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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #05-337(E)

DIGEST

Temporarily adds rules to implement a program to complement the federal Medicare Prescription Drug Benefit and to establish program eligibility and enrollment guidelines. Effective December 1, 2005.

SECTION 1. **(a) Under IC 12-10-16-3, the office of the secretary of family and social services hereby adopts and promulgates this document to phase-out the IPDP discount card program and transition members to the federal Medicare Part D program.**

(b) Definitions in this document apply throughout this document unless the context clearly indicates another meaning.

SECTION 2. **(a) "Centers for Medicare and Medicaid Services" means the federal administrator of the Medicare prescription drug benefit.**

(b) "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.

(c) "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 are not required to pay monthly premiums or annual deductible, have small copayments, and no gap in coverage. Eligibility is determined by the Social Security Administration.

(d) "Low-income subsidy" means either a full low-income subsidy or partial low-income subsidy, as determined by the Social Security Administration.

(e) "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.

(f) "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, determined by Centers for Medicare and Medicaid Services and adjusted annually.

(g) "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.

(h) "Medicare Part D plan" means a Medicare prescription drug plan or a Medicare-Advantage prescription drug plan.

(i) "Member" means a person who has met all eligibility requirements and has been enrolled in the Indiana prescription drug program.

(j) "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 reduced premiums on a sliding-scale, a maximum annual deductible of fifty dollars ($50), fifteen percent (15%) copayments, and no gap in coverage. Eligibility is determined by the Social Security Administration.

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

(l) "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. Does not include enhanced Medicare Part D plans.

SECTION 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.

SECTION 4. **(a) The program may, to 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 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 no 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, prior to the end of the thirty (30) calendar day opt-out period.

(g) 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.

SECTION 5. **(a) The program may, to 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 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 no 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 prior to 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.

SECTION 6. **Under IC 12-10-16-3, the office of the secretary of family and social services hereby adopts and promulgates this document to:**

(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.

SECTION 7. **The definitions in this document apply throughout this document unless the context clearly indicates another meaning.**

SECTION 8. **"Applicant" means the person for whom Indiana prescription drug program enrollment is requested.**

SECTION 9. **"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 nor 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.

SECTION 10. **"Centers for Medicare and Medicaid Services" means the federal administrator of the Medicare prescription drug benefit.**

SECTION 11. **(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 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 via mail, facsimile, telephone, or over the Internet.

SECTION 12. **"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.**

SECTION 13. **"Domicile" means the applicant's true, fixed, principal, and permanent home.**

SECTION 14. **"Eligible" means a person who meets all requirements for enrollment in the program.**

SECTION 15. **"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.**

SECTION 16. **"Federal poverty limit" means the nonfarm income official poverty guideline as determined by the federal Office of Management and Budget.**

SECTION 17. **"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. According to CMS, beneficiaries receiving "full low-income subsidy" will not be responsible for monthly premium costs for basic Medicare Part D plans, will have no annual deductible, and no gap in coverage.**

SECTION 18. **"Income" means the amount of money or its equivalent received in exchange for or as a result of labor or services from the sale of goods or property or as profits from financial investments.**

SECTION 19. **"Indiana prescription drug program" means the program established by IC 12-10-16.**

SECTION 20. **"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.**

SECTION 21. **"Low-income subsidy" means either a full low-income subsidy or partial low-income subsidy, as determined by the Social Security Administration.**

SECTION 22. **"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.**

SECTION 23. **"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, determined by Centers for Medicare and Medicaid Services and adjusted annually.**

SECTION 24. **A definitive determination from the Social Security Administration as to an applicant's eligibility for the low-income subsidy.**

SECTION 25. **"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.**

SECTION 26. **"Medicare Part D plan" means a Medicare prescription drug plan or a Medicare-Advantage prescription drug plan.**

SECTION 27. **"Medicare prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare beneficiaries.**

SECTION 28. **"Member" means a person who has met all eligibility requirements and has been enrolled in the Indiana prescription drug program.**

SECTION 29. **"Noncovered drug" means a drug that is not on a Medicare Part D plan's formulary or being treated as so as a result of a coverage determination or appeal.**

SECTION 30. **"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.**

SECTION 31. **"Office" means the office of the secretary of family and social services.**

SECTION 32. **"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. According to CMS, beneficiaries receiving "partial low-income subsidy" will be responsible for monthly premium on a sliding scale for standard Medicare Part D plans, will have a reduced annual deductible, and no gap in coverage.**

SECTION 33. **"Premium" means the monthly cost of being enrolled in a Medicare prescription drug plan.**

SECTION 34. **"Prescription drug" means any prescription drug that is not a noncovered drug.**

