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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #05-209

DIGEST

Adds 405 IAC 6-10 and 405 IAC 8 to implement a program to complement the federal Medicare Prescription Drug Benefit and to establish program eligibility and enrollment guidelines. Effective 30 days after filing with the Secretary of State.

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

Indiana Code 4-22-2.1-5 requires an agency to submit to the Legislative Services Agency and the Indiana Economic Development Corporation a statement of economic impact of any proposed rule with an economic impact on Small Businesses. The IEDC is required to review the rule and submit written comments to the agency not later than seven days before the public hearing.

The Office of Medicaid Policy and Planning has reviewed the proposed rule to determine the economic impact of the rule on small businesses. The Office of Medicaid Policy and Planning has determined, based on the information available at the time of rule promulgation, that the proposed rule does not impose requirements or costs on small businesses. Therefore, the agency did not submit a statement of economic impact to the Legislative Services Agency and the Indiana Economic Development Corporation.

In reaching this conclusion, the agency determined that the proposed rule is providing a benefit that will indirectly benefit pharmacies. The agency is providing the benefit that will wrap around services mandated by the Medicare Modernization Act.

405 IAC 6-10
405 IAC 8

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

Rule 10. Discontinuance of the Indiana Prescription Drug Program Point of Service Drug Card

405 IAC 6-10-1 General provisions
Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 1. Under IC 12-10-16-3, the office hereby adopts and promulgates this article to phase out the IPDP discount card program and transition members to the federal Medicare Part D program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-1)*

405 IAC 6-10-2 Definitions
Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 2. (a) The definitions in this section apply throughout this rule unless the context clearly indicates another meaning.

(b) "Centers for Medicare and Medicaid Services" means the federal administrator of the Medicare prescription drug benefit.

(c) "Enhanced Medicare Part D plan" means a Medicare Part D plan that is not considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services.

(d) "Full low-income subsidy" means the Centers for Medicare and Medicaid Services benefit provided to eligible low-income individuals enrolled in the Medicare prescription drug benefit. Full low-income subsidy eligible individuals:

(1) are not required to pay monthly premiums or an annual deductible;
(2) have small copayments; and
(3) have no gap in coverage.
Eligibility is determined by the Social Security Administration.

(e) "Low-income subsidy" means either a:
(1) full low-income subsidy; or
(2) partial low-income subsidy;
as determined by the Social Security Administration.

(f) "Low-income subsidy application" means the Application for Help with Medicare Prescription Drug Plan Costs, which is processed and administered through the Social Security Administration.

(g) "Low-income subsidy premium" means the maximum amount the low-income subsidy will pay towards a Medicare Part D beneficiary's monthly premium in the state of Indiana, as determined by the Centers for Medicare and Medicaid Services and adjusted annually.

(h) "Medicare-advantage prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare Advantage beneficiaries.

(i) "Medicare Part D plan" means a:
(1) Medicare prescription drug plan; or
(2) Medicare-Advantage prescription drug plan.

(j) "Member" means a person who has:
(1) met all eligibility requirements; and
(2) been enrolled in the Indiana prescription drug program.

(k) "Partial low-income subsidy" means the Centers for Medicare and Medicaid Services benefit provided to eligible low-income individuals enrolled in the Medicare prescription drug benefit. Partial low-income subsidy eligible individuals are eligible for the following:
(1) Reduced premiums on a sliding scale.
(2) A maximum annual deductible of fifty dollars ($50).
(3) Fifteen percent (15%) copayments.
(4) No gap in coverage.
Eligibility is determined by the Social Security Administration.

(l) "Premium" means the monthly cost of being enrolled in a Medicare Part D plan.

(m) "Standard" means a Medicare Part D plan that is considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. The term does not include enhanced Medicare Part D plans. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-2)*

405 IAC 6-10-3 Benefits
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) The IPDP drug card program will end on December 31, 2005.

(b) Any benefit dollars remaining on IPDP member drug cards will no longer be available to the member after December 31, 2005.

(c) December 31, 2005, will be the last date of service that pharmacy providers will be able to submit a claim to the IPDP.

(d) The IPDP shall accept reversals and rebills electronically ninety (90) days after December 31, 2005. *(Office of the*

Secretary of Family and Social Services; 405 IAC 6-10-3)

405 IAC 6-10-4 Transition to Medicare Part D plan; auto-assignment for full low-income subsidy beneficiaries
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) The program may, to the extent it can identify IPDP members that have been determined eligible for full low-income subsidy from the Centers for Medicare and Medicaid Services, randomly assign members to Medicare prescription drug plans offering standard coverage with a monthly premium below the low-income subsidy premium amount in compliance with subsection (b). In the event the same entity offers more than one (1) such Medicare prescription drug plan in the state, the program will assign members randomly among the entity's eligible Medicare prescription drug plans.

(b) The program shall only auto-assign members to Medicare prescription drug plans that have agreed to accept electronic auto-assignment from the program in a manner defined by the program.

(c) Married couples auto-assigned by the office shall be assigned to the same Medicare prescription drug plan whenever possible.

(d) The program will send the member a letter notifying them that they will have at least thirty (30) calendar days to select a Medicare Part D plan. If no selection has been made within the period of not less than thirty (30) calendar days, the office may auto-assign the member to a Medicare prescription drug plan that has contracted with the IPDP to receive auto-assignment.

(e) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the thirty (30) calendar day period.

(f) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period, that is otherwise eligible for the program, may be auto-assigned to a Medicare Part D plan, before the end of the thirty (30) calendar day opt-out period.

(g) If a member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug plan. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-4)*

405 IAC 6-10-5 Transition to Medicare Part D plan; auto-assignment for partial low-income subsidy beneficiaries
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) The program may, to the extent it can identify IPDP members that have been determined eligible for partial low-income subsidy from the Centers for Medicare and Medicaid Services, randomly assign members to Medicare prescription drug plans offering standard coverage, with a monthly premium below the low income subsidy premium amount, that have contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs. In the event the same entity offers more than one (1) such Medicare prescription drug plan in the state, the program will assign members randomly among the entity's eligible Medicare prescription drug plans.

