TITLE 85 BUDGET AGENCY

LSA Document #02-192(E)

DIGEST

Temporarily adds provisions to allow for the use of the State Revolving Fund to refund outstanding indebtedness of political subdivisions eligible for refinancing under the Clean Water Act. *NOTE: Under IC 13-18-13-18, this document is jointly promulgated with the water pollution control board.* Authority: IC 4-22-2-37.1(a)(8). Effective June 19, 2002.

SECTION 1. **A political subdivision may seek a financial assistance loan under IC 13-18-13 to refinance outstanding indebtedness that was previously incurred to finance construction costs of an eligible project by meeting the requirements of this document and the Clean Water Act.**

SECTION 2. **To be eligible for refinancing, a political subdivision must submit to the agency and the department of environmental management (department) a notice of intent to request refinancing. The notice of intent shall also include a list of all potentially affected parties. The following information shall also be submitted to the agency and the department:**

(1) A brief summary of the project proposed for refinancing.
(2) A cost breakdown of all eligible items requested for refinancing.
(3) A legal description of the project area.
(4) Construction specifications of the project.
(5) Maps showing all project elements, including lines, pump stations, tanks, and treatment plants, in relation to:
  (A) mapped wetlands;
  (B) wellhead protection areas;
  (C) surface waters;
  (D) surface water intakes;
  (E) one hundred (100) year floodplains;
  (F) areas where trees and brush were removed; and
  (G) nature preserves.
(6) Preconstruction descriptions of all off-road sites and routes, including construction corridor widths.
(7) An assessment of the environmental impacts of the project, including:
  (A) farmland;
  (B) air quality;
  (C) groundwater, drinking water, and sole source aquifers;
  (D) floodplains, wetlands, waterways, and other surface waters;
  (E) biota;
  (F) nature preserves;
  (G) archaeological resources; and
(8) Mitigation measures taken to eliminate, minimize, or compensate for environmental impacts.
(9) A due diligence submission required under 327 IAC 13-7-1.
(10) A list of potentially affected parties.
(11) A notice of intent pursuant to SECTION 4 of this document.
(12) Any additional information the agency and department deem necessary to complete the refinancing assessment.

SECTION 3. **(a) Eligible costs include the following:**
(1) Preparation of construction drawings, specifications, estimates, and construction contract documents.
(2) Materials acquired, consumed, or expended specifically for the project.
(3) Labor costs directly associated with construction of the project.
(4) Development and preparation of an operation and maintenance plan and manual.
(5) Safety equipment.
(6) Costs of public notices and hearings.
(7) Inspection fees related to construction.
(8) Legal fees associated with acquisition of easements and rights-of-way directly related to the project.
(9) Costs necessary to mitigate demonstrated direct, adverse impacts resulting from the project.
(10) Costs of undertaking actions required by the program in connection with its making financial assistance available.
(11) Other reasonable direct or indirect costs associated with the project as demonstrated to the satisfaction of the agency and the department.

(b) Ineligible costs include:
(1) fines and penalties due to violations of, or failure to comply with, federal, state, or local law;
(2) purchase of land;
(3) legal fees incurred beyond those directly related to:
  (A) construction activities;
  (B) costs of undertaking actions required by the program in connection with its making financial assistance available; or
  (C) preparation of public notices;
(4) costs outside the scope of the approved project;
(5) bonus payments not legally required for completion of construction before a contractual completion date;
(6) basin or area-wide planning not directly related to the project;
(7) ordinary operating expenses of the political subdivision;
(8) costs of claims resulting from mismanagement or caused by the recipient's vicarious liability for the improper action of others; and
(9) costs incurred in a contract that creates a real or apparent conflict of interest.

SECTION 4. **A political subdivision shall publish the notice of intent to request refinancing in the manner called for by IC 5-1-3-4. The notice of intent shall generally describe the political subdivision's existing indebtedness and the indebtedness it expects to undertake to effectuate the refinancing under the program and how potentially affected parties may receive notice of, and provide comment on, the draft refinancing assessment.**

SECTION 5. **The agency and the department shall evaluate all information, including environmental impacts of the project for which refinancing is requested and issue a draft refinancing assessment. The draft refinancing assessment shall be sent to the political subdivision, all potentially affected parties listed in the notice of intent, and the county commissioners of the county where the project is located. All persons provided notice shall have fifteen (15) days to provide written comment to the department on the draft refinancing assessment. If the department determines that the requested refinancing meets all requirements of this document and 40 CFR 35, Subpart K, the department shall inform the agency that it may, subject to the financial policies and requirements of the program, notwithstanding any requirements of 327 IAC 13 and 85 IAC 2, provide financial assistance to the political subdivision.**

LSA Document #02-192(E)
Filed with Secretary of State: June 19, 2002, 11:28 a.m.

TITLE 312 NATURAL RESOURCES COMMISSION

LSA Document #02-190(E)

DIGEST

Temporarily modifies 312 IAC 9-10-4 to govern game breeder licenses. In addition, the modifications prohibit the release of white-tailed deer into the wild and sets forth penalties for noncompliance. Authority: IC 14-10-2-5. Effective June 30, 2002.

SECTION 1. **(a) Notwithstanding 312 IAC 9-10-4, this document governs individuals issued a game breeder license.**

(b) An application for a license as a game breeder of one (1) or more species of wild animals shall be made on a departmental form.

(c) An application for a permit under this SECTION must be made within five (5) days after the acquisition of an animal within Indiana or within five (5) days after the importation of an animal into Indiana, but after the cages or other enclosures are readied for habitation. Each cage or enclosure will be inspected by a conservation officer before a permit may be issued. Documentation that establishes lawful acquisition or ownership must accompany any transportation of white-tailed deer.

(d) A license holder may add a species to a game breeder operation other than those identified in the application upon written notification to the division within five (5) days of acquisition of the new species.

(e) Each animal possessed under this SECTION must be lawfully acquired. A receipted invoice, bill of lading, or other satisfactory evidence of lawful acquisition shall be presented for inspection upon the request of a conservation officer. Game or furbearing mammals or game birds, other than wild turkeys, lawfully taken in season may be retained alive after the close of the season.

(f) A wild animal must be confined in a cage or other enclosure which makes escape of the animal unlikely. The cage or enclosure shall be large enough to provide the wild animal with ample space for exercise and to avoid overcrowding. Rainproof dens, nest boxes, shelters, shade, and bedding shall be provided as required for the comfort of the particular species of animal. Each animal shall be handled in a sanitary and humane manner. The cages or other enclosures must be made available upon request for inspection by a conservation officer.

(g) A diseased wild animal possessed under this SECTION shall not be released in the wild. No white-tailed deer may be released into the wild. A license holder must report the escape of any white-tailed deer to a conservation officer within twenty-four (24) hours.

(h) A license holder must comply with IC 15-2.1 and 345 IAC.

(i) A game breeder shall record on a bill of sale or other suitable record a transaction by which a wild animal is sold, traded, or given to another person. A copy of the record shall be kept on the premises of the game breeder for at least two (2) years after the transaction and must be presented to a conservation officer upon request.

(j) A license may be suspended, denied, or revoked under IC 4-21.5 if the license holder fails to comply with any of the following:
(1) A license issued under this document.
(2) IC 14-22-20.
(3) IC 15-2.1 and 345 IAC.

LSA Document #02-190(E)
Filed with Secretary of State: June 17, 2002, 4:15 p.m.

TITLE 312 NATURAL RESOURCES COMMISSION

LSA Document #02-191(E)

DIGEST

Temporarily amends 312 IAC 9-3-7 to govern hunting white-tailed deer in a designated county under an extra deer license. Effective November 16, 2002.

SECTION 1. **(a) As anticipated by 312 IAC 9-3-7, this SECTION governs hunting deer under an extra deer license.**

(b) This SECTION is supplemental to 312 IAC 2-2 and governs the activities of an individual who is either:
(1) issued a license to take an extra deer under IC 14-22-12-1(18) or IC 14-22-12-1(19); or
(2) hunting under IC 14-22-11-1 with the use of an extra deer license under IC 14-22-12-1(18) or IC 14-22-12-1(19).

(c) No person may take an antlerless deer under this SECTION unless in possession of an antlerless deer license issued by the department of natural resources, division of fish and wildlife, under this SECTION.

(d) The season for hunting deer under this SECTION is as follows:
(1) From November 16, 2002, through December 1, 2002, with bow and arrows or firearms.
(2) From December 7, 2002, through January 5, 2003, with bow and arrows or crossbows.
(3) From December 7, 2002, through December 22, 2002, with muzzle loading guns.

(e) The seasonal limit for hunting under this SECTION is one (1) antlerless deer for each license issued under this SECTION.

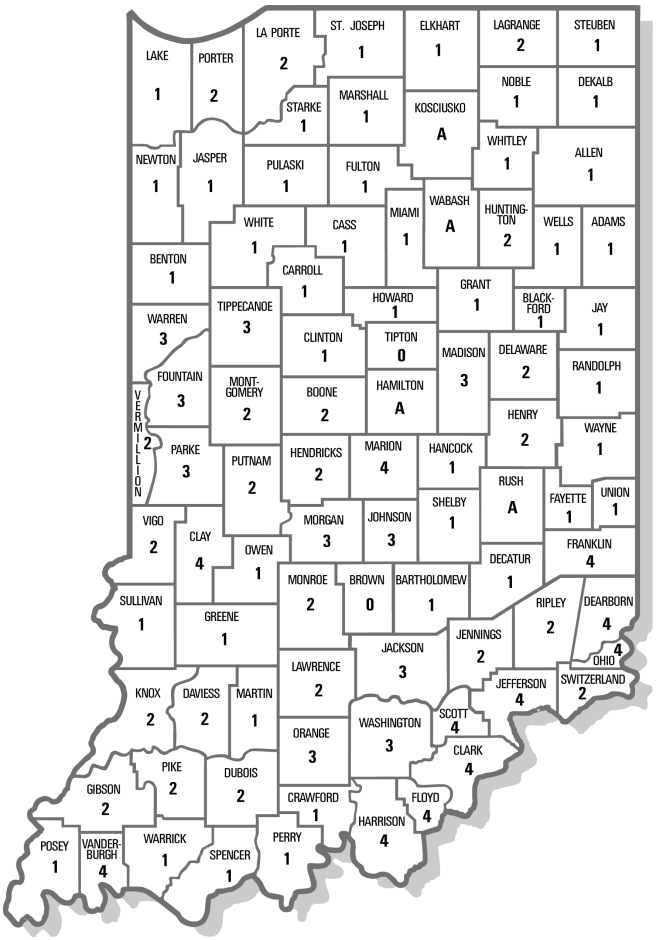
(f) A person who hunts under this SECTION must obtain an extra deer license for each deer. 312 IAC 9-3-2, that governs the use of tags, applies to extra tags.

