



Reprinted
February 28, 2001

HOUSE BILL No. 1857

DIGEST OF HB 1857 (Updated February 27, 2001 6:56 PM - DI 77)

Citations Affected: IC 4-6; IC 4-22; IC 12-7; IC 12-13; IC 12-15; IC 12-17.6; IC 16-42; noncode.

Synopsis: Medicaid. Provides that rulemaking concerning Medicaid waivers for adult foster care, assisted living, or adult day care must comply with certain procedures. Requires a pharmacist who fills a prescription that is covered under the children's health insurance program (CHIP) to fill the prescription with a generically equivalent drug product and inform the customer of the substitution if the substitution results in a lower price, unless the prescribing practitioner indicates that the prescription must be filled with a brand name drug. Provides that reimbursement for legend drugs under Medicaid will be limited to the lowest of: (1) the federal supply schedule price; (2) the maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration; or (3) the provider's submitted charge, representing the provider's usual and customary charge for the drug. Requires the office of Medicaid policy and planning (OMPP) to establish an automated phone system for practitioners to obtain prior approval before writing a prescription for a Medicaid patient. Requires a pharmacist to use the system to confirm the patient has been approved for the drug. Makes changes to the conditions the drug utilization review (DUR) board must meet to place a single source drug on prior approval, restrict the drug in its use, or establish a drug
(Continued next page)

Effective: Upon passage; July 1, 2001.

Crawford, Brown C

(SENATE SPONSORS — JOHNSON, SIMPSON)

January 17, 2001, read first time and referred to Committee on Ways and Means.
February 15, 2001, amended, reported — Do Pass.
February 21, 2001, read second time, amended, ordered engrossed.
February 22, 2001, engrossed.
February 27, 2001, read third time, recommitted to Committee of One, amended; passed.
Yeas 51, nays 42.

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monitoring process. Provides that an outpatient formulary established by OMPP must comply with federal law. Requires a practitioner to obtain prior approval from OMPP before writing a prescription to a Medicaid patient for a brand name drug. Requires OMPP to require Marion County Hoosier Healthwise enrollees to enroll in the risk-based managed care program. Requires OMPP to conduct an annual evaluation on a data analysis of certain information that can be used to determine possible cost containment measures for the state's Medicaid program. Requires the attorney general to submit an annual report to the select joint committee on Medicaid oversight on the state Medicaid fraud control unit's activities during the preceding year. Requires the division of family and children to establish a fraud control unit to investigate and prosecute claims of any violation, abuse, or fraud by recipients of Medicaid, temporary assistance for needy families (TANF), and food stamps and to submit an annual report to the select joint committee on Medicaid oversight on the fraud control unit's activities during the preceding year. Provides certain procedures for the office of the secretary of family and social services to follow to implement certain Medicaid waivers. Makes other changes regarding Medicaid.

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February 28, 2001

First Regular Session 112th General Assembly (2001)

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 2000 General Assembly.

HOUSE BILL No. 1857

A BILL FOR AN ACT to amend the Indiana Code concerning health.

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

- 1 SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.273-1999,
2 SECTION 160, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE UPON PASSAGE]: Sec. 37.1. (a) This section applies
4 to a rulemaking action resulting in any of the following rules:
5 (1) An order adopted by the commissioner of the Indiana
6 department of transportation under IC 9-20-1-3(d) or
7 IC 9-21-4-7(a) and designated by the commissioner as an
8 emergency rule.
9 (2) An action taken by the director of the department of natural
10 resources under IC 14-22-2-6(d) or IC 14-22-6-13.
11 (3) An emergency temporary standard adopted by the
12 occupational safety standards commission under
13 IC 22-8-1.1-16.1.
14 (4) An emergency rule adopted by the solid waste management
15 board under IC 13-22-2-3 and classifying a waste as hazardous.
16 (5) A rule, other than a rule described in subdivision (6), adopted
17 by the department of financial institutions under IC 24-4.5-6-107

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- 1 and declared necessary to meet an emergency.
- 2 (6) A rule required under IC 24-4.5-1-106 that is adopted by the
- 3 department of financial institutions and declared necessary to
- 4 meet an emergency under IC 24-4.5-6-107.
- 5 (7) A rule adopted by the Indiana utility regulatory commission to
- 6 address an emergency under IC 8-1-2-113.
- 7 (8) An emergency rule jointly adopted by the water pollution
- 8 control board and the budget agency under IC 13-18-13-18.
- 9 (9) An emergency rule adopted by the state lottery commission
- 10 under IC 4-30-3-9.
- 11 (10) A rule adopted under IC 16-19-3-5 that the executive board
- 12 of the state department of health declares is necessary to meet an
- 13 emergency.
- 14 (11) An emergency rule adopted by the Indiana transportation
- 15 finance authority under IC 8-21-12.
- 16 (12) An emergency rule adopted by the insurance commissioner
- 17 under IC 27-1-23-7.
- 18 (13) An emergency rule adopted by the Indiana horse racing
- 19 commission under IC 4-31-3-9.
- 20 (14) An emergency rule adopted by the air pollution control
- 21 board, the solid waste management board, or the water pollution
- 22 control board under IC 13-15-4-10(4) or to comply with a
- 23 deadline required by federal law, provided:
- 24 (A) the variance procedures are included in the rules; and
- 25 (B) permits or licenses granted during the period the
- 26 emergency rule is in effect are reviewed after the emergency
- 27 rule expires.
- 28 (15) An emergency rule adopted by the Indiana election
- 29 commission under IC 3-6-4.1-14.
- 30 (16) An emergency rule adopted by the department of natural
- 31 resources under IC 14-10-2-5.
- 32 (17) An emergency rule adopted by the Indiana gaming
- 33 commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.
- 34 (18) An emergency rule adopted by the alcoholic beverage
- 35 commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
- 36 IC 7.1-3-20-24.4.
- 37 (19) An emergency rule adopted by the department of financial
- 38 institutions under IC 28-15-11.
- 39 (20) An emergency rule adopted by the office of the secretary of
- 40 family and social services under IC 12-8-1-12.
- 41 (21) An emergency rule adopted by the office of the children's
- 42 health insurance program under IC 12-17.6-2-11.