(b) The program shall only auto-assign members to Medicare Part D plans that have agreed to accept electronic auto-assignment from the program in a manner defined by the program.

(c) Married couples auto-assigned by the office shall be assigned to the same Medicare Part D plan whenever possible.

(d) The program will send the member a letter notifying them that they will have at least thirty (30) calendar days to select a Medicare Part D plan. If no selection has been made within the period of not less than thirty (30) calendar days, the office may auto-assign the member to a Medicare prescription drug plan that has contracted with the IPDP to receive auto-assignment.

(e) A member may not receive IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs if he or she enrolls in a Medicare Part D plan that has not contracted with the program to administer such benefits.

(f) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the thirty (30) calendar day period.

(g) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period, that is otherwise eligible for the program, may be auto-assigned to a Medicare Part D plan that has contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs before the end of the member's thirty (30) calendar day opt-out period.

(h) If member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug plan. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-5)*

SECTION 2. 405 IAC 8 IS ADDED TO READ AS FOLLOWS:

ARTICLE 8. INDIANA PRESCRIPTION DRUG PROGRAM MEDICARE WRAPAROUND BENEFIT

Rule 1. General Provisions

405 IAC 8-1-1 Intent and purpose
Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 1. Under IC 12-10-16-3, the office hereby adopts and promulgates this article to do the following:
(1) Interpret and implement provisions of IC 12-10-16-3 to provide assistance to low-income seniors with the expense of participating in a Medicare Part D plan.
(2) Ensure the efficient, economical, and reasonable operations of the Indiana prescription drug program.
(Office of the Secretary of Family and Social Services; 405 IAC 8-1-1)

Rule 2. Definitions

405 IAC 8-2-1 Applicability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. The definitions in this rule apply throughout this article unless the context clearly indicates another meaning. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-1)*

405 IAC 8-2-2 "Applicant" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. "Applicant" means the person for whom Indiana prescription drug program enrollment is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-2)*

405 IAC 8-2-3 "Benefit period" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. "Benefit period" means a specified time frame during which a member is concurrently enrolled in both a Medicare Part D plan and the Indiana prescription drug program. The benefit period shall not exceed one (1) calendar year beginning in January with limits specified in 405 IAC 8-6-4. The benefit shall not be paid or begin until the first day of the first month

in which:

(1) the member has an active effective date in a Medicare Part D plan; and

(2) the member's Medicare Part D plan recognizes the member's enrollment in the IPDP.

(Office of the Secretary of Family and Social Services; 405 IAC 8-2-3)

405 IAC 8-2-4 "Centers for Medicare and Medicaid Services" defined

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 4. "Centers for Medicare and Medicaid Services" means the federal administrator of the Medicare prescription drug benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-4)*

405 IAC 8-2-5 "Complete applicant file" defined

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 5. (a) "Complete applicant file" means an enrollment form for the Indiana prescription drug program that includes the following information about the applicant and applicant's spouse, if applicable:

(1) Name.

(2) Address of domicile.

(3) Date of birth.

(4) Social Security number.

(5) Medicare Health Insurance Claim Number (HICN).

(6) Marital status.

(7) Signature.

(8) Proof of low-income subsidy determination by the Social Security Administration. Proof includes either a letter of determination from the Social Security Administration or electronic confirmation provided by the Centers for Medicare and Medicaid Services.

(9) Proof of enrollment in a Medicare prescription drug plan. Acceptable proof should be electronic confirmation provided by the Centers for Medicare and Medicaid Services.

(b) Applicants may provide information to the office by mail, facsimile, or telephone or over the internet. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-5)*

405 IAC 8-2-6 "Deductible" defined

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 6. "Deductible" means the amount a beneficiary must pay out-of-pocket before the member's Medicare Part D plan begins to cover prescription drug costs during each benefit period. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-6)*

405 IAC 8-2-7 "Domicile" defined

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 7. "Domicile" means the applicant's:

(1) true;

(2) fixed;

(3) principal; and

(4) permanent;

home. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-7)*

405 IAC 8-2-8 "Eligible" defined

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 8. "Eligible" means a person who meets all requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-8)*

405 IAC 8-2-9 "Enhanced Medicare Part D plan" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. "Enhanced Medicare Part D plan" means a Medicare Part D plan that is not considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-9)*

405 IAC 8-2-10 "Federal poverty limit" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 10. "Federal poverty limit" means the nonfarm income official poverty guideline as determined by the federal Office of Management and Budget. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-10)*

405 IAC 8-2-11 "Full low-income subsidy" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 11. "Full low-income subsidy" means the full extra help for paying for Medicare prescription drug plan costs provided by the Centers for Medicare and Medicaid Services (CMS). According to CMS, beneficiaries receiving "full low-income subsidy" will:
(1) not be responsible for monthly premium costs for basic Medicare Part D plans;
(2) have no annual deductible; and
(3) have no gap in coverage.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-11)

405 IAC 8-2-12 "Income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12. "Income" means the amount of money or its equivalent received as follows:
(1) In exchange for or as a result of labor or services.
(2) From the sale of goods or property.
(3) As profits from financial investments.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-12)

405 IAC 8-2-13 "Indiana prescription drug program" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 13. "Indiana prescription drug program" means the program established by IC 12-10-16. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-13)*

405 IAC 8-2-14 "Initial enrollment period"
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 14. "Initial enrollment period" means the Medicare Part D initial enrollment period ending May 15, 2005, as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. *(Office of the Secretary of Family and Social*

Services; 405 IAC 8-2-14)

405 IAC 8-2-15 "Low-income subsidy" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 15. "Low-income subsidy" means either a:
(1) full low-income subsidy; or
(2) partial low-income subsidy;
as determined by the Social Security Administration. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-15)*