(g) A person who hunts under this SECTION may use bow and arrows, crossbow, or any firearms that may otherwise be lawfully used to take deer under 312 IAC 9-3.

(h) 312 IAC 9-3-3(d) through 312 IAC 9-3-3(g) and 312 IAC 9-3-4(d) through 312 IAC 9-3-4(g) apply to a license issued under this SECTION.

(i) The seasonal bag limit for taking antlerless deer under this SECTION is four (4) from Indiana.

(j) Except as provided in subsection (k), the county bag limit must not be exceeded from each county as set forth in the following map:



(k) For a county marked on the map in subsection (j) with the letter "A", the county bag limit is one (1) antlerless deer. The deer must be taken from November 28 through December 1, 2002, and December 7 through January 5, 2003.

(l) The extra deer license authorized by this SECTION does not apply to the department properties listed in this subsection. The license is invalid on these properties:
(1) Atterbury Fish and Wildlife Area.
(2) Blue Grass Fish and Wildlife Area.
(3) Brush Creek Fish and Wildlife Area.
(4) Chinook Fish and Wildlife Area.
(5) Crosley Fish and Wildlife Area.
(6) Francis Slocum State Forest.
(7) Glendale Fish and Wildlife Area.
(8) Green-Sullivan State Forest.
(9) Hardy Lake (including adjacent lands administered by the department of natural resources).
(10) Hillenbrand Fish and Wildlife Area.
(11) Hovey Lake Fish and Wildlife Area.
(12) Huntington Lake (including adjacent lands administered by the department of natural resources).

(13) Jasper Pulaski Fish and Wildlife Area.
(14) Kankakee Fish and Wildlife Area.
(15) Lasalle Fish and Wildlife Area.
(16) Minnehaha Fish and Wildlife Area.
(17) Mississinewa Lake (including adjacent lands administered by the department of natural resources).
(18) Patoka Lake, except east of State Road 145 (in Orange County and Crawford County) and south of State Road 164 (in Dubois County and Crawford County).
(19) Pigeon River Fish and Wildlife Area.
(20) Salamonie Lake (including adjacent lands administered by the department of natural resources).
(21) Salamonie State Forest.
(22) Splinter Ridge Fish and Wildlife Area.
(23) Sugar Ridge Fish and Wildlife Area.
(24) Tri-County Fish and Wildlife Area.
(25) Wilbur Wright Fish and Wildlife Area.
(26) Willow Slough Fish and Wildlife Area.
(27) Winamac Fish and Wildlife Area.

SECTION 2. **SECTION 1 of this document expires February 1, 2003.**

LSA Document #02-191(E)
Filed with Secretary of State: June 17, 2002, 4:12 p.m.

TITLE 312 NATURAL RESOURCES COMMISSION

LSA Document #02-194(E)

DIGEST

Temporarily amends 312 IAC 9 to govern noncommercial hunts at Chain O'Lakes State Park, Clifty Falls State Park, Harmonie State Park, Lincoln State Park, McCormick's Creek State Park, Ouabache State Park, Potato Creek State Park, Shades State Park, Shakamak State Park, Spring Mill State Park, Tippecanoe River State Park, Turkey Run State Park, Versailles State Park, Whitewater Memorial State Park, and Twin Swamps Nature Preserve. Under IC 4-22-2-37.1, IC 14-22-2-6, IC 14-10-2-5, and IC 14-22-6-13 (applicable to state parks), the director of the department of natural resources adopts the emergency rule set forth in this document. The emergency rule is adopted with the awareness the regulation of wild animals in Indiana is the responsibility of the department of natural resources, and with a heightened awareness of that responsibility (as well as a responsibility for the welfare of flora and other fauna), within Indiana state parks and dedicated nature preserves. More particularly, based upon the opinion of professional biologists, the director has determined: (A) white-tailed deer have caused, and will continue to cause, obvious and measurable damage to the ecological balance within these properties; and (B) the ecological balance within these properties will not be maintained unless action is taken to control their populations. Examples of damages caused by excessive deer populations include reduction of rare plant species and sampling data that show, more generally, vegetation species disturbance in areas accessible to deer browsing. Effective July 1, 2002.

SECTION 1. **(a) Notwithstanding 312 IAC 9-2-11, 312 IAC 8-2, and any other provision governing hunting a wild animal within a state park, individuals qualified under this SECTION may hunt white-tailed deer at the following sites and within the following schedules:**
(1) Chain O'Lakes State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(2) Clifty Falls State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(3) Harmonie State Park from 6:30 a.m. until 3 p.m., CST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(4) Lincoln State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(5) McCormick's Creek State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(6) Ouabache State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(7) Potato Creek State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(8) Shades State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(9) Shakamak State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(10) Spring Mill State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(11) Tippecanoe River State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(12) Turkey Run State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(13) Versailles State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.
(14) Whitewater Memorial State Park from 7:30 a.m. until 4 p.m., EST on November 18 through November 19, 2002, and December 2 through December 3, 2002.

(b) Except as provided in subsection (r) for Clifty Falls State Park, a deer may be lawfully taken under this SECTION only by the use of a firearm that may be lawfully used to hunt deer in Indiana.

(c) In order to apply for a license under this SECTION, an individual must satisfy both of the following requirements:

(1) Possess at least one (1) valid resident license issued under 312 IAC 9-3-3, 312 IAC 9-3-4, or IC 14-22-12-7 to take deer.

(2) Be at least eighteen (18) years old by September 27, 2002.

(d) The maximum number of individuals for each site each day who may be issued a license is as set forth in this subsection:

(1) For Chain O'Lakes State Park, one hundred ten (110) individuals.

(2) For Clifty Falls State Park, one hundred thirty (130) individuals.

(3) For Harmonie State Park, one hundred seventy (170) individuals.

(4) For Lincoln State Park, eighty (80) individuals.

(5) For McCormick's Creek State Park, eighty (80) individuals.

(6) For Ouabache State Park, fifty (50) individuals.

(7) For Potato Creek State Park, one hundred sixty (160) individuals.

(8) For Shades State Park, one hundred fifty-five (155) individuals.

(9) For Shakamak State Park, sixty (60) individuals.

(10) For Spring Mill State Park, sixty (60) individuals.

(11) For Tippecanoe River State Park, one hundred thirty (130) individuals.

(12) For Turkey Run State Park, one hundred (100) individuals.

(13) For Versailles State Park, two hundred ninety-five (295) individuals.

(14) For Whitewater Memorial State Park, eighty-five (85) individuals.

(e) For each state park other than Clifty Falls State Park, the department will determine the participants for the hunt by first selecting individuals who have completed a course of instruction in hunter safety under IC 14-22-35. If more than the maximum number of individuals who have completed this course apply for a license under this SECTION, the department will select the participants for that state park by a drawing from those individuals who have completed the course. If fewer than the maximum number of individuals who have completed this course apply for a license, the department shall supplement the participation list with applicants who have not completed a course of instruction in hunter safety. If supplementing the participation list with applicants who have not completed a course of instruction results in more applications than the maximum number of individuals who may be issued a license, the department will select the supplemental participants by a drawing from those individuals who have not completed the course.

(f) An application for a license under this SECTION must be completed on a department form as described in this subsection:

(1) The forms are available at all state parks and reservoirs, at the Customer Service Center in the Indiana Government Center-South, 402 West Washington Street, Room W160, Indianapolis, Indiana 46204, and on the Internet through the department's homepage.

(2) In order to qualify an applicant for participation, a completed form (including a photocopy of a license issued to the applicant as identified in subsection (c)(1)) must be actually received by 4 p.m., EST (4 p.m., CDT), on September 27, 2002, at the Department of Natural Resources, Division of State Parks and Reservoirs, 402 West Washington Street, Room W298, Indianapolis, Indiana 46204.

(g) An individual may file no more than three (3) separate applications for three (3) individual applicants, as long as each application is accompanied by a deer license described in subsection (c)(1). Up to three (3) applications may be submitted as a unit so that all or none of the applicants will be selected to participate in the hunt. The submission by an individual of more than one (1) application per period disqualifies the individual (and any other individual submitting as a unit with the individual) from participating in the drawing. For the purposes of this subsection, one (1) "period" is November 18 through November 19, and the other "period" is December 2 through December 3, 2002.

(h) Any drawing required by this SECTION will be conducted on a random basis. Written notice will be mailed by the department to successful applicants.

(i) Each individual issued a license under this SECTION will be randomly assigned to specific management units with designated parking assignments. Each license holder must comply with the requirements set forth in the assignment.

(j) The form of the license under this SECTION shall be as determined by the department. Each participant in the hunt must possess and display evidence of the license as specified by the department.

(k) Notwithstanding 312 IAC 9-1-15, a participant (except for a participant at Clifty Falls State Park) must expose outer garments with hunter orange, which include both of the following:

(1) A hat or cap.
(2) A vest, coat, jacket, or coveralls.

(l) During the hunt, an individual must not take more than:
(1) Three (3) total deer.
(2) Included among the total deer taken, there must not be more than one (1) antlered deer.

(m) A deer taken under this SECTION does not apply to any bag limit for taking deer established by 312 IAC 9.