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- 1 **(22) An emergency rule adopted by the office of the secretary**
 2 **of family and social services to implement a Medicaid waiver**
 3 **for adult foster care, assisted living, or adult day care**
 4 **services.**
- 5 (b) The following do not apply to rules described in subsection (a):
 6 (1) Sections 24 through 36 of this chapter.
 7 (2) IC 13-14-9.
- 8 (c) After a rule described in subsection (a) has been adopted by the
 9 agency, the agency shall submit the rule to the publisher for the
 10 assignment of a document control number. The agency shall submit the
 11 rule in the form required by section 20 of this chapter and with the
 12 documents required by section 21 of this chapter. The publisher shall
 13 determine the number of copies of the rule and other documents to be
 14 submitted under this subsection.
- 15 (d) After the document control number has been assigned, the
 16 agency shall submit the rule to the secretary of state for filing. The
 17 agency shall submit the rule in the form required by section 20 of this
 18 chapter and with the documents required by section 21 of this chapter.
 19 The secretary of state shall determine the number of copies of the rule
 20 and other documents to be submitted under this subsection.
- 21 (e) Subject to section 39 of this chapter, the secretary of state shall:
 22 (1) accept the rule for filing; and
 23 (2) file stamp and indicate the date and time that the rule is
 24 accepted on every duplicate original copy submitted.
- 25 (f) A rule described in subsection (a) takes effect on the latest of the
 26 following dates:
 27 (1) The effective date of the statute delegating authority to the
 28 agency to adopt the rule.
 29 (2) The date and time that the rule is accepted for filing under
 30 subsection (e).
 31 (3) The effective date stated by the adopting agency in the rule.
 32 (4) The date of compliance with every requirement established by
 33 law as a prerequisite to the adoption or effectiveness of the rule.
- 34 (g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and
 35 IC 22-8-1.1-16.1, a rule adopted under this section expires not later
 36 than ninety (90) days after the rule is accepted for filing under
 37 subsection (e). Except for a rule adopted under subsection (a)(14), the
 38 rule may be extended by adopting another rule under this section, but
 39 only for one (1) extension period. A rule adopted under subsection
 40 (a)(14) may be extended for two (2) extension periods. Except for a
 41 rule adopted under subsection (a)(14), for a rule adopted under this
 42 section to be effective after one (1) extension period, the rule must be

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1 adopted under:

2 (1) sections 24 through 36 of this chapter; or

3 (2) IC 13-14-9;

4 as applicable.

5 (h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires
6 on the earlier of the following dates:

7 (1) The expiration date stated by the adopting agency in the rule.

8 (2) The date that the rule is amended or repealed by a later rule
9 adopted under sections 24 through 36 of this chapter or this
10 section.

11 (†) (i) This section may not be used to readopt a rule under
12 IC 4-22-2.5.

13 SECTION 2. IC 4-6-10-4 IS ADDED TO THE INDIANA CODE
14 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
15 1, 2001]: **Sec. 4. The attorney general shall submit an annual report
16 to the select joint committee on Medicaid Oversight by November
17 1 of each year on the state medicaid fraud control unit's activities
18 during the preceding year. The report must include the following:**

19 (1) **The number of incidents reported to the attorney general
20 under this chapter.**

21 (2) **The number of incidents investigated by the attorney
22 general under this chapter.**

23 (3) **The number of incidents found by the attorney general to
24 have merit.**

25 (4) **The projected amount of money spent on investigating and
26 prosecuting an incident.**

27 (5) **The projected amount of money recovered through an
28 investigation or prosecution of an incident.**

29 (6) **The estimated and projected cost of investigating and
30 prosecuting incidents under this chapter for the following
31 year.**

32 SECTION 3. IC 12-7-2-57.3 IS ADDED TO THE INDIANA CODE
33 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
34 1, 2001] **Sec. 57.3. "Delivery system", as used in IC 12-15-12-14
35 and IC 12-17.6-4-8, means a system of:**

36 (1) **a hospital licensed under IC 16-21; and**

37 (2) **primary medical providers;**

38 **that provides services under the Medicaid risk-based managed
39 care program to enrollees in Medicaid or the children's health
40 insurance program.**

41 SECTION 4. IC 12-7-2-85.1 IS ADDED TO THE INDIANA CODE
42 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

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1, 2001] **Sec. 85.1. "Federal supply schedule", for purposes of IC 12-15-31-5, has the meaning set forth in IC 12-15-31-5(a).**

SECTION 5. IC 12-7-2-169.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 169.7. "Risk-based managed care program", as used in IC 12-15 and IC 12-17.6, refers to a program offered by the office in which the office contracts with a health maintenance organization licensed under IC 27-13 to provide covered services to an enrollee in Medicaid or the children's health insurance program.**

SECTION 6. IC 12-13-5-13 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) The division shall establish a fraud control unit to investigate and prosecute claims of any violation, abuse, or fraud by recipients of:**

- (1) Medicaid under IC 12-15;
- (2) Cash assistance under the temporary assistance for needy people (TANF) under 45 CFR 260 et. seq; and
- (3) food stamps under 7 U.S.C. 2016(i).

(b) **The division shall submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on the fraud control unit's activities during the preceding year. The report must include the following:**

- (1) **The number of incidents reported to the division's fraud control unit of possible violations, abuse, or fraud by recipients of:**
 - (A) Medicaid;
 - (B) TANF; and
 - (C) food stamps.
- (2) **The number of incidents investigated by the division's fraud control unit of possible violations, abuse, or fraud by recipients of:**
 - (A) Medicaid;
 - (B) TANF; and
 - (C) food stamps.
- (3) **The number of incidents found by the division's fraud control unit to have merit.**
- (4) **The projected amount of money spent by the division's fraud control unit on investigating and prosecuting an incident.**
- (5) **The projected amount of money recovered through an investigation or prosecution of an incident.**



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1 **(6) The estimated and projected cost of investigating and**
 2 **prosecuting incidents under this section for the following year.**

3 SECTION 7. IC 12-15-1-13.5 IS ADDED TO THE INDIANA
 4 CODE AS A NEW SECTION TO READ AS FOLLOWS
 5 [EFFECTIVE JULY 1, 2001]: **Sec. 13.5. (a) The office shall conduct**
 6 **an annual evaluation and submit an annual report to the select**
 7 **joint committee on Medicaid Oversight by November 1 of each**
 8 **year on a data analysis of information collected by the office:**

9 **(1) by category of services provided;**

10 **(2) by provider; and**

11 **(3) by recipient;**

12 **that can be used to educate the office and determine any possible**
 13 **cost containment measures that may be adopted and implemented**
 14 **for the state's Medicaid program and any cost offsets or cost shifts**
 15 **as a result of the cost containment measures.**

16 **(b) The office shall contract with an independent organization**
 17 **to conduct the evaluation and submit the report described in**
 18 **subsection (a). The office shall cooperate with the independent**
 19 **organization in supplying the organization with the data necessary**
 20 **to complete the report.**

21 **(c) This section does not modify the requirements of other**
 22 **statutes relating to the confidentiality of medical records.**