405 IAC 8-2-16 "Low-income subsidy application" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 16. "Low-income subsidy application" means the Application for Help with Medicare Prescription Drug Plan Costs, which is processed and administered through the Social Security Administration. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-16)*

405 IAC 8-2-17 "Low-income subsidy determination" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 17. "Low-income subsidy determination" means a definitive determination from the Social Security Administration as to an applicant's eligibility for the low-income subsidy. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-17)*

405 IAC 8-2-18 "Low-income subsidy premium" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 18. "Low-income subsidy premium" means the maximum amount the low-income subsidy will pay towards a Medicare Part D beneficiary's monthly premium in the state of Indiana, as determined by the Centers for Medicare and Medicaid Services and adjusted annually. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-18)*

405 IAC 8-2-19 "Medicare-Advantage prescription drug plan" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 19. "Medicare-Advantage prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare-Advantage beneficiaries. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-19)*

405 IAC 8-2-20 "Medicare Part D plan" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 20. "Medicare Part D plan" means a:
(1) Medicare prescription drug plan; or
(2) Medicare-Advantage prescription drug plan.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-20)

405 IAC 8-2-21 "Medicare prescription drug plan" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 21. "Medicare prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare beneficiaries. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-21)*

405 IAC 8-2-22 "Member" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 22. "Member" means a person who has:
(1) met all eligibility requirements; and
(2) been enrolled in the Indiana prescription drug program.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-22)

405 IAC 8-2-23 "Noncovered drug" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 23. "Noncovered drug" means a drug that is:
(1) not on a Medicare Part D plan's formulary; or
(2) being treated as so as a result of a coverage determination or appeal.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-23)

405 IAC 8-2-24 "Not eligible for the Indiana prescription drug program" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 24. "Not eligible for the Indiana prescription drug program" means the applicant does not meet one (1) or more of the eligibility requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-24)*

405 IAC 8-2-25 "Office" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 25. "Office" means the office of the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-25)*

405 IAC 8-2-26 "Partial low-income subsidy" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 26. "Partial low-income subsidy" means the partial extra help for paying for Medicare prescription drug plan costs provided by the Centers for Medicare and Medicaid Services (CMS). According to CMS, beneficiaries receiving "partial low-income subsidy" will:
(1) be responsible for monthly premium on a sliding scale for standard Medicare Part D plans;
(2) have a reduced annual deductible; and
(3) have no gap in coverage.
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-26)

405 IAC 8-2-27 "Premium" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 27. "Premium" means the monthly cost of being enrolled in a Medicare prescription drug plan. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-27)*

405 IAC 8-2-28 "Prescription drug" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 28. "Prescription drug" means any prescription drug that is not a noncovered drug. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-28)*

405 IAC 8-2-29 "Program" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 29. "Program" means the Indiana prescription drug program. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-29)*

405 IAC 8-2-30 "Proof of income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 30. "Proof of income" means documentation of the income of an applicant and an applicant's family. Proof of income for the program should be provided by the Social Security Administration through the low-income subsidy application. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-30)*

405 IAC 8-2-31 "Provider" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 31. "Provider" means an entity that:
(1) provides Medicare prescription drug coverage through a Medicare Part D plan in the state of Indiana; and
(2) participates in the program in accordance with 405 IAC 8-6-1(a) and 405 IAC 8-6-2(b).
(Office of the Secretary of Family and Social Services; 405 IAC 8-2-31)

405 IAC 8-2-32 "Secretary" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 32. "Secretary" means the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-32)*

405 IAC 8-2-33 "Senior" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 33. "Senior" means a person at least sixty-five (65) years of age. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-33)*

405 IAC 8-2-34 "Spouse" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 34. "Spouse" means the legal husband or wife of an applicant. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-34)*

405 IAC 8-2-35 "Standard" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 35. "Standard" means a Medicare Part D plan that is considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. The term excludes enhanced plans. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-35)*

405 IAC 8-2-36 "True out-of-pocket costs" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 36. "True out-of-pocket costs" means prescription drug costs that count towards a member's Medicare Part D plan maximum out-of-pocket costs. *(Office of the Secretary of Family and Social Services; 405 IAC 8-2-36)*

Rule 3. Eligibility Requirements

405 IAC 8-3-1 Age
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. To be eligible for the program, an applicant must be at least sixty-five (65) years of age. *(Office of the Secretary of Family and Social Services; 405 IAC 8-3-1)*

405 IAC 8-3-2 Income
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. To be eligible for the program, an applicant's income must not exceed one hundred fifty percent (150%) of the federal poverty limit applicable to the individual's family size, as defined by the federal Office of Management and Budget. *(Office of the Secretary of Family and Social Services; 405 IAC 8-3-2)*

405 IAC 8-3-3 Ineligibility
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. Notwithstanding any other provision of this article, an individual is not eligible for the program if any of the following apply:
(1) The applicant is not a Medicare beneficiary.
(2) The individual:
(A) is not domiciled in Indiana;
(B) does not intend to reside permanently in the state of Indiana;
(C) has not received a low-income subsidy determination from the Social Security Administration;
(D) has been determined eligible for full low-income subsidy;
(E) is dually eligible for both Medicare and Medicaid;
(F) is an inmate of a correctional facility; or
(G) is not enrolled in a Medicare Part D plan.
(Office of the Secretary of Family and Social Services; 405 IAC 8-3-3)

Rule 4. Application and Enrollment

405 IAC 8-4-1 General requirements
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) A completed applicant file will be processed by the office and must include verification of the following:
(1) That an applicant has completed the Application for Help with Medicare Prescription Drug Plan Costs and received a determination from the Social Security Administration.
(2) Of an applicant's enrollment in a Medicare Part D plan that has contracted with the IPDP to provide state benefits in

coordination with Medicare Part D.

(b) Applicant file information may be submitted to the office by mail or telephone or over the Internet.