(n) All deer must be delivered to a designated check station within the state park.

(o) An individual must not enter a state park described in this SECTION during the following periods:
(1) from 8 p.m., EST (7 p.m., CST) on Sunday, November 17 through 8 a.m., EST (7 a.m., CST) on Wednesday, November 20; or
(2) from 8 p.m., EST (7 p.m., CST) on Sunday, December 1 through 8 a.m., EST (7 a.m., CST) on Wednesday, December 4, 2002;
unless the individual satisfies both subsection *[subsections]* **(p) and (q).**

(p) An individual shall enter a state park only at a site designated by the department.

(q) In order to enter a state park, an individual must be one (1) of the following:
(1) An individual granted a license under this SECTION.
(2) A representative of the media.
(3) An employee of the department.
(4) Another individual with credentials supplied by the department.

(r) This subsection provides additional requirements that must be satisfied by a participant in the hunts at Clifty Falls State Park:
(1) Except as otherwise provided in subdivision (2), an applicant must have successfully completed the International Bowhunter Education Program before participating in a hunt at Clifty Falls State Park. A copy of documents showing completion shall be included with the application.
(2) If the maximum number under subsection (d)(2) is not filled with applicants who have successfully completed the International Bowhunter Education Program, a supplemental drawing shall be held among applicants who hold a valid Hunter Education Card to fill the remaining positions.
(3) An individual who participates in the hunt must not discharge bow and arrows except from a tree stand.

SECTION 2. **(a) Notwithstanding any other provision governing hunting a wild animal within a nature preserve dedicated under IC 14-31-1, individuals qualified under this SECTION may by firearms only hunt white-tailed deer at Twin Swamps Nature Preserve in Posey County from 6:30 a.m. until 3 p.m., CST on November 18 through November 19, 2002, and December 2 through December 3, 2002.**

(b) In order to apply for a license under this SECTION, an individual must satisfy both of the following requirements:
(1) Possess at least one (1) valid resident license issued under 312 IAC 9-3-3, 312 IAC 9-3-4, or IC 14-22-12-7 to take deer.
(2) Be at least eighteen (18) years old by September 27, 2002.

(c) No more than thirty (30) individuals may be issued a license to take deer at Twin Swamps Nature Preserve for each day.

(d) The department will determine the participants for the hunt by first selecting individuals who have completed a course of instruction in hunter safety under IC 14-22-35. If more than the maximum number of individuals who have completed this course apply for a license under this SECTION, the department will select the participants for that nature preserve by a drawing from those individuals who have completed the course. If fewer than the maximum number of individuals who have completed this course apply for a license, the department shall supplement the participation list with applicants who have not completed a course of instruction in hunter safety. If supplementing the participation list with applicants who have not completed a course of instruction results in more applications than the maximum number of individuals who may be issued a license, the department will select the supplemental participants by a drawing from those individuals who have not completed the course.

(e) An application for a license under this SECTION must be completed on a department form as described in this subsection:
(1) The forms are available at all state parks and reservoirs, at Hovey Lake Fish and Wildlife Area, at the Customer Service Center in the Indiana Government Center-South, 402 West Washington Street, Room W160, Indianapolis, Indiana 46204, and on the Internet through the department's homepage. Forms may also be available at other staffed DNR property offices.
(2) In order to qualify an applicant for participation, a completed form (including a photocopy of a license issued to the applicant as identified in subsection (b)(1)) must be actually received by 4:00 p.m., EST (3:00 p.m., CST), on September 27, 2002, at the Department of Natural Resources, Division of State Parks and Reservoirs, 402

West Washington Street, Room W298, Indianapolis, Indiana 46204.

(f) An individual may file no more than three (3) separate applications for three (3) individual applicants, as long as each application is accompanied by a deer license described in subsection (b)(1). Up to three (3) applications may be submitted as a unit so all or none of the applicants will be selected to participate in the hunt. The submission by an individual of more than one (1) application per period disqualifies the individual (and any other individual submitting as a unit with the individual) from participating in the drawing. For the purposes of this subsection, one (1) "period" is November 18 through November 19, and the other "period" is December 2 through December 3, 2002.

(g) Any drawing required by this SECTION will be conducted on a random basis. Written notice will be mailed by the department to successful applicants.

(h) The form of the license under this SECTION shall be as determined by the department. Each participant in the hunt must possess and display evidence of the license as specified by the department.

(i) Notwithstanding 312 IAC 9-1-15, a participant must expose outer garments with hunter orange that include both of the following:
(1) A hat or cap.
(2) A vest, coat, jacket, or coveralls.

(j) During the hunt, an individual must not take more than:
(1) Three (3) total deer.
(2) Included among the total deer taken, there must not be more than one (1) antlered deer.

(k) A deer taken under this SECTION does not apply to any bag limit for taking deer established by 312 IAC 9.

(l) All deer must be delivered to a designated check station within the nature preserve.

(m) An individual must not enter Twin Swamps Nature Preserve during the following periods:
(1) from 8 p.m., EST (7 p.m., CST) on Sunday, November 17 through 8 a.m., EST (7 a.m., CST) on Wednesday, November 20; or
(2) from 8 p.m., EST (7 p.m., CST) on Sunday, December 1 through 8 a.m., EST (7 a.m., CST) on Wednesday, December 4, 2002;
unless the individual satisfies both subsection (n) and subsection (o).

(n) An individual shall enter Twin Swamps Nature Preserve only at a site designated by the department.

(o) In order to enter Twin Swamps Nature Preserve, an individual must be one (1) of the following:
(1) An individual granted a license under this SECTION.
(2) A representative of the media.
(3) An employee of the department.
(4) Another individual with credentials supplied by the department.

SECTION 3. **SECTIONS 1 and 2 of this document expire on December 15, 2002.**

LSA Document #02-194(E)
Filed with Secretary of State: June 24, 2002, 2:07 p.m.

TITLE 312 NATURAL RESOURCES COMMISSION

LSA Document #02-205(E)

DIGEST

Temporarily modifies 312 IAC 18-3-12, which governs the control of larger pine shoot beetles, by additing Bartholomew, Franklin, Monroe, Morgan, and Putnam Counties to the quarantine area. Effective July 15, 2002.

SECTION 1. **Bartholomew, Franklin, Monroe, Morgan, and Putnam Counties are declared to be generally infested with larger pine shoot beetles and made subject to quarantine under 312 IAC 18-3-12. The counties listed in this document are in addition to those counties quarantined at 312 IAC 18-3-12(b).**

SECTION 2. **SECTION 1 of this document expires July 1, 2003.**

LSA Document #02-205(E)
Filed with Secretary of State: July 10, 2002, 10:15 a.m.

TITLE 327 WATER POLLUTION CONTROL BOARD

LSA Document #02-193(E)

DIGEST

Temporarily adds provisions to allow for the use of the State Revolving Fund to refund outstanding indebtedness of political subdivisions eligible for refinancing under the Clean Water Act. *NOTE: Under IC 13-18-13-18, this document is jointly promulgated with the budget agency.* Authority: IC 4-22-2-37.1(a)(8). Effective June 19, 2002.

SECTION 1. **A political subdivision may seek a financial**

assistance loan under IC 13-18-13 to refinance outstanding indebtedness that was previously incurred to finance construction costs of an eligible project by meeting the requirements of this document and the Clean Water Act.

SECTION 2. **To be eligible for refinancing, a political subdivision must submit to the department and the state budget agency (agency) a notice of intent to request refinancing. The notice of intent shall also include a list of all potentially affected parties. The following information shall also be submitted to the department and the agency:**

(1) A brief summary of the project proposed for refinancing.
(2) A cost breakdown of all eligible items requested for refinancing.
(3) A legal description of the project area.
(4) Construction specifications of the project.
(5) Maps showing all project elements, including lines, pump stations, tanks, and treatment plants, in relation to:
(A) mapped wetlands;
(B) wellhead protection areas;
(C) surface waters;
(D) surface water intakes;
(E) one hundred (100) year floodplains;
(F) areas where trees and brush were removed; and
(G) nature preserves.
(6) Preconstruction descriptions of all off-road sites and routes, including construction corridor widths.
(7) An assessment of the environmental impacts of the project, including:
(A) farmland;
(B) air quality;
(C) groundwater, drinking water, and sole source aquifers;
(D) floodplains, wetlands, waterways, and other surface waters;
(E) biota;
(F) nature preserves;
(G) archaeological resources; and
(8) Mitigation measures taken to eliminate, minimize, or compensate for environmental impacts.
(9) A due diligence submission required under 327 IAC 13-7-1.
(10) A list of potentially affected parties.
(11) A notice of intent pursuant to SECTION 4 of this document.
(12) Any additional information the department and the agency deem necessary to complete the refinancing assessment.

SECTION 3. **(a) Eligible costs include the following:**
(1) Preparation of construction drawings, specifications, estimates, and construction contract documents.
(2) Materials acquired, consumed or expended specifically for the project.
(3) Labor costs directly associated with construction of the project.
(4) Development and preparation of an operation and maintenance plan and manual.
(5) Safety equipment.
(6) Costs of public notices and hearings.
(7) Inspection fees related to construction.
(8) Legal fees associated with acquisition of easements and rights-of-way directly related to the project.
(9) Costs necessary to mitigate demonstrated direct, adverse impacts resulting from the project.
(10) Costs of undertaking actions required by the program in connection with its making financial assistance available.
(11) Other reasonable direct or indirect costs associated with the project as demonstrated to the satisfaction of the department and the agency.

(b) Ineligible costs include:
(1) fines and penalties due to violations of, or failure to comply with, federal, state, or local law;
(2) purchase of land;
(3) legal fees incurred beyond those directly related to:
(A) construction activities;
(B) costs of undertaking actions required by the program in connection with its making financial assistance available; or
(C) preparation of public notices;
(4) costs outside the scope of the approved project;
(5) bonus payments not legally required for completion of construction before a contractual completion date;
(6) basin or area-wide planning not directly related to the project;
(7) ordinary operating expenses of the political subdivision;
(8) costs of claims resulting from mismanagement or caused by the recipient's vicarious liability for the improper action of others; and
(9) costs incurred in a contract that creates a real or apparent conflict of interest.

