

Members

Sen. Patricia Miller, Chairperson  
Sen. Ryan Mishler  
Sen. Vaneta Becker  
Sen. Ed Charbonneau  
Sen. Beverly Gard  
Sen. Ron Grooms  
Sen. Jean Leising  
Sen. Jean Breaux  
Sen. Earline Rogers  
Sen. Vi Simpson  
Rep. Timothy Brown, Vice-Chairperson  
Rep. Steven Davisson  
Rep. Ronald Bacon  
Rep. Suzanne Crouch  
Rep. Richard Dodge  
Rep. David Frizzell  
Rep. Donald Lehe  
Rep. Eric Turner  
Rep. Charlie Brown  
Rep. John Day  
Rep. Craig Fry  
Rep. Scott Reske  
Rep. Peggy Welch



## HEALTH FINANCE COMMISSION

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Kathy Norris, Fiscal Analyst for the Commission

Authority: IC 2-5-23

### MEETING MINUTES<sup>1</sup>

**Meeting Date:** October 18, 2011  
**Meeting Time:** 10:00 A.M.  
**Meeting Place:** State House, 200 W. Washington St., the Senate Chambers  
**Meeting City:** Indianapolis, Indiana  
**Meeting Number:** 4

**Members Present:** Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Ed Charbonneau; Sen. Ron Grooms; Sen. Jean Leising; Sen. Jean Breaux; Sen. Vi Simpson; Rep. Timothy Brown, Vice-Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Rep. Donald Lehe; Rep. Eric Turner; Rep. Charlie Brown; Rep. John Day; Rep. Scott Reske; Rep. Peggy Welch.

**Members Absent:** Sen. Beverly Gard; Sen. Earline Rogers; Rep. Craig Fry.

Chairperson Patricia Miller called the meeting to order at 10:02 a.m.

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

### **Credentialing of Hospital Vendors**

Ms. Joyce Irwin, Roche Diagnostics, and Mr. Tim Kennedy, Indiana Hospital Association, told the Commission that manufacturer representatives and the Indiana Hospital Association have met several times over the summer to discuss the vendor credentialing issue. Ms. Irwin stated that the two groups have developed a process with recommended criteria for credentialing hospital vendors. Ms. Irwin said that the parties will continue to meet. Mr. Kennedy added that the meetings have been helpful, and that the recommended set of practices cannot be mandatory for hospitals since some hospitals have national standards that must be followed. Mr. Kennedy said that the group plans to meet in the future at least once a year.

### **Update on Criminal Background Checks for Professional Licensing**

Mr. Marty Allain, Indiana Professional Licensing Agency (PLA), told the Commission that, through September 30, 2011, PLA has conducted 3,223 criminal background checks on licensee applications since the requirement became law on July 1, 2011. See Exhibit 1.

Mr. Allain provided the following additional statistics:

- 267 of these processed applications had a criminal history
- 37% of those applications with a criminal history had a conviction recorded
- 24% of the reports with convictions had multiple convictions
- 8% of the convictions were for felonies
- 80 board decisions have been rendered on the 267 applications with a criminal history: 68 applicants were issued a license, 5 applicants were given a probationary license, 2 applicants withdrew their application, and 5 applicants were denied the license
- 37 of the 100 criminal convictions reported were some form of DUI

Mr. Allain explained that an applicant was considered to have a criminal history if any criminal information was reflected in the report, including arrests, charges, dismissals, diversions, and pending matters. See Exhibit 1 for more information. Commission members discussed whether a law concerning sealing a record after eight years would impact the data received by PLA and Mr. Allain stated that he was not sure.

### **Health Care Reform Update**

Ms. Seema Verma, Indiana Health Care Reform Lead, told the Commission that Indiana received a letter from the federal United States Department of Health and Human Services (HHS) stating that the state plan amendment to use the Healthy Indiana Plan (HIP) for the increased Medicaid eligibility population was denied but encouraged FSSA to submit a waiver to renew HIP for 2013 through 2015. Ms. Verma stated that the following should be released at the end of October:

- an updated health care reform cost estimate
- the state's comments concerning health care reform
- HHS's determination concerning Indiana's medical loss ratio waiver application

See Exhibit 2. Ms. Verma stated that Indiana also filed an appeal to HHS concerning its determination on Indiana's external review laws. Ms. Verma provided information to the Commission concerning health care reform and the following:

- risk adjustment
- reinsurance program
- differences in determining Medicaid eligibility
- core functions of a health care exchange

Ms. Verma said that HHS has provided additional options in the functions that can be operated jointly by the federal government and the state in an exchange, but that there are still many questions concerning this joint operation, including what the state's fiscal responsibilities would be.

### **Commission Action**

Chairperson Miller stated that the following issues discussed during the interim would not be voted on by the Commission: (1) midwifery; (2) prescription labeling access for the blind; (3) diabetes educator certification; and (4) hospital employee immunization requirements and reporting. Chairperson Miller stated that because hospitals are implementing mandatory policies for influenza vaccination programs for hospital workers and because federal rules will require reporting in 2013, state reporting requirements may be unnecessary.

#### **PD 3256- Reestablishment of FSSA**

Staff provided information concerning that draft that would reestablish the offices and divisions of FSSA that expired. Commission members discussed various components of the PD before voting 18-0 to recommend the PD. See Exhibit 3.

#### **PD 3175- HIV Testing**

This PD allows a person to perform a screening or test for HIV unless the individual to be tested indicates a refusal to consent to the test in writing and requires a physician to document a refusal. The Commission discussed how the language may change the current procedures used at hospitals and voted 15-2 to recommend the PD. See Exhibit 4.

#### **PD 3278- Brain Injury Services Study and Committee**

This PD requires the State Department of Health and FSSA to study how to implement brain injury services and neurobehavioral rehabilitation programs in Indiana and to report their findings to the Commission before October 1, 2012. See Exhibit 5. The PD also establishes a brain injury treatment committee to assist with the study. The Commission discussed the make-up of the committee and it was moved and seconded to add the Director of the Division of Aging and one consumer to the committee. The Commission voted 18-0 to recommend the amended PD.

#### **PD 3246- Coverage for Brand Name Anti-epileptic drugs**

This PD prohibits health insurers from placing specified restrictions on brand name anti-epileptic prescription drugs if the same restrictions are not placed on a generic anti-epileptic prescription drug. See Exhibit 6. The Commission received testimony from the insurance industry opposing the PD, stating that the issue concerning brand name anti-epileptic drug substitution is not related to insurance. It was moved and taken by consent to add coverage of state employees to the PD. The PD was defeated 6-11.

#### **Final Report**

The Commission's final report was presented to the Commission, and Chairperson Miller reminded the Commission that today's testimony would need to be added to the report. See Exhibit 7. The Commission adopted the final report 17-0.

### **Reimbursement for Spiritual Care in Health Care Reform**

Ms. Katie Sue Brown, Christian Science Committee on Publication for Indiana, provided the Commission with statistics concerning trends in health concerning alternative medicine. See Exhibit 8. Ms. Brown asked that those charged with implementing health care reform in

Indiana consider making benefits for spiritual care services available. Ms. Brown stated that spiritual care can contribute to lifestyle improvement and healthier outcomes. Ms. Brown testified that she personally has found effective solutions to health care problems through spiritual care. The Commission discussed whether any other states have included spiritual care services in reimbursed care. Ms. Lesley Connery, attorney to Ms. Brown, stated that Washington and Utah have considered the issue.

The Commission adjourned at 12:07 p.m.



Report on  
Criminal Background Check Implementation  
for IPLA Healthcare Board Licensees

Presented to the Health Finance Commission  
on October 18, 2011

Criminal Background Checks Required for Healthcare Licensees. As of July 1, 2011, Ind. Code § 25-1-1.1-4 requires individuals applying for an initial healthcare license with Indiana Professional Licensing Agency (IPLA) healthcare boards to submit to a national criminal history background check. Prior to this requirement, IPLA healthcare boards relied solely on applicant self-disclosure.

Criminal Background Check (CBC) Process. Once an initial applicant applies for a healthcare license with IPLA, the applicant schedules an appointment on-line to be fingerprinted at one (1) of over twenty (20) locations around the state. A payment of \$42.20 is made to the vendor at the time of scheduling. Once the fingerprinting is complete, IPLA boards receive the information within seventy-two (72) to ninety-six (96) hours in a secure database accessible only by username and password. Board employees receiving the data have also been background checked prior to being granted access. The information is confidential and cannot be released.

### Criminal History Report Data<sup>1</sup>

- Number of healthcare licensee applications processed: **3,223**
- Number of healthcare licensees with criminal history<sup>2</sup>: **267**
- Percentage of healthcare licensee applicants with criminal history: **8.28%**
- Percentage of U.S. population with criminal history: **27.8%**<sup>3</sup>
- Percentage of criminal history records with conviction recorded<sup>4</sup>: **37%** (100/267)
- Of those records with a conviction recorded, percentage with multiple convictions: **24%** (24/100)
- Of those records with a conviction recorded, percentage with felony conviction: **8%** (8/100)

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<sup>1</sup> The date range for the data set is from July 1, 2011 through September 30, 2011. There are no benchmarks to compare the data to as self-disclosed criminal history responses were not recorded in IPLA's licensing database. Other than some general aggregate data, all information herein was gleaned from manual review of each criminal history report. The reports are neither comprehensive (See FN 4 below) nor intuitive; as such, only general data from the criminal history records that was readily available and easily identifiable is included in the report.

<sup>2</sup> For the purposes of this report, an applicant has a "criminal history" if there is any criminal information in an applicant's record including allegations in the form of arrests, charges, dismissals, diversion, and pending matters.

<sup>3</sup> As a percentage of the U.S. population over the age of eighteen (18), an estimated 27.8 percent of the U.S. adult population has a criminal record on file with states. *The Case for Reforming Criminal Background Checks for Employment*, The National Employment Law Project (March 2011). This estimate is consistent with a Department of Justice finding that about "30 percent of the Nation's adult population" has a criminal history. *The Attorney General's Report on Criminal History Background Checks*, U.S. Dept. of Justice Office of the Attorney General (June 2006).

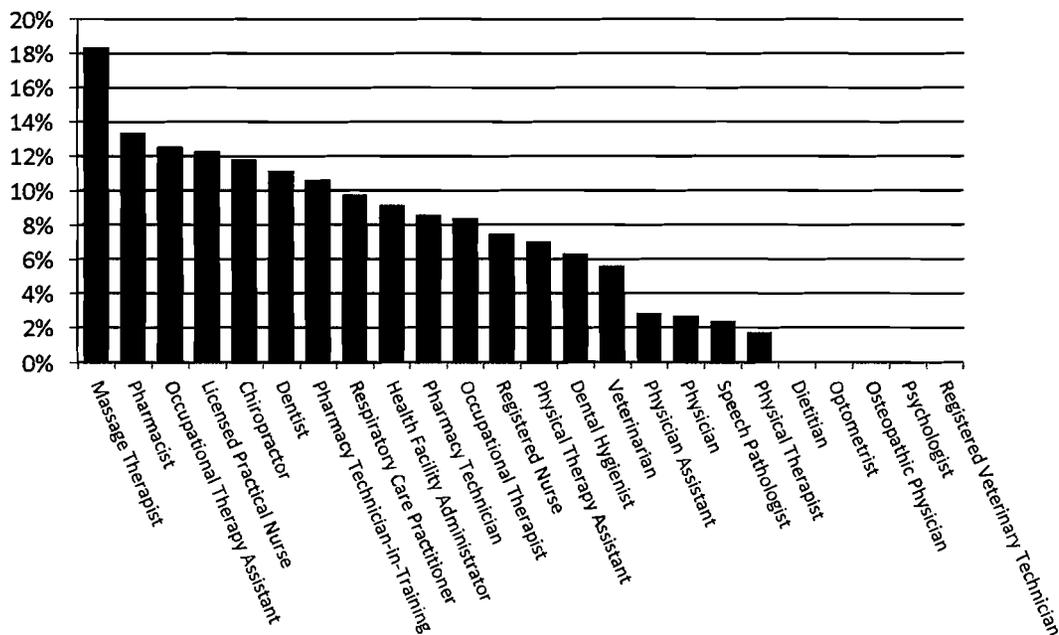
<sup>4</sup> It is not uncommon for CBC records to be incomplete\*; as such, if a conviction was not clearly stated in a record, the information was recorded as "charge – no conviction" for the purposes of this report. In these instances, boards request supplemental records from the applicant to confirm the disposition of a criminal charge. **CBCs are never relied upon solely when rendering a decision on an application.**

\* A total of 21 States reported that 70% or more arrests within the past 5 years in the criminal history database have final dispositions recorded. *Survey of State Criminal History Information System*, Bureau of Justice Statistics (2008).

## Criminal History Report Charts & Graphs

The following graph represents the percentage of applicants with a criminal history by license type. Any licensed profession with fewer than ten (10) applicants over the past three (3) months has been removed from the graph.