(c) An applicant who does not have a complete applicant file will be determined pending. Such an applicant may submit requirements necessary to complete their applicant file to receive a determination from the office. An applicant file that has been pending for sixty (60) calendar days may be closed and determined ineligible by the office. An applicant's application file date will begin the date the office receives an IPDP enrollment form.

(d) After a completed applicant file has been processed and approved by the office, the office will notify the member's Medicare Part D plan of the member's eligibility for benefits under the IPDP. *(Office of the Secretary of Family and Social Services; 405 IAC 8-4-1)*

Rule 5. Auto-Assignment to a Medicare Prescription Drug Plan

405 IAC 8-5-1 Auto-assignment
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) If, according to the Centers for Medicare and Medicaid Services, an applicant otherwise eligible for the Indiana prescription drug program has not selected a Medicare Part D plan, the program may randomly assign the member to a Medicare prescription drug plan that has contracted with the IPDP.

(b) The applicant will be sent a letter notifying them that they will have at least thirty (30) calendar days to select a Medicare prescription drug plan that has contracted with the IPDP. If no selection has been made within the period of not less than thirty (30) calendar days, the office may auto-assign the applicant to a Medicare prescription drug plan that has contracted with the IPDP. An applicant may opt out of the auto-assignment by calling or writing the IPDP before the end of the thirty (30) calendar day period.

(c) Married couples auto-assigned by the office will be assigned to the same Medicare Part D plan when possible.

(d) Any applicant that has not selected a Medicare Part D plan before the end of the initial enrollment period, that is otherwise eligible for the program, may be auto-assigned to a Medicare Part D plan before the end of the thirty (30) calendar day opt-out period. *(Office of the Secretary of Family and Social Services; 405 IAC 8-5-1)*

Rule 6. Benefits

405 IAC 8-6-1 Assistance with Medicare prescription drug plan monthly premium and other Medicare Part D plan costs
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) An eligible member may receive:
(1) premium assistance for the monthly premium cost of the:
(A) Medicare prescription drug plan; or
(B) Medicare-Advantage prescription drug plan; and
(2) assistance with other Medicare prescription drug plan costs as defined in section 2 of this rule;
if the member enrolls, or has been auto-enrolled, into a Medicare Part D plan that has contracted with the IPDP to provide such benefits.

(b) The amount of premium assistance provided by the IPDP shall not exceed the low-income subsidy premium amount per month.

(c) The premium assistance benefit shall be paid directly to the Medicare Part D plan in which the eligible IPDP member is enrolled.

(d) Premium assistance provided by the IPDP will be reduced by the amount of premium assistance a member receives from the Centers for Medicare and Medicaid Services.

(e) The IPDP member is responsible for any premium amount above the low-income subsidy premium per month.

(f) IPDP premium assistance:
(1) may only be applied to the prescription drug portion of a Medicare-Advantage prescription drug plan's monthly premium; and
(2) shall not pay for the medical portion of the Medicare-Advantage prescription drug plan monthly premium.

(g) IPDP premium assistance shall not pay for any portion of the Medicare Part D premium related to late-enrollment penalties. *(Office of the Secretary of Family and Social Services; 405 IAC 8-6-1)*

405 IAC 8-6-2 Deductible or coinsurance assistance benefit
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) An eligible member may receive not more than two hundred fifty dollars ($250) in annual benefits to be applied to his or her Medicare Part D plan deductible or coinsurance requirements.

(b) IPDP deductible or coinsurance assistance benefits shall only be available to IPDP members enrolled in a Medicare Part D plan that has contracted with the IPDP to provide the benefits.

(c) Benefit dollars will be available for a remainder of the benefit period, beginning on the date of enrollment in the IPDP. Benefits not used before the end of this period will not be available to the member. Benefits shall not be paid on a IPDP member's behalf until the member is effectively enrolled in a Medicare Part D plan that has contracted with the IPDP.

(d) The IPDP will pay benefits, up to the two hundred fifty dollar ($250) annual limit, directly to the Medicare Part D plan in which the member is enrolled.

(e) IPDP benefits shall:
(1) only be available for prescription drug plan costs that are countable to the beneficiary's true out-of-pocket costs; and
(2) not be used to pay for noncovered drugs.
(Office of the Secretary of Family and Social Services; 405 IAC 8-6-2)

405 IAC 8-6-3 Assistance with Medicare prescription drug plan monthly premium only
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) An eligible member may receive assistance for the monthly premium cost of the Medicare prescription drug plan or Medicare-Advantage prescription drug plan in which the member is enrolled. Premium assistance shall be available provided the IPDP member:
(1) enrolls in a Medicare Part D plan offering standard coverage in the state of Indiana; and
(2) has a premium at or below the low-income premium subsidy amount, as determined by the Centers for Medicare and Medicaid Services.

(b) The amount of premium assistance provided by the IPDP shall not exceed the low-income subsidy premium per month.

(c) The premium assistance benefit shall be paid directly to the Medicare Part D plan in which the eligible IPDP member is enrolled.

(d) Premium assistance provided by the IPDP shall be reduced by the amount of premium assistance a member receives from the Centers for Medicare and Medicaid Services.

(e) The IPDP member shall be responsible for any premium amount above the low-income subsidy premium per month.

(f) IPDP premium assistance:
(1) may only be applied to the prescription drug portion of a Medicare-Advantage prescription drug plan's monthly premium; and
(2) shall not pay for the medical portion of the Medicare-Advantage prescription drug plan monthly premium.

(g) IPDP premium assistance shall not pay for any portion of the Medicare Part D premium related to late-enrollment penalties. *(Office of the Secretary of Family and Social Services; 405 IAC 8-6-3)*

405 IAC 8-6-4 Benefit limitations
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) Benefits are available under sections 2 and 3 of this rule on a first come, first served basis.

(b) Benefits will exist under this program to the extent that appropriations are available for the program.