23 SECTION 8. IC 12-15-12-13 IS ADDED TO THE INDIANA
 24 CODE AS A NEW SECTION TO READ AS FOLLOWS
 25 [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) This section applies to a**
 26 **Medicaid recipient who:**

27 **(1) is required to be enrolled in a Medicaid managed care**
 28 **program; and**

29 **(2) resides in a county having a consolidated city.**

30 **(b) Beginning September 1, 2001, the office shall, where**
 31 **permitted by federal law, require a new recipient described in**
 32 **subsection (a) to enroll in the risk-based managed care program.**

33 **(c) An individual described in subsection (a) who enrolls in the**
 34 **primary care case management program before September 1,**
 35 **2001, may remain in the primary care case management program.**
 36 **However, if the individual changes primary medical providers**
 37 **after August 31, 2001, the office shall, where permitted by federal**
 38 **law, require the individual to enroll in the risk-based managed care**
 39 **program.**

40 **(d) The office may adopt rules under IC 4-22-2 to implement**
 41 **this section.**

42 SECTION 9. IC 12-15-12-14 IS ADDED TO THE INDIANA

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1 CODE AS A NEW SECTION TO READ AS FOLLOWS
 2 [EFFECTIVE JULY 1, 2001]: **Sec. 14. (a) This section applies**
 3 **whenever the office transfers the assignment of enrollees from the**
 4 **primary care case management program to the risk-based**
 5 **managed care program under section 13 of this chapter.**

6 **(b) A managed care contractor shall establish the terms and**
 7 **conditions that must be met by a delivery system wishing to enter**
 8 **into an agreement with the managed care contractor. The terms**
 9 **and conditions may not unreasonably discriminate against or**
 10 **among delivery systems. For the purposes of this section,**
 11 **differences in price produced by a process of individual negotiation**
 12 **or price differences among other delivery systems in different**
 13 **geographic areas or different specialties do not constitute**
 14 **unreasonable discrimination. Upon request by a delivery system,**
 15 **the managed care contractor shall make available to the delivery**
 16 **system a written statement of the terms and conditions that must**
 17 **be met by a delivery system wishing to enter into an agreement**
 18 **with the managed care contractor.**

19 **(c) A delivery system willing to meet the terms and conditions**
 20 **of an agreement described in subsection (b) may not be denied the**
 21 **right to enter into an agreement with the managed care contractor.**
 22 **If a managed care contractor denies a delivery system the right to**
 23 **enter into an agreement with the managed care contractor on the**
 24 **grounds that the delivery system does not satisfy the terms and**
 25 **conditions established by the managed care contractor, the**
 26 **managed care contractor shall provide the delivery system with a**
 27 **written notice that:**

28 **(1) explains the basis of the managed care contractor's denial;**
 29 **and**

30 **(2) states the specific terms and conditions that the delivery**
 31 **system does not satisfy.**

32 **(d) A cause of action shall not arise against a managed care**
 33 **contractor for:**

34 **(1) disclosing information as required by this section; or**

35 **(2) the subsequent use of the information by unauthorized**
 36 **individuals.**

37 SECTION 10. IC 12-15-31-5 IS ADDED TO THE INDIANA
 38 CODE AS A NEW SECTION TO READ AS FOLLOWS
 39 [EFFECTIVE JULY 1, 2001] **Sec. 5. (a) As used in this section,**
 40 **"federal supply schedule" refers to the price catalog containing**
 41 **goods available for purchase by federal agencies, as published by**
 42 **the United States General Services Administration.**



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1 **(b) The office shall reimburse pharmacy providers for covered**
 2 **legend drugs at the lowest of the following:**

3 **(1) The price listed for the drug on the federal supply schedule**
 4 **as of the date of dispensing, plus any applicable Medicaid**
 5 **dispensing fee.**

6 **(2) The maximum allowable cost (MAC) of the drug as**
 7 **determined by the Health Care Financing Administration**
 8 **under 42 CFR 447.332 as of the date of dispensing, plus any**
 9 **applicable Medicaid dispensing fee.**

10 **(3) The provider's submitted charge, representing the**
 11 **provider's usual and customary charge for the drug, as of the**
 12 **date of dispensing.**

13 SECTION 11. IC 12-15-35-34.5 IS ADDED TO THE INDIANA
 14 CODE AS A NEW SECTION TO READ AS FOLLOWS
 15 [EFFECTIVE JULY 1, 2001]: **Sec. 34.5. Before January 1, 2003, the**
 16 **office shall establish and maintain an automated system for the**
 17 **prior approval of prescription drugs that meets the following**
 18 **requirements:**

19 **(1) The system must allow a provider who writes a**
 20 **prescription to request prior approval for a prescription drug**
 21 **by telephone.**

22 **(2) The system must be capable of receiving and processing**
 23 **multiple telephone requests simultaneously and grant or deny**
 24 **prior approval in a timely manner.**

25 **(3) If prior approval is granted, the system must immediately**
 26 **update the Medicaid recipient's records to indicate prior**
 27 **approval has been granted for the prescription.**

28 **(4) If prior approval is denied, the system must allow the**
 29 **provider the option to speak with a representative of the office**
 30 **concerning the denial.**

31 **(5) The system must allow a pharmacist to determine by**
 32 **telephone that the recipient's prescription has been granted**
 33 **prior approval.**

34 **(b) The office shall adopt rules under IC 4-22-2 to require a**
 35 **provider who writes a prescription to obtain prior approval for the**
 36 **prescription drug before giving the recipient the prescription for**
 37 **the drug.**

38 SECTION 12. IC 12-15-35-35, AS AMENDED BY P.L.231-1999,
 39 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 40 JULY 1, 2001]: **Sec. 35. (a) As used in this section, "single source**
 41 **drug" means a covered outpatient drug that is produced or distributed**
 42 **under an original new drug application approved by the federal Food**

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1 and Drug Administration, including a drug product marketed by any
 2 cross-licensed producers or distributors operating under the new drug
 3 application.

4 (b) Before the board develops a program to place a single source
 5 drug on prior approval, restrict the drug in its use, or establish a drug
 6 monitoring process or program to measure or restrict utilization of
 7 single source drugs other than in the SURS program, the board must
 8 meet the following conditions:

9 (1) Make a determination, after considering evidence and credible
 10 information provided to the board by the office and the public,
 11 that placing a single source drug on prior approval or restricting
 12 the drug's use will not:

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

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

17 (2) Meet to review a formulary or a restriction on a single source
 18 drug after the office provides at least thirty (30) days notification
 19 to the public that the board will review the formulary or
 20 restriction on a single source drug at a particular board meeting.

