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### **3500.00.00 ELIGIBILITY STANDARDS**

Overview of the Healthy Indiana Plan (Section 3505)

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### **3505.00.00 OVERVIEW OF THE HEALTHY INDIANA PLAN (HIP)**

The Healthy Indiana Plan (HIP) is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective January 1, 2008, and it was authorized to continue through January 31, 2014.

HIP 2.0 is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective February 1, 2015, and is authorized to run for 3 years and is subject to renewal. Effective February 1, 2018 the HIP waiver was extended another 3 years with improvements and updates that will be explained in the following sections. The authority for this program is derived from the Special Terms and Conditions approved by the Centers for Medicare and Medicaid Services (CMS), along with regulations at 405 Indiana Administrative Code Article 9.

HIP provides a comprehensive benefit plan for eligible uninsured adults. It is a high-deductible health plan that utilizes an account similar to a health savings account called the POWER account - Personal Wellness and Responsibility Account - which provides incentives for members to obtain recommended preventive care.

The following sections of this chapter explain the eligibility requirements and methodologies used by the Division of Family Resources to determine HIP eligibility and the policies regarding POWER account contributions. Additional information about HIP and how to apply can be found on the website [www.in.gov/fssa/HIP/](http://www.in.gov/fssa/HIP/).

### **3510.00.00 MCE SELECTION PERIOD FOR HIP MEMBERS (MCE LOCK-IN)**

Once fully open after an application, all HIP members are assigned and/or select an MCE for a calendar year and are not able to switch until the end of that calendar year. This is also referred to as a “lock-in” to a specific MCE. Every year between the dates of November 1<sup>st</sup> and December 15<sup>th</sup>, enrolled HIP members are eligible to pick a new MCE for the following year.

All changes will be effective January 1st and stay in effect for the next calendar year, even if the member has a gap in coverage during the year. If a new application is submitted and a different MCE is picked and/or paid, the member will automatically be reassigned to their calendar year MCE and payment will be refunded and HIP will not open until the correct MCE is paid. The member is not eligible to be opened for a past month paid to a wrong MCE, and a member (or ICP or AR) who mistakenly paid the wrong MCE cannot call the enrollment broker to move payment or change MCE.

The only time a HIP applicant can change an MCE with the enrollment broker is:

1. When they are completely new to the system, have not already paid an MCE, and have never been fully open in HIP during the current calendar year. These pending/conditional members have 55 days to make a change but their 60 days to pay does not restart.
2. During the annual MCE Selection period for HIP which occurs every year from November 1 to December 15. The new assignment will not be effective until January 1 of the next year.
3. At any time of the year, when a member requests a “Just Cause” review of their MCE selection because they are completely unable to access the needed provider type (preference for a specific provider is not a “Just Cause”) within their currently assigned MCE. This request should first be made to their current MCE. If the current MCE cannot assist or member is not satisfied with decision, member should contact Maximus. Maximus will coordinate with MCE, and if they believe it to be a “Just Cause” will then forward it to OMPP for a final decision.

## 3515.00.00 GENERAL ELIGIBILITY REQUIREMENTS: AGE AND HEALTH INSURANCE

To qualify for HIP, an individual must<sup>1</sup>

- (1) Be at least age 19 but not yet age 65.
- (2) Not be enrolled in or eligible for enrollment in the federal Medicare program.
- (3) Not be eligible and not enrolled in another Medicaid assistance category.
- (4) Have countable household income equal to or less than 133% (plus the 5% disregard) of the federal poverty level (FPL).

An applicant who may be eligible both for HIP and another Medicaid category will first have their eligibility assessed for the other category of Medicaid. An individual may be enrolled in HIP only if they are ineligible for the other aid category.

However, a person claiming to be disabled, who is not in an institution or approved for HCBS waiver services, may be approved for HIP pending a determination for Medicaid disability, if they request HIP during this time. This can be asked during the interview. If later found eligible for another Medicaid category, HIP must be discontinued to allow for the person's eligibility to be transferred to the other category the following month.

If a disabled person fails to complete the initial interview within 30 days, they should be processed for HIP, rather than automatically denied.

## 3515.05.00 MEDICALLY FRAIL

Medically frail means an individual who is determined to have any one of the following:

- 1) A disabling mental disorder
- 2) A chronic substance abuse disorder
- 3) A serious and complex medical condition
- 4) A physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.<sup>2</sup>
- 5) A disability determination from SSA but is not eligible for MA A, MA B or MA D due to income or resources

HIP health plans will confirm the member's frailty within 60 days of the member's authorization to receive HIP benefits. Effective January 1, 2016, HIP health plans will confirm the member's frailty within 30 days of the member's authorization to receive HIP

benefits.