### Percentage of Applicants with CBC History

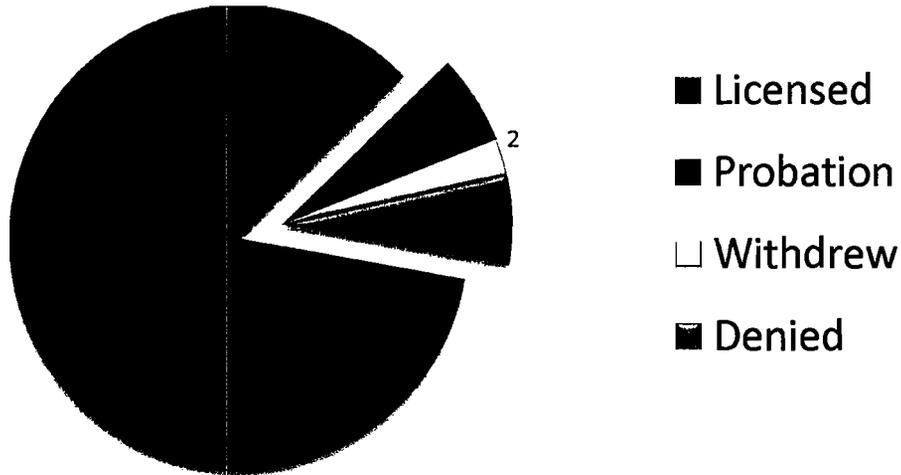


Additional facts related to graph above:

- Indiana State Board of Nursing has processed the highest number of applications (1,749) for licenses that require CBC records since July 1, 2011.
- Indiana Board of Pharmacy has processed the second highest number of applications (595 applications).
- The following licensed professionals have yet to have an applicant with a criminal history apply for a license: Dietitian (11 applications); Optometrist (10); Osteopathic Physician (14); Psychologist (30); and Registered Veterinary Technician (22).
- As reflected above, Massage Therapists have the highest percentage (18%) of applicants with a criminal history (13 out of 71 total applicants since July 1, 2011).
- Pharmacists and Occupational Therapists have the next highest percentages at 13% each.

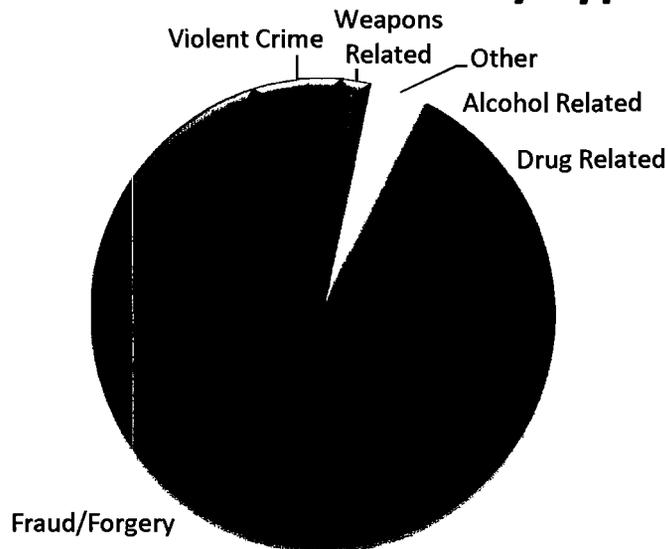
Of the 267 applications with a criminal history, 80 board decisions have been rendered. The following chart represents the specific board action taken. The chart does not consider the applications that are pending in front of boards as of September 30, 2011.

### Decisions on Applications with CBC History



Of the criminal conviction data available, the following chart represents the types of primary offenses by frequency. For example, if a physician was convicted for driving under the influence (regardless of lesser offenses, if any), the conviction is considered one (1) DUI for this chart's purpose. Based on this data sort, thirty seven (37) of the one hundred (100) criminal convictions reported to IPLA were some form of DUI.

### Criminal Convictions by Type



# Affordable Care Act Update



**SEEMA VERMA, STATE HEALTHCARE REFORM LEAD  
HEALTH FINANCE  
OCTOBER 18, 2011**

# Agenda

- Update on Key Activities.
- Federal Notices of Proposed Rulemaking (NPRMs).
- Federal Partnership Option.

# Update on Key Activities

- **HIP**

- CMS response: no decision on HIP.
- Waiver renewal – public comments & hearing.

- **Healthcare Reform Meetings**

- NGA, NAIC, CMS & HHS regulation meetings.

- **Exchange Planning**

- Business requirements.
- Operating cost model.
- Reviewing draft regulations.
- Review of required legislation.

- **MLR**

- Application deemed complete; HHS to respond by October 28<sup>th</sup>, although Secretary can give 30 day extensions.

- **Rate Review Grant Cycle II Approval**

- Grant award of \$3.9M to improve rate filing requirements, and transparency and consumer interfaces.
- DOI has launched “Rate Watch” website where all rate filings are available and searchable.

- **External Review Appeal**

- Submitted to CCIIO on September 12.

- **Updates on Medicaid Cost Model.**

# HHS Proposed Rules

- July 15, 2011.
  - Exchanges (HIX) & Qualified Health Plans (QHPs).
  - Risk adjustment & reinsurance.
- August 11, 2011.
  - Medicaid eligibility changes.
  - Exchange eligibility determinations.
  - Premium tax credits (IRS).
- Yet to be released:
  - Essential benefits.
  - Notice requirements.
  - Quality metric requirements.
  - Risk adjustment/reinsurance final details.
- Comments due to federal government on October 31<sup>st</sup>.

# Risk Adjustment & Reinsurance

- Risk Adjustment

- Permanent program where the State or HHS assesses charges to plans that have a lower than average actuarial risk and makes payments to plans that have a higher than average actuarial risk.
  - States that operate a HIX are eligible to operate the risk adjustment program.

- Reinsurance

- Temporary program (2014-16) that collects from carriers and redistributes the dollars to carriers with the highest costs.
  - If a state operates a HIX, must operate reinsurance.
  - If a state does not operate a HIX, can elect to operate reinsurance or defer to federal government.

# Eligibility for QHPs and “Insurance Affordability Programs”

“Insurance Affordability Programs” = Medicaid, CHIP & premium tax credits

2 key inputs for eligibility:

- Requires verification of citizenship/legal presence, state residency & incarceration.
- Eligibility calculation based on Modified Adjusted Gross Income (MAGI).
  - Household income.
  - Household size.

In most cases, to verify applicant information, the Exchange will:

- Rely on electronic data sources (federal hub), such as Social Security Administration, IRS, Department of Homeland Security and other HHS-approved sources.
- Follow specific procedures to verify information through other means, such as requesting document from applicants, if needed.

If applicant information is inconsistent with electronic data sources

- In the Exchange, the applicant has approximately 90 days to provide documentation to resolve the inconsistency.
- Self attestation.

# MAGI Medicaid Eligibility: 2014 & Beyond

- Multiple categorical groupings are collapsed into 4 major categories for all non-disabled individuals under 65 and under 133% FPL:
  - Parents and caretaker relatives.
  - Adults
  - Pregnant women.
  - Children under age 19.
- Major Departures from Current Eligibility Determination:
  - “Real-time” determinations.
  - Income: Retrieve information from IRS; can continue to look at current monthly income for new applicants but now have option to project annual income for current beneficiaries.
  - Household size: Linked to tax filer status.
  - Asset tests eliminated.
  - Self-Attestation.
  - Single streamlined application for all programs.
  - Renewals: State no longer need a renewal form from all individuals; coverage is continued if information is sufficient to make continued determination.
- Provides enhanced FMAP for newly eligible individuals & proposes three different methodologies for the calculation.

# Five Core Functions of an Exchange

<b>Consumer Assistance</b>	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
<b>Plan Management</b>	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
<b>Eligibility</b>	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
<b>Enrollment</b>	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
<b>Financial Management</b>	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

# Federal-State Exchange Partnerships

Under the proposed partnership, States may choose to operate the following Exchange functions:

**–Option 1 –Plan management functions.**

Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.

**–Option 2 –Selected consumer assistance functions.**

Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.

**–Option 3 –Both selected consumer assistance & plan management functions.**

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.

# Federal Partnership

- Eligibility for Medicaid & Premium Tax Credits combined.
- Will States be charged for federal Exchange?
- User and or carrier Fees?
- State concerns.

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**PRELIMINARY DRAFT**  
**No. 3256**

**PREPARED BY**  
**LEGISLATIVE SERVICES AGENCY**  
**2012 GENERAL ASSEMBLY**

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DIGEST

**Citations Affected:** IC 2-5-26-2; IC 4-22-2-37.1; IC 12-7; IC 12-8; IC 12-9; IC 12-9.1; IC 12-10-12-4; IC 12-12-1-4.1; IC 12-12.7-2-8; IC 12-13; IC 12-14-2-21; IC 12-15-2-0.5; IC 12-21; IC 16-28-15-5; IC 22-4.1-17-6.

**Synopsis:** Reestablishment of FSSA. Reestablishes the office of the secretary of family and social services and other divisions and offices within FSSA.

**Effective:** Upon passage.



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 2-5-26-2 IS AMENDED TO READ AS  
2 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. As used in this  
3 chapter, "office" refers to the office of Medicaid policy and planning  
4 established by ~~IC 12-8-6-1~~. **IC 12-8-6.5-1.**

5 SECTION 2. IC 4-22-2-37.1, AS AMENDED BY P.L.229-2011,  
6 SECTION 58, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
7 UPON PASSAGE]: Sec. 37.1. (a) This section applies to a rulemaking  
8 action resulting in any of the following rules:

9 (1) An order adopted by the commissioner of the Indiana  
10 department of transportation under IC 9-20-1-3(d) or  
11 IC 9-21-4-7(a) and designated by the commissioner as an  
12 emergency rule.

13 (2) An action taken by the director of the department of natural  
14 resources under IC 14-22-2-6(d) or IC 14-22-6-13.

15 (3) An emergency temporary standard adopted by the  
16 occupational safety standards commission under  
17 IC 22-8-1.1-16.1.

18 (4) An emergency rule adopted by the solid waste management  
19 board under IC 13-22-2-3 and classifying a waste as hazardous.

20 (5) A rule, other than a rule described in subdivision (6), adopted  
21 by the department of financial institutions under IC 24-4.5-6-107  
22 and declared necessary to meet an emergency.

23 (6) A rule required under IC 24-4.5-1-106 that is adopted by the  
24 department of financial institutions and declared necessary to  
25 meet an emergency under IC 24-4.5-6-107.

26 (7) A rule adopted by the Indiana utility regulatory commission to  
27 address an emergency under IC 8-1-2-113.

28 (8) An emergency rule adopted by the state lottery commission  
29 under IC 4-30-3-9.

30 (9) A rule adopted under IC 16-19-3-5 or IC 16-41-2-1 that the  
31 executive board of the state department of health declares is



- 1 necessary to meet an emergency.
- 2 (10) An emergency rule adopted by the Indiana finance authority
- 3 under IC 8-21-12.
- 4 (11) An emergency rule adopted by the insurance commissioner
- 5 under IC 27-1-23-7 or IC 27-1-12.1.
- 6 (12) An emergency rule adopted by the Indiana horse racing
- 7 commission under IC 4-31-3-9.
- 8 (13) An emergency rule adopted by the air pollution control
- 9 board, the solid waste management board, or the water pollution
- 10 control board under IC 13-15-4-10(4) or to comply with a
- 11 deadline required by or other date provided by federal law,
- 12 provided:
- 13 (A) the variance procedures are included in the rules; and
- 14 (B) permits or licenses granted during the period the
- 15 emergency rule is in effect are reviewed after the emergency
- 16 rule expires.
- 17 (14) An emergency rule adopted by the Indiana election
- 18 commission under IC 3-6-4.1-14.
- 19 (15) An emergency rule adopted by the department of natural
- 20 resources under IC 14-10-2-5.
- 21 (16) An emergency rule adopted by the Indiana gaming
- 22 commission under IC 4-32.2-3-3(b), IC 4-33-4-2, IC 4-33-4-3,
- 23 IC 4-33-4-14, IC 4-33-22-12, or IC 4-35-4-2.
- 24 (17) An emergency rule adopted by the alcohol and tobacco
- 25 commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
- 26 IC 7.1-3-20-24.4.
- 27 (18) An emergency rule adopted by the department of financial
- 28 institutions under IC 28-15-11.
- 29 (19) An emergency rule adopted by the office of the secretary of
- 30 family and social services under ~~IC 12-8-1-12~~ **IC 12-8-1.5-11**.
- 31 (20) An emergency rule adopted by the office of the children's
- 32 health insurance program under IC 12-17.6-2-11.
- 33 (21) An emergency rule adopted by the office of Medicaid policy
- 34 and planning under IC 12-15-41-15.
- 35 (22) An emergency rule adopted by the Indiana state board of
- 36 animal health under IC 15-17-10-9.
- 37 (23) An emergency rule adopted by the board of directors of the
- 38 Indiana education savings authority under IC 21-9-4-7.
- 39 (24) An emergency rule adopted by the Indiana board of tax
- 40 review under IC 6-1.1-4-34 (repealed).
- 41 (25) An emergency rule adopted by the department of local
- 42 government finance under IC 6-1.1-4-33 (repealed).
- 43 (26) An emergency rule adopted by the boiler and pressure vessel
- 44 rules board under IC 22-13-2-8(c).
- 45 (27) An emergency rule adopted by the Indiana board of tax
- 46 review under IC 6-1.1-4-37(l) (repealed) or an emergency rule



- 1 adopted by the department of local government finance under  
 2 IC 6-1.1-4-36(j) (repealed) or IC 6-1.1-22.5-20.
- 3 (28) An emergency rule adopted by the board of the Indiana  
 4 economic development corporation under IC 5-28-5-8.
- 5 (29) A rule adopted by the department of financial institutions  
 6 under IC 34-55-10-2.5.
- 7 (30) A rule adopted by the Indiana finance authority:  
 8 (A) under IC 8-15.5-7 approving user fees (as defined in  
 9 IC 8-15.5-2-10) provided for in a public-private agreement  
 10 under IC 8-15.5;  
 11 (B) under IC 8-15-2-17.2(a)(10):  
 12 (i) establishing enforcement procedures; and  
 13 (ii) making assessments for failure to pay required tolls;  
 14 (C) under IC 8-15-2-14(a)(3) authorizing the use of and  
 15 establishing procedures for the implementation of the  
 16 collection of user fees by electronic or other nonmanual  
 17 means; or  
 18 (D) to make other changes to existing rules related to a toll  
 19 road project to accommodate the provisions of a public-private  
 20 agreement under IC 8-15.5.
- 21 (31) An emergency rule adopted by the board of the Indiana  
 22 health informatics corporation under IC 5-31-5-8.
- 23 (32) An emergency rule adopted by the department of child  
 24 services under IC 31-25-2-21, IC 31-27-2-4, IC 31-27-4-2, or  
 25 IC 31-27-4-3.
- 26 (33) An emergency rule adopted by the Indiana real estate  
 27 commission under IC 25-34.1-2-5(15).
- 28 (34) A rule adopted by the department of financial institutions  
 29 under IC 24-4.4-1-101 and determined necessary to meet an  
 30 emergency.
- 31 (35) An emergency rule adopted by the state board of pharmacy  
 32 regarding returning unused medication under IC 25-26-23.
- 33 (36) An emergency rule adopted by the department of local  
 34 government finance under IC 6-1.1-12.6 or IC 6-1.1-12.8.
- 35 (37) An emergency rule adopted by the office of the secretary of  
 36 family and social services or the office of Medicaid policy and  
 37 planning concerning the following:  
 38 (A) Federal Medicaid waiver program provisions.  
 39 (B) Federal programs administered by the office of the  
 40 secretary.
- 41 (b) The following do not apply to rules described in subsection (a):  
 42 (1) Sections 24 through 36 of this chapter.  
 43 (2) IC 13-14-9.
- 44 (c) After a rule described in subsection (a) has been adopted by the  
 45 agency, the agency shall submit the rule to the publisher for the  
 46 assignment of a document control number. The agency shall submit the



1 rule in the form required by section 20 of this chapter and with the  
 2 documents required by section 21 of this chapter. The publisher shall  
 3 determine the format of the rule and other documents to be submitted  
 4 under this subsection.