21 The notification shall contain the following information:

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

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

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

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

31 (3) Ensure that:

32 (A) there is access to at least ~~two (2)~~ **one (1)** alternative ~~drugs~~
 33 **drug** within each therapeutic classification, if available, on the
 34 formulary; and

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

37 (4) ~~Reconsider the drug's removal from its restricted status or~~
 38 ~~from prior approval not later than six (6) months after the single~~
 39 ~~source drug is placed on prior approval or restricted in its use.~~

40 (5) Ensure that the program provides either telephone or FAX
 41 approval or denial Monday through Friday, twenty-four (24) hours
 42 a day. The office must provide the approval or denial within

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1 twenty-four (24) hours after receipt of a prior approval request.
 2 The program must provide for the dispensing of at least a
 3 seventy-two (72) hour supply of the drug in an emergency
 4 situation or on weekends.
 5 ~~(6)~~ (5) Ensure that any prior approval program or restriction on
 6 the use of a single source drug is not applied to prevent
 7 acceptable medical use for appropriate off-label indications.
 8 (c) The board shall advise the office on the implementation of any
 9 program to restrict the use of brand name multisource drugs.
 10 (d) The board shall consider:
 11 (1) health economic data;
 12 (2) cost data; and
 13 (3) the use of formularies in the non-Medicaid markets;
 14 in developing its recommendations to the office.
 15 **(e) The board may not require prior approval of a single source**
 16 **drug based solely on the cost of the drug.**
 17 SECTION 13. IC 12-15-35-45, AS AMENDED BY P.L.231-1999,
 18 SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 19 JULY 1, 2001]: Sec. 45. (a) The chairman of the board, subject to the
 20 approval of the board members, ~~may~~ **shall** appoint an advisory
 21 committee to make recommendations to the board on the development
 22 of a Medicaid outpatient drug formulary.
 23 (b) ~~If~~ The office ~~decides to~~ **may** establish a Medicaid outpatient
 24 drug formulary. **If the office establishes a formulary**, the formulary
 25 shall be developed by the board **in compliance with 42 U.S.C. 1396r**.
 26 (c) A formulary used by a Medicaid managed care organization is
 27 subject to sections 46 and 47 of this chapter.
 28 SECTION 14. IC 12-15-35-46, AS ADDED BY P.L.231-1999,
 29 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 30 JULY 1, 2001]: Sec. 46. (a) This section applies to a managed care
 31 organization that enters into an initial contract with the office to be a
 32 Medicaid managed care organization after May 13, 1999.
 33 (b) Before a Medicaid managed care organization described in
 34 subsection (a) implements a formulary, the managed care organization
 35 shall submit the formulary to the office at least thirty-five (35) days
 36 before the date that the managed care organization implements the
 37 formulary for Medicaid recipients.
 38 (c) The office shall forward the formulary to the board for the
 39 board's review and recommendation.
 40 (d) The office shall provide at least thirty (30) days notification to
 41 the public that the board will review a Medicaid managed care
 42 organization's proposed formulary at a particular board meeting. The

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- 1 notification shall contain the following information:
- 2 (1) A statement of the date, time, and place at which the board
- 3 meeting will be convened.
- 4 (2) A general description of the subject matter of the board
- 5 meeting.
- 6 (3) An explanation of how a copy of the formulary to be discussed
- 7 may be obtained.
- 8 The board shall meet to review the formulary at least thirty (30) days
- 9 but not more than sixty (60) days after the notification.
- 10 (e) In reviewing the formulary, the board shall do the following:
- 11 (1) Make a determination, after considering evidence and credible
- 12 information provided to the board by the office and the public,
- 13 that the use of the formulary will not:
- 14 (A) impede the quality of patient care in the Medicaid
- 15 program; or
- 16 (B) increase costs in other parts of the Medicaid program,
- 17 including hospital costs and physician costs.
- 18 (2) Make a determination that:
- 19 (A) there is access to at least ~~two (2)~~ **one (1)** alternative ~~drugs~~
- 20 **drug** within each therapeutic classification, if available, on the
- 21 formulary;
- 22 (B) a process is in place through which a Medicaid member
- 23 has access to medically necessary drugs; and
- 24 (C) the managed care organization otherwise meets the
- 25 requirements of IC 27-13-38.
- 26 (f) The board shall consider:
- 27 (1) health economic data;
- 28 (2) cost data; and
- 29 (3) the use of formularies in the non-Medicaid markets;
- 30 in developing its recommendation to the office.
- 31 (g) Within thirty (30) days after the board meeting, the board shall
- 32 make a recommendation to the office regarding whether the proposed
- 33 formulary should be approved, disapproved, or modified.
- 34 (h) The office shall rely significantly on the clinical expertise of the
- 35 board. If the office does not agree with the recommendations of the
- 36 board, the office shall, at a public meeting, discuss the disagreement
- 37 with the board and present any additional information to the board for
- 38 the board's consideration. The board's consideration of additional
- 39 information must be conducted at a public meeting.
- 40 (i) Based on the final recommendations of the board, the office shall
- 41 approve, disapprove, or require modifications to the Medicaid managed
- 42 care organization's proposed formulary. The office shall notify the

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1 managed care organization of the office's decision within fifteen (15)
2 days of receiving the board's final recommendation.

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

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

9 **(l) A Medicaid managed care organization may not require**
10 **prior approval of a single source drug based solely on the cost of**
11 **the drug.**

12 SECTION 15. IC 12-15-35-47, AS ADDED BY P.L.231-1999,
13 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
14 JULY 1, 2001]: Sec. 47. (a) This section applies to the following
15 changes to a formulary used by a Medicaid managed care organization
16 for Medicaid recipients:

17 (1) Removing one (1) or more drugs from the formulary.

18 (2) Placing new restrictions on one (1) or more drugs on the
19 formulary.

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

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

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

27 (1) review the proposed change; and

28 (2) consider evidence and credible information provided to the
29 board;

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

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

38 (f) A Medicaid managed care organization:

39 (1) may add a drug to the managed care organization's formulary
40 without the approval of the office; and

41 (2) shall notify the office of any addition to the managed care
42 organization's formulary within thirty (30) days after making the

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addition.
(g) A Medicaid managed care organization may not require prior approval of a single source drug based solely on the cost of the drug.

SECTION 16. IC 12-17.6-4-7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. (a) This section applies to a child who:**

- (1) is enrolled in the program established under this article; and**
- (2) resides in a county having a consolidated city.**

(b) Beginning September 1, 2001, the office shall, where permitted by federal law, require a new recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) An individual described in subsection (a) who enrolls in the primary care case management program before September 1, 2001, may remain in the primary care case management program. However, if the individual changes primary medical providers after August 31, 2001, the office shall, where permitted by federal law, require the individual to enroll in the risk-based managed care program.