### **3515.10.00 OTHER MEDICAID AND MEDICARE COVERAGE**

An eligible Medicaid recipient enrolled in another category cannot choose to voluntarily withdraw from another Medicaid category for the purpose of enrolling in HIP. However, a HIP recipient that becomes eligible for another Medicaid category (excluding pregnancy, refer to 3515.10.00) must have HIP discontinued so that the recipient is eligible in the other Medicaid category. Additionally, DFR must evaluate whether the person is entitled to any retroactive coverage under the other Medicaid category, since HIP benefit begin dates are determined upon financial contribution to a POWER account.

In situations of dual processing, it is important to inform the applicant/AR that HIP coverage will not be removed retroactively. For applicants that are in a nursing facility or are in the process of being approved for a waiver, it is best practice to pursue the MA D process as opposed to process for HIP coverage.

Medicare beneficiaries are categorically ineligible for HIP. If a HIP member becomes eligible for Medicare, including eligibility for retroactive Medicare benefits that overlap HIP eligibility, HIP eligibility shall cease to allow for advanced notice of adverse action (see section IHCPPM 2232.00.00). However, the health plan is prevented from recovering any payment for services, where there was overlapping Medicare and HIP coverage, when the member's overlapping Medicare coverage is limited to Part A only.

### **3515.15.00 MINIMUM ESSENTIAL COVERAGE OF DEPENDENTS**

This section is not applicable to low-income parent/caretakers and TMA.

HIP applicants/recipients, who are either a parent or other caretaker relative of a dependent under 19 are required to have their dependents covered under Medicaid, CHIP, or other minimum essential coverage. This is considered verified through attestation by the applicant/recipient parent/caretaker. Such dependents that have applied for or are receiving Medicaid or CHIP meet this requirement.

### **3515.20.00 OTHER GENERAL HIP ELIGIBILITY REQUIREMENTS**

The Medicaid requirements outlined in Chapter 2400 regarding the following are applicable to the HIP program:

Requirement to provide a Social Security Number;

State residency;

Assignment of medical rights and medical support cooperation (does not apply to pregnant women and HIP TMA eligible recipients);

Citizenship status, including the documentation requirements;

Emergency-services-only health coverage is available for eligible immigrants who categorically qualify for HIP. Refer to section 2402.20.50.05. Immigrants who categorically qualify for HIP with limited emergency-services-only will be placed under the MARB category, and the effective date of coverage will be the month benefits are authorized by DFR. Immigrants eligible under MARB with limited emergency-only coverage will not be placed into managed care with a HIP health plan. Immigrants who categorically qualify for HIP with limited emergency-services-only are not required to make any financial contribution to a POWER account. The month of authorization is viewed as the month the payment would have been made had the person been subject to POWER account contributions. DFR must not delay authorization of benefits when an immigrant has met and verified all financial and non-financial requirements to be determined eligible for MARB with limited emergency-services-only. There is no retroactive coverage for any individual receiving emergency services under HIP.

#### **3520.00.00 CATEGORICAL ELIGIBILITY FOR HIP**

The following subsections explain the categorical requirements for each HIP category.

#### **3520.05.00 AMERICAN INDIAN/ALASKA NATIVE**

This category is identified in the Eligibility System as MANA.

An American Indian or Alaska Native eligible for MARP or MASP will also have the option to Opt-out to MANA. Coverage under MARP or MASP is a managed-care health plan, but MANA provides fee-for-service coverage that is equivalent to Package A, but specific to the HIP program. Once an eligible American Indian/Alaskan Native is authorized under HIP Plus or HIP State Plan Plus they will have the option to Opt-out into MANA. An American Indian/Alaskan Native who meets the eligibility requirements for HIP eligibility shall not be subject to any cost-sharing requirements under any HIP category.[2] In order to be eligible for no cost-sharing the individual must be a “verified” American Indian/Alaska Native. Please refer to section 2402.15.10 for a list of acceptable documents.

#### **3520.10.00 HIP Plus-State Plan (MED3)**

This category is identified in the Eligibility System as MASP.

