12-15-44.5-9

Affected: IC 12-15-44.5

Sec. 10. Appeals for the Gateway to Work community engagement program shall follow the appeals process as set forth in 405 IAC 10-5. (*Office of the Secretary of Family and Social Services; 405 IAC 10-12-10; filed Mar 18, 2019, 2:27 p.m.: 20190417-IR-405180371FRA*)

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