

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

## HOUSE ENROLLED ACT No. 2035

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AN ACT to amend the Indiana Code concerning health.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 12-15-5-5 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. A Medicaid managed care organization that provides coverage and reimbursement for outpatient single source legend drugs is subject to IC 12-15-35-46 and IC 12-15-35-47.**

SECTION 2. IC 12-15-35-18.7 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18.7. A formulary established by a Medicaid managed care organization is subject to sections 46 and 47 of this chapter.**

SECTION 3. IC 12-15-35-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 20. The board is composed of the following:

- (1) Four (4) individuals licensed and actively engaged in the practice of medicine or osteopathic medicine in Indiana under IC 25-22.5.
- (2) Four (4) individuals licensed under IC 25-26 and actively engaged in the practice of pharmacy in Indiana.
- (3) One (1) individual with expertise in therapeutic pharmacology who is neither a physician or a pharmacist.
- (4) A representative of the office who shall serve as an ex-officio

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nonvoting member of the board.

**(5) One (1) individual who:**

**(A) is employed by a health maintenance organization that has a pharmacy benefit; and**

**(B) has expertise in formulary development and pharmacy benefit administration.**

**The individual appointed under this subdivision may not be employed by a health maintenance organization that is under contract or subcontract with the state to provide services to Medicaid recipients under this article.**

**(6) One (1) individual who is a health economist.**

SECTION 4. IC 12-15-35-20.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 20.1. (a) Each board member shall fully disclose any potential conflicts of interest, financial or otherwise, relating to an issue that comes before the board for recommendation or other action.**

**(b) A board member may not vote on a recommendation or other action if the member or the member's employer has a conflict of interest, financial or otherwise, in the outcome of the vote.**

**(c) A board member who may not vote on a recommendation or other action under subsection (b) may still participate in any discussions regarding the recommendation or other action.**

SECTION 5. IC 12-15-35-29 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 29. (a) A quorum consists of ~~five (5)~~ six (6) voting members of the board.**

**(b) DUR criteria and standards for appropriate prescribing may only be implemented with the approval of a majority of the quorum of the board. The majority vote must include at least three (3) of the four (4) physician members of the board and may allow the board to accept deviations from the standards on a case-by-case basis.**

SECTION 6. IC 12-15-35-35 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 35. (a) As used in this section, "single source drug" means a covered outpatient drug that is produced or distributed under an original new drug application approved by the federal Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.**

**(b) Before the ~~approval or implementation of a board develops a program to place a single source drug on~~ prior approval, ~~program for outpatient single source drugs,~~ restrict the drug in its use, or establish a drug monitoring process or program to measure or restrict**

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utilization of single source drugs other than in the SURS program, the **program board** must meet the following conditions:

(1) **An outpatient single source drug may not be placed on prior approval or restricted in its use for other than medical reasons. Make a determination, after considering evidence and credible information provided to the board by the office and the public, that placing a single source drug on prior approval or restricting the drug's use will not:**

**(A) impede the quality of patient care in the Medicaid program; or**

**(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.**

(2) **Before a single source drug is placed on prior approval or restricted in its use, the board must hold a public hearing under IC 4-22 at least ninety (90) days before taking the action. Meet to review a formulary or a restriction on a single source drug after the office provides at least thirty (30) days notification to the public that the board will review the formulary or restriction on a single source drug at a particular board meeting. The notification shall contain the following information:**

**(A) A statement of the date, time, and place at which the board meeting will be convened.**

**(B) A general description of the subject matter of the board meeting.**

**(C) An explanation of how a copy of the formulary to be discussed at the meeting may be obtained.**

**The board shall meet to review the formulary or the restriction on a single source drug at least thirty (30) days but not more than sixty (60) days after the notification.**

(3) **The board must provide evidence that placing a single source drug on prior approval or restricting its use will not: impede the quality of patient care and that the single source drug is subject to clinical abuse or misuse before the board recommends that the drug be placed on prior approval or restricted in its use. Ensure that:**

**(A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary; and**

**(B) a process is in place through which a Medicaid recipient has access to medically necessary drugs.**

(4) **Any single source drug placed on prior approval or restricted**

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in its use will be reconsidered for **Reconsider the drug's** removal from its restricted status ~~by the board or~~ from prior approval not later than six (6) months after the single source drug is placed on prior approval or restricted in its use.