5 (d) After the document control number has been assigned, the  
 6 agency shall submit the rule to the publisher for filing. The agency  
 7 shall submit the rule in the form required by section 20 of this chapter  
 8 and with the documents required by section 21 of this chapter. The  
 9 publisher shall determine the format of the rule and other documents  
 10 to be submitted under this subsection.

11 (e) Subject to section 39 of this chapter, the publisher shall:

12 (1) accept the rule for filing; and

13 (2) electronically record the date and time that the rule is  
 14 accepted.

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

17 (1) The effective date of the statute delegating authority to the  
 18 agency to adopt the rule.

19 (2) The date and time that the rule is accepted for filing under  
 20 subsection (e).

21 (3) The effective date stated by the adopting agency in the rule.

22 (4) The date of compliance with every requirement established by  
 23 law as a prerequisite to the adoption or effectiveness of the rule.

24 (g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6,  
 25 IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in  
 26 subsections (j), (k), and (l), a rule adopted under this section expires  
 27 not later than ninety (90) days after the rule is accepted for filing under  
 28 subsection (e). Except for a rule adopted under subsection (a)(13),  
 29 (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting  
 30 another rule under this section, but only for one (1) extension period.  
 31 The extension period for a rule adopted under subsection (a)(28) may  
 32 not exceed the period for which the original rule was in effect. A rule  
 33 adopted under subsection (a)(13) may be extended for two (2)  
 34 extension periods. Subject to subsection (j), a rule adopted under  
 35 subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited  
 36 number of extension periods. Except for a rule adopted under  
 37 subsection (a)(13), for a rule adopted under this section to be effective  
 38 after one (1) extension period, the rule must be adopted under:

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

40 (2) IC 13-14-9;

41 as applicable.

42 (h) A rule described in subsection (a)(8), (a)(12), (a)(19), (a)(20),  
 43 (a)(21), (a)(29), or (a)(37) expires on the earlier of the following dates:

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

45 (2) The date that the rule is amended or repealed by a later rule  
 46 adopted under sections 24 through 36 of this chapter or this



1 section.

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

3 (j) A rule described in subsection (a)(24) or (a)(25) expires not later  
4 than January 1, 2006.

5 (k) A rule described in subsection (a)(28) expires on the expiration  
6 date stated by the board of the Indiana economic development  
7 corporation in the rule.

8 (l) A rule described in subsection (a)(30) expires on the expiration  
9 date stated by the Indiana finance authority in the rule.

10 (m) A rule described in subsection (a)(5) or (a)(6) expires on the  
11 date the department is next required to issue a rule under the statute  
12 authorizing or requiring the rule.

13 SECTION 3. IC 12-7-1-5, AS ADDED BY P.L.220-2011,  
14 SECTION 252, IS AMENDED TO READ AS FOLLOWS  
15 [EFFECTIVE UPON PASSAGE]: Sec. 5. Actions taken under  
16 ~~IC 12-8-1, IC 12-8-2, IC 12-8-6, and IC 12-8-8~~ **IC 12-8-1.5,**  
17 **IC 12-8-2.5, IC 12-8-6.5, and IC 12-8-8.5** after June 30, 1999, and  
18 before December 1, 1999, are legalized and validated to the extent that  
19 those actions would have been legal and valid if P.L.7-2000 had been  
20 enacted before July 1, 1999.

21 SECTION 4. IC 12-7-2-23 IS AMENDED TO READ AS  
22 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 23. "Body", for  
23 purposes of ~~IC 12-8-2,~~ **IC 12-8-2.5,** has the meaning set forth in  
24 ~~IC 12-8-2-1.~~ **IC 12-8-2.5-1.**

25 SECTION 5. IC 12-7-2-99, AS AMENDED BY P.L.141-2006,  
26 SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
27 UPON PASSAGE]: Sec. 99. "A person with a disability" means, for  
28 purposes of the following statutes, an individual who has a physical or  
29 mental disability and meets the program eligibility requirements of the  
30 division of disability and rehabilitative services:

31 (1) ~~IC 12-8-1-11.~~ **IC 12-8-1.5-10.**

32 (2) IC 12-12-1.

33 (3) IC 12-12-6.

34 SECTION 6. IC 12-7-2-129 IS AMENDED TO READ AS  
35 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 129. "Member", for  
36 purposes of ~~IC 12-8-2,~~ **IC 12-8-2.5,** has the meaning set forth in  
37 ~~IC 12-8-2-2.~~ **IC 12-8-2.5-2.**

38 SECTION 7. IC 12-7-2-134, AS AMENDED BY P.L.117-2008,  
39 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
40 UPON PASSAGE]: Sec. 134. "Office" means the following:

41 (1) Except as provided in subdivisions (2) through (4), the office  
42 of Medicaid policy and planning established by ~~IC 12-8-6-1.~~  
43 **IC 12-8-6.5-1.**

44 (2) For purposes of IC 12-10-13, the meaning set forth in  
45 IC 12-10-13-4.

46 (3) For purposes of IC 12-15-13, the meaning set forth in



1 IC 12-15-13-0.4.

2 (4) For purposes of IC 12-17.6, the meaning set forth in  
3 IC 12-17.6-1-4.

4 SECTION 8. IC 12-7-2-135 IS AMENDED TO READ AS  
5 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 135. "Office of the  
6 secretary" refers to the office of the secretary of family and social  
7 services established by ~~IC 12-8-1-1~~. **IC 12-8-1.5-1.**

8 SECTION 9. IC 12-7-2-160 IS AMENDED TO READ AS  
9 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 160. (a)  
10 "Rehabilitation", for purposes of the statutes listed in subsection (b),  
11 means a process of providing services to meet the current and future  
12 needs of persons with disabilities so that the individuals may prepare  
13 for and engage in gainful employment to the extent of their capabilities,  
14 as provided in 29 U.S.C. 720.

15 (b) This section applies to the following statutes:

16 (1) ~~IC 12-8-1-11~~. **IC 12-8-1.5-10.**

17 (2) IC 12-12-1.

18 (3) IC 12-12-3.

19 (4) IC 12-12-6.

20 SECTION 10. IC 12-7-2-172 IS AMENDED TO READ AS  
21 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 172. (a) Except as  
22 provided in subsection (b), "secretary" refers to the secretary of family  
23 and social services appointed under ~~IC 12-8-1-2~~. **IC 12-8-1.5-2.**

24 (b) "Secretary", for purposes of IC 12-13-14, has the meaning set  
25 forth in IC 12-13-14-1.

26 SECTION 11. IC 12-7-2-186 IS AMENDED TO READ AS  
27 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 186. "State plan",  
28 for purposes of ~~IC 12-8-6~~, **IC 12-8-6.5**, refers to the state Medicaid  
29 plan for the Medicaid program.

30 SECTION 12. IC 12-8-1.5 IS ADDED TO THE INDIANA CODE  
31 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
32 UPON PASSAGE]:

33 **Chapter 1.5. Office of Secretary of Family and Social Services**

34 **Sec. 0.3. (a) Actions taken under IC 12-8-1 (expired), after**  
35 **December 31, 2007, and before March 24, 2008, are legalized and**  
36 **validated to the extent that those actions would have been legal and**  
37 **valid if P.L.113-2008 had been enacted before January 1, 2008.**

38 **(b) Actions taken under IC 12-8-1 (expired) after June 30, 2011,**  
39 **are legalized and validated to the extent that those actions would**  
40 **have been legal and valid if IC 12-8-1 had not expired on June 30,**  
41 **2011.**

42 **Sec. 1. (a) The office of the secretary of family and social**  
43 **services is established.**

44 **(b) The office of the secretary includes the following:**

45 **(1) The secretary.**

46 **(2) Each office.**



1           **Sec. 2. The governor shall appoint the secretary of family and**  
 2 **social services to coordinate family and social service programs**  
 3 **among the divisions.**

4           **Sec. 3. (a) The secretary has administrative responsibility for**  
 5 **the office of the secretary.**

6           **(b) Subject to this article, the secretary may organize an office**  
 7 **to perform the duties of the office.**

8           **Sec. 4. (a) The secretary, with the approval of the budget**  
 9 **agency, may hire personnel necessary to perform the duties of each**  
 10 **office.**

11           **(b) All employees of the office of the secretary other than**  
 12 **employees holding confidential or policy making positions are**  
 13 **covered by IC 4-15-2.**

14           **Sec. 5. (a) The secretary, through the offices, is responsible for**  
 15 **coordinating the provision of technical assistance to each division**  
 16 **for the following:**

17           **(1) Compiling program budgets for each division.**

18           **(2) Fiscal performance of each division.**

19           **(3) Management and administrative performance of each**  
 20 **division.**

21           **(4) Program performance of each division.**

22           **(b) The secretary, through the offices, is accountable for the**  
 23 **following:**

24           **(1) Resolution of administrative, jurisdictional, or policy**  
 25 **conflicts among the divisions.**

26           **(2) The coordination of the activities of each division with**  
 27 **other entities, including the general assembly and other state**  
 28 **agencies.**

29           **(3) Coordination of communication with the federal**  
 30 **government and the governments of other states.**

31           **(4) Development and ongoing monitoring of a centralized**  
 32 **management information system and a centralized training**  
 33 **system for orientation and cross-training.**

34           **(5) The overall policy development and management of the**  
 35 **state Medicaid plan under IC 12-15.**

36           **(6) Liaison activities with other governmental entities and**  
 37 **private sector agencies.**

38           **Sec. 6. (a) The secretary and the commissioner of the state**  
 39 **department of health shall cooperate to coordinate family and**  
 40 **social services programs with related programs administered by**  
 41 **the state department of health.**

42           **(b) The secretary, in cooperation with the commissioner of the**  
 43 **state department of health, is accountable for the following:**

44           **(1) Resolving administrative, jurisdictional, or policy conflicts**  
 45 **between a division and the state department of health.**

46           **(2) Formulating overall policy for family, health, and social**



- 1 services in Indiana.
- 2 (3) Coordinating activities between the programs of the
- 3 division of family resources and the maternal and child health
- 4 programs of the state department of health.
- 5 (4) Coordinating activities concerning long term care between
- 6 the division of disability and rehabilitative services and the
- 7 state department of health.
- 8 (5) Developing and implementing a statewide family, health,
- 9 and social services plan that includes a set of goals and
- 10 priorities.

11 **Sec. 7. The secretary, through the offices, may do the following:**

- 12 (1) Employ experts and consultants to carry out the duties of
- 13 the secretary and the offices.
- 14 (2) Utilize, with the consent of the other state agencies, the
- 15 services and facilities of other state agencies without
- 16 reimbursement.
- 17 (3) Accept in the name of the state, for use in carrying out the
- 18 purposes of this article, any money or other property received
- 19 as a gift, by bequest, or otherwise.
- 20 (4) Accept voluntary and uncompensated services.
- 21 (5) Expend money made available according to policies
- 22 enforced by the budget agency.
- 23 (6) Establish and implement the policies and procedures
- 24 necessary to implement this article.
- 25 (7) Advise the governor concerning rules adopted by a
- 26 division.
- 27 (8) Create advisory bodies to advise the secretary about any
- 28 matter relating to the implementation of this article.
- 29 (9) Perform other acts necessary to implement this article.

30 **Sec. 8. (a) The secretary shall cooperate with the federal Social**

31 **Security Administration and with any other agency of the federal**

32 **government in any reasonable manner that may be necessary to**

33 **qualify for federal aid for assistance to persons who are entitled to**

34 **assistance under the provisions of the federal Social Security Act.**

35 **(b) The secretary shall do the following:**

- 36 (1) Make reports in the form and containing the information
- 37 required by the federal Social Security Administration Board
- 38 or any other agency of the federal government.
- 39 (2) Comply with the requirements that the federal Social
- 40 Security Administration Board or other agency of the federal
- 41 government finds necessary to assure the correctness and
- 42 verification of reports.

43 **(c) The secretary shall act as the agent to the federal**

44 **government in the following:**

- 45 (1) Welfare matters of mutual concern.
- 46 (2) The administration of federal money granted to Indiana to



1 aid the welfare functions of the state.

2 Sec. 9. (a) Consistent with the powers and duties of the secretary  
3 under this article, the secretary may adopt rules under IC 4-22-2  
4 relating to the exercise of those powers and duties.

5 (b) The secretary may adopt emergency rules under  
6 IC 4-22-2-37.1(a)(37) for the following:

7 (1) Federal Medicaid waiver program provisions.

8 (2) Federal programs administered by the office of the  
9 secretary.

