ARTICLE 11.1. HOSPITAL CARE FOR THE INDIGENT

Rule 1. Eligibility Standards

470 IAC 11.1-1-1 Application

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 1. When an application for hospital care for the indigent is filed with any county office of family and children, that county office shall promptly determine the patient's county of residence. If the patient's county of residence is different from the county in which the application was filed, the county office shall promptly forward the application to the county office of family and children of the patient's county of residence. The county office of the patient's county of residence shall promptly determine the patient's eligibility for hospital care for the indigent as required by IC 12-5-6-5 *[IC 12-5 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]. (Division of Family Resources; 470 IAC 11.1-1-1; filed Jun 3, 1986, 3:00 p.m.: 9 IR 2713; filed Oct 3, 1997, 4:50 p.m.: 21 IR 375; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-1-2 Patient responsibilities; denial of application

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 2. (a) A patient is required to provide all information necessary to determine his eligibility for hospital care for the indigent and report any change in this information which occurs during the eligibility determination to the county office within ten (10) days of the date on which the change occurs.

(b) A patient is required to verify or assist the county office in verifying all information required to determine his eligibility by:

(1) signing appropriate release of information forms required to obtain verification of information provided to the county office; or

(2) obtaining and providing to the county office documentation which verifies information required to determine his eligibility.

(c) If a patient fails or refuses to provide the county office information or verification of information required to determine his eligibility for hospital care for the indigent, he shall be ineligible for assistance and his application shall be denied.

(d) Prior to denying an application under this section, the county office must provide the patient written notice of the specific information or verification needed to determine eligibility and written notice of the date on which the application will be denied if the information or verification is not provided within ten (10) days of the date of the notice. *(Division of Family Resources; 470 IAC 11.1-1-2; filed Jun 3, 1986, 3:00 p.m.: 9 IR 2714; filed Oct 3, 1997, 4:50 p.m.: 21 IR 375; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-1-3 Monthly eligibility determination

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 3. Eligibility for hospital care for the indigent is determined on a calendar month basis. If covered services extend over more than one month, a separate eligibility determination is required for each month. *(Division of Family Resources; 470 IAC 11.1-1-3; filed Jun 3, 1986, 3:00 pm: 9 IR 2714; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-1-4 Definition of household members

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16-3-1

Sec. 4. (a) For purposes of determining eligibility for hospital care for the indigent, household members are the patient and the following individuals who live with the patient:

(1) The patient's spouse.

(2) The patient's biological, adoptive, and stepchildren under eighteen (18) years of age.

(3) The patient's biological, adoptive, or stepparents if the patient is under eighteen (18) years of age.

(4) The patient's biological, adoptive, or stepsiblings under eighteen (18) years of age if the patient is under eighteen (18) years of age.

(b) The following individuals are excluded from the definition of household member:

(1) Any child whose income, as determined under section 5 of this rule, equals or exceeds one hundred sixty-four dollars ($164).

(2) The stepparent of the patient under eighteen (18) years of age if the stepparent's income, as determined under section 5 of this rule, equals or exceeds one hundred sixty-four dollars ($164), or if the natural parent does not live in the household.

(Division of Family Resources; 470 IAC 11.1-1-4; filed Jun 3, 1986, 3:00 p.m.: 9 IR 2714; filed Jun 14, 1995, 11:00 a.m.: 18 IR 2779; filed Oct 3, 1997, 4:50 p.m.: 21 IR 375; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 11.1-1-5 Income determination

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16-3-1

Sec. 5. (a) Income is all money received by the household members in the month of hospitalization subject to subsection (b).

(b) Income received on a quarterly, semiannual, or annual basis shall be divided by the appropriate number of months to establish monthly income.

(c) Countable income is gross monthly income less the following exclusions:

(1) Supplemental security income of the patient is excluded.

(2) Fifteen dollars and fifty cents ($15.50) is deducted from the income of the patient.

(3) Funds from a grant, scholarship, or fellowship, which 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.

(4) All of the earned income of a child under fourteen (14) years of age is excluded.

(5) Home energy assistance is excluded.

(6) The deductions allowed by the Internal Revenue Service are excluded from gross self-employment income.

(7) The deductions allowed by the Internal Revenue Service are excluded from gross rental income, with the following exceptions:

(A) Depreciation.

(B) Payments on the mortgage principal.

(C) Personal expenses of the owner.

(D) Insurance to pay off the mortgage in the event of death or disability.

(E) Capital expenditures.

(8) Tax refunds are excluded as income and shall be considered personal property under section 6 of this rule.

(9) Net earned income is determined by deducting sixty-five dollars ($65) plus one-half (½) of the remainder from gross earned income. Any part of the exclusion allowed in subdivision (2), which has not been deducted from unearned income, shall be deducted from gross earned income prior to the determination of net earned income.