(5) ~~Any prior approval program must provide~~ **Ensure that the program provides** either telephone or FAX approval or denial Monday through Friday, twenty-four (24) hours a day. The office must provide the approval or denial within twenty-four (24) hours after receipt of a prior approval request. The program must provide for the dispensing of at least a seventy-two (72) hour supply of the drug in an emergency situation or on weekends.

(6) **Ensure that** any prior approval program or restriction on the use of a single source drug ~~may is not be~~ applied to prevent acceptable medical use for appropriate off-label indications.

(c) The ~~ĐUR~~ board shall advise the office on the implementation of any program to restrict the use of brand name multisource drugs.

**(d) The board shall consider:**

**(1) health economic data;**

**(2) cost data; and**

**(3) the use of formularies in the non-Medicaid markets;**

**in developing its recommendations to the office.**

SECTION 7. IC 12-15-35-45 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, may appoint an advisory committee to make recommendations to the board on the development of a Medicaid outpatient drug formulary.

(b) If the office decides to establish a Medicaid outpatient drug formulary, the formulary shall be developed by the ~~ĐUR~~ board.

**(c) A formulary used by a Medicaid managed care organization is subject to sections 46 and 47 of this chapter.**

SECTION 8. IC 12-15-35-46 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 46. (a) This section applies to a managed care organization that enters into an initial contract with the office to be a Medicaid managed care organization after May 13, 1999.**

**(b) Before a Medicaid managed care organization described in subsection (a) implements a formulary, the managed care organization shall submit the formulary to the office at least thirty-five (35) days before the date that the managed care organization implements the formulary for Medicaid recipients.**

**(c) The office shall forward the formulary to the board for the**

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board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will review a Medicaid managed care organization's proposed formulary at a particular board meeting. The notification shall contain the following information:

- (1) A statement of the date, time, and place at which the board meeting will be convened.
- (2) A general description of the subject matter of the board meeting.
- (3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

(e) In reviewing the formulary, the board shall do the following:

- (1) Make a determination, after considering evidence and credible information provided to the board by the office and the public, that the use of the formulary will not:
  - (A) impede the quality of patient care in the Medicaid program; or
  - (B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.
- (2) Make a determination that:
  - (A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary;
  - (B) a process is in place through which a Medicaid member has access to medically necessary drugs; and
  - (C) the managed care organization otherwise meets the requirements of IC 27-13-38.

(f) The board shall consider:

- (1) health economic data;
- (2) cost data; and
- (3) the use of formularies in the non-Medicaid markets;

in developing its recommendation to the office.

(g) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the proposed formulary should be approved, disapproved, or modified.

(h) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendations of the board, the office shall, at a public meeting, discuss the disagreement with the board and present any additional information to the board for the board's consideration. The



board's consideration of additional information must be conducted at a public meeting.

(i) Based on the final recommendations of the board, the office shall approve, disapprove, or require modifications to the Medicaid managed care organization's proposed formulary. The office shall notify the managed care organization of the office's decision within fifteen (15) days of receiving the board's final recommendation.

(j) The managed care organization must comply with the office's decision within sixty (60) days after receiving notice of the office's decision.

(k) Notwithstanding the other provisions of this section, the office may temporarily approve a Medicaid managed care organization's proposed formulary pending a final recommendation from the board.

SECTION 9. IC 12-15-35-47 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 47. (a) This section applies to the following changes to a formulary used by a Medicaid managed care organization for Medicaid recipients:

- (1) Removing one (1) or more drugs from the formulary.
- (2) Placing new restrictions on one (1) or more drugs on the formulary.

(b) Before a Medicaid managed care organization makes a change described in subsection (a), the managed care organization shall submit the proposed change to the office.

(c) The office shall forward the proposed change to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will:

- (1) review the proposed change; and
- (2) consider evidence and credible information provided to the board;

at the board's regular board meeting before making a recommendation to the office regarding whether the proposed change should be approved or disapproved.

(e) Based on the final recommendation of the board, the office may approve or disapprove the proposed change. If a proposed change is not disapproved within ninety (90) days after the date the managed care organization submits the proposed change to the office, the managed care organization may implement the change to the formulary.

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**(f) A Medicaid managed care organization:**

- (1) may add a drug to the managed care organization's formulary without the approval of the office; and**
- (2) shall notify the office of any addition to the managed care organization's formulary within thirty (30) days after making the addition.**

SECTION 10. IC 16-18-2-26.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 26.5. "Association", for purposes of IC 16-39-5-3, has the meaning set forth in IC 16-39-5-3(a).**

SECTION 11. IC 16-18-2-168 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 168. (a) "Health records", for purposes of IC 16-39, means written, **electronic**, or printed information possessed by a provider concerning any diagnosis, treatment, or prognosis of the patient.