To be eligible for MASP an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age and have income less than 133% of the FPL, unless the person qualifies for TMA. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. Participants included are:

1. Low-income parents and caretaker relatives

2. TMA eligible individuals
3. Individuals who qualify as medically frail

HIP Plus State Plan requires the member to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members who are American Indian/Alaska Natives are not required to make financial contribution to a POWER Account. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of HIP PLUS State Plan coverage begins the first day of the month in which the individual makes an initial POWER account contribution.<sup>3</sup>

### **3520.15.00 HIP Basic-State Plan (MED 3)**

This category is identified in the Eligibility System as MASB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with income at or below 100% FPL. The individual will be enrolled in HIP Basic State Plan if they fail to make financial contributions towards a POWER account and meet one of the following groups:

1. Low-income parents and caretaker relatives
2. individuals that qualify as medically frail

An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. The HIP Basic State Plan has no provision for retroactive coverage. The effective date of HIP Basic State Plan coverage begins in the month in which the 60 days to make a power account contribution has expired.<sup>4</sup>

### **3520.20.00 HIP Plus-State Plan with Co-pays (MED 3) This**

category is identified in the Eligibility System as MAPC.

To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133%FLP, and fail to make ongoing financial contributions to a POWER account. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. There will be no lockout periods for MAPC AGs. The effective date of MAPC coverage begins in the month in which the 60 days to make a power account contribution has expired.

### **3520.25.00 HIP Regular Plus (MED 3)**

This category is identified in the Eligibility System as MARP.



To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.<sup>5</sup> The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of HIP PLUS coverage begins the first day of the month in which the individual makes an initial POWER account contribution.<sup>6</sup>

### **3520.30.00 HIP Regular Basic (MED 3)**

This category is identified in the Eligibility System as MARB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with incomes at or below 100% FPL will be enrolled in HIP Basic after failing to make financial contributions to a POWER account within 60 days of authorization. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category.<sup>7</sup> The HIP Basic benefit package applies co-payments to services. The “HIP Basic” plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan has no provision for retroactive coverage.

The effective date of HIP Basic coverage begins when the client does not make a POWER account contribution within the sixty (60) day payment period.<sup>8</sup>

### **3525.00.00 HIP EFFECTIVE DATE FOR ELIGIBILITY**

For individuals meeting all financial and non-financial requirements to be considered HIP eligible, the effective date of eligibility is determined upon whether the person makes a timely financial contribution to his POWER account.

For HIP Regular Plus or HIP State Plus, coverage begins the first day of the month in which the individual makes an initial POWER account contribution. There is no retroactive coverage under HIP PLUS categories (MARP and MASP).<sup>9</sup>

The effective date of HIP Regular Basic or HIP State Basic coverage begins in the month the member, whose income is at or below 100% FPL, fails to make a required contribution to his POWER account within his sixty (60) day payment period. There is no retroactive coverage under HIP Basic categories (MARB and MASB).<sup>10</sup>

### **3525.05.00 FAST TRACK ELIGIBILITY (FTE)**

*See 1825.15.00 regarding the date of the application.*

Upon receipt of an application for health coverage but prior to a HIP eligibility

determination, a HIP health plan will send the pending HIP applicant a \$10 fast track prepayment invoice that is due within sixty (60) calendar days.<sup>11</sup> This initial fast track invoice begins the individual's 60-day deadline to make a required contribution to a POWER account.

If the applicant makes the \$10 fast track payment and is subsequently determined eligible for HIP, the member will have HIP Plus coverage beginning the month the fast track payment was made, and the \$10 will be applied toward any remaining amount owed by the member toward their POWER account.

#### **3525.05.05 FAST TRACK ELIGIBILITY (FTE) WITH CREDIT CARD**

When an application for health coverage is completed on-line, applicants who meet the following conditions will have the option to make the \$10 fast track payment on-line with a credit card:

- a) A health plan was chosen on the application
- b) The applicant is at least 19 years old and is less than 65
- c) The applicant is not eligible for Medicare
- d) The applicant is not identified as former foster youth
- e) The applicant is not incarcerated
- f) The applicant does not have a HIP lock-out penalty period in force (refer to 3555.15.00)

If an applicant makes a \$10 fast track on-line payment with a credit card and is subsequently determined eligible for HIP, coverage begins the month the payment was made, which would be the month of application, and the \$10 will be applied toward any remaining amount owed by the member toward their POWER account. A maximum of 5 individuals on a single application can be eligible for FTE. The Pre-POWER Account Contribution (PPAC) payment of \$10 is required for each individual who is eligible for FTE.

If an applicant who makes a \$10 fast track on-line payment with a credit card is subsequently determined ineligible for HIP, the member is entitled to a refund from the HIP health plan that received the \$10 payment. Please, note it may take up to 60 days for the health plan to issue any refund.

### **3525.05.10 FAST TRACK ELIGIBILITY AND PRESUMPTIVE ELIGIBILITY**

As of 2/1/2018 Presumptive Eligibility (PE) members are no longer eligible to make fast track eligibility (FTE) payments during their PE period. The members going from PE to HIP will go Basic Potential Plus as of the month after authorization of their HIP. The intent of this is to eliminate any possibility of overlap between PE and HIP.

