



Reprinted
February 2, 2010

HOUSE BILL No. 1277

DIGEST OF HB 1277 (Updated February 1, 2010 5:38 pm - DI 104)

Citations Affected: IC 2-5; IC 5-22; IC 12-7; IC 12-15; noncode.

Synopsis: Health disparities in Medicaid. Requires a managed care organization (MCO) that contracts with the office of Medicaid policy and planning (OMPP) to provide Medicaid services to do the following: (1) Report to the select joint commission on Medicaid oversight concerning the MCO's culturally and linguistically appropriate services standards plan and the progress in implementing these standards. (2) Measure health disparities using certain measures. (3) Implement standards concerning culturally and linguistically appropriate services (CLAS), and encourage practices that are more culturally and linguistically accessible. (4) Develop and administer a community based health disparities advisory council. Requires OMPP to, beginning January 1, 2011, withhold a percentage of reimbursement from a managed care organization under specified circumstances. Requires the inclusion of criteria evaluating the MCO's cultural competency in working with minority populations in a request for proposal, and requires preferences to be awarded to an MCO that shows evidence of cultural competency. Requires OMPP to: (1) annually report specified information to the legislative council; (2) Include as part of the member's pharmacy benefits prescription drug labeling in the member's preferred language; and (3) establish standards and guidelines and ensure continuity of care for Medicaid recipients who transfer from an MCO. Requires a pharmacy that participates in the Medicaid program to provide prescription drug labels in the Medicaid recipient's preferred language upon request. Requires Medicaid vendors to establish specified quality initiatives.

Effective: Upon passage; July 1, 2010.

Crawford, Brown C, Welch

January 12, 2010, read first time and referred to Committee on Public Health.
January 25, 2010, reported — Do Pass.
February 1, 2010, read second time, amended, ordered engrossed.

HB 1277—LS 7001/DI 104+



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Second Regular Session 116th General Assembly (2010)

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 2009 Regular and Special Sessions of the General Assembly.

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HOUSE BILL No. 1277

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

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

1 SECTION 1. IC 2-5-26-16 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2010]: **Sec. 16. (a) As used in this section, "managed care
4 organization" has the definition set forth in IC 12-7-2-126.9.**

5 **(b) Before October 1 of each year, a managed care organization
6 that has contracted with the office of Medicaid policy and planning
7 to provide Medicaid services under the risk-based managed care
8 program shall report to the commission concerning the following:**

9 **(1) The managed care organization's culturally and
10 linguistically appropriate services (CLAS) standards plan,
11 including the managed care organization's progress in
12 implementing the standards.**

13 **(2) The progress of a contractor of the managed care
14 organization in implementing a culturally and linguistically
15 appropriate services standards plan.**

16 SECTION 2. IC 5-22-9-2.5 IS ADDED TO THE INDIANA CODE
17 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

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1 1, 2010]: **Sec. 2.5. In a request for proposal or a request for services**
2 **by the office of Medicaid policy and planning concerning managed**
3 **care organizations (as defined in IC 12-7-2-126.9) providing**
4 **services for the risk-based managed care Medicaid program under**
5 **IC 12-15, the office of Medicaid policy and planning shall:**

6 (1) **include as criteria that will be used in evaluating the**
7 **proposal information concerning the managed care**
8 **organization's cultural competency in working with minority**
9 **populations in Indiana; and**

10 (2) **award preferences to a managed care organization that**
11 **provides evidence of cultural competency in working with**
12 **minority populations.**

13 SECTION 3. IC 12-7-2-126.9 IS ADDED TO THE INDIANA
14 CODE AS A NEW SECTION TO READ AS FOLLOWS
15 [EFFECTIVE UPON PASSAGE]: **Sec. 126.9. "Managed care**
16 **organization", for purposes of IC 12-15, includes the following:**

17 (1) **A health maintenance organization established under**
18 **IC 27-13-2 with which the office of Medicaid policy and**
19 **planning has entered into a contract to provide services under**
20 **the risk-based managed care program.**

21 (2) **A person that contracts with the office or a person**
22 **described in subdivision (1) to provide the administration or**
23 **coordination of managed services, including a pharmacy**
24 **benefit manager, case management coordinator, or behavioral**
25 **health services coordinator.**

26 SECTION 4. IC 12-15-1-14 IS AMENDED TO READ AS
27 FOLLOWS [EFFECTIVE JULY 1, 2010]: **Sec. 14. (a) The office shall**
28 **annually submit a report to the legislative council that covers all**
29 **aspects of the office's evaluation, including the following:**

