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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #06-50(E)

DIGEST

Temporarily adds rules to implement a program to complement the federal Medicare Prescription Drug Benefit and to establish program eligibility and enrollment guidelines. Effective February 16, 2006.

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

SECTION 2. **(a) The definitions in this SECTION apply throughout SECTIONS 2 through 5** *[of this document]* **unless the context clearly indicates another meaning.**

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

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

(d) "Full low-income subsidy" means the Centers for Medicare and Medicaid Services benefit provided to eligible low-income individuals enrolled in the Medicare prescription drug benefit. Full low-income subsidy eligible individuals:
(1) are not required to pay monthly premiums or annual deductible;
(2) have small copayments; and
(3) have no gap in coverage.
Eligibility is determined by the Social Security Administration.

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

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

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

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

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

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

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

(1) reduced premiums on a sliding-scale;

(2) a maximum annual deductible of fifty dollars ($50);

(3) fifteen percent (15%) copayments; and

(4) no gap in coverage.

Eligibility is determined by the Social Security Administration.

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

(m) "Standard" means a Medicare Part D plan that is considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. Does not include enhanced Medicare Part D plans.

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

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

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

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

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

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

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

(d) The program will send the member a letter notifying them that they will have at least twenty-five (25) calendar days to select a Medicare Part D Plan. If no selection has been made within the period of not less than twenty-five (25) calendar days, the office may auto-assign the member to a Medicare Prescription Drug Plan that has contracted with the IPDP to receive auto-assignment.

(e) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the twenty-five (25) calendar day period.

(f) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period that is otherwise eligible for the program may be auto-assigned to a Medicare Part D plan before the end of the twenty-five (25) calendar day opt-out period.

(g) If a member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug plan.

SECTION 5. **(a) The program may, to the extent it can identify IPDP members that have been determined eligible for partial low-income subsidy from the Centers for Medicare and Medicaid Services, randomly assign members to Medicare prescription drug plans offering standard coverage, with a monthly premium below the low-income subsidy premium amount**

for the region, that have contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs. In the event the same entity offers more than one (1) such Medicare prescription drug plan in the state, the program will assign members randomly among the entity's eligible Medicare prescription drug plans.

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

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

(d) The program will send the member a letter notifying them that they will have at least twenty-five (25) calendar days to select a Medicare Part D plan. If no selection has been made within the period of not less than twenty-five (25) calendar days, the office may auto-assign the member to a Medicare prescription drug plan that has contracted with the IPDP to receive auto-assignment.

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

(f) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the twenty-five (25) calendar day period.

(g) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period that is otherwise eligible for the program may be auto-assigned to a Medicare Part D plan that has contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs before the end of the member's twenty-five (25) calendar day opt-out period.

(h) If member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug plan.

SECTION 6. **Under IC 12-10-16-3, the office hereby adopts and promulgates all sections following this SECTION to do the following:**

(1) Interpret and implement provisions of IC 12-10-16-3 to provide assistance to low-income seniors with the expense of participating in a Medicare Part D plan.

(2) Ensure the efficient, economical, and reasonable operations of the Indiana prescription drug program.

SECTION 7. **The definitions in SECTION 8 through SECTION 41** *[SECTIONS 8 through 41 of this document]* **apply to all sections following this SECTION unless the context clearly indicates another meaning.**

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

SECTION 9. **"Benefit period" means a specified time frame during which a member is concurrently enrolled in both a Medicare Part D plan and the Indiana prescription drug program. The benefit period shall not exceed one (1) calendar year beginning in January with limits specified in 405 IAC 8-6-4** *[405 IAC 8-6-4 is proposed to be added at 29 IR 862.]***. The benefit shall not be paid or begin until the first day of the first month in which:**

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

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

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

SECTION 11. **(a) "Complete applicant file" means an enrollment form for the Indiana prescription drug program that includes the following information about the applicant and applicant's spouse, if applicable:**

(1) Name.

(2) Address of domicile.

(3) Date of birth.
(4) Social Security number.
(5) Medicare Health Insurance Claim Number (HICN).
(6) Marital status.
(7) Signature.
(8) Proof of low-income subsidy determination by the Social Security Administration. Proof includes either a letter of determination from the Social Security Administration or electronic confirmation provided by the Centers for Medicare and Medicaid Services.
(9) Proof that the applicant's income is below one hundred fifty percent (150%) of the federal poverty limit applicable to the individual's family size.
(10) Proof of enrollment in a Medicare prescription drug plan. Acceptable proof should be electronic confirmation provided by the Centers for Medicare and Medicaid Services or a Medicare Part D plan member identification number.

(b) Applicants may provide information to the office by mail, facsimile, or telephone or over the Internet.