(c) The state budget director shall determine if appropriations are available to continue offering and paying benefits for members.

(d) Upon determination that program benefits will meet or exceed budget, program will implement a waiting list for further benefits, beginning with the members who:
(1) do not receive any partial subsidy from Medicare; and
(2) are between one hundred thirty-five percent (135%) and one hundred fifty percent (150%) FPL.
(Office of the Secretary of Family and Social Services; 405 IAC 8-6-4)

Rule 7. Provider Appeal; Records

405 IAC 8-7-1 Provider appeal procedures
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. All provider appeals from office action taken under this article shall be governed by the procedures and time limits for Medicaid providers set out in 405 IAC 1-1.5 and 405 IAC 8-8-1, if applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 8-7-1)*

405 IAC 8-7-2 Provider records
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. The provisions of 405 IAC 1-5 concerning contents, retention, and disclosure of records of Medicaid providers shall apply to providers of:
(1) Medicare prescription drug plans; and
(2) Medicare-Advantage prescription drug plans.
(Office of the Secretary of Family and Social Services; 405 IAC 8-7-2)

Rule 8. Provider Claims; Payments; Overpayments; Sanctions

405 IAC 8-8-1 Filing of claims; filing date; payment liability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) All Medicare prescription drug plan and Medicare-Advantage prescription drug plan claims for payment for Indiana prescription drug program member benefits must be originally filed with the office's contractor within twelve (12) months of the date of the provision of the service. A provider who is dissatisfied with the amount of his or her reimbursement may appeal under the provisions of 405 IAC 8-7-1. However, before filing an appeal, the provider must do one (1) of the

following:

(1) Resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider.

(2) Submit, if appropriate, an adjustment request to the office contractor's adjustment and resolution unit.

(3) Submit a written request to the office's contractor stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments or reconsideration of a claim that has been denied must be submitted to the office's contractor within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the office's contractor. All claims filed after twelve (12) months of the date of payment of benefits, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted. In extenuating circumstances, a waiver of the filing limit may be authorized by the contractor or the office when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit. Some examples of situations considered to be extenuating circumstances are as follows:

(1) Contractor or state error or action that has delayed payment.

(2) Reasonable and continuous attempts on the part of the provider to resolve a claim problem.

(c) All claims filed for reimbursement shall be reviewed before payment by the office or its contractor for the following:

(1) Completeness, including required documentation.

(2) Accuracy and appropriateness as indicated.

(d) The office is only liable for the payment of claims filed by the Medicare Part D plan that were authorized by the appropriate federal and state agencies as providers at the time the service was rendered and for services provided to persons who were enrolled in the Indiana prescription drug program as members at the time service was provided. The claim will not be paid if the services provided are outside the service parameters as established by the office.

(e) A provider shall collect from:

(1) a member; or

(2) the authorized representative of the member;

that portion of his or her premium above any benefit paid by the Indiana prescription drug program. *(Office of the Secretary of Family and Social Services; 405 IAC 8-8-1)*

405 IAC 8-8-2 Denial of claim payment; basis

Authority: IC 12-10-16-5

Affected: IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 2. (a) The office may deny payment, or instruct the contractor to deny payment, if, after investigation by the office, the office's designee, or other governmental authority, the office finds any of the following:

(1) The benefit cannot be documented by the provider in accordance with 405 IAC 8-7-2.

(2) The services claimed were provided to a person other than a person in whose name the claim is made.

(3) The benefit was provided to a person who was not eligible for benefits at the time of the provision of the service.

(4) The claim arises out of any of the following acts or practices:

(A) Presenting, or causing to be presented, for payment any false or fraudulent claim.

(B) Submitting, or causing to be submitted, information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(C) Submitting, or causing to be submitted, any false information.

(D) Engaging in a course of conduct or performing an act deemed by the office to be improper or abusive of the program or continuing the conduct following notification that the conduct should cease.

(E) A breach of the terms of the Indiana prescription drug program provider agreement or contract.

(F) Violating any provision of state law or any rule or regulation promulgated under this article or any provider bulletin published thereto.

(G) Submission of a false or fraudulent application for provider status.

(H) Failure to meet standards required by the state or federal government for participating in the program.

(I) Refusal to execute a new Indiana prescription drug program provider agreement when requested by the office or the

office's contractor to do so.

(J) Failure to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.

(K) Failure to repay within sixty (60) days or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments, except as provided in this rule.

(L) Presenting claims for which benefits are not available.

(5) The claim arises out of any act or practice prohibited by rules of the office.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the office. This decision shall be final and:

(1) will be:

(A) mailed to the provider by United States mail at the address contained in the office records and on the claims; or

(B) transmitted electronically if the provider receives electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed in accordance with this article.

(c) The decision as to claim payment suspension is at the discretion of the office and may include either of the following:

(1) The denial of payment for all claims that have been submitted by the provider pending further investigation by the office, the office's designee, or other governmental authority.

(2) The suspension or withholding of payment on any or all claims of the provider pending an audit or further investigation by the office, the office's designee, or other governmental authority.

(d) The decision of the office under subsection (c) shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) contain a brief description of the decision;

(3) become final fifteen (15) days after its receipt; and

(4) contain a statement that any appeal from the decision shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 8-7-1.

(e) If an emergency exists, as determined by the office, the office may issue an emergency directive suspending or withholding payment on any or all claims of the provider pending further investigation by the office, the office's designee, or other governmental authority under IC 4-21.5-4. Any order issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) become effective upon receipt;

(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and

(4) contain a statement that any appeal from the decision of the assistant secretary made under this subsection shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 8-7-1.