### **3530.00.00 FINANCIAL ELIGIBILITY REQUIREMENTS**

The income standards for the HIP program are in Section 3010.30.10.

#### **3530.05.00 INCOME ELIGIBILITY REQUIREMENTS**

To be eligible for the HIP program, an individual's countable household income may not exceed 133 percent of the Federal Poverty Level for the appropriate household size, effective February 1, 2015. Household size and income is determined using Modified Adjusted Gross Income (MAGI) methodology. Refer to Chapter 2800 and Chapter 3200 of the IHCPPM for policy surrounding income and assistance group formation.

#### **3530.05.05 ELIGIBILITY REQUIREMENTS FOR HIP LOW-INCOME PARENT-CARETAKERS**

This section applies to MASP and MASB.

To be considered HIP eligible as a low-income parent/caretaker, the HIP adult must be the parent or caretaker relative (refer to sections 2420.05.05 and 2420.10.05) of a dependent less than 18 years of age and have household income that is equal to or less than the standard set in IHCPPM 3010.30.10.05.

HIP low-income parent/caretakers may be eligible to receive coverage for medical services that were received in the ninety (90) calendar days prior to enrollment in HIP. This will be limited to new applicants, defined as those not covered through HIP or Medicaid within the past two years who:

- i. Did not gain coverage through presumptive eligibility;
- ii. Received medical care within the 90 days prior to the effective date of eligibility;  
and
- iii. Submitted for reimbursement within 90 days of the individual's receipt of the bill for such care.

### **3530.05.10 ELIGIBILITY REQUIREMENTS FOR HIP TMA**

To be considered HIP eligible for transitional medical assistance (TMA), the HIP adult must have been financially eligible as a low-income parent/caretaker (refer to Section 3530.05.05) in three of the six months immediately preceding ineligibility as a low-income parent/caretaker due to new or increased earnings. HIP TMA coverage can last up to 12 months. For TMA eligibility periods and requirements, refer to Chapter 3800.

### **3530.05.15 ELIGIBILITY REQUIREMENT FOR POTENTIAL PLUS**

For members' eligible under either MASB or MARB who experience a verified change in which the new household income is above 100% FPL, they will be required to switch to either MASP or MARP and will have 60 days to make a required financial contribution to a POWER account.

Members who are required to be switched to MARP and fail to make a timely payment will be discontinued and may be subject to a 6-month penalty period.<sup>13</sup> Refer to Section 3555.15.00.

### **3530.05.20 ELIGIBILITY REQUIREMENTS FOR HIP LOW-INCOME 19/20 YEAR OLD**

This designation is no longer applicable.

### **3530.10.00 RESOURCE ELIGIBILITY REQUIREMENTS**

There is no resource limit for HIP eligibility.

### **3540.00.00 POWER ACCOUNT CONTRIBUTION ELIGIBILITY REQUIREMENTS**

HIP Plus members must make monthly contributions to their POWER account to move from conditional to fully eligible status after initial determination. Members must continue to make monthly contributions in a timely manner to maintain program enrollment. The following sections discuss the specifics of POWER account contribution requirements.

### **3540.05.00 POWER ACCOUNT CONTRIBUTION AMOUNT DETERMINATION**

All HIP members are initially required to help fund the \$2,500 deductible by contributing to the POWER account, established by the member's health plan and jointly funded by the member and the State, unless the person is an American Indian/Alaska Native.<sup>14</sup> The amount of the required member contribution is determined based on the person's countable household income using MAGI methodology. The difference between the amount of the deductible and the member's annual contribution is paid by the State. If an individual (at or below 100% FPL) does not make the fast track prepayment nor the initial POWER account contribution for HIP Plus, the client will begin HIP Basic or HIP State Plan Basic benefits, as applicable, on the first day of the month in which the sixty

(60) day payment period expires.<sup>15</sup>

A member's monthly POWER Account contribution (PAC) amounts will be tiered, based on the Federal Poverty level (FPL) percentage ranges. The PAC will change only when a member's income change moves them to a different FPL percentage range. Table 1 defines the required PAC amounts associated with each tier of FPL percentages.<sup>16</sup>

HIP will implement a tobacco use surcharge on PAC amounts for all tobacco users effective 1/1/2019. The MCE and/or Maximus will be in charge of assessing and maintaining the member's tobacco use. None of the tobacco use information will be kept in the State Eligibility System, the DFR will merely pass the information on to the MCEs when the member indicates tobacco use or non-use on new applications. The tobacco use surcharge will be equal to a 50% increase in a member's required PAC. PAC amounts for spouses who are tobacco users will also be assessed a tobacco surcharge. See table 1 for the surcharge amounts associated with each PAC tier.