SECTION 4. **A political subdivision shall publish the notice of intent to request refinancing in the manner called for by IC 5-1-3-4. The notice of intent shall generally describe the political subdivision's existing indebtedness and the indebtedness it expects to undertake to effectuate the refinancing under the program and how potentially affected parties may receive notice of, and provide comment on, the draft refinancing assessment.**

SECTION 5. **The department and the agency shall evaluate all information, including environmental impacts of the project for which refinancing is requested and issue a draft refinancing assessment. The draft refinancing assessment shall be sent to the political subdivision, all potentially affected parties listed in the notice of intent, and the county commissioners of the county where the project**

is located. All persons provided notice shall have fifteen (15) days to provide written comment to the department on the draft refinancing assessment. If the department determines that the requested refinancing meets all requirements of this document and 40 CFR 35, Subpart K, the department shall inform the agency that it may, subject to the financial policies and requirements of the program, notwithstanding any requirements of 327 IAC 13 and 85 IAC 2, provide financial assistance to the political subdivision.

LSA Document #02-193(E)
Filed with Secretary of State: June 19, 2002, 11:30 a.m.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-195(E)

DIGEST

Temporarily amends 405 IAC 6-2-3, 405 IAC 6-2-5, 405 IAC 6-2-9, 405 IAC 6-2-12, 405 IAC 6-2-14, 405 IAC 6-2-18, 405 IAC 6-2-20, 405 IAC 6-2-21, 405 IAC 6-3-2, 405 IAC 6-3-3, 405 IAC 6-4-2, 405 IAC 6-5-1, 405 IAC 6-5-2, 405 IAC 6-5-3, 405 IAC 6-5-4, 405 IAC 6-5-5, 405 IAC 6-5-6, 405 IAC 6-6-2, and 405 IAC 6-6-4, provisions affecting applicants, enrollees, eligibility and enrollment requirements, benefits, and policy for the Indiana prescription drug program. Temporarily adds provisions that will set forth procedures for point of service processing and provider claims, payments, overpayments, and appeals for the Indiana prescription drug program. Authority: IC 4-22-2-37.1; IC 12-10-16-5. Effective July 1, 2002.

SECTION 1. **"Benefit period" means a specified time frame during which an enrollee accrues or expends the cost of prescription drugs. The benefit periods are specified in 405 IAC 6-5-3.**

SECTION 2. **"Complete application" means an application which 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) Marital status.
(6) Whether the applicant had health insurance with a prescription drug benefit in the past year.
(7) Whether the applicant currently has insurance that includes a prescription drug benefit.
(8) Whether the applicant is on Medicaid, including Medicaid with a spend-down.
(9) Whether the applicant has resided in Indiana for at least ninety (90) days in the past twelve (12) months.
(10) Proof of income. and
(11) Signature.

SECTION 3. **"Complete claim" means a claim submitted by a provider for processing that contains the enrollee's name and for each drug listed all of the following information:**

(1) The day the drug was dispensed.
(2) Corresponding National Drug Code (NDC) number.
(3) Identification of prescribing physician.
(4) Name and dosage of drug.
(5) Provider's retail price.
(6) Actual price enrollee paid for the drug.

SECTION 4. **"Domicile" means the applicant's true, fixed, principal, and permanent home.**

SECTION 5. **"Family" means the applicant, spouse, and any child who reside in the same residence.**

SECTION 6. **"Health insurance with a prescription drug benefit" means any contract with an insurance company or organization approved or recognized by the Indiana department of insurance, under which an individual receives health benefits, including a prescription drug benefit. This term includes Medicaid and veteran's benefits. A prescription discount offered by an insurance company, department, manufacturer, provider, or organization is not considered to be a prescription drug insurance benefit as long as the discount is deducted prior to the calculation of any enrollee benefit.**

SECTION 7. **"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 profit from financial investments.**

SECTION 8. **"Net income" means the earned income minus tax deductions, tax exemptions, and other tax reductions, and unearned income minus Medicare premiums that an applicant and an applicant's family receives, calculated on a monthly basis.**

SECTION 9. **"Point of service" means receiving the program benefit at the time of purchase of the prescription drugs.**

SECTION 10. **"Prescription printout" means an itemized report prepared by a provider for an enrollee showing prescription data for the enrollee for a stated benefit period. Such prescription data must include, but is not limited to:**

(1) enrollee name and address;
(2) prescription number;
(3) NDC Code;
(4) drug name;
(5) drug strength;

(6) dosage form;
(7) quantity dispensed;
(8) date of dispense;
(9) the amount of any discount provided; and
(10) the amount paid by the enrollee or any insurance plan.

SECTION 11. **"Proof of income" means documentation of the income of an applicant and an applicant's family.**

SECTION 12. **(a) "Provider" means:**
(1) an entity who participates in the program;
(2) is licensed under IC 25-26-13;
(3) holds a proper permit under IC 25-26-13-17; and
(4) who complies with the same state enrollment requirements established for the Medicaid program at 405 IAC 5-4.

(b) Nothing in this rule prevents an enrolled provider from dispensing a prescription from an out-of-state branch location as long as:
(1) the provider has an Indiana presence and is enrolled under the provisions of this article; and
(2) the branch location where the prescription is dispensed is located within the United States of America.

SECTION 13. **"Refund certificate" means the claim document issued to an enrollee by the office which authorizes the enrollee, who has not received a benefit at point of service, to request a refund for prescription drugs purchased during a benefit period.**

SECTION 14. **"Reside" means the place where an applicant actually lives as distinguished from a domicile.**

SECTION 15. **For purposes of determining the effective date of availability of the program to an applicant, the date of application is the date the complete application is received by the office.**

SECTION 16. **(a) The program is available to an enrollee beginning with the benefit period prior to the one in which the enrollee applied for enrollment in the program.**

(b) After July 1, 2002, program availability will be no sooner than the date complete application is received and approved.

(c) Those enrollees applying on or before the tenth of a month will have point of service benefits available on the first day of the following month. Those enrollee's applying after the tenth of a month will have point of service benefits available no later than the first day of the second following month.

(d) The program is not available for prescription drugs purchased prior to the month in which the enrollee turned sixty-five (65) years of age.

SECTION 17. **(a) To be eligible for the program, an applicant's monthly family net income must not exceed the income limit listed below for the applicant's family size:**

Family Size	Net Monthly Income Limit
1	$ 997
2	$1,344
3	$1,690

(b) For each additional family member over three (3), the family member standard shall be added to the net monthly income limit for a family of three (3) in order to calculate the net monthly income limit. A child who earns more than the family member standard per month is not included in the calculation of monthly net income or in family size.

(c) The monthly net income limits are determined by multiplying the annual federal poverty guideline amounts for each family size by one hundred thirty-five percent (135%), dividing by twelve (12), and then rounding up to the next whole dollar. The income standards in *[subsection]* **(a) shall increase annually in the same percentage (%) amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register.**

SECTION 18. **(a) The program shall issue a partial refund to an enrollee for the purchase of prescription drugs, as defined under this article, based upon the limitations set forth in this rule if an enrollee submits a refund certificate.**

(b) Rather than submit a refund certificate, an eligible enrollee may go to any participating provider to purchase prescription drugs and present his or her prescription and program identification card at the point of service to receive immediate program benefits. At the point of service, the provider shall determine the following:
(1) Whether the enrollee is eligible.
(2) Whether the individual whose name appears on the identification card is the same as the individual for whom the prescription is written.
(3) Whether the enrollee has benefits available.
(4) That all prescription discounts are deducted from provider's retail price prior to calculating program benefits.
(5) The amount of the enrollee's copayment.

SECTION 19. **(a) The refund or benefit at the time of purchase, which is issued to an enrollee per benefit period is limited by family monthly net income as follows:**

Income Guideline	Individual's Monthly Net Income	Couple's Monthly Net Income	Annual Benefit
Up to 135% of federal poverty guideline	Up to $997 per month	Up to $1,344 per month	50% benefit, up to $500 benefit/year
Up to 120% of federal poverty guideline	Up to $886 per month	Up to $1,194 per month	50% benefit, up to $750 benefit/year
Under 100% of federal poverty guideline	Up to $739 per month	Up to $995 per month	50% benefit, up to $1,000 benefit/year

(b) An enrollee and spouse who are enrolled in the program will each receive the maximum refund, or benefit at the time of purchase, for prescription drug expenses up to the annual benefit in subsection (a) for which they qualify by family income level.

(c) Upon such time as the enrollee exceeds the annual benefit, the enrollee may use the prescription identification card to access program benefit prescription drug rates as defined by SECTION 28 and SECTION 29 of this document until the enrollee benefit period expires.

SECTION 20. **(a) The refund certificate program shall consist of four (4) benefit periods per year, defined as follows:**

(1) Benefit period one: October 1 through December 31.
(2) Benefit period two: January 1 through March 31.
(3) Benefit period three: April 1 through June 30.
(4) Benefit period four: July 1 through September 30.

(b) The point of service benefit shall be one (1) year of continuous eligibility up to that which is proscribed in SECTION 19 of this document.

SECTION 21. **(a) The refund certificate program is available to an enrollee for a maximum of four (4) consecutive benefit periods.**

(b) The point of service benefit is available to an enrollee for one (1) year.

(c) If an enrollee is utilizing both the refund certificate program and the point of service program, the maximum benefit duration to an enrollee is one (1) year of continuous benefits.

(d) To reenroll in the refund certificate program or for point of service benefits, a new application must be submitted to the office in accordance with this article.

SECTION 22. **An enrollee is ineligible for a program benefit for prescription drugs purchased during any benefit period in which the enrollee has health insurance or Medicaid with a prescription drug benefit.**

SECTION 23. **(a) Upon submission of a completed refund certificate, or at the point of service, benefits are available under this program 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 to enrollees.