(Office of the Secretary of Family and Social Services; 405 IAC 8-8-2)

405 IAC 8-8-3 Overpayments made to providers; recovery

Authority: IC 12-10-16-5

Affected: IC 4-21.5-3; IC 6-8.1-10-1; IC 12-10-16

Sec. 3. (a) The office may recover payment, or instruct its contractor to recover payment, from any provider after investigation or audit finds that:

(1) the benefit:

(A) paid for cannot be documented by the provider as required by 405 IAC 8-7-2;

(B) was provided to a person:

(i) other than the person in whose name the claim was made and paid; or

(ii) who was not eligible for benefits at the time of the provision of the service;

(2) the paid claim arises out of any act or practice prohibited by law or by rules of the office;

(3) overpayment resulted from duplicate billing; or

(4) overpayment to the provider resulted from any other reason not specified in this subsection.

(b) If the office determines that an overcharge has occurred, the office shall notify the provider by certified mail. The notice shall include a demand that the provider reimburse the office, within sixty (60) days of the provider's receipt of the

notification, for any overcharges determined by the office. Except as provided in subsection (f), a provider who receives a notice and request for repayment may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office and not repay the alleged overpayment, except as provided in subsection (e).

(c) If:

(1) a provider elects to proceed under subsection (d)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money; the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(d) The office may enter into an agreement with the provider regarding the repayment of any overpayment made to the provider. The agreement shall state that the amount of overpayment shall be deducted from subsequent payments to the provider. The subsequent payment deduction shall not exceed a period of six (6) months from the date of the agreement. The repayment agreement shall include provisions for the collection of interest on the amount of the overpayment. The interest shall not exceed the percentage rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c). Recovering interest:

(1) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(2) accruing from the date of overpayment on amounts paid to a provider that are in excess of the amount subsequently determined to be due the provider as a result of:

(A) an audit;

(B) a reimbursement cost settlement; or

(C) a judicial or an administrative proceeding.

(e) If the office recovers an overpayment to a provider that is subsequently found not to have been owing to the office, either in whole or in part, then the office will pay to the provider interest on the amount erroneously recovered from the provider. The interest will accrue:

(1) from the date that the overpayment was recovered by the office until the date the overpayment is restored to the provider; and

(2) at the rate of interest set by the commissioner for interest payments from the department of state revenue to a taxpayer. The office will not pay interest to a provider under any other circumstances.

(f) If, after receiving a notice and request for repayment, the:

(1) provider fails to elect one (1) of the options listed in subsection (b) within sixty (60) days; and

(2) administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner; then the office shall immediately certify the facts of the case to the appropriate county prosecutor. *(Office of the Secretary of Family and Social Services; 405 IAC 8-8-3)*

405 IAC 8-8-4 Repayment of overpayment to office

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 4. (a) The office may require the repayment of any amount determined by the office to have been paid to the provider in error, before an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment under section 3(d)(3) of this rule. The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current payments to a provider.

(2) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(3) Enter into an agreement with the provider in accordance with section 3 of this rule.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 8-8-4)*

405 IAC 8-8-5 Sanctions against providers; determination after investigation
Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 5. (a) If, after investigation by the office, the office's designee, or other governmental authority, the office determines that a provider has violated any provision of IC 12-10-16, or has violated any rule established under one (1) of those sections, the office may impose one (1) or more of the following sanctions:
(1) Deny payment to the provider for services rendered during a specified period of time.
(2) Reject a prospective provider's application for participation in the program.
(3) Remove a provider's certification for participation in the program.
(4) Assess a fine against the provider in an amount not to exceed three (3) times the amounts paid to the provider in excess of the amounts that were legally due.
(5) Assess an interest charge, at a rate not to exceed the rate established within this article, on the amounts paid to the provider in excess of the amounts that were legally due. The interest charge shall accrue from the date of the overpayment to the provider.

(b) Specifically, the office may impose the sanctions in subsection (a) if, after investigation by the office, the office's designee, or other governmental authority, the office determines that the provider did any of the following:
(1) Submitted, or caused to be submitted, any of the following:
(A) Claims for benefits:
(i) that cannot be documented by the provider; or
(ii) provided to a person other than a person in whose name the claim is made.
(B) Any false or fraudulent claims for services.
(C) Information with the intent of obtaining greater compensation than that which the provider is legally entitled.
(2) Engaged in a course of conduct or performed an act deemed by the office to be abusive of the program or continuing the conduct following notification that the conduct should cease.
(3) Breached, or caused to be breached, the terms of the contract.
(4) Submitted, or caused to be submitted, any claims arising out of any act or practice prohibited by the criminal provisions of the Indiana Code or by the rules of the office.
(5) Failed to:
(A) disclose or make available to the office, the office's designee, or other governmental authority, after reasonable request and notice to do so, documentation of benefits provided to members; or
(B) meet standards required by federal or state law for participation.
(6) Refused to execute a contract when requested to do so.
(7) Failed to:
(A) correct deficiencies to provider operations after receiving written notice of these deficiencies from the office; or
(B) repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments, unless an appeal is pending and the provider has elected not to repay an alleged overpayment.

(c) The office may enter a directive imposing a sanction under IC 4-21.5-3-6. Any directive issued under this subsection shall be as follows:
(1) Be served upon the provider by certified mail, return receipt requested.
(2) Contain a brief description of the order.
(3) Become final fifteen (15) days after its receipt.
(4) Contain a statement that any appeal from the decision of the office made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(d) If an emergency exists, as determined by the office, the office may issue an emergency directive imposing a sanction under IC 4-21.5-4. Any order issued under this subsection shall be as follows:
(1) Be served upon the provider by certified mail, return receipt requested.
(2) Become effective upon receipt.

(3) Include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive.
(4) Contain a statement that any appeal from the decision made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(e) The decision to impose a sanction shall be made at the discretion of the office. *(Office of the Secretary of Family and Social Services; 405 IAC 8-8-5)*

Rule 9. Member Appeals

405 IAC 8-9-1 Purpose
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) The purpose of this rule is to establish a uniform method of administrative review and administrative adjudication for appeals concerning applicants and enrollees of the program, in order to determine whether or not any action for which there is a complaint was done in accordance with state statutes, regulations, rules, and policies. As used in this rule, "policies" include:
(1) program manuals;
(2) administrative directives;
(3) transmittals; and
(4) other official written pronouncements;
of state policy.

