

Members

Sen. Patricia Miller, Chairperson
Sen. Ryan Mishler
Sen. Brandt Hershman
Sen. Jean Breaux
Sen. Vi Simpson
Sen. Earline Rogers
Rep. Timothy Brown
Rep. Suzanne Crouch
Rep. Don Lehe
Rep. William Crawford
Rep. Charlie Brown
Rep. Peggy Welch



SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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Authority: IC 2-5-26

MEETING MINUTES¹

Meeting Date: October 18, 2011
Meeting Time: 2:00 P.M.
Meeting Place: State House, 200 W. Washington St.,
Senate Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 3

Members Present: Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Brandt Hershman; Sen. Jean Breaux; Sen. Vi Simpson; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Don Lehe; Rep. William Crawford; Rep. Charlie Brown; Rep. Peggy Welch.

Members Absent: Sen. Earline Rogers.

The third and final meeting of the Select Joint Commission on Medicaid Oversight was called to order by Senator Patricia Miller, Chairperson, at 2:05 PM.

I. Report on Access to Mental Health Drugs (See Exhibit A)

Sarah Jagger, Director of Policy, Office of Medicaid Policy and Planning (OMPP)

Ms. Jagger reviewed the membership of the Mental Health Quality Advisory Committee (MHQAC), the entity that assists OMPP with quality oversight. She reported on the areas of the program selected for examination; appropriate use of antipsychotic medications in children and adolescents, drug utilization edits for new drug products, the review of prior authorization (PA) statistics, and implementation of PA for brand medically necessary mental health drugs. Commission questions and discussion followed with regard to dispensing practices for prescriptions written as "brand medically-necessary", generic substitution, and the prior authorization process. (See the slide presentation at Exhibit A.)

¹ 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.

II. Reports on Denial of Behavioral Health Claims

John Barth, MHS

Mr. Barth reported that MHS is compliant with contract requirements across all measures. He added that denials for behavioral health claims were usually associated with professional claims and attributed to small providers that tend to have less Medicaid billing expertise. He added that one community mental health center had experienced billing problems and held claims which were later allowed to be submitted for reimbursement. In response to a Commission question concerning the ability to track complaints from patients regarding lengthy waits for appointments, Mr. Barth stated that MHS audits 100% of its providers to ensure that patients get appointments within a defined time frame. That data indicates that delayed access is not a problem for MHS.

Katherine Wentworth, Chief Operating Officer, Mdwise (See Exhibit B)

Ms. Wentworth commented that Mdwise denial rates for claims were below the level required by the contract. She explained that reported denial percentages are related to the first time the claim is submitted - the denial percentage is not an indicator of the ultimate disposition of the claims. Ms. Wentworth said that behavioral health claims tend to have higher rates of initial claims denials since the behavioral services providers are generally smaller billing entities, are more likely to submit paper claims, and have more turnover in billing staff leading to less familiarity with the process. In addition, she stated that three large behavioral health providers changed their billing systems during the period reported, an action that usually results in higher numbers of claims with errors during initial implementation. She further stated that Mdwise had changed system edits to allow bundling of claims and to result in fewer denials. In response to a Commission question regarding generic substitution, Ms. Wentworth clarified that managed care organizations (MCOs) no longer process pharmacy benefits.

Minga Williams, Anthem (See Exhibit C)

Ms. Williams stated that Anthem claims denials were below contract benchmarks for facility and professional claims. She added that Anthem tracks claims denial trends to identify opportunities to educate providers or to identify when system edits should be adjusted to reduce the number of denials.

Trish Hunter, HP

Ms. Hunter reported that HP had no particular issues with regard to behavioral health care claims.

III. Report on Hospital Assessment Fee

Paul Bowling, CFO, FSSA

Mr. Bowling reviewed the current hospital assessment fee proposal, actions taken over the last four months, and the projected aggregate hospital reimbursement increase. (See slide presentation at Exhibit D.) Commission questions followed with regard to the availability of the model, specific details of the assessment, and details concerning the State Plan Amendment

(SPA) submission process. Mr. Bowling stated that the Indiana Hospital Association (IHA) had developed the model and described the process and time line for submission of a State Medicaid Plan amendment.