(d) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 17. IC 12-17.6-4-8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 8. (a) This section applies whenever the office transfers the assignment of enrollees from the primary care case management program to the risk-based managed care program under section 7 of this chapter.**

(b) A managed care contractor shall establish the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor. The terms and conditions may not unreasonably discriminate against or among delivery systems. For the purposes of this section, differences in price produced by a process of individual negotiation or price differences among other delivery systems in different geographic areas or different specialties do not constitute unreasonable discrimination. Upon request by a delivery system, the managed care contractor shall make available to the delivery system a written statement of the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor.

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1 (c) A delivery system willing to meet the terms and conditions
2 of an agreement described in subsection (b) may not be denied the
3 right to enter into an agreement with the managed care contractor.
4 If a managed care contractor denies a delivery system the right to
5 enter into an agreement with the managed care contractor on the
6 grounds that the delivery system does not satisfy the terms and
7 conditions established by the managed care contractor, the
8 managed care contractor shall provide the delivery system with a
9 written notice that:

- 10 (1) explains the basis of the managed care contractor's denial;
11 and
12 (2) states the specific terms and conditions that the delivery
13 system does not satisfy.

14 (d) A cause of action shall not arise against a managed care
15 contractor for:

- 16 (1) disclosing information as required by this section; or
17 (2) the subsequent use of the information by unauthorized
18 individuals.

19 SECTION 18. IC 16-42-22-8, AS AMENDED BY P.L.239-1999,
20 SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
21 JULY 1, 2001]: Sec. 8. (a) For substitution to occur for a prescription
22 other than a prescription filled under the Medicaid program (42 U.S.C.
23 1396 et seq.), **the children's health insurance program established**
24 **under IC 12-17.6-2**, or the Medicare program (42 U.S.C. 1395 et seq.):

- 25 (1) the practitioner must sign on the line under which the words
26 "May substitute" appear; and
27 (2) the pharmacist must inform the customer of the substitution.

28 (b) This section does not authorize any substitution other than
29 substitution of a generically equivalent drug product.

30 SECTION 19. IC 16-42-22-10, AS AMENDED BY P.L.239-1999,
31 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
32 JULY 1, 2001]: Sec. 10. (a) **Except as provided in subsection (d)**, if
33 a prescription is filled under the Medicaid program (42 U.S.C. 1396 et
34 seq.), **the children's health insurance program established under**
35 **IC 12-17.6-2**, or the Medicare program (42 U.S.C. 1395 et seq.), the
36 pharmacist shall substitute a generically equivalent drug product and
37 inform the customer of the substitution if the substitution would result
38 in a lower price unless:

- 39 (1) the words "Brand Medically Necessary" are written in the
40 practitioner's own writing on the form; or
41 (2) the practitioner has indicated that the pharmacist may not
42 substitute a generically equivalent drug product by orally stating

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that a substitution is not permitted.

(b) If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the "Brand Medically Necessary" instruction appropriately indicated in the physician's own handwriting.

(c) This section does not authorize any substitution other than substitution of a generically equivalent drug product.

(d) If a prescription is filled under the Medicaid program, before a practitioner writes "Brand Medically Necessary" on the form or indicates that the pharmacist may not substitute a generically equivalent drug product, the practitioner must receive prior approval for the drug product from the office of Medicaid policy and planning.

(e) Every six (6) months, the drug utilization review board established by IC 12-15-35-19 shall:

- (1) recommend to the office of Medicaid policy and planning established by IC 12-15-1-1 those brand name drugs with generic equivalents that are to be subject to prior approval; and
- (2) analyze:
 - (A) the cost savings achieved by the prior approval program; and
 - (B) any concerns with:
 - (i) cost shifting; and
 - (ii) lowered health outcomes;

as a result of the prior approval program.

SECTION 20. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "waiver" means a Section 1915(b) freedom of choice waiver under the federal Social Security Act (42 U.S.C. 1315).

(b) Before July 1, 2001, the office of Medicaid policy and planning established by IC 12-15-1-1 shall apply to the United States Department of Health and Human Services for approval of an amendment to the state Medicaid plan or waiver to implement IC 12-15-12-13 and IC 12-17.6-4-7, both as added by this act.

(c) If a provision of this SECTION differs from the requirements of a state plan or waiver amendment, the office shall submit the amendment request in a manner that complies with the requirements of the amendment. However, after the amendment is approved, the office shall apply within one hundred twenty (120) days for an amendment to the approved amendment that contains the provisions of this SECTION that were not included in the

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approved amendment.

(d) The office of Medicaid policy and planning may not implement the amended state plan or waiver until the office files an affidavit with the governor attesting that the federal amendment applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the amendment is approved.

(e) If the office of Medicaid policy and planning receives approval of an amendment under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement the amendment not more than sixty (60) days after the governor receives the affidavit.

(f) The office of Medicaid policy and planning may adopt rules under IC 4-22-2 that are necessary to implement this SECTION.

(g) This SECTION expires July 1, 2005.

SECTION 21. P.L.100-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION

1. (a) The office of the secretary of family and social services shall develop and submit to the federal Health Care Financing Administration proposals to do the following:

- (1) Fund adult foster care and assisted living services through the Medicaid waiver program.
- (2) Expand adult day care services available through the aged and disabled Medicaid waiver.

(b) The proposals under subsection (a) must be reviewed by the community and home options to institutional care for the elderly and disabled (CHOICE) board established under IC 12-10-11 before the proposals are submitted to the federal Health Care Financing Administration regarding the following:

- (1) The definitions of adult foster care and assisted living.
- (2) The number of individuals to be served by each waiver.
- (3) The schedule of services to be delivered to individuals served by each waiver.
- (4) Consumer eligibility standards established for each waiver.
- (5) The means for expanding adult day care services.
- (6) The number of individuals to be served by expanded adult day care services.
- (7) Administrative oversight standards for each waiver described in this SECTION.

(c) The office of the secretary of family and social services must receive input from affected providers and consumers when drafting the

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1 language of applications for Medicaid waivers described in this
2 SECTION.

3 (d) The office of the secretary of family and social services may
4 submit the proposals described in this SECTION to the federal Health
5 Care Financing Administration as amendments to existing waivers.

6 (e) The proposals described in this SECTION must be submitted to
7 the federal Health Care Financing Administration before October 1,
8 2000.

9 (f) The office of the secretary of family and social services shall
10 report to the legislative council, the governor, and the CHOICE board
11 before January 1, 2001, regarding implementation of the provisions of
12 this SECTION.