SECTION 12. **"Deductible" means the amount a beneficiary must pay out of pocket before the member's Medicare Part D plan begins to cover prescription drug costs during each benefit period.**

SECTION 13. **"Domicile" means the applicant's:**
(1) true;
(2) fixed;
(3) principal; and
(4) permanent;
home.

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

SECTION 15. **"Enhanced Medicare Part D plan" means a Medicare Part D plan that is not considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services.**

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

SECTION 17. **"Full low-income subsidy" means the full extra help for paying for Medicare prescription drug plan costs provided by the Centers for Medicare and Medicaid Services (CMS). According to CMS, beneficiaries receiving full low-income subsidy will:**
(1) not be responsible for monthly premium costs for basic Medicare Part D plans;
(2) have no annual deductible; and
(3) have no gap in coverage.

SECTION 18. **"Income" means the amount of money or its equivalent received as follows:**
(1) In exchange for or as a result of labor or services.
(2) From the sale of goods or property.
(3) As profits from financial investments.

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

SECTION 20. **"Initial enrollment period" means the Medicare Part D initial enrollment period ending May 15, 2006, as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.**

SECTION 21. **"Low-income subsidy" means either:**
(1) a full low-income subsidy;
(2) or partial low-income subsidy;
as determined by the Social Security Administration.

SECTION 22. **"Low-income subsidy application" means the Application for Help with Medicare Prescription Drug Plan Costs, which is processed and administered through the Social Security Administration.**

SECTION 23. **"Low-income subsidy determination" means a definitive determination from the Social Security Administration as to an applicant's eligibility for the low-income subsidy.**

SECTION 24. **"Low-income subsidy premium" means the maximum amount the low-income subsidy will pay towards a Medicare Part D beneficiary's monthly premium in the state of Indiana, as determined by the Centers for Medicare and Medicaid Services and adjusted annually.**

SECTION 25. **"Medicare-Advantage prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare-Advantage beneficiaries.**

SECTION 26. **"Medicare Part D plan" means a:**
(1) Medicare prescription drug plan; or
(2) Medicare-Advantage prescription drug plan.

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

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

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

SECTION 30. **"Not eligible for the Indiana prescription drug program" means the applicant does not meet one (1) or more of the eligibility requirements for enrollment in the program.**

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

SECTION 32. **"Partial low-income subsidy" means the partial extra help for paying for Medicare prescription drug plan costs provided by the Centers for Medicare and Medicaid Services. According to CMS, beneficiaries receiving partial low-income subsidy will:**
(1) be responsible for monthly premium on a sliding scale for standard Medicare Part D plans;
(2) have a reduced annual deductible; and
(3) have no gap in coverage.

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

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

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

SECTION 36. **"Proof of income" means documentation of the income of an applicant and an applicant's family. Proof of income for the program should be provided by the Social Security Administration through the low-income subsidy application. If the Social Security Administration's low-income subsidy determination does not include an income determination, the office may make an income determination using the same protocol that the Social Security Administration uses to determine income.**

SECTION 37. **"Secretary" means the secretary of family and social services.**

SECTION 38. **"Senior" means a person at least sixty-five (65) years of age.**

SECTION 39. **"Spouse" means the legal husband or wife of an applicant.**

SECTION 40. **"Standard" means a Medicare Part D plan that is considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. The term excludes enhanced plans.**

SECTION 41. **"True out-of-pocket costs" means prescription drug costs that count towards a member's Medicare Part D plan maximum out-of-pocket costs.**

SECTION 42. **To be eligible for the program, an applicant must be at least sixty-five (65) years of age.**

SECTION 43. **To be eligible for the program, an applicant's income must not exceed one hundred fifty percent (150%) of the federal poverty limit applicable to the individual's family size, as defined by the federal Office of Management and Budget.**

SECTION 44. **Notwithstanding any other provision of this document, an individual is not eligible for the program if any of the following apply:**

(1) The applicant is not a Medicare beneficiary.

(2) The individual:

(A) is not domiciled in Indiana;

(B) does not intend to reside permanently in the state of Indiana;

(C) has not received a low-income subsidy determination from Social Security Administration;

(D) has been determined eligible for full low-income subsidy;

(E) is dually eligible for both Medicare and full Medicaid;

(F) is an inmate of a correctional facility; or

(G) is not enrolled in a Medicare Part D plan.

SECTION 45. **(a) A completed applicant file will be processed by the office and must include verification of the following:**

(1) That an applicant has completed the Application for Help with Medicare Prescription Drug Plan Costs and received a determination from the Social Security Administration.

(2) Of an applicant's enrollment in a Medicare Part D plan that has contracted with the IPDP to provide state benefits in coordination with Medicare Part D.