10 Sec. 10. The office of the secretary is designated as the sole state  
11 agency responsible for administering programs concerning the  
12 vocational rehabilitation of individuals with a disability under 29  
13 U.S.C. 701 et seq.

14 Sec. 11. (a) If:

15 (1) the sums appropriated by the general assembly in the  
16 biennial budget to the family and social services  
17 administration for the Medicaid assistance, Medicaid  
18 administration, public assistance (TANF), and the IMPACT  
19 (JOBS) work program are insufficient to enable the office of  
20 the secretary to meet its obligations; and

21 (2) the failure to appropriate additional funds would:

22 (A) violate a provision of federal law; or

23 (B) jeopardize the state's share of federal financial  
24 participation applicable to the state appropriations  
25 contained in the biennial budget for Medicaid assistance,  
26 Medicaid administration, public assistance (TANF), or the  
27 IMPACT (JOBS) program;

28 then there are appropriated further sums as may be necessary to  
29 remedy a situation described in this subsection, subject to the  
30 approval of the budget director and the unanimous  
31 recommendation of the members of the budget committee.  
32 However, before approving a further appropriation under this  
33 subsection, the budget director shall explain to the budget  
34 committee the factors indicating that a condition described in  
35 subdivision (2) would be met.

36 (b) If:

37 (1) the sums appropriated by the general assembly in the  
38 biennial budget to the family and social services  
39 administration for Medicaid assistance, Medicaid  
40 administration, public assistance (TANF), and the IMPACT  
41 (JOBS) work program are insufficient to enable the family  
42 and social services administration to meet its obligations; and

43 (2) neither of the conditions in subsection (a)(2) would result  
44 from a failure to appropriate additional funds;

45 then there are appropriated further sums as may be necessary to  
46 remedy a situation described in this subsection, subject to the



1 approval of the budget director and the unanimous  
 2 recommendation of the members of the budget committee.  
 3 However, before approving a further appropriation under this  
 4 subsection, the budget director shall explain to the budget  
 5 committee the factors indicating that a condition described in  
 6 subdivision (2) would be met.

7 (c) Notwithstanding IC 12-14 and IC 12-15 (except for a clinical  
 8 advisory panel established under IC 12-15), and except as provided  
 9 in subsection (d), the office of the secretary may by rule adjust  
 10 programs, eligibility standards, and benefit levels to limit  
 11 expenditures from Medicaid assistance, Medicaid administration,  
 12 public assistance (TANF), and the IMPACT (JOBS) work  
 13 program. The office of the secretary may adopt emergency rules  
 14 under IC 4-22-2-37.1 to make an adjustment authorized by this  
 15 subsection. However, adjustments under this subsection may not:

- 16 (1) violate a provision of federal law; or
- 17 (2) jeopardize the state's share of federal financial  
 18 participation applicable to the state appropriations contained  
 19 in the biennial budget for Medicaid assistance, Medicaid  
 20 administration, public assistance (TANF), and the IMPACT  
 21 (JOBS) work program.

22 (d) Subject to IC 12-15-21-3, any adjustments made under  
 23 subsection (c) must:

- 24 (1) allow for a licensed provider under IC 12-15 to deliver  
 25 services within the scope of the provider's license if the benefit  
 26 is covered under IC 12-15; and
- 27 (2) provide access to services under IC 12-15 from a provider  
 28 under IC 12-15-12.

29 Sec. 12. (a) Subject to the appropriation limits established by the  
 30 state's biennial budget for the office of the secretary and its  
 31 divisions, and after assistance, including assistance under TANF  
 32 (IC 12-14), medical assistance (IC 12-15), and food stamps (7  
 33 U.S.C. 2016(i)), is distributed to persons eligible to receive  
 34 assistance, the secretary may adopt rules under IC 4-22-2 to offer  
 35 programs on a pilot or statewide basis to encourage recipients of  
 36 assistance under IC 12-14 to become self-sufficient and discontinue  
 37 dependence on public assistance programs. Programs offered  
 38 under this subsection may do the following:

- 39 (1) Develop welfare-to-work programs.
- 40 (2) Develop home child care training programs that will  
 41 enable recipients to work by providing child care for other  
 42 recipients.
- 43 (3) Provide case management and supportive services.
- 44 (4) Develop a system to provide for public service  
 45 opportunities for recipients.
- 46 (5) Provide plans to implement the personal responsibility.



- 1 agreement under IC 12-14-2-21.
- 2 (6) Develop programs to implement the school attendance
- 3 requirement under IC 12-14-2-17.
- 4 (7) Provide funds for county planning council activities under
- 5 IC 12-14-22-13 (repealed).
- 6 (8) Provide that a recipient may earn up to the federal income
- 7 poverty level (as defined in IC 12-15-2-1) before assistance
- 8 under this title is reduced or eliminated.
- 9 (9) Provide for child care assistance, with the recipient paying
- 10 fifty percent (50%) of the local market rate as established
- 11 under 45 CFR 256 for child care.
- 12 (10) Provide for medical care assistance under IC 12-15, if the
- 13 recipient's employer does not offer the recipient health care
- 14 coverage.

15 (b) If the secretary offers a program described in subsection (a),  
 16 the secretary shall annually report the results and other relevant  
 17 data regarding the program to the legislative council in an  
 18 electronic format under IC 5-14-6.

19 Sec. 13. The office of the secretary shall implement methods to  
 20 facilitate the payment of providers under IC 12-15.

21 Sec. 14. The office of the secretary shall improve its system  
 22 through the use of technology and training of staff to do the  
 23 following:

- 24 (1) Simplify, streamline, and destigmatize the eligibility and
- 25 enrollment processes in all health programs serving children.
- 26 (2) Ensure an efficient provider payment system.
- 27 (3) Improve service to families.
- 28 (4) Improve data quality for program assessment and
- 29 evaluation.

30 Sec. 15. (a) The office of the secretary shall:

- 31 (1) cooperate with; and
- 32 (2) assist;

33 a nonprofit organization with the purpose to implement and  
 34 administer a program to provide health care to uninsured Indiana  
 35 residents.

36 (b) The office of the secretary shall assist a nonprofit  
 37 organization that has the purpose described in subsection (a) with  
 38 the following:

- 39 (1) Determining eligibility of potential participants who have
- 40 an income of not more than one hundred percent (100%) of
- 41 the federal poverty level for a program described in this
- 42 section.
- 43 (2) Issuing a plan card that is valid for one (1) year to an
- 44 individual if:
- 45 (A) the office of the secretary has determined the
- 46 individual is eligible for the program; and



1 (B) the individual has paid the office of the secretary a  
2 registration fee determined by the office.

3 (3) Operating a toll free telephone number that provides  
4 provider referral services for participants in the program.

5 (4) Implementing the program described in this section to  
6 combine the resources of the office of the secretary and the  
7 nonprofit organization in a manner that would not result in  
8 the additional expenditure of state funds.

9 SECTION 13. IC 12-8-2.5 IS ADDED TO THE INDIANA CODE  
10 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
11 UPON PASSAGE]:

12 **Chapter 2.5. Family and Social Services Bodies**

13 **Sec. 0.3. (a) Actions taken under IC 12-8-2 (expired), after**  
14 **December 31, 2007, and before March 24, 2008, are legalized and**  
15 **validated to the extent that those actions would have been legal and**  
16 **valid if P.L.113-2008 had been enacted before January 1, 2008.**

17 **(b) Actions taken under IC 12-8-2 (expired) after June 30, 2011,**  
18 **are legalized and validated to the extent that those actions would**  
19 **have been legal and valid if IC 12-8-2 had not expired on June 30,**  
20 **2011.**

21 **Sec. 1. As used in this chapter, "body" refers to an entity**  
22 **described in section 3 of this chapter.**

23 **Sec. 2. As used in this chapter, "member" refers to a member of**  
24 **a body.**

25 **Sec. 3. Unless otherwise provided by a statute, this chapter**  
26 **applies to the following:**

27 **(1) The following advisory councils:**

28 **(A) The division of disability and rehabilitative services**  
29 **advisory council.**

30 **(B) The division of family resources advisory council.**

31 **(C) The division of mental health and addiction advisory**  
32 **council.**

33 **(2) A body:**

34 **(A) established by statute for a division; and**

35 **(B) whose enabling statute makes this chapter applicable**  
36 **to the body.**

37 **Sec. 3.5. Up to five (5) individuals appointed by the secretary to**  
38 **serve on an entity not described in section 3(1) of this chapter may**  
39 **be appointed to serve concurrently on an advisory council**  
40 **described in section 3(1) of this chapter. However, an individual**  
41 **may not serve concurrently on more than one (1) advisory council**  
42 **described in section 3(1) of this chapter.**

43 **Sec. 4. (a) This section applies only to a member who by statute**  
44 **is appointed to a fixed term.**

45 **(b) The term of an individual serving as a member begins on the**  
46 **latter of the following:**



1 (1) The day the term of the member whom the individual is  
 2 appointed to succeed expires. If the individual does not  
 3 succeed a member, the member's term begins as provided in  
 4 subdivision (2).

5 (2) The day the individual is appointed.

6 (c) The term of a member expires on July 1 of the second year  
 7 after the expiration of the term of the member's immediate  
 8 predecessor. If the member has no immediate predecessor, the  
 9 term of the member expires on July 1 of the second year after the  
 10 member's term began.

11 (d) A member may be reappointed for a new term. A  
 12 reappointed member is the member's own:

13 (1) successor for purposes of subsection (b); and

14 (2) immediate predecessor for purposes of subsection (c).

15 Sec. 5. (a) This section applies only to an individual who serves  
 16 as a member because of an office the individual holds.

17 (b) The individual serves as a member until the individual no  
 18 longer holds the office.

19 Sec. 6. The appointing authority of a member shall appoint an  
 20 individual to fill a vacancy in the office of the member.

21 Sec. 7. Except as provided in another statute, the governor shall  
 22 appoint a voting member of the body to be the presiding officer of  
 23 the body.

24 Sec. 8. Unless otherwise provided by a statute, a member is a  
 25 voting member.

26 Sec. 9. A majority of the voting members of the body constitutes  
 27 a quorum.

28 Sec. 10. The affirmative vote of a majority of the voting  
 29 members of the body is required for the body to take any action.

30 Sec. 11. (a) A member who is not a state employee is entitled to  
 31 both of the following:

32 (1) The minimum salary per diem provided by  
 33 IC 4-10-11-2.1(b).

34 (2) Reimbursement for travel expenses and other expenses  
 35 actually incurred in connection with the member's duties, as  
 36 provided in the state travel policies and procedures  
 37 established by the Indiana department of administration and  
 38 approved by the budget agency.

39 (b) A member who is a state employee is entitled to  
 40 reimbursement for travel expenses and other expenses actually  
 41 incurred in connection with the member's duties, as provided in the  
 42 state travel policies and procedures established by the Indiana  
 43 department of administration and approved by the budget agency.

44 (c) A member who is a member of the general assembly is  
 45 entitled to receive the same per diem, mileage, and travel  
 46 allowances paid to members of the general assembly serving on



1 interim study committees established by the legislative council.

2 Sec. 11.5. In addition to the requirements of IC 5-14-1.5, the  
3 office of the secretary or a division will make a good faith effort to  
4 ensure that members of any body subject to this chapter receive a  
5 copy of an agenda at least forty-eight (48) hours before any  
6 meeting of the body.

7 SECTION 14. IC 12-8-6.5 IS ADDED TO THE INDIANA CODE  
8 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
9 UPON PASSAGE]:

10 **Chapter 6.5. Office of Medicaid Policy and Planning**

11 Sec. 0.3. (a) Actions taken under IC 12-8-6 (expired), after  
12 December 31, 2007, and before March 24, 2008, are legalized and  
13 validated to the extent that those actions would have been legal and  
14 valid if P.L.113-2008 had been enacted before January 1, 2008.

15 (b) Actions taken under IC 12-8-6 (expired) after June 30, 2011,  
16 are legalized and validated to the extent that those actions would  
17 have been legal and valid if IC 12-8-6 had not expired on June 30,  
18 2011.

19 Sec. 1. The office of Medicaid policy and planning is established.

20 Sec. 2. The secretary shall appoint an administrator responsible  
21 for management of the office.

22 Sec. 3. The office is designated as the single state agency for  
23 administration of the state Medicaid program under IC 12-15.

24 Sec. 4. The office shall develop and coordinate Medicaid policy  
25 for the state.

26 Sec. 5. The secretary may adopt rules under IC 4-22-2 to  
27 implement this chapter and the state Medicaid program.

28 Sec. 6. (a) For purposes of IC 4-21.5, the secretary is the  
29 ultimate authority for the state Medicaid program.

30 (b) The secretary shall adopt rules under IC 4-22-2 to specify  
31 any additional necessary procedures for administrative review of  
32 an agency action under IC 4-21.5 and the state Medicaid program.

33 Sec. 7. The office and the division of mental health and addiction  
34 shall develop a written memorandum of understanding that  
35 provides the following:

36 (1) Program responsibilities for the provision of care and  
37 treatment for individuals with a mental illness.

38 (2) Responsibilities to educate and inform vendors of the  
39 proper billing procedures.

40 (3) Responsibilities in administering the state plan.

41 (4) Responsibilities for Medicaid fiscal and quality  
42 accountability and audits for mental health services.

43 (5) That the division shall recommend options and services to  
44 be reimbursed under the state plan.

45 (6) That the office and the division agree that, within the  
46 limits of 42 U.S.C. 1396 et seq., individuals with a mental



1 illness cannot be excluded from services on the basis of  
2 diagnosis unless these services are otherwise provided and  
3 reimbursed under the state plan.

4 (7) That the office shall seek review and comment from the  
5 division before the adoption of rules or standards that may  
6 affect the service, programs, or providers of medical  
7 assistance services for individuals with a mental illness.

8 (8) That the division shall develop rate setting policies for  
9 medical assistance services for individuals with a mental  
10 illness.

11 (9) Policies to facilitate communication between the office and  
12 the division.