13 (g) **The office of the secretary of family and social services may
14 not implement a waiver until the office files an affidavit with the
15 governor attesting that the federal waiver applied for under this
16 SECTION is in effect. The office shall file the affidavit under this
17 subsection not later than five (5) days after the office is notified
18 that the waiver is approved.**

19 (h) **If the office of the secretary of family and social services
20 receives a waiver under this SECTION from the federal Health
21 Care Financing Administration and the governor receives the
22 affidavit filed under subsection (g), the office shall implement the
23 waiver not more than sixty (60) days after the governor receives
24 the affidavit.**

25 (i) **The office of the secretary of family and social services shall
26 adopt standards that an entity must meet in order to provide
27 services under a waiver required by this SECTION.**

28 (j) **The office of the secretary of family and social services shall
29 approve an entity that meets the standards described in subsection
30 (i).**

31 (k) **The office of the secretary of family and social services shall
32 adopt rules under IC 4-22-2 to implement the waiver required by
33 this SECTION.**

34 (l) **The office of the secretary of family and social services may
35 adopt emergency rules under IC 4-22-2-37.1 to implement the
36 waiver required under this SECTION on an emergency basis.**

37 (m) **This SECTION expires January 1, ~~2002~~ 2006.**
38 SECTION 22. **An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1857, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 4-6-10-4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 4. The attorney general shall submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on the state medicaid fraud control unit's activities during the preceding year. The report must include the following:**

- (1) The number of incidents reported to the attorney general under this chapter.**
- (2) The number of incidents investigated by the attorney general under this chapter.**
- (3) The number of incidents found by the attorney general to have merit.**
- (4) The projected amount of money spent on investigating and prosecuting an incident.**
- (5) The projected amount of money recovered through an investigation or prosecution of an incident.**
- (6) The estimated and projected cost of investigating and prosecuting incidents under this chapter for the following year.**

SECTION 2. IC 12-7-2-57.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 57.3. "Delivery system", as used in IC 12-15-12-14 and IC 12-17.6-4-8, means a system of:**

- (1) a hospital licensed under IC 16-21; and**
- (2) primary medical providers;**

that provides services under the Medicaid risk-based managed care program to enrollees in Medicaid or the children's health insurance program.

SECTION 3. IC 12-7-2-85.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 85.1. "Federal supply schedule", for purposes of IC 12-15-31-5, has the meaning set forth in IC 12-15-31-5(a).**

SECTION 4. IC 12-7-2-169.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 169.7. "Risk-based managed care**

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program", as used in IC 12-15 and IC 12-17.6, refers to a program offered by the office in which the office contracts with a health maintenance organization licensed under IC 27-13 to provide covered services to an enrollee in Medicaid or the children's health insurance program.

SECTION 5. IC 12-13-5-13 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) The division shall establish a fraud control unit to investigate and prosecute claims of any violation, abuse, or fraud by recipients of:**

- (1) Medicaid under IC 12-15;
- (2) Cash assistance under the temporary assistance for needy people (TANF) under 45 CFR 260 et. seq; and
- (3) food stamps under 7 U.S.C. 2016(i).

(b) The division shall submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on the fraud control unit's activities during the preceding year. The report must include the following:

- (1) The number of incidents reported to the division's fraud control unit of possible violations, abuse, or fraud by recipients of:
 - (A) Medicaid;
 - (B) TANF; and
 - (C) food stamps.
- (2) The number of incidents investigated by the division's fraud control unit of possible violations, abuse, or fraud by recipients of:
 - (A) Medicaid;
 - (B) TANF; and
 - (C) food stamps.
- (3) The number of incidents found by the division's fraud control unit to have merit.
- (4) The projected amount of money spent by the division's fraud control unit on investigating and prosecuting an incident.
- (5) The projected amount of money recovered through an investigation or prosecution of an incident.
- (6) The estimated and projected cost of investigating and prosecuting incidents under this section for the following year.

SECTION 6. IC 12-15-1-13.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13.5. (a) The office shall conduct**

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an annual evaluation and submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on a data analysis of information collected by the office:

- (1) by category of services provided;
- (2) by provider; and
- (3) by recipient;

that can be used to educate the office and determine any possible cost containment measures that may be adopted and implemented for the state's Medicaid program.

(b) The office shall contract with an independent organization to conduct the evaluation and submit the report described in subsection (a). The office shall cooperate with the independent organization in supplying the organization with the data necessary to complete the report.

(c) This section does not modify the requirements of other statutes relating to the confidentiality of medical records.

SECTION 7. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 13. (a) This section applies to a Medicaid recipient who is required to be enrolled in a Medicaid managed care program.

(b) Beginning September 1, 2001, the office shall, where permitted by federal law, require a new recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) An individual described in subsection (a) who enrolls in the primary care case management program before September 1, 2001, may remain in the primary care case management program. However, if the individual changes primary medical providers after August 31, 2001, the office shall, where permitted by federal law, require the individual to enroll in the risk-based managed care program.

(d) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 8. IC 12-15-12-14 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 14. (a) This section applies whenever the office transitions the assignment of enrollees from the primary care case management program to the risk-based managed care program under section 13 of this chapter.

(b) A managed care contractor shall establish the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor. The terms

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and conditions may not unreasonably discriminate against or among delivery systems. For the purposes of this section, differences in price produced by a process of individual negotiation or price differences among other delivery systems in different geographic areas or different specialties constitutes unreasonable discrimination. Upon request by a delivery system, the managed care contractor shall make available to the delivery system a written statement of the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor.

(c) A delivery system willing to meet the terms and conditions of an agreement described in subsection (b) may not be denied the right to enter into an agreement with the managed care contractor. If a managed care contractor denies a delivery system the right to enter into an agreement with the managed care contractor on the grounds that the delivery system does not satisfy the terms and conditions established by the managed care contractor, the managed care contractor shall provide the delivery system with a written notice that:

- (1) explains the basis of the managed care contractor's denial; and
- (2) states the specific terms and conditions that the delivery system does not satisfy.

(d) A cause of action shall not arise against a managed care contractor for:

- (1) disclosing information as required by this section; or
- (2) the subsequent use of the information by unauthorized individuals.

SECTION 9. IC 12-15-31-5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] Sec. 5. (a) As used in this section, "federal supply schedule" refers to the price catalog containing goods available for purchase by federal agencies, as published by the United States General Services Administration.