30 (1) **The number and demographic characteristics of the**
31 **individuals receiving Medicaid during the preceding fiscal year.**

32 (2) **The number of births during the preceding fiscal year.**

33 (3) **The number of infant deaths during the preceding fiscal year.**

34 (4) **The improvement in the number of low birth weight babies for**
35 **the preceding fiscal year.**

36 (5) **The total cost of providing Medicaid during the preceding**
37 **fiscal year.**

38 (6) **The total cost savings during the preceding fiscal year that are**
39 **realized in other state funded programs because of providing**
40 **Medicaid.**

41 (7) **The number of Medicaid recipients who transfer from a**
42 **managed care organization to a different managed care**

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organization under the Medicaid program, including the following:

(A) The number of Medicaid recipients transferring out of each managed care organization.

(B) The number of Medicaid recipients transferring into each managed care organization.

(C) The following information regarding the transferring recipient:

(i) Race.

(ii) Reason for transfer.

(iii) The health outcomes for each recipient during the six (6) months after the recipient transfers.

(9) The information required to be reported in IC 12-15-12-23.

The report must be in an electronic format under IC 5-14-6.

(b) The office shall report the information required in subsection (a) in the aggregate and in a manner that protects individual identifiable health information.

(c) The legislative council may request that the office also submit the information reported under IC 12-15-12-23 in an electronic format under IC 5-14-6.

SECTION 5. IC 12-15-1-21 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: **Sec. 21. The office shall establish standards and guidelines and ensure continuity of care for Medicaid recipients who transfer from a managed care organization to another managed care organization within the Medicaid program. Continuity of care includes maintaining the same level of management and access to programs.**

SECTION 6. IC 12-15-1-22 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: **Sec. 22. The office, or a person that has contracted with the office to assist in the application or enrollment of individuals in the Medicaid program, shall do the following:**

(1) Collect data on race and primary languages as a part of the application and enrollment process.

(2) Provide the data collected under subdivision (1) to the office or managed care organization providing the care to the recipient.

SECTION 7. IC 12-15-1-23 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: **Sec. 23. (a) In the pharmacy drug benefit for Medicaid**

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1 recipients, the office or a contractor of the office shall require a
2 pharmacy filling a prescription for a recipient to provide the label
3 for the prescription drug in the recipient's preferred language.

4 (b) Upon request, a pharmacy that participates in and receives
5 reimbursement from the Medicaid program shall provide the label
6 for a prescription drug in the recipient's preferred language.

7 SECTION 8. IC 12-15-12-23 IS ADDED TO THE INDIANA
8 CODE AS A NEW SECTION TO READ AS FOLLOWS
9 [EFFECTIVE JULY 1, 2010]: Sec. 23. (a) A managed care
10 organization that has a contract with the office to provide
11 Medicaid services under the risk-based managed care program
12 shall do the following:

- 13 (1) Measure health disparities using HEDIS standards.
- 14 (2) Implement standards concerning culturally and
15 linguistically appropriate services (CLAS) issued by the
16 federal Office of Minority Health within the United States
17 Department of Health and Human Services to encourage
18 practices that are more culturally and linguistically
19 accessible, including:
 - 20 (A) establishing and administering a written plan; and
 - 21 (B) reporting annually on the progress of the plan.
- 22 (3) Develop and administer a community based health
23 disparities advisory council as described in subsection (c). A
24 managed care organization may partner with other managed
25 care organizations in the establishment of the council
26 required under this subdivision.
- 27 (4) Complete two (2) health risk assessments for each
28 recipient who has transferred from another managed care
29 organization to assist in measuring health outcomes of the
30 recipient as required by IC 12-15-1-14(a)(8)(C)(iii). The
31 health risk assessments must be completed as follows:
 - 32 (A) The first health risk assessment must be completed not
33 later than fifteen (15) days after the transfer date.
 - 34 (B) The second health risk assessment must be completed
35 not later than six (6) months after the transfer date.