13 (10) Any additional provisions that enhance communication  
14 between the office and the division or facilitate more efficient  
15 or effective delivery of mental health services.

16 **Sec. 8. The office and the division of disability and rehabilitative**  
17 **services shall develop a written memorandum of understanding**  
18 **that provides the following:**

19 (1) Program responsibilities for the provision of care and  
20 treatment for individuals with a developmental disability and  
21 long term care recipients.

22 (2) Responsibilities to educate and inform vendors of the  
23 proper billing procedures.

24 (3) Responsibilities in administering the state plan.

25 (4) Responsibilities for Medicaid fiscal and quality  
26 accountability and audits for developmental disability and  
27 long term care services.

28 (5) That the division shall recommend options and services to  
29 be reimbursed under the state plan.

30 (6) That the office and the division agree that, within the  
31 limits of 42 U.S.C. 1396 et seq., individuals with a  
32 developmental disability and long term care recipients cannot  
33 be excluded from services on the basis of diagnosis unless  
34 these services are otherwise provided and reimbursed under  
35 the state plan.

36 (7) That the office shall seek review and comment from the  
37 division before the adoption of rules or standards that may  
38 affect the service, programs, or providers of medical  
39 assistance services for individuals with a developmental  
40 disability and long term care recipients.

41 (8) That the division shall develop rate setting policies for  
42 medical assistance services for individuals with a  
43 developmental disability and long term care recipients.

44 (9) That the office, with the assistance of the division, shall  
45 apply for waivers from the United States Department of  
46 Health and Human Services to fund community and home



1 based long term care services as alternatives to  
2 institutionalization.

3 (10) Policies to facilitate communication between the office  
4 and the division.

5 (11) Any additional provisions that enhance communication  
6 between the office and the division or facilitate more efficient  
7 or effective delivery of developmental disability or long term  
8 care services.

9 Sec. 9. The office, the division of family resources, and the  
10 department of child services shall develop a written memorandum  
11 of understanding that provides the following:

12 (1) Program responsibilities for the provision of care and  
13 treatment for recipients served by the division.

14 (2) Responsibilities to educate and inform vendors of the  
15 proper billing procedures.

16 (3) Responsibilities in administering the state plan.

17 (4) Responsibilities for Medicaid fiscal and quality  
18 accountability and audits for services administered by the  
19 division.

20 (5) That the division shall recommend options and services to  
21 be reimbursed under the Medicaid state plan.

22 (6) That the office and the division agree that, within the  
23 limits of 42 U.S.C. 1396 et seq., recipients served by the  
24 division cannot be excluded from services on the basis of  
25 diagnosis unless these services are otherwise provided and  
26 reimbursed under the state plan.

27 (7) That the office shall seek review and comment from the  
28 division before the adoption of rules or standards that may  
29 affect the service, programs, or providers of medical  
30 assistance services for recipients served by the division.

31 (8) That the division shall develop rate setting policies for  
32 medical assistance services administered by the division.

33 (9) Policies to facilitate communication between the office and  
34 the division.

35 (10) Any additional provisions that enhance communication  
36 between the office and the division or facilitate more efficient  
37 or effective delivery of services.

38 Sec. 10. (a) The office shall reduce reimbursement rates for  
39 over-the-counter drugs by ten percent (10%) not later than July 1,  
40 2001.

41 (b) The office shall implement a Maximum Allowable Cost  
42 schedule for off-patent drugs not later than November 1, 2001.

43 (c) Not later than January 1, 2002, the office shall implement an  
44 information strategy directed to high volume prescribers.

45 (d) Beginning July 1, 2002, the office shall phase in case  
46 management for aged, blind, and disabled Medicaid recipients.



1           **Sec. 11.** The office shall adopt emergency rules under  
 2 IC 4-22-2-37.1 to achieve the reductions needed to avoid  
 3 expenditures exceeding the Medicaid appropriation made by  
 4 P.L.224-2003 in the line item appropriation to the FAMILY AND  
 5 SOCIAL SERVICES ADMINISTRATION, MEDICAID -  
 6 CURRENT OBLIGATIONS. To the extent that reductions are  
 7 made to optional Medicaid services as set forth in 42 U.S.C. 1396  
 8 et seq., the reductions may be accomplished on a pro rata basis  
 9 with each optional service being reduced by a proportionate  
 10 amount. However, the reductions may not be made in a manner  
 11 that results in the elimination of any optional Medicaid service.

12           SECTION 15. IC 12-8-8.5 IS ADDED TO THE INDIANA CODE  
 13 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 14 UPON PASSAGE]:

15           **Chapter 8.5. Divisions and Directors**

16           **Sec. 0.3.** (a) Actions taken under IC 12-8-8 (expired), after  
 17 December 31, 2007, and before March 24, 2008, are legalized and  
 18 validated to the extent that those actions would have been legal and  
 19 valid if P.L.113-2008 had been enacted before January 1, 2008.

20           (b) Actions taken under IC 12-8-8 (expired) after June 30, 2011,  
 21 are legalized and validated to the extent that those actions would  
 22 have been legal and valid if IC 12-8-8 had not expired on June 30,  
 23 2011.

24           **Sec. 1.** Subject to the approval of the governor, the secretary:

25           (1) shall appoint each director; and

26           (2) may terminate the employment of a director.

27           **Sec. 2.** (a) A director is the chief administrator of the director's  
 28 division.

29           (b) A director is responsible to the secretary for the operation  
 30 and performance of the director's division.

31           **Sec. 3.** A director is the appointing authority for the director's  
 32 division.

33           **Sec. 4.** (a) A director may adopt rules under IC 4-22-2 relating  
 34 to the operation of the director's division and to implement the  
 35 programs of the director's division.

36           (b) Whenever a division is required to adopt rules under  
 37 IC 4-22-2, the director of the division is the statutory authority that  
 38 adopts the rules.

39           **Sec. 5.** (a) A director is the ultimate authority under IC 4-21.5  
 40 for purposes of the operation of the director's division and the  
 41 programs of the director's division.

42           (b) The director shall consult with the secretary on issues of  
 43 family, social services, or health policy arising in a proceeding  
 44 under IC 4-21.5.

45           **Sec. 6.** A director is responsible for development and  
 46 presentation of the budget of the director's division.



1 SECTION 16. IC 12-9-1-2 IS AMENDED TO READ AS  
 2 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~  
 3 **IC 12-8-8.5** applies to the division.

4 SECTION 17. IC 12-9-2-1 IS AMENDED TO READ AS  
 5 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. The division  
 6 shall be administered by a director appointed under ~~IC 12-8-8-1~~.  
 7 **IC 12-8-8.5-1**.

8 SECTION 18. IC 12-9-2-2 IS AMENDED TO READ AS  
 9 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~  
 10 **IC 12-8-8.5** applies to the director.

11 SECTION 19. IC 12-9-4-4 IS AMENDED TO READ AS  
 12 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. Each member of  
 13 the council appointed under section 3(2) of this chapter has a fixed  
 14 term as provided in ~~IC 12-8-2-4~~. **IC 12-8-2.5-4**.

15 SECTION 20. IC 12-9-4-7 IS AMENDED TO READ AS  
 16 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. ~~IC 12-8-2~~  
 17 **IC 12-8-2.5** applies to the council.

18 SECTION 21. IC 12-9.1-1-2, AS ADDED BY P.L.141-2006,  
 19 SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 20 UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~ **IC 12-8-8.5** applies to the  
 21 division.

22 SECTION 22. IC 12-9.1-2-1, AS ADDED BY P.L.141-2006,  
 23 SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 24 UPON PASSAGE]: Sec. 1. The division shall be administered by a  
 25 director appointed under ~~IC 12-8-8-1~~. **IC 12-8-8.5-1**.

26 SECTION 23. IC 12-9.1-2-2, AS ADDED BY P.L.141-2006,  
 27 SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 28 UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~ **IC 12-8-8.5** applies to the  
 29 director.

30 SECTION 24. IC 12-10-12-4 IS AMENDED TO READ AS  
 31 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. As used in this  
 32 chapter, "office" refers to the office of Medicaid policy and planning  
 33 established by ~~IC 12-8-6-1~~. **IC 12-8-6.5-1**.

34 SECTION 25. IC 12-12-1-4.1 IS AMENDED TO READ AS  
 35 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4.1. (a) The bureau  
 36 may do the following:

37 (1) Establish vocational rehabilitation centers separately or in  
 38 conjunction with community rehabilitation centers.

39 (2) Contract with governmental units and other public or private  
 40 organizations to provide any of the vocational rehabilitation  
 41 services permitted or required by this article, ~~IC 12-8-1-11~~;  
 42 **IC 12-8-1.5-10**, IC 12-9-6, and IC 12-11-6.

43 (3) Provide or contract for the provision of other services that are  
 44 consistent with the purposes of this article, ~~IC 12-8-1-11~~;  
 45 **IC 12-8-1.5-10**, IC 12-9-6, and IC 12-11-6.

46 (b) When entering into contracts for job development, placement,



1 or retention services, the bureau shall contract with governmental units  
 2 and other public or private organizations or individuals that are  
 3 accredited by one (1) of the following organizations:

4 (1) The Commission on Accreditation of Rehabilitation Facilities  
 5 (CARF), or its successor.

6 (2) The Council on Quality and Leadership in Supports for People  
 7 with Disabilities, or its successor.

8 (3) The Joint Commission on Accreditation of Healthcare  
 9 Organizations (JCAHO), or its successor.

10 (4) The National Commission on Quality Assurance, or its  
 11 successor.

12 (5) An independent national accreditation organization approved  
 13 by the secretary.

14 (c) To the extent that the accreditation requirements of an  
 15 accrediting organization listed in subsection (b) do not cover a specific  
 16 requirement determined by the bureau to be necessary for a contracted  
 17 service under subsection (a), the bureau shall include these specific  
 18 requirements as part of the bureau's contract for job development,  
 19 placement, or retention services.

20 SECTION 26. IC 12-12.7-2-8, AS ADDED BY P.L.93-2006,  
 21 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 22 UPON PASSAGE]: Sec. 8. (a) The council consists of at least fifteen  
 23 (15) but not more than twenty-five (25) members appointed by the  
 24 governor as follows:

25 (1) At least twenty percent (20%) of the members must be  
 26 individuals who:

27 (A) are parents, including minority parents, of infants or  
 28 toddlers with disabilities or of children who are less than  
 29 thirteen (13) years of age with disabilities; and

30 (B) have knowledge of or experience with programs for infants  
 31 and toddlers with disabilities.

32 At least one (1) of the members described in this subdivision must  
 33 be a parent of an infant or toddler with a disability or of a child  
 34 less than seven (7) years of age with a disability.

35 (2) At least twenty percent (20%) of the members must be public  
 36 or private providers of early intervention services.

37 (3) At least one (1) member must be a member of the general  
 38 assembly.

39 (4) Each of the state agencies involved in the provision of or  
 40 payment for early intervention services to infants and toddlers  
 41 with disabilities and their families must be represented by at least  
 42 one (1) member. The members described in this subdivision must  
 43 have sufficient authority to engage in policy planning and  
 44 implementation on behalf of the state agency the member  
 45 represents.

46 (5) At least one (1) member must be involved in personnel



- 1 preparation.
- 2 (6) At least one (1) member must:
- 3 (A) represent a state educational agency responsible for
- 4 preschool services to children with disabilities; and
- 5 (B) have sufficient authority to engage in policy planning and
- 6 implementation on behalf of the agency.
- 7 (7) At least one (1) member must represent the department of
- 8 insurance created by IC 27-1-1-1.
- 9 (8) At least one (1) member must represent an agency or program
- 10 that is:
- 11 (A) located in Indiana; and
- 12 (B) authorized to participate in the Head Start program under
- 13 42 U.S.C. 9831 et seq.
- 14 (9) At least one (1) member must represent a state agency
- 15 responsible for child care.
- 16 (10) At least one (1) member must represent the office of
- 17 Medicaid policy and planing established by ~~IC 12-8-6-1.~~
- 18 **IC 12-8-6.5-1.**
- 19 (11) At least one (1) member must be a representative designated
- 20 by the office of coordinator for education of homeless children
- 21 and youths.
- 22 (12) At least one (1) member must be a state foster care
- 23 representative from the department of child services established
- 24 by IC 31-33-1.5-2.
- 25 (13) At least one (1) member must represent the division of
- 26 mental health and addiction established by IC 12-21-1-1.
- 27 (b) To the extent possible, the governor shall ensure that the
- 28 membership of the council reasonably represents the population of
- 29 Indiana.
- 30 SECTION 27. IC 12-13-1-2 IS AMENDED TO READ AS
- 31 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~
- 32 **IC 12-8-8.5** applies to the division.
- 33 SECTION 28. IC 12-13-2-1 IS AMENDED TO READ AS
- 34 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. The division
- 35 shall be administered by a director appointed under ~~IC 12-8-8-2.~~
- 36 **IC 12-8-8.5-2.**
- 37 SECTION 29. IC 12-13-4-4 IS AMENDED TO READ AS
- 38 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. Each member of
- 39 the council appointed under section 3(2) of this chapter has a fixed
- 40 term as provided in ~~IC 12-8-2-4.~~ **IC 12-8-2.5-4.**
- 41 SECTION 30. IC 12-13-4-7 IS AMENDED TO READ AS
- 42 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. ~~IC 12-8-2~~
- 43 **IC 12-8-2.5** applies to the council.
- 44 SECTION 31. IC 12-13-15.2-2 IS AMENDED TO READ AS
- 45 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The division
- 46 shall collaborate with the office of Medicaid policy and planning



1 established by ~~IC 12-8-6-1~~ **IC 12-8-6.5-1** and the state department of  
 2 health established by IC 16-19-1-1 to establish programs that facilitate  
 3 children's access to oral health services.