(b) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following:

- (1) The price listed for the drug on the federal supply schedule as of the date of dispensing, plus any applicable Medicaid dispensing fee.
- (2) The maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration under 42 CFR 447.332 as of the date of dispensing, plus any



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applicable Medicaid dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

SECTION 10. IC 12-15-35-34.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 34.5. Before January 1, 2003, the office shall establish and maintain an automated system for the prior approval of prescription drugs that meets the following requirements:**

(1) The system must allow a provider who writes a prescription to request prior approval for a prescription drug by telephone.

(2) The system must be capable of receiving and processing multiple telephone requests simultaneously and grant or deny prior approval in a timely manner.

(3) If prior approval is granted, the system must immediately update the Medicaid recipient's records to indicate prior approval has been granted for the prescription.

(4) If prior approval is denied, the system must allow the provider the option to speak with a representative of the office concerning the denial.

(5) The system must allow a pharmacist to determine by telephone that the recipient's prescription has been granted prior approval.

(b) The office shall adopt rules under IC 4-22-2 to require a provider who writes a prescription to obtain prior approval for the prescription drug before giving the recipient the prescription for the drug.

SECTION 11. IC 12-15-35-35, AS AMENDED BY P.L.231-1999, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **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 board develops a program to place a single source drug on prior approval, restrict the drug in its use, or establish a drug monitoring process or program to measure or restrict utilization of single source drugs other than in the SURS program, the board must meet the following conditions:



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(1) 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) 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) Ensure that:

(A) there is access to at least ~~two (2)~~ **one (1)** alternative ~~drugs~~ **drug** 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) Reconsider the drug's removal from its restricted status 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) 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) (5) Ensure that any prior approval program or restriction on the use of a single source drug is not applied to prevent acceptable medical use for appropriate off-label indications.~~

(c) The board shall advise the office on the implementation of any

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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 12. IC 12-15-35-45, AS AMENDED BY P.L.231-1999, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, ~~may~~ **shall** 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~~ **shall** establish a Medicaid outpatient drug formulary **and** the formulary shall be developed by the board.

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

SECTION 13. IC 12-15-35-46, AS ADDED BY P.L.231-1999, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: 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 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

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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)~~ **one (1)** alternative ~~drugs~~ **drug** 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 14. IC 12-17.6-4-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. (a) This section applies to a**

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child enrolled in the program established under this article.

(b) Beginning September 1, 2001, the office shall, where permitted by federal law, require a new recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) An individual described in subsection (a) who enrolls in the primary care case management program before September 1, 2001, may remain in the primary care case management program. However, if the individual changes primary medical providers after August 31, 2001, the office shall, where permitted by federal law, require the individual to enroll in the risk-based managed care program.

(d) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 15. IC 12-17.6-4-8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 8. (a) This section applies whenever the office transitions the assignment of enrollees from the primary care case management program to the risk-based managed care program under section 7 of this chapter.

(b) A managed care contractor shall establish the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor. The terms and conditions may not unreasonably discriminate against or among delivery systems. For the purposes of this section, differences in price produced by a process of individual negotiation or price differences among other delivery systems in different geographic areas or different specialties constitutes unreasonable discrimination. Upon request by a delivery system, the managed care contractor shall make available to the delivery system a written statement of the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor.

(c) A delivery system willing to meet the terms and conditions of an agreement described in subsection (b) may not be denied the right to enter into an agreement with the managed care contractor. If a managed care contractor denies a delivery system the right to enter into an agreement with the managed care contractor on the grounds that the delivery system does not satisfy the terms and conditions established by the managed care contractor, the managed care contractor shall provide the delivery system with a written notice that:

(1) explains the basis of the managed care contractor's denial;



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(2) states the specific terms and conditions that the delivery system does not satisfy.

(d) A cause of action shall not arise against a managed care contractor for:

- (1) disclosing information as required by this section; or
- (2) the subsequent use of the information by unauthorized individuals."

Page 1, line 14, after "(a)" insert "Except as provided in subsection (d),".

Page 1, line 14, delete "If" and insert "if".

Page 2, after line 14, begin a new paragraph and insert:

"(d) If a prescription is filled under the Medicaid program, before a practitioner writes "Brand Medically Necessary" on the form or indicates that the pharmacist may not substitute a generically equivalent drug product, the practitioner must receive prior approval for the drug product from the office of Medicaid policy and planning.

SECTION 17. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "waiver" means a Section 1915(b) freedom of choice waiver under the federal Social Security Act (42 U.S.C. 1315).

(b) Before July 1, 2001, the office of Medicaid policy and planning established by IC 12-15-1-1 shall apply to the United States Department of Health and Human Services for approval of an amendment to the state Medicaid plan or waiver to implement IC 12-15-12-13 and IC 12-17.6-4-8, both as added by this act.

(c) If a provision of this SECTION differs from the requirements of a state plan or waiver amendment, the office shall submit the amendment request in a manner that complies with the requirements of the amendment. However, after the amendment is approved, the office shall apply within one hundred twenty (120) days for an amendment to the approved amendment that contains the provisions of this SECTION that were not included in the approved amendment.

(d) The office of Medicaid policy and planning may not implement the amended state plan or waiver until the office files an affidavit with the governor attesting that the federal amendment applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the amendment is approved.

(e) If the office of Medicaid policy and planning receives approval of an amendment under this SECTION from the United

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States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement the amendment not more than sixty (60) days after the governor receives the affidavit.

(f) The office of Medicaid policy and planning may adopt rules under IC 4-22-2 that are necessary to implement this SECTION.

(g) This SECTION expires July 1, 2005.

SECTION 18. An emergency is declared for this act."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1857 as introduced.)

BAUER, Chair

Committee Vote: yeas 21, nays 3.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1857 be amended to read as follows:

Page 4, line 13, delete "transitions" and insert "**transfers**".

Page 4, line 23, delete "constitutes" and insert "**constitute**".

Page 9, line 35, delete "transitions" and insert "**transfers**".

Page 10, line 3, delete "constitutes" and insert "**constitute**".

Page 11, line 30, delete "IC 12-17.6-4-8" and insert "**IC 12-17.6-4-7**".

(Reference is to HB 1857 as printed February 16, 2001.)

CRAWFORD

 HOUSE MOTION

Mr. Speaker: I move that House Bill 1857 be amended to read as follows:

Page 3, line 37, after "a" insert "**Medicaid recipient who:**

(1) is required to be enrolled in a Medicaid managed care program; and

(2) resides in a county having a consolidated city."

Page 3, delete lines 38 through 39.

Page 4, line 23, delete "constitutes" and insert "**do not constitute**".

Page 9, line 18, after "a" insert "**child who:**

(1) is enrolled in the program established under this article; and

(2) resides in a county having a consolidated city."

Page 9, delete line 19.

Page 10, line 3, delete "constitutes" and insert "**do not constitute**".