SECTION 24. **Once the office has determined eligibility, the applicant will receive a letter of eligibility notifying the applicant of his or her status in the program. An applicant will either be eligible and enrolled in the program, or ineligible and not enrolled in the program. New applicants determined to be eligible after July 1, 2002, will receive an approved letter of eligibility and a program benefit card.**

SECTION 25. **(a) If the enrollee is using refund certificates, during each refund period, the enrollee must submit the applicable refund certificate with the prescription printout for the corresponding benefit period to the office in the manner prescribed by the office.**

(b) The refund period deadline is the date which corresponds to the later of thirty-five (35) days from the date on the letter of eligibility or the last day of the applicable refund period.

(c) An enrollee will be notified by mail if the enrollee submits an incomplete request for refund. An incomplete request for refund includes:

(1) an unsigned refund certificate;
(2) a refund certificate with no insurance verification;
(3) a prescription printout which fails to state all information in SECTION 10 of this document;
(4) the absence of a refund certificate for the applicable benefit period;
(5) the absence of a prescription printout for the applicable benefit period; or
(6) the absence of any other information that is necessary under this article to process a refund request.

The enrollee must submit the information requested in the letter of notification by the deadline in the letter of notification.

(d) Refund certificates received by the office after the refund deadline date will not be processed and no refund will be issued. Any refund certificate or prescription printout requested in *[subsection]* **(c) that is received by the office after the stated deadline date will not be processed and no refund will be issued.**

SECTION 26. **All provider appeals from office action taken under this 405 IAC 6 and this document shall be governed by the procedures and time limits for Medicaid providers set out in 405 IAC 1-1.5.**

SECTION 27. **The provisions of 405 IAC 1-5 concerning contents, retention, and disclosure of records of Medicaid providers shall apply to providers of covered drugs under this title.**

SECTION 28. **The rates of reimbursement for the covered prescription drugs provided under this title shall be the same as those calculated for Medicaid prescription drugs under rules adopted by the secretary at 405 IAC 5-24.**

SECTION 29. **The Indiana prescription drug dispensing fee maximum under this title shall be the same as that which is allowable under rules adopted by the secretary at 405 IAC 5-24-6.**

SECTION 30. **(a) All provider claims for payment for point of service benefits rendered to enrollees 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 reimbursement may appeal under the provisions of SECTION 26 of this document. However, prior to filing such an appeal, the provider must either:**

(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 and/or reconsideration of a claim that has been denied must be submitted to the office 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 provision of the service, 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:

(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, appropriateness of services and charges, application of discounts, and other areas of accuracy and appropriateness as indicated.

(d) The office is only liable for the payment of claims filed by providers who were certified providers at the time the service was rendered and for services provided to persons who were enrolled in the Indiana prescription drug program as eligible enrollees 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 an enrollee or from the authorized representative of the enrollee that portion of his charge for a benefit as defined by SECTION 19 of this document which is not reimbursed by the Indiana prescription drug program and after all prescription discounts have been calculated as proscribed by this article.

SECTION 31. **(a) The office may deny payment, or instruct the contractor to deny payment, to any provider if, after investigation by the office, the office's designee, or other governmental authority, the office finds any of the following:**

(1) The services claimed cannot be documented by the provider in accordance with SECTION 27 of this document.

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

(3) The services claimed were 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) Failure to disclose, or make available to the office, or its authorized agent, records of services provided to enrollees and records of payments made therefor.

(E) 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.

(F) Breach of the terms of the Indiana Prescription

Drug Provider Certification Agreement or failure to comply with the terms of the Provider Certification on the Claim Form.

(G) Violating any provision of state law or any rule or regulation promulgated pursuant to 405 IAC 6, this document, or any provider bulletin published thereto.

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

(I) Failure to meet standards required by the state of Indiana for participating in the program.

(J) Refusal to execute a new Provider Certification Agreement when requested by the office or its contractor to do so.

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

(L) 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.

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

(5) The claim arises out of any act or practice prohibited by rules and regulations 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 has elected to receive electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed under SECTION 30 of this document.

(c) The decision as to claim payment suspension is at the discretion of the office and may include any 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 SECTION 26 of this document.

(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 SECTION 26 of this document.

SECTION 32. **(a) The office may recover payment, or instruct its contractor to recover payment, from any provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:**

(1) the services paid for cannot be documented by the provider as required by SECTION 27 of this document;

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

(3) the service reimbursed 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 an inaccurate description of prescription data;

(6) overpayment resulted from duplicate billing;

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

(b) The office may determine the amount of overpayments made to a provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana prescription drug program. The following criteria apply to random sample audits:

(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.

(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must be completed within one hundred eighty (180) days of the date of appeal and must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law. The provider must submit supporting documentation to demonstrate this compliance.

(d) 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).

(e) 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.

(f) 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).

(g) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c). Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. When an overpayment is determined pursuant to the results of a random sample audit, the date the overpayment occurred shall be considered to be the last day of the audit period, and interest will be calculated from the last day of the audit period.

(1) Recovering interest:

(A) 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' previous fiscal year, excluding pension fund investments, as published in the auditor of state' comprehensive annual financial report; and

(B) 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.

(h) 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.

(i) If, after receiving a notice and request for repayment, the provider fails to elect one (1) of the options listed in subsection (d) 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 33. **(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 32 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 32 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 34. **(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 (decertify the provider).

(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:

(1) submitted, or caused to be submitted, claims for services which cannot be documented by the provider;

(2) submitted, or caused to be submitted, claims for services 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 provider certification agreement;

(7) failed to comply with the terms of the provider certification on the claim form;

(8) overutilized, or caused to be overutilized, the program;

(9) submitted, or caused to be submitted, a false or fraudulent provider certification agreement;

(10) submitted, or caused to be submitted, any claims for services arising out of any act or practice prohibited by the criminal provisions of the Indiana Code or by the rules of the office;

(11) 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 services provided to enrollees and office records of payments made therefor;

(12) failed to meet standards required by the state of Indiana law for participation;

(13) charged an enrollee copayment for covered services over and above that allowable under this article;

(14) refused to execute a new provider certification agreement when requested to do so;

(15) failed to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office;

(16) 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 SECTION 26 of this document.

(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 SECTION 26 of this document.

(e) The decision to impose a sanction shall be made at the discretion of the office.

SECTION 35. **SECTIONS 1 through 34 of this document expire September 26, 2002.**

LSA Document #02-195(E)
Filed with Secretary of State: June 28, 2002, 10:18 a.m.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-196(E)

DIGEST

Temporarily adds provisions to set out eligibility requirements for Medicaid for Employees with Disabilities (MED Works). Authority: IC 4-22-2-37.1(a); IC 12-15-41-15(b). Effective July 1, 2002.

SECTION 1. **(a) This document establishes the eligibility requirements for the two (2) optional Medicaid categories for Employees with Disabilities identified in 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI), and in accordance with the provisions of IC 12-15-41.**

(b) As used in this document, "applicant or recipient" means an individual whose Medicaid eligibility is being determined under one (1) of the above referenced Medicaid categories and in accordance with the requirements of this document.

(c) A person who is less than sixteen (16) years of age, or age sixty-five (65) or older is not eligible for Medicaid for Employees with Disabilities.

(d) A recipient must report any change in income, resources, employment status, or marital status within ten (10) days of the date of the change. An additional ten (10) days is allowed to provide any necessary verification.

(e) A disabled individual will be considered for eligibility under this document if the individual is ineligible for Medicaid under the Disability category for any of the following reasons:

(1) The individual's income exceeds the applicable standard specified in IAC 2-3-18 *[sic.]***.**

(2) The individual's resources exceed the limit in IC 12-15-3-1 or IC 12-15-3-2.

(3) The individual's gross earnings exceed the substantial gainful activity amount established by the Social Security Administration in 20 CFR 416.974.

(f) In addition to the requirements in this document, the requirements in the following rules apply to applicants and recipients of Medicaid for Employees with Disabilities:

(1) 405 IAC 2-1-2.
(2) 405 IAC 2-1-3.
(3) 405 IAC 2-2-4.
(4) 405 IAC 2-3-1.1.
(5) 405 IAC 2-3-2.
(6) 405 IAC 2-3-11.
(7) 405 IAC 2-3-12.
(8) 405 IAC 2-3-13.
(9) 405 IAC 2-3-14.
(10) 405 IAC 2-3-22.
(11) 405 IAC 2-4-1.
(12) 405 IAC 2-5-1.
(13) 405 IAC 2-8-1.
(14) 405 IAC 2-8-2.

SECTION 2. **(a) Countable income is gross monthly income less the deductions and exclusions required by federal or state statute or regulation and the deductions and exclusions in this SECTION.**

(b) The following are disregarded or deducted in determining net earned income:

(1) Up to ten dollars ($10) of earned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars ($10), this disregard cannot be applied.

(2) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determine net self-employment earnings.

(3) Sixty-five dollars ($65) of earned income per month, plus impairment-related work expenses described in (4) below *[subdivision (4)]***, plus one-half (½) of remaining earned income is excluded.**

(4) Impairment-related work expenses are expenses that are paid by the applicant or recipient for the purchase or rental of certain items and services that are necessary, due to the severity of his or her impairment, in order for the applicant or recipient to work. No deduction is allowed if the expense has been, could be, or will be paid by another source or if the applicant or recipient will be reimbursed by another source, including, but not limited to, Medicaid, Medicare, private health insurance, or another agency. Allowable impairment-related expenses are listed below:

(A) Payments for attendant care services in the following circumstances:

(i) Because of the applicant's or recipient's impairment, he or she needs assistance in traveling to and from work, or while at work needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating).

(ii) Because of the applicant's or recipient's impairment, assistance is needed at home with personal functions (e.g., dressing, administering medications) in preparation for going to and returning from work.

(iii) Payments made to a family member for attendant care services will be allowed only if the family member suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked in order to perform the services.

(iv) A family member is anyone who is related to the applicant or recipient by blood, marriage, or adoption, whether or not that person lives with the applicant or recipient.