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

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

(d) After a completed applicant file has been processed and approved by the office, the office will notify the member's Medicare Part D plan of the member's eligibility for benefits under the IPDP.

(e) If the office receives an eligible applicant's completed applicant file on or before the fifteenth day of the month, the applicant shall be eligible for program benefits beginning the first day of the following month. If the office receives an eligible applicant's completed applicant file after the fifteenth day of the month, the applicant shall be eligible to receive program benefits beginning the first day of the month after the following month.

SECTION 46. **(a) If, according to the Centers for Medicare and Medicaid Services, an applicant otherwise eligible for the Indiana prescription drug program has not selected a Medicare Part D plan, the program may randomly assign the member to a Medicare prescription drug plan that has contracted with the IPDP.**

(b) The applicant will be sent a letter notifying them that they will have at least twenty-five (25) calendar days to select a Medicare prescription drug plan that has contracted with the IPDP. If no selection has been made within the period of not less than twenty-five (25) calendar days, the office may auto-assign the applicant to a Medicare prescription drug plan that has entered into agreement with the IPDP. An applicant may opt out of the auto-assignment by calling or writing the IPDP

before the end of the twenty-five (25) calendar day period.

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

(d) Any applicant that has not selected a Medicare Part D plan before the end of the initial enrollment period that is otherwise eligible for the program may be auto-assigned to a Medicare Part D plan before the end of the twenty-five (25) calendar day opt-out period.

SECTION 47. **(a) An eligible member may receive:**
(1) premium assistance for the monthly premium cost of the:
(A) Medicare prescription drug plan; or
(B) Medicare-Advantage prescription drug plan; and
(2) assistance with other Medicare prescription drug plan costs as defined in SECTION 48 *[of this document]***;**
if the member enrolls, or has been auto-enrolled, into a Medicare Part D plan that has contracted with the IPDP to provide such benefits.

(b) The amount of monthly premium assistance provided by the IPDP shall not exceed the low-income subsidy premium amount for the region as determined by the Centers for Medicare and Medicaid Services.

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

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

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

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

(g) IPDP premium assistance shall not pay for any portion of the Medicare Part D premium related to late-enrollment penalties.

SECTION 48. **(a) An eligible member may receive not more than two hundred fifty dollars ($250) in annual benefits to be applied to his or her Medicare Part D plan deductible or coinsurance requirements.**

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

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

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

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

SECTION 49. **(a) An eligible member may receive assistance for the monthly premium cost of the Medicare prescription drug plan or Medicare-Advantage prescription drug plan in which the member is enrolled. Premium assistance shall be available provided the IPDP member enrolls in a Medicare Part D plan that has contracted with the state to provide such**

benefits.

(b) The amount of premium assistance provided by the IPDP shall not exceed the low-income subsidy premium in the region as determined by the Centers for Medicare and Medicaid Services.

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

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

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

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

(g) IPDP premium assistance shall not pay for any portion of the Medicare Part D premium related to late-enrollment penalties.

SECTION 50. **(a) Benefits are available under SECTIONS 48 and 49** *[of this document]* **on a first come, first served basis.**

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

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

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

SECTION 51. **(a) The purpose of this SECTION is to establish a uniform method of administrative review and administrative adjudication for appeals concerning applicants and enrollees of the program, in order to determine whether or not any action for which there is a complaint was done in accordance with state statutes, regulations, rules, and policies. As used in this rule, "policies" include:**
(1) program manuals;
(2) administrative directives;
(3) transmittals; and
(4) other official written pronouncements of state policy.

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

(c) In the event that any provision of this document is deemed to be in conflict with any other provision of state statute, regulation, or rule that is specifically applicable to the program, then such other statute, regulation, or rule shall supersede that part of this document in which the conflict is found.

SECTION 52. **(a) In the event that the:**
(1) rights;
(2) duties;
(3) obligations;

(4) privileges; or
(5) other legal relations;
of any person or entity are required or authorized by law to be determined by the office, then such person or entity may request an administrative review by the office as provided for in SECTION 53 *[of this document]***.**

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

SECTION 53. **(a) Any party complaining of an action of the office in accordance with this document may file a request for administrative review as provided in this SECTION.**

(b) The enrollee or applicant is required to seek administrative review before filing an administrative appeal under SECTION 55 *[of this document]***.**

(c) Unless otherwise provided for by statute, regulation, or rule, a request for administrative review by an enrollee or applicant shall be filed in writing with the office not later than thirty-five (35) days following the date of the action being reviewed.

SECTION 54. **(a) Upon receipt of a request for administrative review, the office will conduct a review of the action.**

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

(c) The written decision shall do the following:
(1) Specify the reasons for the decision.
(2) Identify the:
(A) statutes;
(B) regulations;
(C) rules; and
(D) policies;
supporting the decision.