(10) A loan shall not be considered as income in the month of receipt if the written or verbal loan agreement is legally binding under state law and includes the following:

(A) The borrower’s acknowledgment of an obligation to repay.

(B) A timetable and plan for repayment.

(C) The borrower’s expressed intent to repay either by pledging real or personal property or anticipated income.

(d) If the countable income, as determined in subsection (c), of the household members exceeds the monthly income standard as set forth in this subsection, the patient is ineligible for hospital care for the indigent.

Household Size	Maximum Monthly Income
1	$544
2	$747
3	$939
4	$1,132
Each additional household member	$193

(e) The income standards specified in subsection (d) shall be adjusted on a biennial basis beginning in the year 2004, effective for hospitalizations that begin on and after October 1, 2004. Every two (2) years thereafter, the income standards shall be adjusted effective October 1. The standards shall be in an amount equal to seventy-five percent (75%) of the Federal Poverty Income Guidelines as published in the Federal Register. *(Division of Family Resources; 470 IAC 11.1-1-5; filed Jun 3, 1986, 3:00 p.m.: 9 IR 2714; filed Dec 4, 1989, 4:40 p.m.: 13 IR 629; errata filed Jun 20, 1990, 4:10 p.m.: 13 IR 2005; filed Jun 14, 1995, 11:00 a.m.: 18 IR 2779; filed Oct 3, 1997, 4:50 p.m.: 21 IR 375; filed Feb 13, 2001, 3:07 p.m.: 24 IR 2090; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; filed Feb 10, 2003, 3:25 p.m.: 26 IR 2321)*

470 IAC 11.1-1-6 Real and personal property ownership; limitations

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 6. (a) Definitions.

(1) Current market value is the average price that the property will sell for on the open market to a private individual in the particular geographic area involved.

(2) Equity value is the current value minus the total amount of liens against the property.

(b) A patient is ineligible for hospital care for the indigent if the total equity value of available nonexempt real and personal property owned by the household members exceeds the applicable limitation as set forth below, during any part of the month of hospitalization.

(1) $1500 for an unmarried patient, or for a patient who does not live with his spouse, including the amount determined in subsection (c) of this section, if applicable; or

(2) $2250 for a married patient and his spouse.

(c) If the patient is under age eighteen (18) his real and personal property includes the value of his parent's real and personal property in excess of the following exclusions:

(1) If the patient lives with one parent $1500 of the parent's real and personal property is excluded.

(2) If the child lives with two parents, $2250 of the parent's real and personal property is excluded.

(d) The following real and personal property is exempt from consideration:

(1) the home which is the principal residence of the patient;

(2) all household goods and personal effects;

(3) 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 $1,400 or less if provision has been made for payment of the patient's funeral expenses from the proceeds of such insurance. However, the $1,400 limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement;

(5) the value of one motor vehicle per household according to the following provisions:

(A) One motor vehicle is excluded if:

(i) it is necessary for employment;

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

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

(B) If no motor vehicle is excluded under (A) above, $4500 of the current market value of one (1) motor vehicle is excluded.

(6) real and personal property owned solely by children under age eighteen (18), other than the patient;

(7) real and personal property owned solely by the step-parent of the patient under age eighteen (18);

(8) burial spaces.

(Division of Family Resources; 470 IAC 11.1-1-6; filed Jun 3, 1986, 3:00 pm: 9 IR 2715; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 11.1-1-7 Effective date

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 7. These rules (470 IAC 11.1) are effective for hospitalizations that begin on or after July 1, 1986. *(Division of Family*

Resources; 470 IAC 11.1-1-7; filed Jun 3, 1986, 3:00 pm: 9 IR 2716; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

Rule 2. Hospitalization, Financial Assistance and Covered Services; Patient Data

470 IAC 11.1-2-1 Limitation on the duration of services

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 1. (a) Financial assistance to eligible hospital patients shall not be available to pay any part of the cost of said hospitalization or medical services until the onset of a medical condition that manifested itself by symptoms of sufficient severity that the absence of immediate medical attention would probably result in:

(1) placing the person's life in jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(b) Financial assistance to eligible hospital patients shall be available, consistent with reasonable medical necessity, until such time as the patient is medically stable and can be safely discharged. Stable means the alleviation of the condition which prompted the hospitalization. *(Division of Family Resources; 470 IAC 11.1-2-1; filed Dec 16, 1986, 3:35 pm: 10 IR 1076, eff Jan 1, 1987 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #86-121 was filed Dec 16, 1986.]; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-2-2 Covered hospital services; review and approval

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 2. (a) In-patient and out-patient hospital and physician services, when rendered in a hospital, are covered when such services are medically necessary for the treatment of a medical condition that manifested itself by symptoms of sufficient severity that the absence of immediate medical attention would probably result in:

(1) placing the person's life in jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(b) A qualified resident of Indiana shall be eligible to receive assistance to pay for any part of the cost of care that is a direct consequence of the medical condition that necessitated the emergency care providing such care is rendered in the hospital. No post-hospital care shall be reimbursable under the hospital care for the indigent program.