(v) If only part of the payment to a person is for services that come under the provisions of items (i) and (ii), only the portion attributable to those services will be allowed.

(B) Payments for medical devices. If the impairment requires the applicant or recipient to utilize medical devices in order to work, the payments made for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment that can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators, and pacemakers.

(C) Payments for prosthetic devices. If the impairment requires the applicant or recipient to utilize a prosthetic device in order to work, the payments made for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs, and other parts of the body.

(D) Payments for work-related equipment. If the impairment requires the applicant or recipient to utilize special equipment in order to do his or her job, the payments made for that equipment may be deducted.

(E) Payments for residential modifications. If the impairment requires the applicant or recipient to make modifications to his or her place of residence, the location of the workplace will determine if the cost of these modifications will be deducted. If the applicant or recipient is employed away from home, only the cost of changes made outside of the home to permit the applicant or recipient to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the home will not be deducted if the person works away from home. If the applicant or recipient works at home, the costs of modifying the inside of the home in order to create a working space to accommodate his or her impairment will be deducted to the extent that the changes pertain specifically to the space in which he or she works. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if the applicant or recipient is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(F) Payments for transportation costs in the following circumstances are allowed:

(i) The impairment requires that in order for the applicant or recipient to get to work, a vehicle that has structural or operational modifications is required. The modifications must be critical to the applicant's or recipient's operation or use of the vehicle and directly related to his or her impairment. The costs of the modifications will be deducted, but not the cost of the vehicle. A mileage allowance for the trip to and from work will be allowed in the same amount as allowed by the Supplemental Security Income program for this purpose.

(ii) The impairment requires the applicant or recipient to use driver assistance, taxicabs, or other hired vehicles in order to work. Amounts paid to the driver and, if the applicant's or recipient's own vehicle is used, a mileage allowance will be deducted, for the trip to and from work.

(iii) The impairment prevents the applicant or recipient from taking available public transportation to and from work, and he or she must drive his or her (unmodified) vehicle to work. A mileage allowance for the trip to and from work will be deducted if verification is obtained through the applicant's or recipient's physician or other sources that the need to drive is caused by the impairment, and not due to the unavailability of public transportation.

(G) All other impairment-related expenses allowed by the Supplemental Security Income program.

(c) Funds from a grant, scholarship, or fellowship that are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds except as prohibited by federal regulations.

(d) Tax refunds are excluded from income.

(e) Home energy assistance is disregarded.

(f) Up to twenty dollars ($20) of unearned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total

amount of infrequent or irregular unearned income received in a month exceeds twenty dollars ($20), this disregard cannot be applied.

(g) A general income disregard of fifteen dollars and fifty cents ($15.50) is deducted per month.

(h) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department are excluded.

(i) Income of the spouse of the applicant or recipient is excluded.

(j) Income of the parents of the applicant or recipient is excluded.

SECTION 3. **(a) An applicant's or recipient's income eligibility shall be determined by the following procedures:**

(1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.

(2) Subtract the general income disregard specified in SECTION 2 of this document. The resulting amount is countable unearned income.

(3) Determine the earned income of the applicant or recipient.

(4) Subtract any remaining general income disregard.

(5) Subtract the earned income disregard(s) specified in SECTION 2 of this document. The resulting amount is countable earned income.

(6) Combine countable unearned and countable earned income.

(7) Subtract the monthly income standard that is equal to three hundred fifty percent (350%) of the Federal Poverty Guideline for a family size of one (1) , divided by twelve (12) and rounded up to the next whole dollar.

(8) If the resulting amount in *[subdivision]* **(7) is zero dollars ($0) or less than zero dollars ($0), the applicant or recipient is eligible for Medicaid for Employees with Disabilities. If the resulting amount is greater than zero dollars ($0), the applicant or recipient is not eligible.**

(b) The income standard referenced in *[subsection]* **(a)(7) shall be increased annually beginning the second month following the month in which the federal poverty guidelines are published in the Federal Register.**

(c) The following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under subsection (a) of this SECTION and who is residing in a Title XIX certified health care facility:

(1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under subsection (a).

(2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant's or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

(4) Subtract the amount of health insurance premiums.

(5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

SECTION 4. **(a) An applicant or recipient is ineligible for Medicaid for Employees with Disabilities for any month in which the total equity value of all nonexempt personal property owned by the applicant and his or her spouse exceeds the applicable limitation for a single individual or married couple as prescribed by the Supplemental Security Income program.**

(b) The resources of the applicant's or recipient's parents are excluded.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

(1) All household goods and personal effects.

(2) Personal property required by an individual's employer while the individual is employed.

(3) The equity value of personal property used to produce food for home consumption or used in the production of income.

(4) The value of life insurance with a total face value of ten thousand dollars ($10,000) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the ten thousand dollar ($10,000) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demon-

strates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

(i) necessary for employment;

(ii) necessary for the medical treatment of a specific or regular medical problem; or

(iii) modified for operation by or transportation of a handicapped person.

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars ($4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

(A) the applicant or recipient;

(B) the spouse of the applicant or recipient;

(C) the parent of the applicant or recipient who is under age eighteen (18);

(D) the applicant's or recipient's biological or adoptive child under eighteen (18) years of age; or

(E) the applicant's or recipient's blind or disabled biological or adoptive child eighteen (18) years of age or older.

(9) Income producing real property if the income is greater than the expenses of ownership.

(10) Up to twenty thousand dollars ($20,000), as approved by the central office of the family and social services administration, for an independence and self-sufficiency account defined in IC 12-15-41-2(3). A resource disregard for this purpose will be approved if the applicant or recipient submits a plan in writing to the local office of family and children caseworker that describes specifically the goods and or services that he or she intends to purchase that will increase, maintain, or retain his or her employability or independence. The items must be reasonable in terms of the applicant's or recipient's ability to achieve a stated goal which is focused on the individual's employability by removing barriers. Items for personal recreational use will not be approved. A request to save money without specifying goods or services to be purchased within an achievable period of time will not be approved. An approved account will be reviewed by the local office of family and children caseworker at each annual redetermination. If the terms of the original approved account have not been met, the recipient will be required to submit an updated request to the caseworker within thirty (30) days of receiving written notification from the caseworker that such an update is required. If the recipient fails to submit the update, the disregard will be disapproved and resource eligibility will be redetermined without it. The caseworker will forward updates to the central office for approval. At any time during the period of eligibility under the Medicaid for Employees with Disabilities program, the recipient may submit an update requesting an adjustment in the approved amount. Approval will not be given for any services that are available to the recipient under Medicaid or any other publicly funded program.

(11) Retirement accounts held by the applicant or recipient or his or her spouse are exempt. This includes Individual Retirement Accounts, Keogh Plans, 401(k), 403(b), and 457 plans, and any employer-related retirement account.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for Medicaid for Employees with Disabilities, an applicant or recipient and his or her spouse must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her spouse own.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the recipient shall be ineligible.

SECTION 5. **(a) In order for an individual to be eligible for Medicaid for Employees with Disabilities, the individual must be engaged in a substantial and reasonable work effort. This means that the person must be either employed or self-employed, with the intent of such work activity being ongoing. Employment must be verifiable by pay stubs or other verification from an employer documenting that the income is subject to income tax and FICA withholding. Self-employment must be verified by the individual's income tax return or, in the case of a new business for which a tax return has not yet been filed, the personal business records of the individual.**

(b) In order for a recipient of Medicaid for Employees with Disabilities to remain eligible when the definition of medically improved disability in SECTION 7 *[of this document]* **is met, the recipient must be employed as defined in** *[subsection]* **(a) and must have monthly earnings as calculated under 405 IAC 2-5-1 that are equal to or greater than the federal minimum wage times forty (40), unless the provisions in** *[subsection]* **(c) are met.**

(c) A recipient who is involuntarily not working can

remain eligible for the Medicaid for Employees with Disabilities program for up to twelve (12) months if he or she meets all other program requirements and is either:

(1) on temporary medical leave from his or her employment as defined in *[subsection]* **(d); or**

(2) maintains a connection to the workforce by participating in at least one (1) of the following activities below:

(A) Enrollment in a vocational rehabilitation program.

(B) Enrollment or registration with the department of workforce development.

(C) Participation in a transition from school to work program.

(D) Participation with an approved provider of employment services.

(d) As used in this SECTION, "temporary medical leave" means a leave from the place of employment due to health reasons when the employer is keeping a position open for the individual to return. If the employer is no longer holding a position open, the recipient must maintain a connection to the workforce as defined in subdivision *[subsection]* **(c)(2) in order for coverage to continue under Medicaid for Employees with Disabilities.**

(e) In order to remain eligible upon becoming unemployed, the recipient or his or her authorized representative must submit a written request for continued coverage to the local office of family and children no later than sixty (60) days after termination of employment. Attached to this written request must be verification that the recipient meets the requirements in subsection (c). On a quarterly basis thereafter, as long as the recipient continues to be unemployed and wishes coverage to continue, verification of his or her medical leave or workforce connection status must be provided to the local office of family and children. The quarterly verification must consist of a statement from the agency or service provider that documents the recipient's continued participation in an activity that constitutes connection to the workforce, or from the recipient's employer stating he or she remains on a temporary involuntary medical leave.

(f) A recipient who voluntarily terminates his or her employment for any reason is not eligible for Medicaid for Employees with Disabilities. Eligibility for the other Medicaid categories will be pursued.

(g) A recipient who fails to submit the initial request for coverage continuation within the required sixty (60) day period or who fails to submit the quarterly verification report is no longer eligible for Medicaid for Employees with Disabilities. Eligibility for other Medicaid categories will be pursued.

SECTION 6. **(a) In order to qualify for Medicaid for Employees with Disabilities, an applicant must meet the definition of disability in IC 12-14-15-1(2). If not for earned income, the applicant or recipient would medically qualify for Medicaid under the traditional disability category according to statute.**

(b) The determination of disability is made by the Medicaid medical review team (MMRT) based upon the principles found in 405 IAC 2-2-3, except that the determination of whether an impairment is substantial enough to meet the definition of disability is made without considering work activity, earnings, and substantial gainful activity (SGA). If not for the fact that the applicant or recipient is working, the condition would otherwise be substantial enough to prevent the person from participating in gainful activity.