Table 1 – Monthly PAC amounts based on FPL percentages and tobacco surcharges.

FPL%	Individual PAC Amount	Individual PAC with Tobacco Surcharge
≤ 22%	\$1.00	\$1.50
23-50%	\$5.00	\$7.50
51-75%	\$10.00	\$15.00
76-100%	\$15.00	\$22.50
101-138%	\$20.00	\$30.00

An employer or health care provider or provider-related entity may contribute up to one hundred percent (100%) of a member's annual POWER account obligation.<sup>17</sup> A health care provider or provider-related entity may make a contribution to a member's POWER account 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 or Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care for any purpose.<sup>18</sup>

Except for the \$1 minimum contribution to a POWER account, a member's out-of-pocket cost sharing amount shall not exceed five percent (5%) of the member's annual household income.<sup>19</sup> The 5% maximum contribution value will be calculated by ICES on a quarterly frequency. In the case where two 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.<sup>20</sup> A member's POWER account under either MASP or MARP may change in accordance with change processing policy when changes are verified.

### **3545.00.00 CHANGE PROCESSING**

HIP members are required to timely notify DFR of any changes. (Refer to sections 2220.05.00 and 2220.10.00). Members receive notice of this requirement through the Rights and Responsibilities portion of their application for health coverage.

An individual who is in the HIP program, who become pregnant during their eligibility period will be transitioned to the MAMA category, have their POWER Account suspended and stop all cost sharing, refer to Section 2426.00.00. For pregnant HIP members during redetermination, refer to 3550.10.00.

### **3545.05.00 POWER ACCOUNT CONTRIBUTIONS IN MULTIPLE-MEMBER HOUSEHOLDS**

For households in which two members are enrolled in HIP, each enrollee will have his/her own POWER account. However, for a married couple, the total of both enrollees' POWER account contributions may not exceed two percent (2%) of the family's household income as specified in Section 3550.05.00 of this Chapter. This does not apply to unmarried couples.

### **3545.10.00 POWER ACCOUNT CONTRIBUTIONS AND INITIAL ELIGIBILITY**

After an individual meets all eligibility requirements for the HIP program, they are considered "conditionally eligible" until the first POWER account contribution is made to the health plan, unless an FTE payment had already been made (refer to 3525.05.05). If the individual fails to make this initial payment within a 60 day timeframe, they are no longer conditionally eligible for HIP PLUS. If the individual income is at or below 100% FPL they will be enrolled in HIP Basic after failing to make the first POWER account contribution. If the individual's income is above 100% FPL, they are denied HIP eligibility for failure to pay Pac payment.

The effective date of HIP coverage is the first day of the month in which the health plan receives the first contribution and establishes the member's POWER account.<sup>21</sup>

## **3545.15.00 POWER ACCOUNT CONTRIBUTIONS AND CONTINUED ELIGIBILITY**

Members must continue to make POWER account contributions in a timely manner to remain enrolled in HIP Plus. If an enrollee fails to make a required contribution within 60 days after the due date, they will be terminated from HIP Plus. If the individual income is at or below 100% FPL they will be enrolled in HIP Basic.

If an individual is dis-enrolled for failing to make a required contribution, they will be ineligible for six (6) months.

## **3550.00.00 HIP REDETERMINATIONS**

Sections 2205.00.00, 2205.05.00, 2205.10.00, and 2205.15.00 are applicable to HIP members.

HIP Plus members (MASP or MARP) are required to continue making contributions to their POWER account during their redetermination, and if redetermined eligible for HIP will be re-enrolled as HIP Plus members (MASP or MARP).

HIP TMA recipients are exempt from being required to complete an annual redetermination. Refer to Chapter 3800.

## **3550.05.00 BASIC POTENTIAL PLUS AT REDETERMINATION**

Members that are eligible under either MASB or MARB during their annual redetermination and are re-enrolled into HIP with household income less than 100% FPL will have the potential to switch to either MASP or MARP if they make a financial contribution to a POWER account.<sup>22</sup>

## **3550.10.00 PREGNANT HIP MEMBERS AT REDETERMINATION**

Pregnant hip members will not change categories during redetermination, regardless of income changes. Due to the pregnancy, the member is not required to complete the annual redetermination.