Tim Kennedy, Indiana Hospital Association

Mr. Kennedy thanked FSSA staff for their assistance and described the process taken by the IHA. The IHA hospital assessment task force is comprised of chief financial officers representing a cross-section of hospitals in the state. Mr. Kennedy emphasized that the hospital assessment fee is at the end of the beginning of the project. Everyone wants to see the numbers, but that is premature since the Centers for Medicare and Medicaid Services (CMS) decisions will probably result in changes to the numbers that were initially submitted. Mr. Kennedy reviewed a few major points of the submitted SPA; the fee would be based on patient days and adjusted outpatient days for the Disproportionate Share Hospital program (DSH), the fee would substitute for intergovernmental transfers (IGT) currently being done, and hospital reimbursement for Medicaid services would increase to the Medicare level. He emphasized that the increased payments would be available to all hospitals - not just to DSH-eligible hospitals. He discussed the issues of reimbursement for Medicare/Medicaid dual eligibles and MCO rates that will need to be adjusted. He emphasized that nothing is certain or set right now. Mr. Kennedy responded to Commission questions addressing the issue of winners and losers. He stated that in the current model, 15 of 130 total facilities would be net contributors and that the affected facilities were aware of their status in the submitted SPA. Mr. Kennedy explained that similar to the Quality Assessment Fee on nursing facilities, all hospitals must be subject to the fee. Details within the model factor in the needs of vulnerable providers such as substance abuse treatment providers and have stair-stepped the fee by the provider's rate of Medicaid usage. In response to additional Commission questions for detail, he reiterated that nothing is certain at this point in time; there are more details to be worked out in a complicated program.

IV. Consideration of draft legislation & Final Report

PD 3225 - Cash Assistance Point of Service and Drug Reports

Senator Miller introduced PD 3225 (See Exhibit E) and asked Ms. Susie Howard, FSSA, to discuss the content. Ms. Howard stated that the PD would define adult entertainment establishments and add them to the list of venues with automated teller machines that may not be used to receive cash assistance benefits under the Title IV-A assistance program. She added that the PD also changes the frequency of a report concerning the preferred drug list (PDL) from two times each year to once annually. Commission discussion followed with regard to how much of a problem existed with welfare benefits being withdrawn from automated teller machines or point-of-sale terminals located in adult entertainment venues. Ms. Howard replied that the extent to which this activity occurs is not known, but that the PD adds this type of establishment to an existing list of similar kinds of venues. Senator Miller advised the members of the Commission that a minimum of seven votes are needed to move an issue out of the Commission.

Upon proper motion and second, the Commission voted 9-1 to recommend PD 3225.

PD 3260 Voiding of Certain Medicaid Rules

Senator Simpson introduced PD 3260 (See Exhibit F) and discussed the expansion of emergency rule-making authority that the legislature enacted in the budget bill during the 2011

session. She explained that the PD would void emergency rules promulgated since July 1, 2011, that reduce reimbursement to several provider groups and eliminate the changes made to the emergency rule-making authority enacted in HEA 1001-2011. Commission discussion followed with regard to what the draft would actually do and the impact on the emergency rules promulgated in July. Casey Kline, Commission Attorney, clarified that revisions made in the budget bill allow the emergency rule-making authority to be used more broadly and allow an emergency rule to remain in effect for an indefinite period of time as opposed to the 90-day limit normally imposed on emergency rules.

Ms. Kristina Moorhead, Policy Director, OMPP, testified that the fiscal impact of voiding the emergency rules would be approximately \$25.3 M in state Medicaid expenditures. Mr. Jim Zieba, Indiana Optometric Association, commented on the speed that rules were effective and the fact that the OMPP could not answer questions with regard to rules that were effective the next day. Mr. Bill Cowan, Indiana Pharmacy Alliance, stated that although the rules in question were limited to two years, an emergency rule can now stay in place forever - they do not necessarily need to have an expiration date. Mr. Ed Popcheff, Indiana Dental Association also stated that the emergency rules could be permanent. Ms. Howard, FSSA, commented that the emergency rule-making authority granted to FSSA in HEA 1001-2011, is not unique to the agency - other state agencies also have this authority. Commission discussion continued with concerns expressed about the arbitrary nature of the emergency rule-making process, the ability to maintain access to necessary services, as well as the source of fiscal impact information.

Upon proper motion and second to recommend PD 3260, the Commission vote was 4-6 against recommendation of the PD.

Final Report

Upon proper motion and second, the Commission voted 7-0 to approve the draft final report, to be amended to include information provided at the October 18, 2011, Commission meeting.