(b) The term includes mental health records and alcohol and drug abuse records.

**(b) For purposes of IC 16-39-5-3(d), the term includes information that describes services provided to a patient and a provider's charges for services provided to a patient.**

SECTION 12. IC 16-18-2-295 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 295. (a) "Provider", for purposes of IC 16-25, means a hospice program certified under IC 16-25-1.

(b) "Provider", for purposes of **IC 16-38-5**, IC 16-39 (except for IC 16-39-7), ~~and for purposes of~~ IC 16-41-1 through IC 16-41-9, and IC 16-41-37, means any of the following:

- (1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

- (A) A physician.
- (B) A psychotherapist.
- (C) A dentist.
- (D) A registered nurse.
- (E) A licensed practical nurse.
- (F) An optometrist.
- (G) A podiatrist.
- (H) A chiropractor.
- (I) A physical therapist.
- (J) A psychologist.
- (K) An audiologist.

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(L) A speech-language pathologist.

(M) A dietitian.

(N) An occupational therapist.

(O) A respiratory therapist.

(P) A pharmacist.

(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.

(3) A health facility licensed under IC 16-28-2.

(4) A home health agency licensed under IC 16-27-1.

(5) An employer of a certified emergency medical technician, a certified advanced emergency medical technician, or a certified paramedic.

**(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.**

(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a).

SECTION 13. IC 16-22-3-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 17. (a) The governing board may mortgage all or part of an interest in real or personal property owned by the hospital and may enter into a sale and leaseback of hospital property on terms and conditions acceptable to the board.

(b) The following property may be disposed of on terms and conditions acceptable to the board:

(1) Real or personal property subject to a mortgage or sale and leaseback arrangement.

(2) Real or personal property in which the hospital has an ownership interest as a participant in an organization or activity described in section 1(b) of this chapter.

(3) An arrangement in which at least two (2) hospitals participate for the provision of any hospital or related services, including participation or ownership as a tenant in common with other hospitals.

(c) Except as provided in subsection (b), real or personal property or an interest in real or personal property owned by the hospital may be disposed of as follows:

(1) Personal property:

(A) that has limited or no use to the hospital; and

(B) that:

(i) has value not exceeding ~~five~~ **fifteen** thousand dollars (~~\$5,000~~); **(\$15,000)**; or

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(ii) is traded upon purchase of other personal property; may be disposed of without the necessity of advertising, auctioning, or requesting bids.

(2) Real property that the board considers no longer necessary for hospital purposes shall be sold after the following occur:

(A) The property is appraised by three (3) disinterested owners of taxable real property of the county.

(B) The board publishes notice of the sale one (1) time at least seven (7) days before the date of the sale.

(C) The sale is approved by the commissioners.

The board shall determine the time, terms, and conditions of the sale of property.

(3) Personal property other than property described in subdivision (1) shall be sold at public auction. The board shall publish notice of the sale one (1) time at least seven (7) days before the date of the sale. If sealed bids are solicited in the published notice of the sale, the bids must be opened in public on the date and time of the sale to satisfy the public auction requirement.

Upon the sale of real property under this subsection and the payment of the purchase price, the board and the commissioners shall execute a deed of conveyance to the purchaser. The proceeds of all sales are a part of the hospital funds to be held and used for the use and benefit of the hospital.

(d) If a trust (as defined in IC 30-4-1-1(a)) submits a bid in a sale or lease conducted under subsection (b), (c), or (e), the bid must identify each:

(1) beneficiary of the trust; and

(2) settlor empowered to revoke or modify the trust.

(e) If it is determined by the board, the county executive, and the county fiscal body, by joint resolution, that:

(1) the hospital should cease doing business as a county hospital;

(2) the hospital should be terminated and dissolved; and

(3) the entire hospital building or buildings should be sold or leased to a for-profit corporation, partnership, or entity;

the proposed sale or lease shall be considered publicly, and the board, the county executive, and the county fiscal body shall follow the procedures of IC 16-22-6-18 concerning notice and hearing on the terms and provisions of the sale or lease. The terms and provisions of the sale or lease shall be determined by the board, the county executive, and the county fiscal body and shall be presented at a hearing as required by IC 16-22-6-18.