## **3555.00.00 LOSS OF ELIGIBILITY**

When an eligible HIP recipient loses eligibility for HIP, the member may or may not be subject to a 6-month penalty period depending on the reason for termination. If a member has eligibility terminated for failing to make a required contribution if over 100% FPL, the member will be subject to a 6-month penalty period.<sup>23</sup> During this time, the individual will not be considered eligible for HIP. Members whose benefits are terminated for reasons listed in section 3555.15.05 will not be subject to any 6-month penalty and refer to 3555.15.05 for exemption process.

The Exemption Process refers to 6-month penalty request only. Potentially being eligible for a Lockout Exemption does not protect against denial/closure of HIP for non-payment. The Lockout Exemption process and determination would only apply after the member submits a

new application and is again forming a HIP category with the Lockout forming.

For more information, see 3555.05.00 .

### **3555.05.00 LOSS OF ELIGIBILITY**

In addition to the failure to make required POWER account contributions in a timely manner and voluntarily withdrawing,<sup>24</sup> there are several other reasons a member may lose HIP eligibility within the 12 month coverage period:

- (1) The individual is no longer an Indiana resident;
- (2) The member is enrolled or is otherwise eligible for enrollment in the federal Medicare program.
- (3) The individual becomes eligible for another Medicaid category, except for pregnant women (refer to section 2220.05.00);
- (4) The member has household income above one hundred percent (100%) of the FPL and is discontinued for failing to make the required POWER account contributions.
- (5) The member or the member's duly authorized representative requests in writing that coverage be terminated (voluntary withdrawal).
- (6) The State discovers that the individual has falsified information on the application. In this case, the individual may be held financially responsible for the amount of payments made on his behalf by the State, including POWER account contributions.
- (7) The member turns 65 years old.
- (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.
- (9) The member fails to verify citizenship or immigration status within 95 days of being determined eligible for HIP or conditionally eligible for HIP. (Refer to Sections 2402.15.10 and 2402.20.50).
- (10) The member dies.
- (11) The member does not complete a redetermination timely. Refer to Section 3555.10.00.

NOTE: If continued eligibility for HIP under these requirements cannot be determined due to failure of the member to respond to a request for verification of new or changed



information, HIP will be closed according to normal MAGI Medicaid guidelines for advance notice and appeal rights.<sup>25</sup>

### **3555.10.00 LOSS OF ELIGIBILITY AT REDETERMINATION**

In order to continue HIP participation, members must complete a renewal process every 12 months. If the agency is unable to redetermine the eligibility of the individual with already available information the member is sent an Eligibility Review Form. Members who do not follow the renewal process and do not return all documentation requested by the agency within 45 days (before the end of the individual's 12 month coverage period) will be dis-enrolled.

Closure due to eligibility failure in the month of redetermination (ex. over the income limit for month of redetermination) is not eligible for rescission even if circumstances change; a new application would be required. However, if the closure happened because correct/complete documentation was not provided, the member may qualify to have the closure rescinded.

To qualify for rescission of the closure, the member must comply with returning all needed documentation (including signature on the redetermination form, if applicable) and if the paperwork is returned late, but before the end of the redet month, the member's HIP may be restored with no gap in coverage and no lockout will apply. If the member complies after the redet month but before the 90th day after the eligibility period ends, a new application is not required, but the member can only be authorized conditionally. Fully open HIP will not resume until the member either pays the first POWER Account payment and opens in Plus coverage, or waits 60 days and defaults to Basic coverage. At the end of this 90 day period, a new application would be required in order for benefits to be reopened.

### **3555.15.00 SIX MONTH PENALTY PERIOD**

When a member is discontinued from HIP eligibility for failing to make a required financial contribution toward a POWER account, the member is subject to a 6-month penalty period, in which the member is ineligible for HIP.<sup>26</sup> The penalty period will begin the first day of the month following the month the individual was discontinued and will last for 6 months.

When a member is closed for failure to complete a redetermination, (for example: failure to sign or complete the Redetermination Mailer or failure to verify requested verifications) the member has 90 days from the effective date of closure to rectify the issue and get benefits reopened.

### 3555.15.05 EXCEPTIONS TO THE SIX-MONTH PENALTY PERIOD

When a member is subject to a penalty period (refer to Section 3555.15.00), the person may have that penalty period lifted under the following circumstances.

The following exceptions are applicable<sup>26</sup>:

- a) The member is confirmed to be Frail;
- b) The member obtained and subsequently lost private insurance coverage;
- c) The member had a loss of income after disqualification due to increased income;
- d) The member took up residence in another state and later returned to Indiana;
- e) The member was a victim of domestic violence;
- f) The member was residing in a county subject to a disaster declaration made at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan;
- g) Other allowable reasons approved by Medicaid Policy

Note: **Members must submit a new application.** Being exempt from the Lockout does not make a person exempt from closing due to non-payment of their HIP Power Account Contribution. Upon reapplication, a 2032 Request for Verification and a Lockout Exemption Form will be mailed by DFR. All Exemption Request Forms received by DFR with the exemption reason of “other” must be reviewed and approved by OMPP.