(c) A redetermination of disability is required annually of each recipient at the time the county office does its complete redetermination of all factors of eligibility. A redetermination of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient.

SECTION 7. **(a) In order to qualify for the Medicaid For Employees with Disabilities program after improvement of a medical condition, a recipient must meet the requirements in this SECTION.**

(b) The person must be a recipient of Medicaid under the Medicaid For Employees with Disabilities group described in SECTION 6 of this document who no longer qualifies for coverage under that category due to a medical improvement in his/her condition. The improvement of the condition must be verifiable by acceptable clinical standards; however, the disease, illness, or process must be of a type that, due to the nature and course of the illness, will continue to be a disabling impairment. A condition that has been resolved or a person who is completely recovered does not medically qualify for this program.

(c) The determination of whether a recipient meets the medical eligibility requirements for this category will be made at the time of the regularly scheduled annual redetermination for Medicaid by the county office. Determination of medical eligibility under this SECTION is made by the Medicaid medical review team (MMRT).

SECTION 8. **(a) To be eligible for Medicaid for Employees with Disabilities, an individual must pay monthly premiums in accordance with the requirements specified in this SECTION, unless the gross income of the individual and the individual's spouse is less than one hundred fifty percent (150%) of the federal poverty level. The amount of the premium is based on the gross income of the recipient and the recipient's spouse as a percentage of the federal poverty level for the applicable family size as determined in**

subsection (b) or (c). The amount of the premium will be adjusted by the premium amount of other creditable private health insurance as defined in 42 U.S.C. §300gg-91 that covers the applicant or recipient and is paid by the applicant or recipient, or his or her spouse or parent. The amount of the premium is calculated as described in the following table:

Income as a Percent of the Federal Poverty Level	Amount of Premium	
Less than 150%–No Premium is Required	Individual	Married Couple
150% to 175%	$ 48	$ 65
More than 175% to 200%	$ 69	$ 93
More than 200% to 250%	$ 107	$ 145
More than 250% to 300%	$ 134	$ 182
More than 300% to 350%	$ 161	$ 218
More than 350%	$ 187	$ 254

(b) The individual premium amount is used when the individual, regardless of age, is not married or not living with his or her spouse. When the individual premium amount is used, only the individual's income is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of one (1).

(c) The married couple premium amount is used when the individual is legally married and living with his or her spouse. When the couple premium amount is used, the income of both spouses is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of two (2).

(d) When an applicant is determined eligible, the applicant will be conditionally approved pending payment of the premium. The first month for which a premium is required is the month following the month in which an applicant is approved as conditional. After the premium is received, coverage will be retroactive to the first day of the third month prior to the month of application if all eligibility requirements were met in the prior months.

(e) The individual must pay the first premium in order to receive coverage. If payment is not received by the due date specified in the second premium notice, the Medicaid application will be denied. A payment of less than the full amount due will be considered nonpayment.

(f) If any premium after the first premium is not paid by the due date, coverage will continue for a maximum of sixty (60) days before being discontinued. When an individual or couple have been discontinued from the program due to nonpayment of premiums, an application must be filed in order to be considered for eligibility. To be reenrolled based on an application filed after such a discontinuance, the individual must pay all past due premiums in addition to premiums owed for the current application. Past due premiums remain the obligation of the individual as a condition of eligibility for two (2) years after the date of discontinuance.

(g) When both spouses are recipients of Medicaid for Employees with Disabilities, the enrollment and continued eligibility of the couple is based on the payment of the married couple premium amount. Failure to pay the required premium amount in accordance with this SECTION will result in the discontinuance of Medicaid coverage for both spouses.

(h) When a recipient reports a change in income or marital status as required by SECTION 1(d) of this document, and the change results in a lower premium, the new premium amount will be effective the first month following the date in which verification of the change is received.

(i) When a recipient who is eligible for Medicaid in the blind or disabled categories obtains employment, the change must be reported within ten (10) days as required by 470 IAC 2.1-1-2. An additional ten (10) days is allowed to provide verification of the employment. If the recipient is eligible for Medicaid for Employees with Disabilities, eligibility begins the first month following the date on which verification is received, subject to the timely notice requirements in 42 CFR 431.211.

SECTION 9. **SECTIONS 1 through 8 of this document expire July 10, 2002.**

LSA Document #02-196(E)
Filed with Secretary of State: June 28, 2002, 10:19 a.m.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-197(E)

DIGEST

Temporarily amends 405 IAC 1-18-2 to specify Medicaid reimbursement methodology for Medicare cross-over claims. Temporarily repeals 405 IAC 1-18-3. Authority: IC 4-22-2-37.1; IC 12-8-1-12; Public Law 291-2001, Section 48. Effective July 1, 2002.

SECTION 1. **(a) Cross-over claims filed by Medicaid providers are reimbursed as set out in this SECTION.**

(b) If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero (0).

(c) If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

(1) the difference between the Medicaid allowable amount minus the Medicare payment amount; or

(2) the Medicare coinsurance and deductible, if any, for the claim.

SECTION 2. 405 IAC 1-18-3, AS ADDED AT 25 IR 2476, IS TEMPORARILY REPEALED.

SECTION 3. **SECTIONS 1 and 2 of this document expire September 26, 2002.**

LSA Document #02-197(E)
Filed with Secretary of State: June 28, 2002, 10:20 a.m.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-198(E)

DIGEST

Temporarily amends 405 IAC 1-14.6-2, 405 IAC 1-14.6-4, 405 IAC 1-14.6-6, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, 405 IAC 1-14.6-12, 405 IAC 1-14.6-16, and 405 IAC 1-14.6-22 to revise the case mix reimbursement methodology that the Medicaid program utilizes to reimburse nursing facilities as follows: removes from consideration as allowable cost indirect costs associated with ancillary services provided to non-Medicaid residents; establishes a children's nursing facility designation for Medicaid reimbursement purposes and removes the profit add-on portion of the direct care component for nursing facilities not designated as children's nursing facilities; establishes a minimum occupancy parameter for the direct care, indirect care, and administrative rate components; provides for rebasing of Medicaid payment rates every other year, rather than annually; and updates mortgage interest rate parameter used to establish Medicaid reimbursement for capital costs of nursing facilities. Authority: IC 4-22-2-37.1; IC 12-8-1-12; Public Law 291-2001, Section 48. Effective July 1, 2002.

SECTION 1. **(a) As used in this document and 405 IAC 1-14.6, "administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:**

(1) Administrator and co-administrators, owners' compensation (including directors fees) for patient-related services.

(2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.

(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) Travel.
(7) Telephone.
(8) License dues and subscriptions.
(9) Office supplies.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified mental retardation professional (QMRP).

(b) As used in this document and 405 IAC 1-14.6, "allowable per patient day cost" means a ratio between allowable cost and patient days.

(c) As used in this document and 405 IAC 1-14.6, "annual financial report" refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this document and 405 IAC 1-14.6.

(d) As used in this document and 405 IAC 1-14.6, "allowable cost determination" means a computation performed by the office or its contractor to determine a nursing facility's per patient day cost based on a review of an annual financial report and supporting information by applying this document and 405 IAC 1-14.6.

(e) As used in this document and 405 IAC 1-14.6, "average allowable cost of the median patient day applicable to providers with an actual occupancy rate of at least sixty-five percent (65%)" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed annual financial report, and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(f) As used in this document and 405 IAC 1-14.6, "average allowable cost of the median patient day applicable to providers with an actual occupancy rate of less than sixty-five percent (65%)" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation

adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of sixty-five percent (65%), or each provider's actual occupancy rate from the most recently completed annual financial report, and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) As used in this document and 405 IAC 1-14.6, "average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of 405 IAC 1-14.6-14(a).

(h) As used in this document and 405 IAC 1-14.6, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(i) As used in this document and 405 IAC 1-14.6, "capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.
(2) Property taxes.
(3) Property insurance.

(j) As used in this document and 405 IAC 1-14.6, "case mix index" (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.
(2) All residents.

(k) As used in this document and 405 IAC 1-14.6, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(l) As used in this document and 405 IAC 1-14.6, "children's nursing facility" means a nursing facility that has twenty-five percent (25%) or more of its residents who are under the chronological age of twenty-one (21) years, and has received written approval from the office to be designated as a children's nursing facility.

(m) As used in this document and 405 IAC 1-14.6, "delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(n) As used in this document and 405 IAC 1-14.6, "desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(o) As used in this document and 405 IAC 1-14.6, "direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all:

(1) nursing and nursing aide services;
(2) nurse consulting services;
(3) pharmacy consultants;
(4) medical director services;
(5) nurse aide training;
(6) medical supplies;
(7) oxygen; and
(8) medical records costs.

(p) As used in this document and 405 IAC 1-14.6, "fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(q) As used in this document and 405 IAC 1-14.6, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) As used in this document and 405 IAC 1-14.6, "forms prescribed by the office" means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(s) As used in this document and 405 IAC 1-14.6, "general line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(t) As used in this document and 405 IAC 1-14.6, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(u) As used in this document and 405 IAC 1-14.6, "incomplete MDS resident assessment" means an assess-

ment that not printed by the nursing facility provider upon request by the office or its contractor.

(v) As used in this document and 405 IAC 1-14.6, "indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Allowable dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.

(w) As used in this document and 405 IAC 1-14.6, "minimum data set (MDS)" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration.

(x) As used in this document and 405 IAC 1-14.6, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients.

(y) As used in this document and 405 IAC 1-14.6, "non-rebasing year" means the year during which a nursing facility's annual Medicaid rate is not established based on a review of its annual financial report covering its most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate components from the previous year by an inflation adjustment. The following year shall be a non-rebasing year: July 1, 2003, through June 30, 2004.