(c) Any costs of services rendered by a physician pursuant to the hospital care for the indigent program must conform to the global or single billing concept as defined in 405 IAC 1-7-1 *[405 IAC 1-7 was repealed filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365.]* and be included in the charges initially incurred by an eligible patient while hospitalized.

(d) Any emergency medical transportation costs reasonably necessary to transport an eligible patient to a hospital for the treatment of a medical condition described in subsection (a), above, shall be reimbursed to said transportation provider if said provider is properly licensed in the state of Indiana to render the transportation service for which he seeks payment. The department shall not pay more to the transportation provider than the prevailing rate in the community for similar service. *(Division of Family Resources; 470 IAC 11.1-2-2; filed Dec 16, 1986, 3:35 p.m.: 10 IR 1077, eff Jan 1, 1987 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #86-121 was filed Dec 16, 1986.]; filed Oct 3, 1997, 4:50 p.m.: 21 IR 376; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-2-3 Collection of data; recipient profile

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 3. (a) Each county office of family and children shall submit to the division of family and children within sixty (60) days following disposition of patient's application for eligibility, on forms prescribed by the division of family and children, information concerning the patient, which shall include, but not be limited to, the following:

(1) Name.
(2) County and state of residence.
(3) Welfare/SSI status.
(4) Age.
(5) Race.
(6) Sex.
(7) Household status.
(8) Employment.
(9) Household income.
(10) Reason for care.
(11) Diagnosis.
(12) Status of application.

(b) Any provider seeking reimbursement under the above-noted patient's application shall assist the county office of family and children in completing the required forms by submitting that information which is not available to the county office of family and children. *(Division of Family Resources; 470 IAC 11.1-2-3; filed Dec 16, 1986, 3:35 p.m.: 10 IR 1077, eff Jan 1, 1987 [IC 4-22-2-36 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #86-121 was filed Dec 16, 1986.]; filed Oct 3, 1997, 4:50 p.m.: 21 IR 376; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

Rule 3. Provider Claims (Repealed)
(Repealed by Division of Family and Children; filed May 25, 1989, 1:45 p.m.: 12 IR 1862)

Rule 4. Hospital Care for the Indigent Payment Procedures

470 IAC 11.1-4-1 Claims submissions
Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 1. (a) All claims for payment to providers for medical care rendered in the hospital care for the indigent program shall be submitted upon a form or format approved by the division of family and children or its designee.

(b) All “completed” and “approved” claims submitted to the department for hospital admissions occurring in any given state fiscal year must be postmarked or delivered no later than the thirty-first day of October immediately following the state fiscal year in which the admission occurred or said claim shall be disallowed for reimbursement.

(c) An “approved” claim as used in this rule, means a claim for a period during which the patient has been determined to be financially and medically eligible for the hospital care for the indigent program.

(d) A “completed” claim as used in this rule, means a claim which includes all required information presented timely for payment on forms prescribed by the department.

(e) An “amended” claim as used in this rule, means a claim originally presented timely for payment on forms prescribed by the department, returned to the provider by the department, and subsequently resubmitted in accordance with the department's directives to correct the claim. An “amended” claim not received by the department on or before the deadline set out in subsection (b) shall be subject to the deadline for the following year and shall be treated for purposes of payment as a claim originating in the calendar year in which it is accepted by the department as a “completed” and “approved” claim.

(f) In the event that a provider is precluded from submitting a “completed” claim by the deadline set out in subsection (b) for the reasons set out below, the deadline shall be waived if the provider can demonstrate to the division's reasonable satisfaction one (1) of the following circumstances:

(1) Division of family and children or county office action which prevented the submission of a “completed” claim by the deadline.
(2) Continuous, bona fide attempts on the part of the provider to obtain payment from another liable payor.
(3) An “amended” claim as described in subsection (e).

A cover letter requesting waiver of the deadline, accompanied by appropriate documentation supporting one (1) of the reasons set out in subdivision (1), (2), or (3) must be attached to each claim submitted after the deadline set out in subsection (b).

(g) Claims arising from successful provider or recipient appeals shall be subject to the deadlines and payment schedules set

out as follows, in accordance with the date of receipt of the appeal decision:

(1) Claims arising from favorable appeal decisions received on or before the fifteenth day prior to the deadline for claims originating in the preceding calendar year shall be subject to the deadline for claims originating in the preceding calendar year. Said claims shall be treated for purposes of payment as claims originating in the preceding calendar year.