(b) This rule shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard in accordance with due process of law. As used in this rule, "party" means either of the following:
(1) A person to whom the agency action is specifically directed.
(2) The office.

(c) In the event that any provision of this article is deemed to be in conflict with any other provision of state statute, regulation, or rule that is specifically applicable to the program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found. *(Office of the Secretary of Family and Social Services; 405 IAC 8-9-1)*

405 IAC 8-9-2 Standing
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) In the event that the:
(1) rights;
(2) duties;
(3) obligations;
(4) privileges; or
(5) other legal relations;
of any person or entity are required or authorized by law to be determined by the office, then such person or entity may request an administrative review by the office as provided for in section 3 of this rule.

(b) Unless otherwise provided by law, only those persons or entities, or their respective attorneys at law, whose:
(1) rights;
(2) duties;
(3) obligations;
(4) privileges; or
(5) other legal relations;
are alleged to have been adversely affected by any action or determination of the office, may request administrative review under this rule. Any alleged harm to an enrollee or applicant must be direct and immediate to the party and not indirect and general in character. *(Office of the Secretary of Family and Social Services; 405 IAC 8-9-2)*

405 IAC 8-9-3 Requests for administrative review
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) Any party complaining of an action of the office in accordance with this article may file a request for administrative review as provided in this section.

(b) The enrollee or applicant is required to seek administrative review before filing an administrative appeal under section 5 of this rule.

(c) Unless otherwise provided for by statute, regulation, or rule, a request for administrative review by an enrollee or applicant shall be filed in writing with the office not later than thirty-five (35) days following the date of the action being reviewed. *(Office of the Secretary of Family and Social Services; 405 IAC 8-9-3)*

405 IAC 8-9-4 Conduct of administrative review
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) Upon receipt of a request for administrative review, the office will conduct a review of the action.

(b) Upon completion of the review, the office will issue a written decision. The decision will be final unless a party requests an administrative appeal in accordance with this rule.

(c) The written decision shall do the following:
(1) Specify the reasons for the decision.
(2) Identify the:
(A) statutes;
(B) regulations;
(C) rules; and
(D) policies;
supporting the decision.
(Office of the Secretary of Family and Social Services; 405 IAC 8-9-4)

405 IAC 8-9-5 Filing an administrative appeal; scheduling appeals
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) Any party who is not satisfied with the administrative review of the office as provided for in this rule may file a request for an administrative appeal as provided in this section. The person or entity requesting the administrative appeal shall be known as the appellant.

(b) Unless otherwise provided for by statute, regulation, or rule, appeal requests by an appellant shall be filed in writing with the hearings and appeals section of the family and social services administration not later than thirty (30) days following the effective date of the administrative review being appealed. Appeal hearings shall be conducted at a reasonable time, place, and date.

(c) The hearings and appeals section of the family and social services administration, upon application of any party, or in its own discretion, may consolidate appeals to promote administrative efficiency. Hearings may only be consolidated in cases in which the sole issue involved is one of state law or policy.

(d) Any party filing an appeal under this rule is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review before the filing of an administrative appeal. Any issues not raised within the interim review procedures of the administrative review in a timely manner are waived and shall not be an issue during the evidentiary hearing of the administrative appeal.

(e) The hearings and appeals section of the family and social services administration will schedule evidentiary hearings and issue notices to the parties regarding the date, time, and location of the scheduled hearing.

(f) A continuance of a hearing will be granted only for good cause shown. An objection to a request for a continuance shall be considered before a continuance is granted or denied. Requests for a continuance shall be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes the following:

(1) The inability to attend the hearing because of a serious physical or mental condition.

(2) An incapacitating injury.

(3) A death in the family.

(4) Severe weather conditions making it impossible to travel to the hearing.

(5) The unavailability of a witness and the evidence cannot be obtained otherwise.

(6) Other reasons similar to those listed in this section.

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.
(Office of the Secretary of Family and Social Services; 405 IAC 8-9-5)

405 IAC 8-9-6 Conduct and authority of administrative law judge

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 6. (a) The conduct of an administrative law judge (ALJ) shall be in a manner that promotes public confidence in the integrity and impartiality of the administrative hearing process. The ALJ who conducts a hearing is prohibited from any of the following:

(1) Consulting any party or party's agent on any fact in issue unless upon notice and opportunity for all parties to participate.

(2) Performing any of the investigative or prosecutorial functions of the family and social services administration in the administrative appeal heard or to be heard by him or her or in a factually related administrative or judicial action.

(3) Being influenced by any of the following:

(A) Partisan interests.

(B) Public clamor.

(C) Fear of criticism.

(4) Conveying or permitting others to convey the impression that they are in a special position to influence the ALJ.

(5) Commenting publicly, except as to hearing schedules or procedures, about pending or impending proceedings.

(6) Engaging in financial or business dealings that tend to do any of the following:

(A) Reflect adversely on his or her impartiality.

(B) Interfere with the proper performance of his or her duties.

(C) Exploit the ALJ's position.

(D) Involve the ALJ in frequent financial business dealings with attorneys or other persons who are likely to come before the ALJ.

(b) An ALJ shall disqualify himself or herself in a proceeding in which:

(1) his or her impartiality might reasonably be questioned; or

(2) the ALJ's personal bias, prejudice, or knowledge of a disputed evidentiary fact might influence the decision.

Nothing in this subsection prohibits a person who is an employee of the family and social services administration from serving as an ALJ.

(c) The ALJ shall be authorized to do the following:

(1) Administer oaths and affirmations.

(2) Issue subpoenas.

(3) Rule upon offers of proof.

(4) Receive relevant evidence.

(5) Facilitate discovery in accordance with the Indiana rules of trial procedure.

(6) Regulate the course of the hearing and conduct of the parties.