SECTION 35. **"Program" means the Indiana prescription drug program.**

SECTION 36. **"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.**

SECTION 37. **"Provider" means an entity that provides Medicare prescription drug coverage through a Medicare Part D plan in the state of Indiana and participates in the program in accordance with 8-6-1(a) and 8-6-2(b)** *[sic.]***.**

SECTION 38. **"Secretary" means the secretary of family and social services.**

SECTION 39. **"Senior" means a person sixty-five (65) years of age or older.**

SECTION 40. **"Spouse" means the legal husband or wife of an applicant.**

SECTION 41. **"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. Standard Coverage and excludes enhanced plans.**

SECTION 42. **"True out-of-pocket costs" means prescription drug costs that count towards a member's Medicare Part D plan maximum out-of-pocket costs.**

SECTION 43. **To be eligible for the program, an applicant must be sixty-five (65) years of age or older.**

SECTION 44. **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.**

SECTION 45. **Notwithstanding any other provision of this document, 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 is not domiciled in Indiana.
(3) The individual does not intend to reside permanently in the state of Indiana.
(4) The individual has not received a low-income subsidy determination from Social Security Administration.
(5) The individual has been determined eligible for full low-income subsidy.
(6) The individual is dually eligible for both Medicare and Medicaid.
(7) The individual is an inmate of a correctional facility.
(8) The individual is not enrolled in a Medicare Part D plan.

SECTION 46. **(a) A completed applicant file will be processed by the office. A completed applicant file must include contain** *[sic.]***:**

(1) Verification 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) Verification 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, over the telephone, or 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.

SECTION 47. **(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 no 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, prior to the end of the thirty (30) calendar day opt-out period.

SECTION 48. **(a) An eligible member may receive premium assistance for the monthly premium cost of the Medicare prescription drug plan or Medicare-Advantage prescription drug plan and assistance with other Medicare prescription drug plan costs as defined in 405 IAC 8-6-2** *[405 IAC 8-6-2 is proposed to be added at 29 IR 861.]* **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 may only be applied to the prescription drug portion of a Medicare-Advantage prescription drug plan's monthly premium. IPDP premium assistance 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.

SECTION 49. **(a) An eligible member may receive no 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 such 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 only be available for prescription drug plan costs that are countable to the beneficiary's true out-of-pocket costs. IPDP benefits shall not be used to pay for noncovered drugs.

SECTION 50. **(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 enrolls in a Medicare Part D plan offering standard coverage in the state of Indiana and 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 low-income subsidy premium per month.

(f) IPDP premium assistance may only be applied to the prescription drug portion of a Medicare-Advantage prescription drug plan's monthly premium. IPDP premium assistance 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.

SECTION 51. **(a) Benefits are available under 405 IAC 8-6-2 and 405 IAC 8-6-3** *[405 IAC 8-6-2 and 405 IAC 8-6-3 are proposed to be added at 29 IR 861.]* **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 do not receive any partial subsidy from Medicare and are between one hundred thirty-five percent (135%) and one hundred fifty percent (150%) FPL.

SECTION 52. **All provider appeals from office action taken under this document 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** *[405 IAC 8-8-1 is proposed to be added at 29 IR 862.]***, if applicable.**

SECTION 53. **The provisions of 405 IAC 1-5 concerning contents, retention, and disclosure of records of Medicaid providers shall apply to providers of Medicare prescription drug plans and Medicare-Advantage prescription drug plans.**

SECTION 54. **(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** *[405 IAC 8-7-1 is proposed to be added at 29 IR 862.]***. However, prior to filing such an appeal, the provider must:**

(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; or

(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 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 prior to payment by the office or its contractor, for completeness, including required documentation, and accuracy and appropriateness as indicated.

(d) The office is only liable for the payment of claims filed by 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 a member or from the authorized representative of the member that portion of his or her premium above any benefit paid by the Indiana prescription drug program.

SECTION 55. **(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 *[405 IAC 8-7-2 is proposed to be added at 29 IR 862.]***.**

(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 such conduct following notification that the conduct should cease.

(E) 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 pursuant to this document 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 SECTION.

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

(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 *[405 IAC 8-7-1 is proposed to be added at 29 IR 862.]***.**

(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 *[405 IAC 8-7-1 is proposed to be added at 29 IR 862.]***.**

SECTION 56. **(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 paid for cannot be documented by the provider as required by 405 IAC 8-7-2 *[405 IAC 8-7-2 is proposed to be added at 29 IR 862.]***;**

(2) the benefits were provided to a person other than the person in whose name the claim was made and paid;

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

(5) overpayment resulted from duplicate billing; or

(6) 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 (d), 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 (d).