4 SECTION 32. IC 12-14-2-21, AS AMENDED BY P.L.161-2007,  
 5 SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 6 UPON PASSAGE]: Sec. 21. (a) A TANF recipient or the parent or  
 7 essential person of a TANF recipient, if the TANF recipient is less than  
 8 eighteen (18) years of age, must sign a personal responsibility  
 9 agreement to do the following:

10 (1) Develop an individual self-sufficiency plan with other family  
 11 members and a caseworker.

12 (2) Accept any reasonable employment as soon as it becomes  
 13 available.

14 (3) Agree to a loss of assistance, including TANF assistance  
 15 under this article, if convicted of a felony under IC 35-43-5-7 or  
 16 IC 35-43-5-7.1 for ten (10) years after the conviction.

17 (4) Subject to section 5.3 of this chapter, understand that  
 18 additional TANF assistance under this article will not be available  
 19 for a child born more than ten (10) months after the person  
 20 qualifies for assistance.

21 (5) Accept responsibility for ensuring that each child of the  
 22 person receives all appropriate vaccinations against disease at an  
 23 appropriate age.

24 (6) If the person is less than eighteen (18) years of age and is a  
 25 parent, live with the person's parents, legal guardian, or an adult  
 26 relative other than a parent or legal guardian in order to receive  
 27 public assistance.

28 (7) Subject to ~~IC 12-8-1-12~~ **IC 12-8-1.5-11** and section 5.1 of this  
 29 chapter, agree to accept assistance for not more than twenty-four  
 30 (24) months under the TANF program (IC 12-14).

31 (8) Be available for and actively seek and maintain employment.

32 (9) Participate in any training program required by the division.

33 (10) Accept responsibility for ensuring that the person and each  
 34 child of the person attend school until the person and each child  
 35 of the person graduate from high school or attain a high school  
 36 equivalency certificate (as defined in IC 12-14-5-2).

37 (11) Raise the person's children in a safe, secure home.

38 (12) Agree not to abuse illegal drugs or other substances that  
 39 would interfere with the person's ability to attain self-sufficiency.

40 (b) Except as provided in subsection (c), assistance under the TANF  
 41 program shall be withheld or denied to a person who does not fulfill the  
 42 requirements of the personal responsibility agreement under subsection  
 43 (a).

44 (c) A person who is granted an exemption under section 23 of this  
 45 chapter may be excused from specific provisions of the personal  
 46 responsibility agreement as determined by the director.



1 SECTION 33. IC 12-15-2-0.5, AS AMENDED BY P.L.1-2010,  
 2 SECTION 58, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 3 UPON PASSAGE]: Sec. 0.5. (a) This section applies to a person who  
 4 qualifies for assistance:

- 5 (1) under sections 13 through 16 of this chapter;
- 6 (2) under section 6 of this chapter when the person becomes  
 7 ineligible for medical assistance under IC 12-14-2-5.1 or  
 8 IC 12-14-2-5.3; or
- 9 (3) as an individual with a disability if the person is less than  
 10 eighteen (18) years of age and otherwise qualifies for assistance.

11 (b) Notwithstanding any other law, the following may not be  
 12 construed to limit health care assistance to a person described in  
 13 subsection (a):

- 14 (1) ~~IC 12-8-1-13~~ **IC 12-8-1.5-12.**
- 15 (2) IC 12-14-1-1.
- 16 (3) IC 12-14-1-1.5.
- 17 (4) IC 12-14-2-5.1.
- 18 (5) IC 12-14-2-5.2.
- 19 (6) IC 12-14-2-5.3.
- 20 (7) IC 12-14-2-17.
- 21 (8) IC 12-14-2-18.
- 22 (9) IC 12-14-2-20.
- 23 (10) IC 12-14-2-21.
- 24 (11) IC 12-14-2-24.
- 25 (12) IC 12-14-2-25.
- 26 (13) IC 12-14-2-26.
- 27 (14) IC 12-14-2.5.
- 28 (15) IC 12-14-5.5.
- 29 (16) Section 21 of this chapter.

30 SECTION 34. IC 12-21-1-2 IS AMENDED TO READ AS  
 31 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~  
 32 **IC 12-8-8.5** applies to the division.

33 SECTION 35. IC 12-21-2-1 IS AMENDED TO READ AS  
 34 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. The division  
 35 shall be administered by a director appointed under ~~IC 12-8-8-1~~.  
 36 **IC 12-8-8.5-1.**

37 SECTION 36. IC 12-21-2-2 IS AMENDED TO READ AS  
 38 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. ~~IC 12-8-8~~  
 39 **IC 12-8-8.5** applies to the director.

40 SECTION 37. IC 12-21-2-3, AS AMENDED BY P.L.143-2011,  
 41 SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 42 UPON PASSAGE]: Sec. 3. In addition to the general authority granted  
 43 to the director under ~~IC 12-8-8~~, **IC 12-8-8.5**, the director shall do the  
 44 following:

- 45 (1) Organize the division, create the appropriate personnel  
 46 positions, and employ personnel necessary to discharge the



- 1 statutory duties and powers of the division or a bureau of the  
2 division.
- 3 (2) Subject to the approval of the state personnel department,  
4 establish personnel qualifications for all deputy directors,  
5 assistant directors, bureau heads, and superintendents.
- 6 (3) Subject to the approval of the budget director and the  
7 governor, establish the compensation of all deputy directors,  
8 assistant directors, bureau heads, and superintendents.
- 9 (4) Study the entire problem of mental health, mental illness, and  
10 addictions existing in Indiana.
- 11 (5) Adopt rules under IC 4-22-2 for the following:
- 12 (A) Standards for the operation of private institutions that are  
13 licensed under IC 12-25 for the diagnosis, treatment, and care  
14 of individuals with psychiatric disorders, addictions, or other  
15 abnormal mental conditions.
- 16 (B) Licensing or certifying community residential programs  
17 described in IC 12-22-2-3.5 for individuals with serious  
18 mental illness (SMI), serious emotional disturbance (SED), or  
19 chronic addiction (CA) with the exception of psychiatric  
20 residential treatment facilities.
- 21 (C) Certifying community mental health centers to operate in  
22 Indiana.
- 23 (D) Establish exclusive geographic primary service areas for  
24 community mental health centers. The rules must include the  
25 following:
- 26 (i) Criteria and procedures to justify the change to the  
27 boundaries of a community mental health center's primary  
28 service area.
- 29 (ii) Criteria and procedures to justify the change of an  
30 assignment of a community mental health center to a  
31 primary service area.
- 32 (iii) A provision specifying that the criteria and procedures  
33 determined in items (i) and (ii) must include an option for  
34 the county and the community mental health center to  
35 initiate a request for a change in primary service area or  
36 provider assignment.
- 37 (iv) A provision specifying the criteria and procedures  
38 determined in items (i) and (ii) may not limit an eligible  
39 consumer's right to choose or access the services of any  
40 provider who is certified by the division of mental health  
41 and addiction to provide public supported mental health  
42 services.
- 43 (6) Institute programs, in conjunction with an accredited college  
44 or university and with the approval, if required by law, of the  
45 commission for higher education, for the instruction of students  
46 of mental health and other related occupations. The programs may



- 1 be designed to meet requirements for undergraduate and  
 2 postgraduate degrees and to provide continuing education and  
 3 research.
- 4 (7) Develop programs to educate the public in regard to the  
 5 prevention, diagnosis, treatment, and care of all abnormal mental  
 6 conditions.
- 7 (8) Make the facilities of the Larue D. Carter Memorial Hospital  
 8 available for the instruction of medical students, student nurses,  
 9 interns, and resident physicians under the supervision of the  
 10 faculty of the Indiana University School of Medicine for use by  
 11 the school in connection with research and instruction in  
 12 psychiatric disorders.
- 13 (9) Institute a stipend program designed to improve the quality  
 14 and quantity of staff that state institutions employ.
- 15 (10) Establish, supervise, and conduct community programs,  
 16 either directly or by contract, for the diagnosis, treatment, and  
 17 prevention of psychiatric disorders.
- 18 (11) Adopt rules under IC 4-22-2 concerning the records and data  
 19 to be kept concerning individuals admitted to state institutions,  
 20 community mental health centers, or other providers.
- 21 (12) Compile information and statistics concerning the ethnicity  
 22 and gender of a program or service recipient.
- 23 (13) Establish standards for services described in IC 12-7-2-40.6  
 24 for community mental health centers and other providers.
- 25 SECTION 38. IC 12-21-4-4 IS AMENDED TO READ AS  
 26 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. Each member of  
 27 the council appointed under section 3(2) of this chapter has a fixed  
 28 term as provided in ~~IC 12-8-2-4~~ **IC 12-8-2.5-4**.
- 29 SECTION 39. IC 12-21-4-7 IS AMENDED TO READ AS  
 30 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. ~~IC 12-8-2~~  
 31 **IC 12-8-2.5** applies to the council.
- 32 SECTION 40. IC 16-28-15-5, AS ADDED BY P.L.229-2011,  
 33 SECTION 162, IS AMENDED TO READ AS FOLLOWS  
 34 [EFFECTIVE UPON PASSAGE]: Sec. 5. As used in this chapter,  
 35 "office" refers to the office of Medicaid policy and planning established  
 36 by ~~IC 12-8-6-1~~ **IC 12-8-6.5-1**.
- 37 SECTION 41. IC 22-4.1-17-6, AS ADDED BY P.L.110-2010,  
 38 SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 39 UPON PASSAGE]: Sec. 6. As used in this chapter, "secretary" refers  
 40 to the secretary of family and social services appointed under  
 41 ~~IC 12-8-1-2~~ **IC 12-8-1.5-2**.
- 42 SECTION 42. **An emergency is declared for this act.**







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**PRELIMINARY DRAFT**  
**No. 3175**

**PREPARED BY**  
**LEGISLATIVE SERVICES AGENCY**  
**2012 GENERAL ASSEMBLY**

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**DIGEST**

**Citations Affected:** IC 16-41-6-1.

**Synopsis:** HIV testing. Allows a person to perform a screening or test for the antibody or antigen to HIV unless the individual to be tested indicates a refusal to consent to the test in writing. (Current law prohibits a person from performing the test without the oral or written consent of the individual.) Requires a physician to document a refusal by an individual or the individual's representative.

**Effective:** July 1, 2012.



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 16-41-6-1, AS AMENDED BY P.L.94-2010,  
2 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
3 JULY 1, 2012]: Sec. 1. (a) ~~Except as provided in IC 16-41-8-6,~~  
4 ~~IC 16-41-10-2.5; and subsection (b);~~ a person may not perform ~~Unless~~  
5 ~~an individual or the individual's representative (as defined in~~  
6 ~~IC 16-36-1) refuses in writing to have a screening or confirmatory~~  
7 ~~test for the antibody or antigen to HIV without the oral or written~~  
8 ~~consent of the individual to be tested or a representative as authorized~~  
9 ~~under IC 16-36-1. A performed, a physician may perform the~~  
10 ~~screening or test. The physician ordering the test or the physician's~~  
11 ~~authorized representative shall document whether or not the individual~~  
12 ~~has consented. The test for the antibody or antigen to HIV may not be~~  
13 ~~performed on a woman under section 5 or 6 of this chapter if the~~  
14 ~~woman refuses under section 7 of this chapter to consent to the test.~~  
15 ~~refused.~~

16 (b) ~~The~~ If one (1) of the following conditions exists, a test for the  
17 antibody or antigen to HIV may be performed if ~~one (1) of the~~  
18 ~~following conditions exists:~~ regardless of the individual's written  
19 ~~refusal described in subsection (a):~~

20 (1) If ordered by a physician who has obtained a health care  
21 consent under IC 16-36-1 or ~~an implied consent under emergency~~  
22 ~~circumstances~~ and the test is medically necessary to diagnose or  
23 treat the patient's condition.

24 (2) Under a court order based on clear and convincing evidence  
25 of a serious and present health threat to others posed by an  
26 individual. A hearing held under this ~~subsection~~ ~~subdivision~~ shall  
27 be held in camera at the request of the individual.

28 (3) If the test is done on blood collected or tested anonymously as  
29 part of an epidemiologic survey under IC 16-41-2-3 or  
30 IC 16-41-17-10(a)(5).

31 (4) The test is ordered under section 4 of this chapter.



- 1 (5) The test is required or authorized under IC 11-10-3-2.5.
- 2 (6) **The individual upon whom the test will be performed is**
- 3 **described in IC 16-41-8-6 or IC 16-41-10-2.5.**
- 4 (e) (7) A court may order a person **has ordered the individual** to
- 5 undergo testing for HIV under IC 35-38-1-10.5(a) or
- 6 IC 35-38-2-2.3(a)(16).



BILL NUMBER: PD 3175

DATE: Oct. 18, 2011

COMMITTEE: \_\_\_\_\_

AUTHORS/SPONSORS: \_\_\_\_\_

ATTORNEY: \_\_\_\_\_ PHONE # \_\_\_\_\_

AMT #		AMT #		AMT #		COMMITTEE MEMBERS	AMEND			
Yes	No	Yes	No	Yes	No		DO PASS	DO PASS	DO PASS	DO PASS
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
						Sen. Ryan Mishler			✓	
						Sen. Vaneta Becker			✓	
						Sen. Ed Charbonneau			✓	
						Sen. Beverly Gard				
						Sen. Ron Grooms			✓	
						Sen. Jean Leising			✓	
						Sen. Jean Breaux				
						Sen. Earline Rogers				
						Sen. Vi Simpson				
						Rep. Timothy Brown, Vice-Chairperson			✓	
						Rep. Steven Davisson			✓	✓
						Rep. Ronald Bacon			✓	
						Rep. Suzanne Crouch			✓	
						Rep. Richard Dodge			✓	
						Rep. David Frizzell			✓	
						Rep. Donald Lehe			✓	
						Rep. Eric Turner				
						Rep. Charlie Brown				✓
						Rep. John Day			✓	
						Rep. Craig Fry				
						Rep. Scott Reske			✓	
						Rep. Peggy Welch			✓	
						Sen. Patricia Miller, Chairperson			✓	

FINAL VOTE TOTAL  

		15	2
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**PRELIMINARY DRAFT**  
**No. 3278**

**PREPARED BY**  
**LEGISLATIVE SERVICES AGENCY**  
**2012 GENERAL ASSEMBLY**

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**DIGEST**

**Citations Affected:** None (noncode).

**Synopsis:** Brain injury services study and committee. Requires the state department of health (state department) and the office of the secretary of family and social services (office) to study how to implement brain injury services and neurobehavioral rehabilitation programs. Requires the state department and the office to report orally and in writing to the health finance commission before October 1, 2012. Establishes the brain injury treatment committee to assist the state department and the office with the required study.