- 36 (b) The managed care organization shall:
 - 37 (1) provide the culturally and linguistically appropriate
38 services (CLAS) standards report required by subsection (a)
39 to the interagency state council on black and minority health
40 established by IC 16-46-6-3; and
 - 41 (2) make the report available to the public upon request.
- 42 (c) The community based health disparities advisory council

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1 developed by managed care organizations as required in subsection
 2 (a)(3) must include the following:
 3 (1) At least two (2) members who are minority (as defined in
 4 IC 16-46-6-2) Medicaid recipients.
 5 (2) Seventy-five percent (75%) of the members must be
 6 individuals who are not employed by the managed care
 7 organization, representing the following:
 8 (A) Health care professionals.
 9 (B) Advocates in the health and human services area.
 10 (C) Individuals who provide direct services to risk-based
 11 managed care recipients.
 12 (3) At least one (1) member representing each of the
 13 following:
 14 (A) The Indiana Minority Health Coalition.
 15 (B) The commission on Hispanic/Latino affairs established
 16 by IC 4-23-28-2.
 17 (C) American Indian Center of Indiana.
 18 (D) Asian Help Services.
 19 (E) The Arc of Indiana.
 20 (F) The Central Indiana Council on Aging.
 21 (G) An entity that provides direct services to risk-based
 22 managed care recipients.
 23 The council membership must reflect the population served.
 24 (d) A community based health disparities advisory council shall
 25 do the following:
 26 (1) Provide input and assist the managed care organization in
 27 the development and implementation of the culturally and
 28 linguistically appropriate services (CLAS) standards.
 29 (2) Review the annual assessment and evaluate whether the
 30 plan is improving minority health outcomes.
 31 (3) Review the final report required by subsection (a)(1).
 32 (4) Approve stipend reimbursement for travel expenses,
 33 including mileage for council members who reside in a city
 34 other than where the council meeting is being held to travel to
 35 attend a council meeting.
 36 (e) A managed care organization shall pay for the costs of the
 37 managed care organization's community based health disparities
 38 advisory council.
 39 (f) Beginning January 1, 2011, the office shall withhold a
 40 percentage of reimbursement from a managed care organization
 41 based on a lack of progress by the managed care organization in
 42 improving health disparity outcomes.

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1 SECTION 9. IC 12-15-30-2 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 2. (a) The office shall
3 do the following:

4 (1) Prepare requirements, including qualifications, for bidders
5 offering to contract with the state to perform the functions under
6 section 3 of this chapter.

7 (2) Assist the Indiana department of administration in preparing
8 bid specifications in conformity with requirements.

9 (b) **The office shall comply with the requirements of
10 IC 5-22-9-2.5 in preparing a bid for managed care organization
11 services under the risk-based managed care program.**

12 SECTION 10. IC 12-15-30-8 IS ADDED TO THE INDIANA
13 CODE AS A NEW SECTION TO READ AS FOLLOWS
14 [EFFECTIVE JULY 1, 2010]: Sec. 8. (a) A person that:

15 (1) contracts with the office to provide direct services,
16 including pharmacy vendors; and

17 (2) receives reimbursement under Medicaid;

18 shall implement at least two (2) quality improvement initiatives to
19 reduce health disparities, at least one (1) of which addresses race,
20 ethnic, or other geographic disparities.

21 (b) The initiatives required in subsection (a) must do the
22 following:

23 (1) Include baseline data on individuals who receive services
24 from the contractor.

25 (2) Include measurable goals and outcomes.

26 (3) Use a third party source to evaluate the contractor's
27 initiatives.

28 (4) Be in one (1) of the following categories:

29 (A) Obstetrics.

30 (B) Asthma.

31 (C) Diabetes.

32 (D) Immunizations.

33 (E) Healthcare effectiveness data and information set.

34 SECTION 11. [EFFECTIVE UPON PASSAGE] (a) As used in this
35 SECTION, "office" refers to the office of Medicaid policy and
36 planning established by IC 12-8-6-1.

37 (b) If the office of Medicaid policy and planning has a request
38 for proposal or a request for services that:

39 (1) is already in progress upon the passage of this act; and

40 (2) is affected by the requirements of IC 5-22-9-2.5, as added
41 by this act;

42 the office shall communicate the requirements of IC 5-22-9-2.5, as

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1 **added by this act, and the culturally and linguistically appropriate**
2 **services (CLAS) standards to a person that has submitted a**
3 **proposal for the request.**

4 **(c) This SECTION expires December 31, 2010.**

5 **SECTION 12. An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1277, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

BROWN C, Chair

Committee Vote: yeas 8, nays 1.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1277 be amended to read as follows:

Page 1, line 3, after "16." insert "**(a) As used in this section, "managed care organization" has the definition set forth in IC 12-7-2-126.9.**

(b)".

Page 1, line 17, after "proposal" insert "**or a request for services**".

Page 2, line 2, after "organizations" insert "**(as defined in IC 12-7-2-126.9)**".