(Reference is to HB 1857 as printed February 16, 2001.)

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1857 be amended to read as follows:

Page 3, line 27, delete "." and insert "**and any cost offsets or cost shifts as a result of the cost containment measures.**".

Page 7, between lines 24 and 25, begin a new paragraph and insert:

"(e) The board may not require prior approval of a single source drug based solely on the cost of the drug.

(f) The use of prior authorization must be based on the recommendation of the board."

Page 7, line 31, delete "shall" and insert "**may**".

Page 7, line 32, after "drug" delete "formulary and" and insert "formulary. **If the office establishes a formulary,**".

Page 7, line 32, delete "board." and insert "**board in compliance with 42 U.S.C. 1396r.**".

Page 9, between lines 15 and 16, begin a new paragraph and insert:

(l) A Medicaid managed care organization may not require prior approval of a single source drug based solely on the cost of the drug.

(m) The use of prior authorization must be based on the recommendation of the board.

SECTION 14. IC 12-15-35-47, AS ADDED BY P.L.231-1999, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: 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.

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(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.

(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.

(g) A Medicaid managed care organization may not require prior approval of a single source drug based solely on the cost of the drug.

(h) The use of prior authorization must be based on the recommendation of the board."

Page 11, between lines 22 and 23, begin a new paragraph and insert:

"(e) Every six (6) months, the drug utilization review board established by IC 12-15-35-19 shall:

- (1) recommend to the office of Medicaid policy and planning established by IC 12-15-1-1 those brand name drugs with generic equivalents that are to be subject to prior approval; and**
 - (2) analyze:**
 - (A) the cost savings achieved by the prior approval program; and**
 - (B) any concerns with:**
 - (i) cost shifting; and**
 - (ii) lowered health outcomes;**
- as a result of the prior approval program."**

Re-number all SECTIONS consecutively.

(Reference is to HB 1857 as printed February 16, 2001.)

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1857 be recommitted to a Committee of One, its sponsor, with specific instructions to amend as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.273-1999, SECTION 160, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

- (1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.
- (2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.
- (3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.
- (4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.
- (5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.
- (6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.
- (7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.
- (8) An emergency rule jointly adopted by the water pollution control board and the budget agency under IC 13-18-13-18.
- (9) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.
- (10) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.
- (11) An emergency rule adopted by the Indiana transportation finance authority under IC 8-21-12.
- (12) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.
- (13) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

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(14) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

- (A) the variance procedures are included in the rules; and
- (B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(15) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(16) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(17) An emergency rule adopted by the Indiana gaming commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(18) An emergency rule adopted by the alcoholic beverage commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(19) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(20) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(21) An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-11.

(22) An emergency rule adopted by the office of the secretary of family and social services to implement a Medicaid waiver for adult foster care, assisted living, or adult day care services.

(b) The following do not apply to rules described in subsection (a):

- (1) Sections 24 through 36 of this chapter.
- (2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the secretary of state for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The secretary of state shall determine the number of copies of the rule

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and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the secretary of state shall:

- (1) accept the rule for filing; and
- (2) file stamp and indicate the date and time that the rule is accepted on every duplicate original copy submitted.

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

- (1) The effective date of the statute delegating authority to the agency to adopt the rule.
- (2) The date and time that the rule is accepted for filing under subsection (e).
- (3) The effective date stated by the adopting agency in the rule.
- (4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and IC 22-8-1.1-16.1, a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(14), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. A rule adopted under subsection (a)(14) may be extended for two (2) extension periods. Except for a rule adopted under subsection (a)(14), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

- (1) sections 24 through 36 of this chapter; or
- (2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires on the earlier of the following dates:

- (1) The expiration date stated by the adopting agency in the rule.
- (2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(†) (i) This section may not be used to readopt a rule under IC 4-22-2.5."

Page 7, delete lines 30 through 31.

Page 9, delete lines 27 through 28.

Page 10, delete lines 22 through 23.

Page 13, between lines 35 and 36, begin a new paragraph and insert:

"SECTION 20. P.L.100-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 1. (a) The office of the secretary of family and social services shall

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develop and submit to the federal Health Care Financing Administration proposals to do the following:

- (1) Fund adult foster care and assisted living services through the Medicaid waiver program.
- (2) Expand adult day care services available through the aged and disabled Medicaid waiver.

(b) The proposals under subsection (a) must be reviewed by the community and home options to institutional care for the elderly and disabled (CHOICE) board established under IC 12-10-11 before the proposals are submitted to the federal Health Care Financing Administration regarding the following:

- (1) The definitions of adult foster care and assisted living.
- (2) The number of individuals to be served by each waiver.
- (3) The schedule of services to be delivered to individuals served by each waiver.
- (4) Consumer eligibility standards established for each waiver.
- (5) The means for expanding adult day care services.
- (6) The number of individuals to be served by expanded adult day care services.
- (7) Administrative oversight standards for each waiver described in this SECTION.

(c) The office of the secretary of family and social services must receive input from affected providers and consumers when drafting the language of applications for Medicaid waivers described in this SECTION.

(d) The office of the secretary of family and social services may submit the proposals described in this SECTION to the federal Health Care Financing Administration as amendments to existing waivers.

(e) The proposals described in this SECTION must be submitted to the federal Health Care Financing Administration before October 1, 2000.

(f) The office of the secretary of family and social services shall report to the legislative council, the governor, and the CHOICE board before January 1, 2001, regarding implementation of the provisions of this SECTION.

(g) The office of the secretary of family and social services may not implement a waiver until the office files an affidavit with the governor attesting that the federal waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.

(h) If the office of the secretary of family and social services

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receives a waiver under this SECTION from the federal Health Care Financing Administration and the governor receives the affidavit filed under subsection (g), the office shall implement the waiver not more than sixty (60) days after the governor receives the affidavit.

(i) The office of the secretary of family and social services shall adopt standards that an entity must meet in order to provide services under a waiver required by this SECTION.

(j) The office of the secretary of family and social services shall approve an entity that meets the standards described in subsection (i).

(k) The office of the secretary of family and social services shall adopt rules under IC 4-22-2 to implement the waiver required by this SECTION.

(l) The office of the secretary of family and social services may adopt emergency rules under IC 4-22-2-37.1 to implement the waiver required under this SECTION on an emergency basis.

(m) This SECTION expires January 1, ~~2002~~ 2006."

Renumber all SECTIONS consecutively.

(Reference is to HB 1857 as reprinted February 22, 2001.)

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COMMITTEE REPORT

Mr. Speaker: Your Committee of One, to which was referred House Bill 1857, begs leave to report that said bill has been amended as directed.

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