**Effective:** Upon passage.



A BILL FOR AN ACT concerning health.

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

1           SECTION 1. [EFFECTIVE UPON PASSAGE] (a) The state  
2 department of health and the office of the secretary of family and  
3 social services shall:

4           (1) study the current brain injury services offered in Indiana;

5           and

6           (2) determine:

7               (A) any deficiencies in the services; and

8               (B) how to implement additional brain injury services and  
9               neurobehavioral rehabilitation programs in Indiana.

10          (b) The study described in subsection (a) must include the  
11 following:

12           (1) Development of a licensure category for neurobehavioral  
13 rehabilitation facilities and the criteria to be included for the  
14 license.

15           (2) Assessment of whether incentives are needed to encourage  
16 a person to provide brain injury and neurobehavioral services  
17 in Indiana.

18           (3) Determination of the adequate reimbursement under the  
19 Medicaid program for brain injury and neurobehavioral  
20 services.

21           (4) Determination of whether funds from the Medicaid health  
22 facility closure and conversion fund could be used to assist  
23 qualified service providers in opening a neurobehavioral  
24 rehabilitation facility or to enhance reimbursement for brain  
25 injury or neurobehavioral services in Indiana.

26           (5) Determination of whether existing Medicaid waivers  
27 should be amended to increase the number of individuals  
28 covered under the waiver or the services provided to  
29 individuals with traumatic brain injuries under the waiver,  
30 and the amendments that would be needed.

31          (c) Before October 1, 2012, the state department of health and  
32 the office of the secretary of family and social services shall report



1 orally and in writing to the health finance commission established  
 2 by IC 2-5-23-3 concerning the study conducted under subsection  
 3 (a) and any recommendations resulting from the study.

4 (d) The brain injury treatment committee is established for the  
 5 purpose of assisting the state department of health and the office  
 6 of the secretary of family and social services with the study  
 7 required under this SECTION. The committee consists of the  
 8 following members:

9 (1) The commissioner of the state department of health or the  
 10 commissioner's designee, who should act as chairperson of the  
 11 committee.

12 (2) The director of the office of Medicaid policy and planning,  
 13 or the director's designee.

14 (3) The director of the rehabilitation services bureau within  
 15 the office of the secretary of family and social services, or the  
 16 director's designee.

17 (4) The following members appointed by the governor not  
 18 later than May 1, 2012:

19 (A) One (1) member representing the Brain Injury  
 20 Association of Indiana.

21 (B) Six (6) individuals representing any of the following:

22 (i) Brain injury service providers.

23 (ii) Residential care providers.

24 (iii) Health care providers who have knowledge  
 25 concerning brain injuries.

26 (C) One (1) representative of the rate setting contractor  
 27 used by the office of Medicaid policy and planning.

28 The state department of health shall staff the committee. The  
 29 committee shall meet at least four (4) times at the call of the  
 30 chairperson. The members of the committee are not entitled to per  
 31 diem or reimbursement for expenses incurred in connection with  
 32 the member's committee duties.

33 (e) This SECTION expires December 31, 2012.

34 SECTION 2. An emergency is declared for this act.



BILL NUMBER: PD 3278

DATE: Oct. 18, 2011

COMMITTEE: HFC

AUTHORS/SPONSORS: \_\_\_\_\_

ATTORNEY: \_\_\_\_\_

PHONE # \_\_\_\_\_

AMT # Yes No    AMT # Yes No    AMT # Yes No

COMMITTEE MEMBERS

AMEND  
DO PASS DO PASS  
Yes No    Yes No

Add to comm: ① Dir. of PoA ② Consumer of health services								Sen. Ryan Mishler	✓			
								Sen. Vaneta Becker	✓			
								Sen. Ed Charbonneau	✓			
								Sen. Beverly Gard				
								Sen. Ron Grooms	✓			
								Sen. Jean Leising	✓			
								Sen. Jean Breaux				
								Sen. Earline Rogers				
								Sen. Vi Simpson	✓			
								Rep. Timothy Brown, Vice-Chairperson	✓			
								Rep. Steven Davisson	✓			
								Rep. Ronald Bacon	✓			
								Rep. Suzanne Crouch	✓			
								Rep. Richard Dodge	✓			
								Rep. David Frizzell	✓			
								Rep. Donald Lehe	✓			
								Rep. Eric Turner				
								Rep. Charlie Brown	✓			
							Rep. John Day	✓				
							Rep. Craig Fry					
							Rep. Scott Reske	✓				
							Rep. Peggy Welch	✓				
							Sen. Patricia Miller, Chairperson	✓				

FINAL VOTE TOTAL  

18	0		
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**PRELIMINARY DRAFT**  
**No. 3246**

**PREPARED BY**  
**LEGISLATIVE SERVICES AGENCY**  
**2012 GENERAL ASSEMBLY**

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DIGEST

**Citations Affected:** IC 27-8-32.5; IC 27-13-7-20.1.

**Synopsis:** Coverage for brand name anti-epileptic drugs. Prohibits health insurers from placing specified restrictions on brand name anti-epileptic prescription drugs if the same restrictions are not placed on a generic equivalent anti-epileptic prescription drug.

**Effective:** July 1, 2012.



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

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

1 SECTION 1. IC 27-8-32.5 IS ADDED TO THE INDIANA CODE  
2 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
3 JULY 1, 2012]:

4 **Chapter 32.5. Generic Anti-Epileptic Drug Substitution**

5 **Sec. 1. This chapter applies to a policy of accident and sickness**  
6 **insurance that provides coverage for prescription drugs.**

7 **Sec. 2. As used in this chapter, "insured" means an individual**  
8 **who is entitled to coverage under a policy of accident and sickness**  
9 **insurance.**

10 **Sec. 3. As used in this chapter, "policy of accident and sickness**  
11 **insurance" has the meaning set forth in IC 27-8-5-1.**

12 **Sec. 4. Coverage for a brand name anti-epileptic prescription**  
13 **drug under a policy of accident and sickness insurance may not be**  
14 **subject to dollar limits, copayments, deductibles, prior**  
15 **authorization, or coinsurance provisions that are less favorable to**  
16 **an insured than the dollar limits, copayments, deductibles, prior**  
17 **authorization, or coinsurance provisions that apply to coverage for**  
18 **a generic anti-epileptic prescription drug under the policy of**  
19 **accident and sickness insurance.**

20 SECTION 2. IC 27-13-7-20.1 IS ADDED TO THE INDIANA  
21 CODE AS A NEW SECTION TO READ AS FOLLOWS  
22 [EFFECTIVE JULY 1, 2012]: **Sec. 20.1. (a) This section applies to an**  
23 **individual contract or a group contract that provides coverage for**  
24 **prescription drugs.**

25 **(b) Coverage for a brand name anti-epileptic prescription drug**  
26 **under an individual contract or a group contract may not be**  
27 **subject to dollar limits, copayments, deductibles, prior**  
28 **authorization, or coinsurance provisions that are less favorable to**  
29 **an enrollee than the dollar limits, copayments, deductibles, prior**  
30 **authorization, or coinsurance provisions that apply to coverage for**  
31 **a generic anti-epileptic prescription drug under the individual**



1 **contract or group contract.**



BILL NUMBER: PD 3246

DATE: Oct 18, 2011

COMMITTEE: HFC

AUTHORS/SPONSORS: Coverage for Brand-name Anti-Epile. Drugs

ATTORNEY: \_\_\_\_\_

PHONE # \_\_\_\_\_

AMT # Yes No    AMT # Yes No    AMT # Yes No

COMMITTEE MEMBERS

AMEND  
NO PASS DO PASS  
Yes No Yes No

Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
								Sen. Ryan Mishler	✓			
								Sen. Vaneta Becker	✓			
								Sen. Ed Charbonneau		✓		
								Sen. Beverly Gard				
								Sen. Ron Grooms		✓		
								Sen. Jean Leising		✓		
								Sen. Jean Breaux				
								Sen. Earline Rogers				
								Sen. Vi Simpson	✓			
								Rep. Timothy Brown, Vice-Chairperson		✓		
								Rep. Steven Davisson		✓		
								Rep. Ronald Bacon	✓	✓		
								Rep. Suzanne Crouch	✓			
								Rep. Richard Dodge		✓		
								Rep. David Frizzell		✓		
								Rep. Donald Lehe		✓		
								Rep. Eric Turner				
								Rep. Charlie Brown		✓		
								Rep. John Day	✓			
								Rep. Craig Fry				
								Rep. Scott Reske				
								Rep. Peggy Welch		✓		
								Sen. Patricia Miller, Chairperson	✓			

add state employees

FINAL VOTE TOTAL

6	11		
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FINAL REPORT**Health Finance Commission****I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES**

The Indiana General Assembly enacted legislation (IC 2-5-23) establishing the Health Finance Commission to study health finance in Indiana. The Commission may study any topic: (1) directed by the chairperson of the Commission; (2) assigned by the Legislative Council; or (3) concerning issues that include the delivery, payment, and organization of health services and rules that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government.

The Legislative Council assigned the following additional responsibilities to the Commission for the 2011 interim:

- (1) Possible prohibitions on certain insurer and health maintenance organization activities related to outpatient benefits (SEA 178);
- (2) The credentialing of vendors in hospitals (SEA 199);
- (3) Whether to require a hospital to report to the state department of health the immunization rate for influenza for the individuals who work in the hospital, including employees, staff, and contractors and the manner and format for the report (SEA 366);
- (4) Whether a pharmacist should be required to notify the prescribing physician and inform the patient if the pharmacist selects a drug other than the brand name drug listed on an anti-epileptic drug prescription; and whether a pharmacist should be required to dispense a prescription in a manner to allow label accessibility to an individual who is blind (SB 25);
- (5) Legislation necessary to design, establish, and implement the exchanges for health insurance coverage, including the following:
  - (A) Whether an exchange should be administered by an agency of the state or a nonprofit organization;
  - (B) Any necessary governing structure for an exchange;
  - (C) Authority and responsibilities of an exchange, including procedures for staff hiring and procurement of resources;
  - (D) Responsibilities of state agencies in coordination of activities with an exchange; and
  - (E) Other recommendations determined appropriate by the Health Finance Commission;
- (6) Innovations in nursing home services and housing (SC 11); and
- (7) Enhancing employment and training opportunities for Indiana's citizens with disabilities through studying the feasibility of establishing a non-profit business enterprises preference program for contracting or subcontracting with prime contractors for products and services provided by reviewing and making recommendations of how to maximize employment opportunities through IC

## **II. SUMMARY OF WORK PROGRAM AND TESTIMONY**

The Commission met four times during the 2011 interim: July 13, 2011; September 14, 2011; September 28, 2011; and October 18, 2011. For more detailed information concerning the testimony at a meeting, please see the minutes on the Commission's website: <http://www.in.gov/legislative/interim/committee/hfco.html>

### July 13, 2011

Seema Verma, Indiana Health Care Reform Lead, provided the Commission with an update on Indiana's development of a health care exchange program and other matters involving federal health care reform. The Commission heard from other interested parties concerning the development of a state health insurance exchange.

The Commission also heard testimony on innovations in the nursing home industry. Sister Barbara Ann Zeller told the Commission about Villas of Guerin Woods, which is a nursing home that is modeled after a home setting rather than an institutional setting. Mr. Vince McGowen, Magnolia Health Systems, stated that long term care focus should be on how to improve quality of care and how to keep an individual in the home with home health care. Mr. Christopher Nanni, Community Foundation of St. Joseph County, informed the Commission of a year-long initiative being conducted in South Bend, Indiana, to increase quality elder care through a regional nursing home learning collaborative.

### September 14, 2011

The Commission heard testimony concerning the lack of traumatic brain injury rehabilitative services in Indiana, which forces individuals to seek care in neighboring states.

Dr. Lance Trexler, co-chairperson of the Brain Injury Association of Indiana, told the Commission that a committee led by the Association was developed to gather possible solutions for providing adequate brain injury services in Indiana. The committee determined the following solutions: (1) establishing a licensing category for neuro-behavior rehabilitation facilities administered by the Indiana State Department of Health (ISDH); (2) modifying existing Medicaid waivers and investing in resource facilitative services that improve return to work rates for people with brain injuries; and (3) ensuring quality coordination and cost effectiveness of brain injury services through an oversight committee. Ms. Pat Casanova, Office of Medicaid Policy and Planning (OMPP), stated that the lack of brain injury services is a statewide problem, not just a Medicaid issue. The commission heard testimony from nursing home representatives who stated that increased reimbursement would be needed in order to operate a neuro-behavioral

rehabilitation facility.

The Commission heard testimony on the need to license diabetes educators to encourage growth in the profession and to protect consumers. Commission members questioned individuals on whether licensure was needed or whether certification would be sufficient. Ms. Anne Graves, Director of Health Initiatives, YMCA of Greater Indianapolis, described a five- year program operated by the YMCA for pre-diabetic individuals.

Dr. Elaine Cox, Riley Hospital for Children, informed the Commission that the federal Center for Disease Control (CDC) has recommended an opt out approach for HIV testing, indicating that general consent for medical care should be sufficient to test for HIV. Dr. Madonna Biritwum, Parkview Hospital, advocated for an opt out model that includes a process of informed consent, education, assistance to patients who test positive for HIV or AIDS, and confidentiality for the patient. Mr. Paul Chase, representing himself, expressed concerns with changing the current testing laws. Mr. Brian Carnes, ISDH, testified that services for patients who have tested positive for HIV or AIDS are available through an ISDH-administered federal grant, in which money is allotted to a state based on the state's needs.