SECTION 55. **(a) Any party who is not satisfied with the administrative review of the office as provided for in this SECTION may file a request for an administrative appeal as provided in this SECTION. The person or entity requesting the administrative appeal shall be known as the appellant.**

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

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

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

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

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

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

(2) An incapacitating injury.

(3) A death in the family.

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

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

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

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.

SECTION 56. **(a) The conduct of an administrative law judge (ALJ) shall be in a manner that promotes public confidence in the integrity and impartiality of the administrative hearing process. The ALJ who conducts a hearing is prohibited from any of the following:**

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

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

(3) Being influenced by any of the following:

(A) Partisan interests.

(B) Public clamor.

(C) Fear of criticism.

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

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

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

(A) Reflect adversely on his or her impartiality.

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

(C) Exploit the ALJ's position.

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

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

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

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

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

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

(1) Administer oaths and affirmations.

(2) Issue subpoenas.

(3) Rule upon offers of proof.

(4) Receive relevant evidence.

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

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

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

(8) Dispose of procedural motions and similar matters.

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

SECTION 57. **(a) The administrative law judge (ALJ) shall conduct the hearing in an informal manner and without recourse to the technical common law rules of evidence.**

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

(c) Every party shall have the right to submit evidence. In the event that an objection to evidence is sustained, the party proffering the evidence may make an offer of proof. Each party shall have the right to cross-examine the witnesses and offer rebutting evidence.

SECTION 58. **(a) Following completion of the hearing, or after submission of briefs by the parties (if briefing is permitted by the administrative law judge (ALJ), the ALJ shall issue his or her decision in the matter concurrently to the parties. The decision shall be final unless a party requests agency review of the decision in accordance with this SECTION.**

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

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

SECTION 59. **(a) Any party who is not satisfied with the decision of the administrative law judge (ALJ) may request agency review of the decision within ten (10) days of receipt thereof in accordance with instructions issued with the decision.**

(b) After receiving a request for agency review of a hearing decision, the hearings and appeals section of the family and social services administration shall notify the parties when the decision will be reviewed. The agency review shall be completed by the secretary of the family and social services administration or the secretary's designee. All such reviews shall be conducted upon the record, as defined in SECTION 57 *[of this document]***, except that a transcript of the oral testimony shall not be necessary for review unless the party requests that one be transcribed at the party's expense.**

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

(d) The secretary of family and social services administration or the secretary's designee shall review the ALJ's decision to determine if the decision is supported by the evidence in the record and is in accordance with statutes, regulations, rules, and policies applicable to the issues under appeal.

(e) Following the review of the secretary or designee, the secretary or designee shall issue a written decision doing one (1) of the following:
(1) Affirming the decision of the ALJ.
(2) Amending or modifying the decision of the ALJ.
(3) Reversing the decision of the ALJ.
(4) Remanding the matter to the ALJ for further specified action.
(5) Making such other order or determination as is proper on the record.

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

(g) The hearings and appeals section of the family and social services administration shall distribute the written notice on agency review to the following:
(1) All parties of record.
(2) The ALJ who rendered the decision following the evidentiary hearing.
(3) Any other person designated by the secretary or designee.

SECTION 60. **(a) The record of the administrative proceedings shall be that as defined in IC 4-21.5-3-33.**

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

(c) The appellant is required to seek agency review before filing a petition for judicial review.

SECTION 61. **(a) The IPDP may contract with Medicare Part D plans to administer state assistance with Medicare prescription drug plan monthly premium and other Medicare Part D plan costs. Only Medicare Part D plans offering standard coverage that have a monthly premium at or below the low-income subsidy premium amount may contract with the IPDP to administer the state's assistance with Medicare prescription drug plan monthly premium and other Medicare Part D plan costs.**

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

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

(2) Only invoice the state for premium expenses up to the low-income subsidy regional premium as determined by the Centers for Medicare and Medicaid Services.

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

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

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

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

(B) for reconciliation of incurred and paid amounts.

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

SECTION 62. **(a) The IPDP may contract with Medicare Part D plans to administer state Medicare Part D premium-only assistance. Medicare Part D plans offering coverage in the state of Indiana may contract with the IPDP to administer the state's Medicare Part D premium assistance programs.**

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

(1) Only invoice the state for premium expenses up to the low-income subsidy regional premium as determined by the Centers for Medicare and Medicaid Services.

(2) Provide IPDP with data on IPDP members in order for the IPDP to understand the utilization underlying its costs and for reconciliation of incurred and paid amounts.

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

SECTION 63. **This document expires May 17, 2006.**

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