V. Medicaid Spend-Down Issues

Sarah Jagger, Director of Policy, OMPP

Ms. Jagger reviewed the spend-down program explaining that the spend-down of income in excess of the Social Security disability (SSD) level by the Aged Blind and Disabled eligibility group is required by federal law as a result of the state's decision to retain a more restrictive definition of disability than that used by Social Security Disability. Referred to as 209(b) status, Indiana is one of 11 states that does not use the more lenient Social Security definition of disability to determine Medicaid eligibility status. Most states use the option of accepting the Social Security definition of disability to determine eligibility for their Medicaid programs. This option is referred to as 1634 status. SEA 461-2011 allows the FSSA to transition the Medicaid program to 1634 status, effective with the implementation of federal health care reform on January 1, 2014.

Ms. Jagger explained that the constituent questions the Commission members were hearing related to spend-down and not to Medicaid copayments. The issue is that most providers, with the exception of pharmacies, cannot know what the Medicaid member's spend-down status is at the time of service. If services are provided while the member is in spend-down status, then the provider must later collect payment from the member who may be unable to pay. Once the spend-down is met, the patient becomes eligible for Medicaid for the remainder of the month.

Ms. Jagger reviewed the adjudication process that spend-down claims go through each month before a member may be determined to be eligible for Medicaid services (See Exhibit G for the slide presentation.)

Ms. Jagger also distributed written answers to Commission questions asked at the previous Commission meeting of September 14, 2011. (See Exhibit H.)

Commission questions followed regarding how a provider would know if a member has met the spend-down for the month and is eligible for Medicaid reimbursement or if payment should be collected at the time of service. Senator Simpson noted that from the patient's perspective, even though the system is now automated they receive notification of their status after the close of the month - they still must keep track of bills that have been submitted during the month to determine if and/or when the spend-down has been met. Commission discussion followed concerning eliminating spend-down before January 1, 2014. Ms. Jagger explained that it is unlikely that OMPP will address the spend-down problem in the interim period before the January 1, 2014, implementation date of federal healthcare reform Medicaid expansion provisions.

Representative Ron Bacon testified that as the vice-president and CEO of 3-M Medical Home Healthcare the spend-down program was a problem. He explained that his business checks the eligibility and spend-down status of the Medicaid recipient at the time of service and dispenses the product. Medicaid is billed for the product after which they may receive payment or be advised how much should be collected from the patient. He stated that 75% of the time they are unable to collect anything from the recipient and that often they cannot find the recipient. He clarified that collecting spend-down is more of a problem with younger individuals than with elderly patients. Rep. Bacon stated that for privately insured individuals, copayments and deductibles can be collected up front. Pharmacies are allowed to collect up front from Medicaid, but other providers are not. He asked where in the law is it stated that the provider cannot collect the spend-down before services or products are delivered?

Mr. Ed Popchef, Indiana Dental Association, stated that inability to collect spend-down is causing some dentists to close their patient panels. He commented that oral surgeons and other specialists who have short-term relationships with patients have particular problems being paid for their services - reporting that 90% of spend-down patients do not pay. This is a tipping point for providers to discontinue accepting Medicaid patients.

Commission discussion followed regarding the policy that prevents the providers from collecting up front from patients. The policy provides protection for the patients, but may ultimately eliminate access to needed services if the providers cannot collect what the patients owe. Ms. Jagger stated that prohibiting providers from collecting at the time of service is an agency policy; there is no direct law. She explained that due to a pharmaceutical industry technology initiative, pharmacy claims are adjudicated in real-time so the spend-down member's status can be known at the point of sale. She added that this is a technology issue that would be expensive for other providers and the state to implement. Members of the Commission expressed interest in what would be necessary to add the technology to allow all providers access to the same kind of information.

There being no further business to conduct, Senator Miller thanked the Commission members for their service during the interim session. The meeting was adjourned at 4:25 PM.