(f) An individual who is a:

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(1) board member in the member's capacity as a board member;  
or

(2) member of:

(A) the county executive; or

(B) the county fiscal body;

is immune from potential or actual liability attributable to the individual with respect to a sale or lease under subsection (e).

(g) In the event of a sale or lease under this section, the county is not liable for:

(1) any liabilities of the hospital that:

(A) were incurred on or before; or

(B) are incurred at any time after;

the sale or lease date; or

(2) any future liabilities incurred by the successor entity;

unless otherwise agreed to by the county at the time of the sale or lease in the sale or lease document. Any liabilities described in this subsection are the responsibility of the purchasing or leasing entity, unless agreed to otherwise in the sale or lease document.

(h) After the hearing on the proposed sale or lease, if it is determined by the board, the county executive, and the county fiscal body that the sale or lease should proceed, the hospital building or buildings shall be sold or leased in accordance with proposed terms and provisions.

(i) The board, the county executive, and the county fiscal body shall execute:

(1) a deed of conveyance upon payment of the purchase price if the buildings are sold; or

(2) a lease upon terms the board, the county executive, and the county fiscal body consider reasonable if the buildings are leased.

(j) The proceeds of the sale or lease of all of the hospital buildings must first be applied to outstanding indebtedness attributable to the hospital buildings. The commissioners shall deposit the balance of the proceeds from the sale or lease and any property in the hospital fund in:

(1) a nonexpendable interest bearing trust fund from which claims are paid for county hospital claims for the indigent or any other fund that the county executive and county fiscal body designate;

or

(2) the county general fund.

SECTION 14. IC 16-38-5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

**Chapter 5. Immunization Data Registry**

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**Sec. 1. The state department may develop an immunization data registry.**

**Sec. 2. A provider may provide immunization data to the immunization data registry with specific written authorization of the patient.**

**Sec. 3. (a) Records maintained as part of the immunization data registry are confidential.**

**(b) The state department may release confidential information concerning individual immunization patient records to the immunization data registry of another state or a provider if the following conditions are met:**

- (1) The other state registry or provider has entered into an agreement with the state department.**
- (2) The agreement provides that information that identifies a patient will not be released to any other person without the written consent of the patient.**

**SECTION 15. IC 16-39-5-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) As used in this section, "association" refers to an Indiana hospital trade association founded in 1921.**

**(b) Except as provided in IC 16-39-4-5, the original health record of the patient is the property of the provider and as such may be used by the provider without specific written authorization for legitimate business purposes, including the following:**

- (1) Submission of claims for payment from third parties.**
- (2) Collection of accounts.**
- (3) Litigation defense.**
- (4) Quality assurance.**
- (5) Peer review.**
- (6) Scientific, statistical, and educational purposes.**

**(~~b~~) (c) In use under subsection (~~a~~); (b), the provider shall at all times protect the confidentiality of the health record and may disclose the identity of the patient only when disclosure is essential to the provider's business use or to quality assurance and peer review.**

**(~~c~~) (d) A provider may disclose a health record to another provider or to a nonprofit medical research organization to be used in connection with a joint scientific, statistical, or educational project. Each party that receives information from a health record in connection with the joint project shall protect the confidentiality of the health record and may not disclose the patient's identity except as allowed under this article.**

**(e) A provider may disclose a health record or information**

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obtained from a health record to the association for use in connection with a voluntary scientific, statistical, or educational project undertaken by the association. However, the provider may disclose the identity of a patient to the association only when the disclosure is essential to the project. The association may disclose the information it receives from a provider under this subsection to the state department to be used in connection with a voluntary scientific, statistical, or educational project undertaken jointly by the association and the state department if the association and the state department have agreed to the project's scope, nature, and duration. The information disclosed by:

- (1) a provider to the association; or
- (2) the association to the state department;

under this subsection is confidential.

(f) Information contained in final results obtained by the state department for a voluntary scientific, statistical, or educational project undertaken jointly by the state department and the association that:

- (1) uses information disclosed under subsection (e); and
- (2) identifies or could be used to determine the identity of a patient;

is confidential. All other information contained in the final results is not confidential.

(g) Information that is:

- (1) advisory or deliberative material of a speculative nature; or
- (2) an expression of opinion;

including preliminary reports produced in the course of a voluntary scientific, statistical, or educational project undertaken jointly by the state department and the association using information disclosed under subsection (e), is confidential and may only be disclosed by the state department to the association and to the provider who disclosed the information to the association.