Additionally, if member indicates they are Medically Frail, OMPP will forward request to MCE for final approval. If MCE determines Member is not Medically Frail, OMPP will notify DFR. Member can file an Appeal with their MCE for these denials.

The following members who reapply after a closure are exempt from lockout of coverage for any reason. If such a member is closed and reapplies, the system should not show a lockout and no lockout exemption form is required from them to be reselected for coverage and processed as a normal application.

- 1) Have a current Medically Frail confirmation
- 2) Pregnant or in the postpartum period
- 3) Low-Income Parent/Caretakers
- 4) Verified Native Americans
- 5) Ryan White program members

### 3560.00.00 Gateway to Work Program

Gateway to Work is a part of the Healthy Indiana Plan that connects HIP members with job training and search assistance, education, community engagement or work opportunities. Starting in 2019, some HIP members will be required to work, go to school, volunteer or participate in other qualifying Gateway to Work activities.

Any HIP member can participate in the Gateway to Work program but some are required to participate. Based upon the information the member has in their file, one of the following status has been assigned to every HIP member:

**Exempt** – Exempt members are not required to participate for as long as they remain exempt.

**Reporting met** – These members already work at least 20 hours per week. As long as their employment information in ICES (screen AEINC) reflects at least 20 hours a week or 80 hours

a month, they are not required to do anything new for Gateway to Work.

**Reporting** – These members are required to participate in Gateway to Work by working, attending classes or volunteering.

Most exemptions and many qualifying activities can be determined using information already in ICES, as long as items are entered and coded correctly (for example, correct hours are listed on AEINC or correct parent/caretaker status is listed on AEIHH). If member has not reported something or it has not been updated in ICES, it is possible the member will have to continue separate reporting of exemption or qualifying hours through the methods noted below under “Required Reporting Hours.” Best practice is for members to ensure their data in ICES is correct and current so they can avoid such additional efforts, but **reasonable compatibility rules (see CITE NEEDED) should be applied and members should not be closed if their HIP eligibility is not in question, only their GTW status.** For example, a member has a job and income in ICES, but calls to report the number of hours they work at that job weekly—if not questionable, the number of hours can be updated on screen AEINC without affecting the MAGI income screen AEMWS.

Not all of the exemptions and reported hours can be reflected in ICES—some will be entered into the online portal but will not show in ICES itself. Members can find the most up to date reflection of the GTW status by checking in the portal or with their MCE. If the member feels that their current status is not accurate but their information in ICES is correct/complete, please have them contact their MCE to discuss.

- Anthem – 1-866-408-6131
- Caresource – 1-844-607-2829
- MHS - 1-877-647-4848
- MDWise - 1-800-356-1204

Many resources are available to help participate in the Gateway to Work program.

- Website: [www.HIP.in.gov](http://www.HIP.in.gov), click on “Gateway to Work”
  - General information about Gateway to Work with helpful links to assessments, reporting and partners.
  - How and when to contact their health plan and how they can assist with this program.

### Required Reporting Hours

If the Gateway to Work status is “reporting,” the member must participate in qualifying activities for a set number of hours each month. The number will gradually increase over several months following the schedule listed below.

<u>Date</u>	<u>Required participation hours</u>
January 2019 – June 2019	0 hours per week/0 hours per month
July 2019 – September 2019	5 hours per week/20 hours per month
October 2019 – December 2019	10 hours per week/40 hours per month
January 2020 – June 2020	15 hours per week/60 hours per month
July 2020 – Ongoing	20 hours per week/80 hours per month

Hours can carry over from week to week, but cannot carry over from month to month. The requirement can be met by completing all the hours in one activity or by combining multiple activities to reach the required number of hours.

### **Reporting Hours**

Members can report hours:

- Online – using the member portal. This can be done on their phone or with a desktop computer.
- With a Partner – they can find a partner on the GTW website to help report hours.
- At their Health Plan – they can call their health plan to report hours.

Members will need to report the type of activity, the date the activity occurred, the location of the activity and the number of hours completed.

### **Exemptions**

If members meet any of the following exemptions, they will not be required to participate in Gateway to Work. Members may have more than one exemption at a time.