The Commission heard testimony concerning the relationship between a pharmacy benefit manager (PBM) and a health care provider. Ms. Heather Macek, Medco, stated that Medco is a PBM that looks for cost savings by switching an individual from a brand name drug to a generic drug. Ms. Macek stated that Medco will contact a provider to inform the provider that a generic is available for the prescription even if the provider had specified "dispense as written" on the prescription. Ms. Macek said that if the provider declines to prescribe the generic drug for the prescription, Medco enters that information into the system to block further requests to the provider for that prescription. Mr. Dederichs, Express Scripts, stated that Express Scripts, which is also a PBM, includes as part of a benefit model design a target for switching individuals from a brand name prescription to a generic drug. Mr. Don Stumpp, Indiana Medical Group Managers Association, testified that physicians often comment on the amount of uncompensated time spent dealing with a PBM concerning benefit issues.

The Commission heard testimony concerning improving employment opportunities for individuals with a disability. Mr. Mike Cruz, CDC Resources, stated that establishing a preference for state contract bids for the approximate 50 statewide companies that provide services to this population is one of the revenue solutions he has identified. Ms. Jill Dunn, President of Bona Vista Programs, asked for a level playing field in bidding for state contracts by providing for this preference. Mr. Jim Hammond, INARF, stated that this preference could be included in the existing state use program.

#### September 28, 2011

The Commission heard testimony concerning a proposal to require generic drug manufacturers to bid to participate in the Medicaid program. Mr. Michael O'Connor, Eli

Lilly and Co., and Professor Mick Kolassa set forth the proposal. Ms. Sarah Jagger, OMPP, described Medicaid's current Maximum Allowable Cost (MAC) drug program and stated that OMPP still has some concerns and questions concerning Professor Kolassa's proposal. Other interested parties expressed concerns with the proposal as well.

Commission members heard testimony concerning whether to require hospitals to: (1) mandate hospital employees to receive the influenza immunization; and (2) report employee influenza immunization rates. Ms. Sarah Strawbridge, Indiana Immunization Coalition, testified that all hospital personnel, including students and medical staff, should be required to get the influenza vaccine and should be recorded by the hospital in the Children and Hoosiers Immunization Registry Program (CHIRP) database. Mr. Tim Kennedy, Indiana Hospital Association, told the Commission that a federal law that goes into effect in 2013 will require hospitals to report employee flu immunization rates to the federal government and stated that a state reporting requirement is unnecessary.

Dr. Thomas Vidic, Elkhart, IN, informed the Commission that the American Academy of Neurology opposes generic substitution of anti-convulsant drugs for treatment of epilepsy without the attending physician's approval. Dr. Steven Maynard stated that seizure medications are only effective under a narrow therapeutic range and that changes in the drug given to a patient with epilepsy impact the individual's care. Ms. Brynna Clark, Indiana Generic Pharmaceutical Association, stated that the Federal Drug Administration (FDA) has reported the efficacy of generic drugs and that substitution is cost effective. Mr. Dave Dederichs, Express Scripts, stated that the existing law prohibiting substitution when the prescription specifies to "dispense as written" is sufficient.

Commission members heard testimony from Representative Craig Fry and other individuals concerning the problem the visually impaired have in reading prescription drug labels and the availability of low cost technology that can assist the visually impaired with this issue. Mr. Grant Monahan stated that his members are reviewing the various technologies available for reliability and cost.

Testimony was provided to the Commission concerning whether Indiana should license and regulate midwifery. Ms. Mary Ann Griffin testified that CPMs are licensed, certified, or registered in 28 states, and that Indiana is one of nine states that prohibit this type of midwifery. Ms. Griffin stated that home birth is safe and referred to the CPM 2000 study which found that home birth for low risk women is just as safe as hospital birth. Dr. Joseph LaRosa testified that the Indiana Section of the American Congress of Obstetricians and Gynecologists (ACOG) does not support lay midwifery. Other physicians testified in opposition to the proposal.

The Commission received testimony on the need to license adult day service facilities. Commission members discussed whether the issue of licensure was still in the

development stage and may need more time before legislation is considered.

October 18, 2011

INSERT AFTER MEETING

### **III. COMMITTEE ACTION**

The Commission took the following action:

INSERT PDs/FINAL REPORT votes

## WITNESS LIST

Linda Barton-Kirch, RN, CNM  
Doug Beebe, Co-Chairperson of the Brain Injury Association of Indiana  
Dr. Madonna Biritwum, Parkview Hospital  
Elena Butkus, Director of Government Relations, Mid-America Region, Aetna  
John Cardwell, Generations Project  
Brian Carnes, ISDH  
Pat Casanova, OMPP, FSSA  
Zach Cattell, IHCA  
Georg'ann Cattelona, Director of Bloomington Area Birth Services  
Paul Chase, AARP, self  
Libby Cierzniak, Delta Dental, YMCA  
Brynna Clark, Generic Pharmaceutical Association  
Dr. Elaine Cox, Riley Hospital for Children  
Mike Cruz, CDC Resources, Inc.  
Heidi Curtis  
Heather Dane  
Dave Dederichs, Express Scripts  
Anne Doran, Eli Lilly and Co.  
Jill Dunn, Bona Vista Programs  
Michael DuValle, IDOA  
Anne Graves, Director of Health Initiatives, YMCA of Greater Indianapolis  
Dr. Charlene Graves, Indiana Chapter of the American Academy of Pediatrics  
Shannon Greika  
Mary Ann Griffin, CPM  
Jim Hammond, INARF  
Dr. Lindsay Harmon, Emergency Room Physician  
Charlie Hiltunen, Indiana Minority Health Coalition  
Julia Holloway, DDRS, FSSA  
June Holt, Consumer  
Dr. Maria Del Rio Hoover  
John Huffman, American Council of the Blind of Indiana  
Joyce Irwin, Roche Diagnostics  
Sarah Jagger, OMPP  
Susan Jones  
Tim Kennedy, IHA  
Mick Kolassa, MME, LLC  
Dr. John Labban, Bloomington, IN  
Dennis Lanane, President, United Senior Action of Indiana  
Dr. Joseph LaRosa  
Jim Leich, IAHS  
Heather Macek, Medco  
Lee Martin  
Dr. Steven Maynard, Terre Haute, IN  
Vince McGowen, Magnolia Health Systems

Tina McIntosh, Indiana Association of Adult Day Services  
David Miller, Certified Diabetes Educator  
Grant Monahan, Indiana Retail Council  
Christopher Nanni, V.P. of Programming, Community Foundation of St. Joseph County  
Dennis Neary, IHCA  
Michael O'Connor, Eli Lilly and Co.  
Doris Parlette, consumer  
Vicki Perry, Advantage Health Solutions  
Michelle Rice, National Hemophiliac Foundation  
Mark Richert, American Foundation for the Blind  
Mike Rinebold, Indiana State Medical Association  
Rylin Rogers, Indiana Chapter of the American Academy of Pediatrics  
Geoff Sandler, Senior Actuary, Aetna  
George Schaffer, consumer  
Dr. Rhonda Sharp  
Glenna Shelby, ISNA  
Kim Smith, Indiana Association of Adult Day Services  
James Specker, American Association of Diabetes Educators  
Robert Spolyar, CVS/Caremark  
Sarah Strawbridge, Indiana Immunization Coalition  
Don Stumpp, Indiana Medical Group Manager's Association  
Mary Teipen, Certified Diabetes Educator  
Dr. Lance Trexler, Co-Chairperson of the Brain Injury Association of Indiana  
Seema Verma, Indiana Health Care Reform Lead  
Dr. Thomas Vidic, Elkhart, IN  
Sister Barbara Ann Zeller, President/CEO Villas of Guerin Woods



# Trends in health

*Data shows Americans increasingly turning to other options*

80% of internet users look for health information online.<sup>1</sup>

**3** out of **4**

U.S. health care workers use some form of complementary or alternative medicine to help stay healthy.<sup>2</sup>



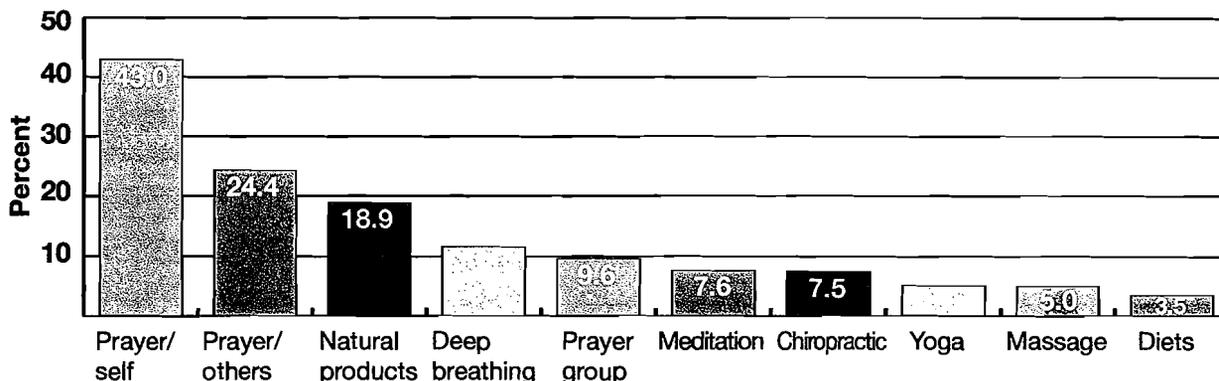
**40%**

of Americans spend

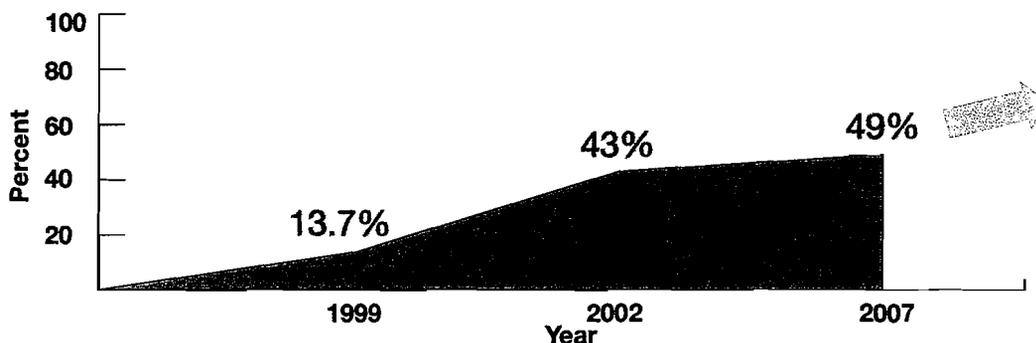


on complementary or alternative health.<sup>3</sup>

## 10 most common complementary and alternative medicine therapies of 2002<sup>4</sup>



## Usage of prayer for health concerns is increasing<sup>5</sup>



\*\$34 billion in out of pocket expenses.

<sup>1</sup>Source: Pew Internet, Pew Internet & American Life Project, a project of the Pew Research Center, February 1, 2011: Health Topics: 80% of internet users look for health information online by Susannah Fox, Associate Director. [Link: http://pewinternet.org/Reports/2011/HealthTopics.aspx](http://pewinternet.org/Reports/2011/HealthTopics.aspx)

<sup>2</sup>Source: Health Services Research 10-0587: *Personal Use of Complementary and Alternative Medicine (CAM) by U.S. Healthcare Workers* by Pamela Jo Johnson, MPH, PhD (corresponding author) Center for Healthcare Innovation Allina Hospitals & Clinics; Andrew Ward, MPH, PhD Division of Health Policy & Management University of Minnesota; Lori Krumson, RN, BSN, HN-BC Penny George Institute for Health & Healing Allina Hospitals & Clinics; Sue Sendelbach, PhD, RN, CCNS, FAHA Abbott Northwestern Hospital Allina Hospitals & Clinics. [Link: http://www.cfah.org/hbns/archives/viewSupportDoc.cfm?supportingDocID=1037](http://www.cfah.org/hbns/archives/viewSupportDoc.cfm?supportingDocID=1037)

<sup>3</sup>Source: National Health Statistics Reports, Number 18, July 30, 2009: *Costs of Complementary and Alternative Medicine (CAM) and Frequency of Visits to CAM Practitioners: United States, 2007* by Richard L. Nahin, Ph.D., M.P.H., National Institutes of Health; Patricia M. Barnes, M.A.; Barbara J. Sussman, B.A.; and Barbara Bloom, M.P.A., Division of Health Interview Statistics. [Link: http://nccam.nih.gov/news/camstats/costs/nhsrn18.pdf](http://nccam.nih.gov/news/camstats/costs/nhsrn18.pdf)

<sup>4</sup>Source: National Center for Complementary and Alternative Medicine, NIH, DDHHS, May 27, 2004: *Complementary Alternative Medicine (CAM) Use Among Adults: United States, 2002*. Barnes P, Powell-Griner E, McFann K, Nahin R. CDC Advance Data Report #343. [Link: http://nccam.nih.gov/news/camstats/2002/graphics2002.htm](http://nccam.nih.gov/news/camstats/2002/graphics2002.htm)

<sup>5</sup>Source: American Psychological Association 2011. *Psychology of Religion and Spirituality 2011*, Vol. 3, No. 2, 67-77. 1941-1022/11, DOI:10.1037/a0021598: *National Trends in Prayer Use as a Coping Mechanism for Health Concerns: Changes From 2002 to 2007* by Amy Wachholtz, University of Massachusetts Medical School; and Usha Sambamoorthi, West Virginia University and Morehouse School of Medicine. [Link: http://www.apa.org/pubs/journals/releases/rel-3-2-67.pdf](http://www.apa.org/pubs/journals/releases/rel-3-2-67.pdf)