(2) Claims arising from favorable appeal decisions received after the fifteenth day prior to the deadline for claims originating in the preceding state fiscal year shall be subject to the deadline for claims originating in the state fiscal year in which the appeal decision is received. Said claims shall be treated for purposes of payment as claims originating in the state fiscal year in which the appeal decision is received.

A cover letter documenting the appeal decision must accompany each claim submitted as a result of a favorable appeal decision. *(Division of Family Resources; 470 IAC 11.1-4-1; filed May 25, 1989, 1:45 p.m.: 12 IR 1860; filed Oct 3, 1997, 4:50 p.m.: 21 IR 377; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-4-2 Payment of provider claims

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16-7-4

Sec. 2. (a) Upon receipt of the provider's "completed" and "approved" claim, the division or its designee shall pay two-thirds (⅔) of the "allowed rate" for said claim within a reasonable period after receipt thereof subject to the provisions of subsection (c).

(b) An "allowed rate" as used in this rule, means the current rate of reimbursement which a hospital would have received as a Medicaid provider at its "Medicaid interim rate" for having rendered the same service, or that rate of reimbursement which a nonhospital provider would have received as a Medicaid provider for having rendered the same service.

(c) In the event that funds allocated to pay claims for a given state fiscal year are insufficient to pay the two-thirds (⅔) of "completed" and "approved" claims submitted for that state fiscal year, the department's liability for further payment hereunder is limited to the provisions of IC 12-16-7-4(b).

(d) In the event that there are funds available at the end of each state fiscal year, the department shall, to the extent of such available funds, pay each provider a pro rata portion of the one-third (⅓) balance on paid claims at the allowed rate. The formula for such year end payments shall be:

$$\frac{\text{Total HCI funds available}}{\text{Total one-third (⅓) balance}} \times \text{Total amount of a provider's unpaid balance} = \text{Amount paid at fiscal year end to provider}$$

Note: The numerator shall not exceed the dollar amount represented in the denominator. *(Division of Family Resources; 470 IAC 11.1-4-2; filed May 25, 1989, 1:45 p.m.: 12 IR 1861; filed Oct 3, 1997, 4:50 p.m.: 21 IR 378; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

470 IAC 11.1-4-3 Payment denials; recovery of overpayments

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 3. (a) The division shall deny the payment of any claim or seek the recovery of any improper payment on any claim when the provider or the patient has failed to comply with the requirements of IC 12-5-6 *[IC 12-5 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, et seq. or any of the rules promulgated thereunder.

(b) The division shall also deny the payment of any claim or seek the recovery of any improper payment on any claim where it is shown that either the provider or the patient has failed to comply with 405 IAC 1-1-4 or 405 IAC 1-1-5.

(c) The division shall also deny payments if the allocated funds for the hospital care for the indigent program are insufficient to meet the otherwise allowed rate as defined in section 2(b) of this rule.

(d) In the event that the division denies a provider's claim, said claim will be returned to the provider within a reasonable period after receipt thereof with an explanation of the reasons for its denial. *(Division of Family Resources; 470 IAC 11.1-4-3; filed May 25, 1989, 1:45 p.m.: 12 IR 1861; filed Oct 3, 1997, 4:50 p.m.: 21 IR 378; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

Rule 5. Hospital Care for the Indigent Appeal Procedures

470 IAC 11.1-5-1 Provider and recipient appeals

Authority: IC 12-13-2-3; IC 12-13-5-3
Affected: IC 12-16

Sec. 1. (a) All appeals of division's adverse actions, by either providers or recipients in the Indiana hospital care for the indigent program, shall be conducted pursuant to 470 IAC 1-4.

(b) The administrative law judge shall determine the scheduling and location of said appeal hearing taking into consideration the needs of all the parties. As provided for in 470 IAC 1-4-3(d), the location of the appeal hearings for applicants or patients shall be in the county of their residence.

(c) The administrative law judge shall provide for an opportunity to hold part or all of the appeal hearing by means of a telecommunication device providing that:

(1) it is requested by a party;

(2) all other parties agree to its use in the manner suggested;

(3) such equipment is available to the administrative law judge whereby a record may be made of such telecommunication hearing or portions thereof; and

(4) the administrative law judge is confident that the use of such telecommunication devices will not compromise the integrity of the evidentiary hearing process in the case which is then pending.

(d) The Indiana division of family and children shall be deemed a party to all administrative appeals filed under this section.

(e) In the event that a patient or applicant requests an administrative appeal hearing, then that individual must file said request pursuant to 470 IAC 1-4-3(b).

(f) In the event that a hospital or other provider requests an appeal hearing, then the hospital or other provider must file said requests pursuant to 470 IAC 1-4-3(c). *(Division of Family Resources; 470 IAC 11.1-5-1; filed May 25, 1989, 1:45 p.m.: 12 IR 1862; filed Oct 3, 1997, 4:50 p.m.: 21 IR 378; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)*

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