(7) Hold informal conferences for the settlement or simplification of the issues under appeal.

(8) Dispose of procedural motions and similar matters.
(9) Exercise such other powers as may be given by the law relating to the particular program area under appeal.
(Office of the Secretary of Family and Social Services; 405 IAC 8-9-6)

405 IAC 8-9-7 Conduct of hearing; hearing decisions
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 7. (a) The administrative law judge (ALJ) shall conduct the hearing in an informal manner and without recourse to the technical common law rules of evidence.

(b) The ALJ shall exclude from consideration irrelevant, immaterial, or unduly repetitious evidence.

(c) Every party shall have the right to submit evidence. In the event that an objection to evidence is sustained, the party proffering the evidence may make an offer of proof. Each party shall have the right to cross-examine the witnesses and offer rebutting evidence. *(Office of the Secretary of Family and Social Services; 405 IAC 8-9-7)*

405 IAC 8-9-8 Hearing decision
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 8. (a) Following completion of the hearing, or after submission of briefs by the parties (if briefing is permitted by the administrative law judge (ALJ)), the ALJ shall issue his or her decision in the matter concurrently to the parties. The decision shall be final unless a party requests agency review of the decision in accordance with this rule.

(b) The ALJ's decision shall do the following:
(1) Include findings of fact.
(2) Specify the reasons for the decision.
(3) Identify the evidence and statutes, regulations, rules, and policies supporting the decision.

(c) The findings of fact need not include a recitation of every piece of evidence admitted in the evidentiary hearing. Rather, the findings should contain the basic facts that have formed the basis for the ALJ's ultimate decision. The ALJ's decision must also do the following:
(1) Cite the relevant laws upon which the ultimate decision is based.
(2) Relate the facts to the law.
(Office of the Secretary of Family and Social Services; 405 IAC 8-9-8)

405 IAC 8-9-9 Agency review
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. (a) Any party who is not satisfied with the decision of the administrative law judge (ALJ) may request agency review of the decision within ten (10) days of receipt thereof in accordance with instructions issued with the decision.

(b) After receiving a request for agency review of a hearing decision, the hearings and appeals section of the family and social services administration shall notify the parties when the decision will be reviewed. The agency review shall be completed by the secretary of the family and social services administration or the secretary's designee. All such reviews shall be conducted upon the record, as defined in section 7 of this rule, except that a transcript of the oral testimony shall not be necessary for review unless the party requests that one be transcribed at the party's expense.

(c) No new evidence will be considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the hearings and appeals section of the family and social services administration.

(d) The secretary of family and social services administration or the secretary's designee shall review the ALJ's decision

to determine if the decision is supported by the evidence in the record and is in accordance with statutes, regulations, rules, and policies applicable to the issues under appeal.

(e) Following the review of the secretary or designee, the secretary or designee shall issue a written decision doing one (1) of the following:

(1) Affirming the decision of the ALJ.

(2) Amending or modifying the decision of the ALJ.

(3) Reversing the decision of the ALJ.

(4) Remanding the matter to the ALJ for further specified action.

(5) Making such other order or determination as is proper on the record.

(f) The parties will be issued a written notice of the action taken as a result of the agency review. If the decision of the ALJ is reversed, amended, or modified, the secretary or designee shall state the reasons for the action in the written decision.

(g) The hearings and appeals section of the family and social services administration shall distribute the written notice on agency review to the following:

(1) All parties of record.

(2) The ALJ who rendered the decision following the evidentiary hearing.

(3) Any other person designated by the secretary or designee.

(Office of the Secretary of Family and Social Services; 405 IAC 8-9-9)

405 IAC 8-9-10 Agency record; judicial review

Authority: IC 12-10-16-5

Affected: IC 4-21.5-3-33; IC 4-21.5-5; IC 12-10-16

Sec. 10. (a) The record of the administrative proceedings shall be that as defined in IC 4-21.5-3-33.

(b) If the appellant is not satisfied with the secretary's final action after agency review, he or she may file for judicial review in accordance with IC 4-21.5-5.

(c) The appellant is required to seek agency review before filing a petition for judicial review. *(Office of the Secretary of Family and Social Services; 405 IAC 8-9-10)*

Rule 10. Contracts with Part D Plans

405 IAC 8-10-1 General provisions

Authority: IC 12-10-16-5

Affected: IC 12-10-16

Sec. 1. (a) The IPDP may contract with Medicare Part D plans to administer state Medicare Part D assistance. Only Medicare Part D plans offering standard coverage that have a monthly premium at or below the low-income subsidy premium amount may contract with the IPDP.

(b) Medicare Part D plans contracting with the IPDP to administer state Medicare Part D assistance may place an IPDP logo on joint IPDP and PDP member prescription drug cards, if approved by the program, and shall do the following:

(1) Accept electronic auto-enrollment records in a standard defined by the IPDP.

(2) Administer the IPDP Medicare Part D assistance program. Per member expenses shall not exceed two hundred fifty dollars ($250) in a calendar year, or other period of eligibility defined by the IPDP.

(3) Communicate IPDP assistance to the Centers for Medicare and Medicaid Services true out-of-pocket facilitator to apply towards members' true out-of-pocket expenses.

(4) Provide IPDP with claims data on IPDP members:

(A) in order for the IPDP to understand the utilization underlying its costs; and

(B) for reconciliation of incurred and paid amounts.

(5) Comply with all federal regulations pertaining to Medicare Part D plans as outlined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(Office of the Secretary of Family and Social Services; 405 IAC 8-10-1)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on December 27, 2005 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room C, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed new rules concerning the Indiana Prescription Drug Program's wraparound benefit for Medicare Part D plan recipients.

This rule is being implemented to offer a continued benefit to needy elderly Hoosiers who will be enrolled in new Medicare drug plans beginning January 1, 2006.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

E. Mitchell Roob Jr.
Secretary
Office of the Secretary of Family and Social Services