Page 2, between lines 11 and 12, begin a new paragraph and insert: "**SECTION 3. IC 12-7-2-126.9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 126.9. "Managed care organization", for purposes of IC 12-15, includes the following:**

(1) A health maintenance organization established under IC 27-13-2 with which the office of Medicaid policy and planning has entered into a contract to provide services under the risk-based managed care program.

(2) A person that contracts with the office or a person described in subdivision (1) to provide the administration or coordination of managed services, including a pharmacy benefit manager, case management coordinator, or behavioral health services coordinator."

Page 2, line 13, after "14." insert "**(a)**".

Page 3, between lines 20 and 21, begin a new line block indented and insert:

"(9) The information required to be reported in IC 12-15-12-23."

Page 3, between lines 21 and 22, begin a new paragraph and insert:

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"(b) The office shall report the information required in subsection (a) in the aggregate and in a manner that protects individual identifiable health information."

Page 3, between lines 29 and 30, begin a new paragraph and insert:

"SECTION 5. IC 12-15-1-22 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 22. The office, or a person that has contracted with the office to assist in the application or enrollment of individuals in the Medicaid program, shall do the following:

- (1) Collect data on race and primary languages as a part of the application and enrollment process.**
- (2) Provide the data collected under subdivision (1) to the office or managed care organization providing the care to the recipient.**

SECTION 6. IC 12-15-1-23 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 23. (a) In the pharmacy drug benefit for Medicaid recipients, the office or a contractor of the office shall require a pharmacy filling a prescription for a recipient to provide the label for the prescription drug in the recipient's preferred language.

(b) Upon request, a pharmacy that participates in and receives reimbursement from the Medicaid program shall provide the label for a prescription drug in the recipient's preferred language."

Page 3, line 40, after "member." insert **"The report must be made in the aggregate and in a manner that protects individual identifiable health information."**

Page 4, line 6, after "(c)." insert **"A managed care organization may partner with other managed care organizations in the establishment of the council required under this subdivision."**

Page 4, line 7, delete "Include as part of the member's pharmacy benefits that" and insert **"Complete two (2) health risk assessments for each recipient who has transferred from another managed care organization to assist in measuring health outcomes of the recipient as required by IC 12-15-1-14(a)(8)(C)(iii). The health risk assessments must be completed as follows:**

- (A) The first health risk assessment must be completed not later than fifteen (15) days after the transfer date.**
- (B) The second health risk assessment must be completed not later than six (6) months after the transfer date."**

Page 4, delete lines 8 through 9.

Page 4, line 17, delete "each".

Page 4, line 17, delete "organization" and insert **"organizations"**.

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Page 6, after line 7, begin a new paragraph and insert:

"SECTION 9. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) If the office of Medicaid policy and planning has a request for proposal or a request for services that:

- (1) is already in progress upon the passage of this act; and**
- (2) is affected by the requirements of IC 5-22-9-2.5, as added by this act;**

the office shall communicate the requirements of IC 5-22-9-2.5, as added by this act, and the culturally and linguistically appropriate services (CLAS) standards to a person that has submitted a proposal for the request.

(c) This SECTION expires December 31, 2010.

SECTION 10. An emergency is declared for this act."

Re-number all SECTIONS consecutively.

(Reference is to HB 1277 as printed January 25, 2010.)

CRAWFORD

HOUSE MOTION

Mr. Speaker: I move that House Bill 1277 be amended to read as follows:

Page 3, line 42, delete "as required by" and insert **"issued by the federal Office of Minority Health within the United States Department of Health and Human Services"**.

Page 4, line 1, delete "federal law".

(Reference is to HB 1277 as printed January 25, 2010.)

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HOUSE MOTION

Mr. Speaker: I move that House Bill 1277 be amended to read as follows:

Page 3, delete lines 36 through 40, begin a new line block indented and insert:

"(1) Measure health disparities using HEDIS standards."

(Reference is to HB 1277 as printed January 25, 2010.)

BROWN T

HOUSE MOTION

Mr. Speaker: I move that House Bill 1277 be amended to read as follows:

Page 2, line 13, after "14." insert **"(a)"**.

Page 2, delete lines 27 through 42.

Page 3, delete lines 1 through 6.

Page 3, line 7, delete "(8)" and insert **"(7)"**.

Page 3, between lines 21 and 22, begin a new paragraph and insert:

"(b) The legislative council may request that the office also submit the information reported under IC 12-15-12-23 in an electronic format under IC 5-14-6."

(Reference is to HB 1277 as printed January 25, 2010.)

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