(z) As used in this document and 405 IAC 1-14.6, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average case mix index (CMI) for all residents.

(aa) As used in this document and 405 IAC 1-14.6, "office" means the office of Medicaid policy and planning.

(bb) As used in this document and 405 IAC 1-14.6, "ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(cc) As used in this document and 405 IAC 1-14.6, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(dd) As used in this document and 405 IAC 1-14.6, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this document and 405 IAC 1-14.6.

(ee) As used in this document and 405 IAC 1-14.6, "rebasing year" means the year during which a nursing facility's Medicaid rate is based on a review of its annual financial report covering its most recently completed historical period. The following years shall be rebasing years:

(1) July 1, 2002 through June 30, 2003.
(2) July 1, 2004 through June 30, 2005.
(3) And every year thereafter.

(ff) As used in this document and 405 IAC 1-14.6, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(gg) As used in this document and 405 IAC 1-14.6, "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI and facility-average CMI for Medicaid residents.

(hh) As used in this document and 405 IAC 1-14.6, "therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this document and 405 IAC 1-14.6.

(ii) As used in this document and 405 IAC 1-14.6, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(jj) As used in this document and 405 IAC 1-14.6, "unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15, and such data items result in the assessment being classified into a different RUG-III category.

(kk) As used in this document and 405 IAC 1-14.6, "untimely MDS resident assessment" means a significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy.

SECTION 2. **(a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider and must coincide with the fiscal year end for Medicare cost reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic cost report (ECR) file copy of their Medicare cost report that covers their most recently completed historical reporting period. Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.**

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic ECR file copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(10) Copy of the working trial balance that was used in the preparation of their submitted Medicare cost report.

(d) Extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report, or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.

(2) When an annual financial report, or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end, and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the

calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the new operation is not currently enrolled or submitting MDS assessments under the Medicare program and the provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment, or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or transfer to hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or transfer to hospital.

(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has untimely MDS resident assessments, then such assessment(s) shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).

(k) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office or its contractor shall audit a sample of MDS resident assessments and will determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the sample that are unsupported is greater than the threshold percent as shown in column (B) of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the field portion of the MDS audit and no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on all residents, the office or its contractor will determine the percent of assessments audited that are unsupported.

(4) If the percent of assessments of all residents that are unsupported is greater than the threshold percent as shown in column (B) of the table below, a corrective remedy shall apply, which shall be calculated as follows. The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below. In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments of all residents that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the MDS audit and no corrective remedy shall apply.

(6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table in this subdivision, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

Effective Date (A)	Threshold Component (B)	Administrative Corrective Percent Remedy Percent (C)
October 1, 2002	40%	5%
January 1, 2004	30%	10%
April 1, 2005	20%	15%

(l) Based on findings from the MDS audit, beginning on the effective date of this document, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(m) Beginning on the effective date of this document, upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made.

SECTION 3. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative, and capital components, which are applicable to the facility based on their actual occupancy rate from the most recently completed historical period, shall only be determined during a rebasing year for each provider for the purpose of performing the provider's annual rate review.

(b) The annual rate review that shall become effective during a rebasing year shall be established by determining the normalized allowable per patient day cost for the direct care component, and the allowable per patient day costs for the therapy, indirect care, administrative, and capital components for each provider based on the annual financial report.

(c) The annual rate review that shall become effective during a nonrebasing year shall be established by applying an inflation adjustment to the previous year's indirect care, administrative, capital, and therapy Medicaid rate components. The direct care component of the annual rate review during a nonrebasing year shall be established by applying an inflation adjustment to the previous year's normalized allowable cost, and applying the Medicaid case mix adjustment as prescribed by this document and 405 IAC 1-14.6. The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(d) The rate effective date of the annual rate review during rebasing years and nonrebasing years shall be the first day of the second calendar quarter following the provider's reporting year end.

(e) Subsequent to the annual rate review established during rebasing years and nonrebasing years, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(f) The case mix index for Medicaid residents in each facility shall be updated each calendar quarter and shall be used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(g) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

SECTION 4. **(a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review during a rebasing year, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:**

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning on the effective date of this document through September 30, 2003, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, 2003, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months for use in establishing the annual rebasing year rate review, the previous provider's most recently completed annual financial report shall be utilized to calculate the new provider's first annual rebasing year rate review. The inflation adjustment for the new provider's first annual rebasing year rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable costs per patient day for direct care, indirect care, and administrative costs shall be computed based on an occupancy rate equal to the greater of sixty-five percent (65%), or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the month following the date that the conditions specified in this subsection are met, by applying all provisions of this document and 405 IAC 1-14.6, except for the sixty-five percent (65%) minimum occupancy requirement, if the following conditions can be established to the satisfaction of the office:

(1) the provider demonstrates that its current resident census has increased to sixty-five percent (65%) or greater since the facility's fiscal year end of the cost report used to establish its Medicaid rate during the most recent rebasing year, and has remained at such level for no less than ninety (90) days; and

(2) the provider demonstrates that its resident census has increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the cost report used to establish its Medicaid rate during the most recent rebasing year.

(f) Allowable costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%), or the provider's actual occupancy rate from the most recently completed historical period.

(g) The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents, and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports serve as confirmation of the MDS assessments transmitted by the nursing facility and provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments. The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(i) The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to such facilities at a rate of eight dollars and seventy-nine cents ($8.79) per Medicaid resident day. Such additional reimbursement shall be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents and shall remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

SECTION 5. **(a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:**

(1) The indirect care, administrative, and capital components, are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable per patient day direct therapy costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(b) The profit add-on payment will be calculated as follows:

(1) For nursing facilities designated by the office as children's nursing facilities, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(2) Beginning on the effective date of this document, and continuing for eight (8) full calendar quarters thereafter, for nursing facilities that are not designated by the office as children's nursing facilities, the direct care component profit add-on is equal to zero (0). Beginning on the first day of the ninth full calendar quarter after the effective date of this document, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(3) The indirect care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

(4) The administrative component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

(5) The capital component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus

(B) a provider's allowable per patient day cost.

(6) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).
(2) The average allowable cost of the median patient day for indirect care costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times one hundred percent (100%).
(3) The average allowable cost of the median patient day for administrative costs applicable to the facility based on its actual occupancy rate from the most recently completed historical period, times one hundred percent (100%).
(4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).
(5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

SECTION 6. **Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.**

(1) The fair rental value allowance is calculated by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.
(2) The inflation-adjusted historical cost of property per bed as determined above is arrayed to arrive at the average historical cost of property of the median bed.
(3) The average historical cost of property of the median bed as determined above is extended times the number of beds for each facility that are used to provide nursing facility services, to arrive at the fair rental value amount.
(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in SECTION 6(a) of this document. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

SECTION 7. **(a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.**

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall apply cost allocation principles established by the federal Medicare cost report methodology based on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit

a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall apply cost allocation principles established by the federal Medicare cost report methodology based on a statewide average ratio of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports.

SECTION 8. **(a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate or allowable cost determinations as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).**

(b) If the provider disagrees with a rate or allowable cost redetermination resulting from a financial audit adjustment or reportable condition affecting a rate or allowable cost redetermination, the provider must request an administrative reconsideration from the Medicaid financial audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate or allowable cost redeterminations computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the MDS audit contractor shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the MDS audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3.

SECTION 9. **For purposes of implementing the revisions to 405 IAC 1-14.6 contained in this document, the following shall apply:**

(1) Reimbursement rates for all Medicaid certified nursing facilities shall be calculated effective on the effective date of this document. The office or its designee shall calculate a new rate for each nursing facility under this document based on the most recent submitted and completed cost report filed under 405 IAC 1-14.6. Subsequent quarterly changes to a nursing facility's rate will be made as prescribed by this document and 405 IAC 1-14.6.

(2) The average inflated allowable cost of the median patient day and the historical cost of property of the median bed used to calculate reimbursement rates shall be established on the effective date of this document using the most recent cost report data for which a Medicaid

rate is established as of the effective date of this document. Subsequent revisions to these parameters shall be made as prescribed by this document.

(3) The case mix indices (CMIs) shall be recalculated using the 5.12, 34-grouper version of the Resource Utilization Group, version III (RUG-III) based on the same MDS data that was previously used to establish the CMIs using the 5.01, 44-grouper version of the RUG-III.

(4) For purposes of implementing SECTION 7 of this document, the office or its contractor shall use the most recent Medicare cost report that has been submitted to the Medicare fiscal intermediary. For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that fail to timely submit their Medicare cost report upon request, the office or its contractor shall determine the portion of such facility's costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services based on a statewide average ratio of indirect costs to direct costs for such therapy and ancillary services, as determined from Medicare cost reports of nursing facilities that timely submit their Medicare cost report.

SECTION 10. **SECTIONS 1 through 9 of this document expire September 26, 2002.**

LSA Document #02-198(E)
Filed with Secretary of State: June 28, 2002, 10:21 a.m.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-199(E)

DIGEST

Temporarily amends 405 IAC 5-24-7 to revise copayment structure for drugs reimbursed by Medicaid. Brand name legend drugs will be subject to a three dollar copayment. Generic legend drugs, all nonlegend drugs, and compounded prescriptions will be subject to a fifty cent copayment. Authority: IC 4-22-2-37.1; IC 12-8-1-12; Public Law 291-2001, Section 48. Effective July 1, 2002.

SECTION 1. **(a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:**

(1) The copayment shall be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.

(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be as follows:

(A) Fifty cents ($0.50) for each generic legend drug dispensed.

(B) Fifty cents ($0.50) for each nonlegend drug dispensed, whether brand name or generic.

(C) Three dollars ($3) for each brand name legend drug dispensed.

(D) Fifty cents ($0.50) for each compounded prescription, whether legend or nonlegend.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions.

(5) Family planning services and supplies furnished to individuals of child bearing age.

(6) Health maintenance organization (HMO) pharmacy services.

SECTION 2. **SECTION 1 of this document expires September 26, 2002.**

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