TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #18-371

DIGEST

Amends 405 IAC 10-1-4 to update references. Amends 405 IAC 10-3-1 to clarify enrollment procedures. Amends 405 IAC 10-4-1 to remove conflicting language. Amends 405 IAC 10-4-3 and 405 IAC 10-6-1 to align the medically frail standards and processes with the State Plan. Amends 405 IAC 10-4-9 and 405 IAC 10-8-2 to clarify enrollment procedures. Amends 405 IAC 10-4-11 to change how presumptive eligibility is treated. Amends 405 IAC 10-10-4 to clarify POWER account contributions. Amends 405 IAC 10-10-7 to change how member debt is calculated. Amends 405 IAC 10-10-12 to remove plan withdrawal language. Adds 405 IAC 10-12 to create the Gateway to Work community engagement program. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 10-1-4; 405 IAC 10-3-1; 405 IAC 10-4-1; 405 IAC 10-4-3; 405 IAC 10-4-9; 405 IAC 10-4-11; 405 IAC 10-6-1; 405 IAC 10-8-2; 405 IAC 10-10-4; 405 IAC 10-10-7; 405 IAC 10-10-12; 405 IAC 10-12

SECTION 1. 405 IAC 10-1-4 IS AMENDED TO READ AS FOLLOWS:

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, ~~2014,~~ **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)

SECTION 2. 405 IAC 10-3-1 IS AMENDED TO READ AS FOLLOWS:

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) In order to be screened for medically frail eligibility under 405 IAC 10-6-1, an applicant shall answer the health screening questions on the application form regarding the applicant's health status. If the applicant does not complete the health screening questions on the application, the division shall review the application for eligibility in the plan but shall not review it initially for medically frail eligibility.~~

~~(d)~~ **(c)** The following individuals may sign an application:
(1) The applicant.
(2) The applicant's next of kin.

(3) The applicant's authorized representative.

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

~~(f)~~ **(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.

~~(g)~~ **(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.

~~(h)~~ **(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.

~~(i)~~ **(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.

~~(j)~~ **(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)

SECTION 3. 405 IAC 10-4-1 IS AMENDED TO READ AS FOLLOWS:

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) ~~A member who becomes~~ **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) ~~The office shall refer all members or conditionally eligible individuals who are unemployed or work less than twenty (20) hours per week to a workforce training program. Individuals who are full-time students enrolled in a postsecondary education institution or technical school shall be exempt from this referral.~~ **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)

SECTION 4. 405 IAC 10-4-3 IS AMENDED TO READ AS FOLLOWS:

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 ~~conditionally~~ 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)

SECTION 5. 405 IAC 10-4-9 IS AMENDED TO READ AS FOLLOWS:

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 ~~subject to the nonpayment penalties set forth in 405 IAC 10-10-12~~, **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)

SECTION 6. 405 IAC 10-4-11 IS AMENDED TO READ AS FOLLOWS:

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 ~~be enrolled with a managed care organization and be provided benefits equivalent~~ **receive coverage under the fee-for-service model comparable** to HIP Basic, including applicable copayments. ~~as set forth in 405 IAC 10-10-3(c).~~

(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 ~~stay~~ **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)

SECTION 7. 405 IAC 10-6-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 10-6-1 Medically frail screening

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

Sec. 1. (a) ~~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 ~~application questionnaire~~ **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) The division shall forward an applicant's responses to the health screening questions obtained in accordance with 405 IAC 10-3-1(c) to a managed care organization for verification of medically frail status if the division determines:~~
~~(1) the applicant is eligible under the plan; and~~
~~(2) the applicant's responses indicate the possible existence of a medically frail condition.~~

~~(c)~~ **(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.

~~(d)~~ **(c)** A member identified as potentially medically frail in accordance with subsection (b) ~~shall receive HIP State Plan benefits during the verification period and~~ shall be enrolled in either HIP ~~State Plan~~ Plus or HIP ~~State Plan~~ Basic in accordance with ~~405 IAC 10-4-3~~. **405 IAC 10-3-2 or 405 IAC 10-3-3, as applicable, until the medically frail verification is completed.**

~~(e)~~ **(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 responses to the application questionnaire.~~
~~(2)~~ **(1)** The member's initial health screen.
~~(3)~~ **(2)** The member's health assessment.
~~(4)~~ **(3)** The member's medical records.
~~(5)~~ **(4)** The member's present or historical medical claims data.
~~(6)~~ **(5)** Any other information relevant to the member's health condition.

~~(f)~~ **(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 ~~be transferred to either:~~
~~(1) HIP Plus if the member was enrolled in HIP State Plan Plus during the verification period; or~~
~~(2) HIP Basic if the member was enrolled in HIP State Plan Basic during the verification period.~~
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.

~~(g)~~ **(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.

~~(h)~~ **(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 responses to the application questionnaire.~~
~~(2)~~ **(1)** The member's medical records.
~~(3)~~ **(2)** Communication with or other outreach to the managed care organization, the member, or the member's provider or providers.
~~(4)~~ **(3)** The member's past claims history, if available and accessible.

~~(5)~~ **(4)** Other processes, as determined by the office.

~~(i)~~ **(h)** If, under subsection ~~(h),~~ **(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)

SECTION 8. 405 IAC 10-8-2 IS AMENDED TO READ AS FOLLOWS:

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)

SECTION 9. 405 IAC 10-10-4 IS AMENDED TO READ AS FOLLOWS:

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)

SECTION 10. 405 IAC 10-10-7 IS AMENDED TO READ AS FOLLOWS:

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 following amounts:~~
~~(1) For a member with household income above one hundred percent (100%) of the FPL, an amount that does not exceed ten percent (10%) of the cost of services received.~~
~~(2) For a member with household income at or below one hundred percent (100%) of the FPL, an amount that~~

~~does not exceed~~ the sum of the unpaid monthly contributions ~~as determined in accordance with section 3(a) of this rule~~ that accrued during the months in which the member received HIP Plus coverage.

~~(d) In some cases, the two thousand five hundred dollar ($2,500) deductible will be met before a HIP Plus or HIP State Plan Plus member has made all of the member's required contributions. The fact that a member has not yet made all required POWER account contributions does not relieve the managed care organization of the responsibility to pay providers for covered services rendered. A managed care organization may deduct amounts a member owes from future POWER account contributions.~~

~~(e)~~ **(d)** If a member ~~ends participation in the plan before the conclusion of the member's twelve (12) month benefit period and the individual~~ 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)

SECTION 11. 405 IAC 10-10-12 IS AMENDED TO READ AS FOLLOWS:

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
~~(1)~~ shall be subject to subsection (b). ~~and~~
~~(2) except as otherwise provided in section 13 of this rule, may not reapply to the plan for a period of six (6) months from the date of withdrawal from the plan.~~

(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)

SECTION 12. 405 IAC 10-12 IS ADDED TO READ AS FOLLOWS:

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 to include:

(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)

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)

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 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)

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)

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)

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)

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)

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)

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)

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)

Notice of Public Hearing

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