(h) A person who recklessly violates or fails to comply with subsection (e) subsections (d) through (g) commits a Class C infraction. Each day a violation continues constitutes a separate offense.

(i) This chapter does not do any of the following:

- (1) Repeal, modify, or amend any statute requiring or authorizing the disclosure of information about any person.
- (2) Prevent disclosure or confirmation of information about patients involved in incidents that are reported or required to be

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reported to governmental agencies and not required to be kept confidential by the governmental agencies.

SECTION 16. IC 20-8.1-7-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 9.5. (a) Every child residing in Indiana shall be immunized against:

- (1) diphtheria;
- (2) pertussis (whooping cough);
- (3) tetanus;
- (4) measles;
- (5) rubella;
- (6) poliomyelitis; and
- (7) ~~hepatitis B~~; **mumps**.

(b) Every child residing in Indiana who ~~has not completed~~ **enters kindergarten or** grade 1 ~~before July 1, 1985~~, shall be immunized against ~~mumps~~ **hepatitis B**.

(c) The state department of health may expand or otherwise modify the list of communicable diseases that require documentation of immunity as medical information becomes available that would warrant the expansion or modification in the interest of public health.

(d) The state department of health shall adopt rules under IC 4-22-2 specifying the:

- (1) required immunizations;
- (2) ~~the~~ child's age for administering each vaccine;
- (3) ~~the~~ adequately immunizing doses; and
- (4) ~~the~~ method of documentation of proof of immunity.

(e) Each school shall notify each parent of a child who enrolls in the school of the requirement that the child must be immunized and that the immunization is required for the child's continued enrollment, attendance, or residence at the school unless:

- (1) the parent or child provides the appropriate documentation of immunity; or
- (2) section 2 or 2.5 of this chapter applies.

SECTION 17. IC 25-26-18 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

**Chapter 18. Mail Order and Internet Based Pharmacies**

**Sec. 1. As used in this chapter, "mail order or Internet based pharmacy" means a pharmacy that is located in Indiana or is a nonresident pharmacy (as defined in IC 25-26-17-2) that dispenses prescription drugs:**

- (1) **through the United States Postal Service or other delivery services; or**

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(2) after receiving a request for prescription drugs through the Internet;  
to patients in Indiana.

**Sec. 2. A mail order or Internet based pharmacy shall comply with the following:**

(1) The licensure laws of the state in which the mail order or Internet based pharmacy is domiciled.

(2) The drug substitution laws of Indiana.

SECTION 18. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "board" has the meaning set forth in IC 12-15-35-2.

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established under IC 12-8-6-1.

(c) If a Medicaid managed care organization is using a formulary for Medicaid recipients as of the effective date of this SECTION, the managed care organization shall submit the formulary to the office not later than May 21, 1999.

(d) The office shall forward the formulary to the board for the board's review and recommendation.

(e) The office shall provide at least fifteen (15) days notification to the public that the board will review a Medicaid managed care organization's formulary at a particular board meeting. The notification shall contain the following information:

(1) A statement of the date, time, and place at which the board meeting will be convened.

(2) A general description of the subject matter of the board meeting.

(3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

(f) In reviewing the formulary, the board shall do the following:

(1) Make a determination after considering evidence and credible information provided to the board by the office and the public that the use of the formulary will not:

(A) impede the quality of patient care in the Medicaid program; or

(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.

(2) Make a determination that:

(A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary;

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- (B) a process is in place through which a Medicaid recipient has access to medically necessary drugs; and**
- (C) the managed care organization otherwise meets the requirements of IC 27-13-38.**

**(g) The board shall consider:**

- (1) health economic data;**
- (2) cost data; and**
- (3) the use of formularies in the non-Medicaid markets;**

**in developing the board's recommendation to the office.**

**(h) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the formulary should be approved, disapproved, or modified.**

**(i) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendation of the board, the office shall discuss the disagreement with the board and present any additional information to the board for consideration.**

**(j) Based on the final recommendation of the board, the office shall approve, disapprove, or require modifications to the Medicaid managed care organization's formulary. The office shall notify the managed care organization of the office's decision within fifteen (15) days after receiving the board's final recommendation.**

**(k) The managed care organization must comply with the office's decision within sixty (60) days after receiving notice of the office's decision.**

**(l) This SECTION expires June 30, 2000.**

**SECTION 19. An emergency is declared for this act.**

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