- Age 60 years and older
- TANF/SNAP recipients (*A loss in SNAP/TANF benefits will result in a loss of this exemption*)
- Medically frail (*A loss in frail status will result in a loss of this exemption*)
- Pregnant
- Homeless
- Institutionalized
- Substance use disorder treatment
- Recently incarcerated (for a period of at least 30 days in the past six months)
- Certified temporary illness or incapacity
- Caregiver:
  - Parent or primary caregiver of a dependent child under age 13 (must be coded as such on ICES screen AEIHH)
  - Primary caregiver of a disabled dependent
  - Kinship caregivers of abused or neglected children.
- Student (full- or half-time)
- Good cause exemption based on individual review

If they meet one of the above listed exemptions and have not been given Gateway to Work status of “exempt,” they would need to report the exemption to their health plan. Good cause exemptions will be reviewed by the State GTW Unit on an individual basis, when necessary.

### **Qualifying Activities**

Any combination of activities and hours may be applied each month.

Work

- Employment
- Job search activities
- Education related to employment (On-the-job training)
- Homeschooling
- Members of the Pokagon Band of Potawatomi participating in the tribe's Comprehensive Pathways program

#### Learn

- Adult education (GED/HSE)
- General education
- College level courses
- Job skills training
- Vocational education or training
- English as a Second Language education

#### Serve

- Volunteer work
- Community service/public service
- Community work experience
- Caregiving services
- Other qualifying activity based on individual review

#### **Appeals of GTW Participation Status (pre-suspension)**

Members wanting to appeal their GTW participation status must appeal first with their MCE. Appeals of GTW status only which are submitted as regular eligibility appeals will be not be heard unless the member has already appealed with the MCE and remains unsatisfied with the MCE's decision.

#### **Compliance and Suspension**

Gateway to Work compliance will be reviewed each year. Reporting members will need to meet their participation requirement in at least 8 of 12 months of the calendar year. Any months they are not enrolled in HIP will not count against them and are counted as meeting. The health plan will send them their Gateway to Work status each month on a monthly statement. This will help them keep track of their progress throughout the year. They may also log on to the member portal to review progress.

Beginning in October 2019, and annually in October for subsequent years, if they have not yet met their requirement for the year, they will have the chance to complete online pre-suspension activities to avoid suspension. If they do not meet the annual requirement, their HIP health benefits will be suspended on January 1 of the following year. The suspension could last up to one full calendar year. They can reactivate benefits by completing a month of qualified activity or if they become exempt during the suspension. If they are still suspended for Gateway to Work noncompliance at year end, the suspended HIP benefits will be fully terminated effective December 31 of the year of the suspension and will need to reapply for HIP benefits.

### Category Changes and Reapplications during a GTW Suspension Period

A member who is eligible for another full coverage category (example: MA D) can transition to that category rather than have suspension applied. Members will not be moved to MA E Family Planning Only category as a result of GTW suspension activities, as they remain technically eligible for HIP during the suspension and would only need to complete compliance activities or verify an exemption to resume their full HIP benefits.

A member who reapplies during their GTW suspension period without having come back into compliance or who does not currently meet an exemption can be processed for another full coverage category (again, not MA E); but if only eligible for HIP and still suspended, their reapplication will be denied as a duplicate with language on the denial notice directing them to instead contact the GTW Unit or their MCE to resolve the suspension.

### 3565.00.00 HIP ID CARDS

A HIP card will be issued from the assigned managed care health plan within five (5) calendar days of a new member's full enrollment.

### 3570.00.00 FOOTNOTES FOR CHAPTER 3500

The following are the footnotes for Chapter 3500:

- 
- 1 405 IAC 10-4-1
  - 2 405 IAC 10-2-1
  - [2] 405 IAC 10-4-7
  - 3 405 IAC 10-3-2
  - 4 405 IAC 10-3-2
  - 5 405 IAC 10-4-1
  
  - 6 405 IAC 10-3-2
  - 7 405 IAC 10-4-1
  - 8 405 IAC 10-3-2
  - 9 405 IAC 10-3-2
  - 10 405 IAC 10-3-2
  - 11 405 IAC 10-3-3
  - 12 405 IAC 10-3-3(e)
  - 13 405 IAC 10-4-9(f)
  
  - 14 405 IAC 10-10-3
  - 15 405 IAC 10-3-3
  - 3 CFR 435.603
  - 17 405 IAC 10-10-10
  - 18 405 IAC 10-10-4
  - 19 405 IAC 10-10-3
  - 20 405 IAC 10-10-3

21 405 IAC 10-3-3(f)(1)

22 405 IAC 10-4-9(e)(2); 405 IAC 10-4-9(e)(4)

23 405 IAC 10-10-12

24 405 IAC 10-10-12

25 42CFR 435.916(c)(d)

26 405 IAC 10-10-13