(c) If:

(1) a provider elects to proceed under subsection (b)(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. Such agreement shall state that the amount of overpayment shall be deducted from subsequent payments to the provider. Such 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. Such 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 an audit, a reimbursement cost settlement or 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. Such interest will accrue from the date that the overpayment was recovered by the office until the date the overpayment is restored to the provider. Such interest will accrue 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 provider fails to elect one (1) of the options listed in subsection (b) within sixty (60) days and the 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.

SECTION 57. **(a) The office may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to SECTION 56(b)(3) of this document. 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 56 of this document.

(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.

SECTION 58. **(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 document 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, claims for benefits which cannot be documented by the provider.
(2) Submitted, or caused to be submitted, claims for benefits provided to a person other than a person in whose name the claim is made.
(3) Submitted, or caused to be submitted, any false or fraudulent claims for services.
(4) Submitted, or caused to be submitted, information with the intent of obtaining greater compensation than that which the provider is legally entitled.
(5) Engaged in a course of conduct or performed an act deemed by the office to be abusive of the program or continuing such conduct following notification that the conduct should cease.
(6) Breached, or caused to be breached, the terms of the contract.
(7) 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.
(8) Failed to 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.
(9) Failed to meet standards required by federal or state law for participation.
(10) Refused to execute a contract when requested to do so.
(11) Failed to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.
(12) Failed to 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:
(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; and
(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:
(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 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.

SECTION 59. **(a) It is the purpose of this SECTION 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 SECTION, policies include program manuals, administrative directives, transmittals, and other official written pronouncements of state policy.**

(b) This SECTION 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 SECTION, "party" means:
(1) a person to whom the agency action is specifically directed; or
(2) the office of the secretary of family and social services.

(c) In the event that any provision of this document 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 document in which the conflict is found.

SECTION 60. **(a) In the event that the rights, duties, obligations, privileges, or 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 56 of this document.**

(b) Unless otherwise provided by law, only those persons or entities, or their respective attorneys at law, whose rights, duties, obligations, privileges, or other legal relations are alleged to have been adversely affected by any action or determination of the office, may request administrative review under this SECTION. Any alleged harm to an enrollee or applicant must be direct and immediate to the party and not indirect and general in character.

SECTION 61. **(a) Any party complaining of an action of the office in accordance with this document may file a request for administrative review as provided in this SECTION.**

(b) The enrollee or applicant is required to seek administrative review prior to filing an administrative appeal under SECTION 63 of this document.

(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.

SECTION 62. **(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 SECTION.

(c) The written decision shall specify the reasons for the decision and identify the statutes, regulations, rules, and policies supporting the decision.

SECTION 63. **(a) Any party who is not satisfied with the administrative review of the office as provided for in this SECTION 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 SECTION is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review prior to 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:

(1) inability to attend the hearing because of a serious physical or mental condition;
(2) incapacitating injury;
(3) death in the family;
(4) severe weather conditions making it impossible to travel to the hearing;
(5) unavailability of a witness and the evidence cannot be obtained otherwise; or
(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.

SECTION 64. **(a) An administrative law judge's (ALJ) conduct 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:**

(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 partisan interests, public clamor, or 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; or

(6) engaging in financial or business dealings that tend to:

(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; or

(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 his or her impartiality might reasonably be questioned, or in which 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:

(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; and

(9) exercise such other powers as may be given by the law relating to the particular program area under appeal.

SECTION 65. **(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.

SECTION 66. **(a) Following completion of the hearing, or after submission of briefs by the parties (if briefing is permitted by the 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 SECTION 67** *[of this document]***.**

(b) The ALJ's decision shall:

(1) include findings of fact;

(2) specify the reasons for the decision; and

(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 cite the relevant laws upon which the ultimate decision is based, and relate the facts to the law.

SECTION 67. **(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 65 of this document, 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:
(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; or
(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:
(1) all parties of record;
(2) the ALJ who rendered the decision following the evidentiary hearing; and
(3) any other person designated by the secretary or designee.

SECTION 68. **(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 prior to filing a petition for judicial review.

SECTION 69. **(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 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:
(1) Shall accept electronic auto-enrollment records in a standard defined by the IPDP.
(2) Shall 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) Shall 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) May place an IPDP logo on joint IPDP and PDP member prescription drug cards, if approved by the program.
(5) Shall provide IPDP with claims data on IPDP members in order for the IPDP to understand the utilization underlying its costs and for reconciliation of incurred and paid amounts.
(6) Shall comply with all federal regulations pertaining to Medicare Part D plans as outlined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

SECTION 70. **This document expires Feb. 28, 2006.**

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