MEDICAID ACCESS TO MENTAL HEALTH DRUGS

October 18, 2011

Select Joint Commission on Medicaid Oversight

Office of Medicaid Policy and Planning



Exhibit A
Selection Joint Commission on
Medicaid Oversight
Meeting #3 October 18, 2011



Collaborative Quality Oversight

OMPP and the Mental Health Quality Advisory Committee (MHQAC)

- Appropriate use of antipsychotic medications in children and adolescents
- Prescriber outreach and education
- MHQAC utilization edit changes
- Prior Authorization (PA) statistics
- Implementation of PA requirements for brand medically necessary mental health drug prescriptions



Appropriate use of antipsychotic medications in children and adolescents

Directed Medicaid Medical Advisory Cabinet (MMAC) to update past national study which examined the use of antipsychotics in children and adolescents and to focus research on Indiana Medicaid specific data.

- Initial study published in 2010 by Rutgers in collaboration with the Medicaid Medical Directors Learning Network (2004 – 2007)
- Key findings suggest improving pediatric mental health treatment and outcomes in Medicaid have the potential for considerable public health impact, such as:
 - % of the pediatric FFS population receiving antipsychotic medications
 - Outlier utilization in specific populations (e.g., foster children)
 - Changes in utilization trends in the Medicaid population
 - Utilization patterns in Indiana Medicaid as compared to other State programs.



Appropriate use of antipsychotic medications in children and adolescents

- MMAC will incorporate changes to the Indiana Medicaid program and additional data specific to Indiana:
 - Addition of quality edits (2007)
 - Implementation of utilization edits & quantity limits (2007)
 - Implementation of Smart PA (2009)
 - Consolidation of Medicaid Pharmacy Benefit (2010)
- Intent of study is to:
 - Translate national study results to Indiana specific experience and data.
 - Gain clearer understanding of Indiana Medicaid population to inform future policy.
 - Improved prescribing guidelines
 - Reduction in adverse patient events
 - Reduction in overutilization, waste and Medicaid expenditures
 - Improved health outcomes



Prescriber outreach and education

- Recommended to the Drug Utilization Review (DUR) Board a Retrospective Drug Utilization Review (RetroDUR) focusing on the appropriate use of antipsychotic medication in children and adolescents.
 - RetroDUR is federally required educational intervention to prescribers.
 - The DUR Board directed the adoption of the RetroDUR and execution will occur over the next 18 months.
- The expected outcomes of the RetroDUR are:
 - improved prescribing,
 - appropriate utilization and
 - positive treatment outcomes.



MHQAC utilization edit changes

- Utilization edits are policies to establish appropriate utilization standards.
- Development of utilization edits are part of the duties assigned to the MHQAC.
- Five new utilization edits have been developed by clinical experts to address new drug products.
- Edits will be considered for approval by MHQAC and DUR board in October.



Prior Authorization (PA) statistics

- PA statistics are reviewed in order to:
 - measure the impact and effectiveness of the MHQAC edits.
 - identify potential issues or burdens to providers or members.
- Statistics covering the period of January - June 2011 are being compiled and will be presented to the MHQAC at the October meeting.
- PA statistics are presented every 6 months.



Implementation of PA requirements for brand medically necessary mental health drug prescriptions

- Budget bill (Sec. 145) allowed PA for a prescriber's indication of "brand medically necessary" for generically equivalent drug products for brand name drug products within the mental health drug classes.
 - This change :
 - Allows the State to encourage the use of generic mental health drug products which would result in a cost savings to the State.
 - Ensures that members have access to brand name drugs when it is determined to be medically necessary.
- Implemented July 1, 2011 with minimal member or provider complaints for mental health medications. In the first two months following implementation:
 - 150 PA requests were made for brand medically necessary drugs with a mental health indication.
 - The PA denial rate for these requests was 6%.



QUESTIONS?

MDwise Behavioral Health Claims

Presented to the Select Joint Committee on Medicaid Oversight - October 18, 2011

Summary of MDwise Behavioral Health Claims denials

- From January – June 2010, MDwise Behavioral Health Claims denials were well below the State targeted level of 15% with facility claims (UB-04) denials at 10% and Professional Claims (CMS 1500) at 6%. MDwise's successful denial rates are the result of the MDwise Provider Relations Team work with the Behavioral Health Community across the State.
- MDwise's top 3 behavioral health denial reasons were:
 - 1) Duplicate claim / service
 - 2) Non-covered charges
 - 3) Benefit maximum for this time period or occurrence has been reached

Factors to consider in reviewing these denials:

- The total number of behavioral health claims is significantly smaller than the number of medical claims submitted so even a small number of denials can affect the denial rate.
- Behavioral health (BH) provider offices tend to be small and more likely to operate with a paper billing system. This results in a high portion of claims being submitted through a manual process, which can lead to a higher rate of error.
- Particular issues in 2011:
 - During this reporting time, three of the State's largest BH providers, who are contracted with MDwise, installed new claims systems: It is not unusual for a higher rate of denials during a billing system implementation. MDwise Provider Relations team worked closely with these providers' staffs to resolve the implementation issues as quickly as possible.
 - The new NCCI edits also affected many behavioral health providers, especially the bundling edits. Because these edits are not mandated for the MCEs, MDwise has recently made changes to our edits which will now allow some of these claims to pay. We focused these changes to encourage the integrated care model and certain services we believe will increase quality, such as medication management and group or family therapy provided on the same day as another service.
- MDwise would like to note that we work very closely with the behavioral health community across Indiana to ensure that many denied claims are then corrected and resubmitted for payment. Our Provider Relations staff keeps an ear to the issues out in the field and where possible, we personally assist our providers to help them get paid for their services to our members. We hear mainly positive feedback from behavioral health providers regarding our responsiveness to their provider claims issues.

Behavioral Health Claims Performance Update



**Exhibit C
Selection Joint Commission on
Medicaid Oversight
Meeting #3 October 18, 2011**

Anthem Claims Payment Timeliness – Behavioral Health April 2011-June 2011

	Facility Claims* (UB-04)	Professional Claims** (CMS 1500)
% Paper Claims Paid Within 30 Days	98.67%	98.11%
% Electronic Claims Paid Within 21 Days	98.42%	99.36%
% Denied	18.05%	14.51%

*A facility claim is one billed on a UB-04 / CMS-1450 claim form by institutional providers including hospitals, skilled nursing facilities and home health care providers.

**A professional claim is one billed on a CMS-1500 claim form by physicians and professional services providers including physical, occupational and speech therapists. Specific ancillary providers are also to use this claim form.

Top 10 Claims Denial Reasons – Behavioral Health

April 2011- June 2011

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Pricing or benefit issue	1. NPI attestation needed
2. Duplicate charges paid	2. Pricing or benefit issue
3. Non-contracted provider, no authorization	3. Duplicate charges paid
4. No response to COB questionnaire	4. Non-contracted provider, no authorization
5. Not an eligible member on date of service	5. Not an eligible member on date of service
6. Duplicate claim	6. Member covered by other plan
7. Invalid POA indicator request	7. Not a covered service
8. Claim submitted after filing limit	8. Claim submitted after filing limit
9. NPI attestation needed	9. No response to COB questionnaire
10. Member covered by other plan	10. Duplicate claim

Anthem Claims Payment Timeliness – Behavioral Health July-August 2011

	Facility Claims* (UB-04)	Professional Claims** (CMS 1500)
% Paper Claims Paid Within 30 Days	98.67%	99%
% Electronic Claims Paid Within 21 Days	99%	100%
% Denied	14%	10%

*A facility claim is one billed on a UB-04 / CMS-1450 claim form by institutional providers including hospitals, skilled nursing facilities and home health care providers.

**A professional claim is one billed on a CMS-1500 claim form by physicians and professional services providers including physical, occupational and speech therapists. Specific ancillary providers are also to use this claim form.

Top Claims Denial Reasons – Behavioral Health July-August 2011

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Not a covered expense	1. Not a covered expense
2. Duplicate of a previously adjudicated claim charges paid	2. Submitted untimely
3. Submitted untimely	3. Duplicate of a previously adjudicated claim
4. Non participating provider	4. Provider not attested with State
5. Other carrier payment exceeds allowable	5. Non participating provder



Hospital Assessment Fee

Select Joint Commission on Medicaid Oversight

October 18, 2011



Exhibit D
Selection Joint Commission on
Medicaid Oversight
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Hospital Assessment Fee Current Proposal

- Effective two years: July 1, 2011—June 30, 2013
- Medicaid hospital reimbursement increased
 - To a level that “in the aggregate, will result in payments equivalent to that level of reimbursement that would be paid under federal Medicare payment principles”
 - Applied to both fee for service and managed care payments
- Collection of fee is predicted upon federal approval of enhanced payments to hospitals
- Fees will be collected through an offset to a hospital’s Medicaid payments throughout the year similar to the current Quality Assessment Fee (QAF) for nursing facilities.

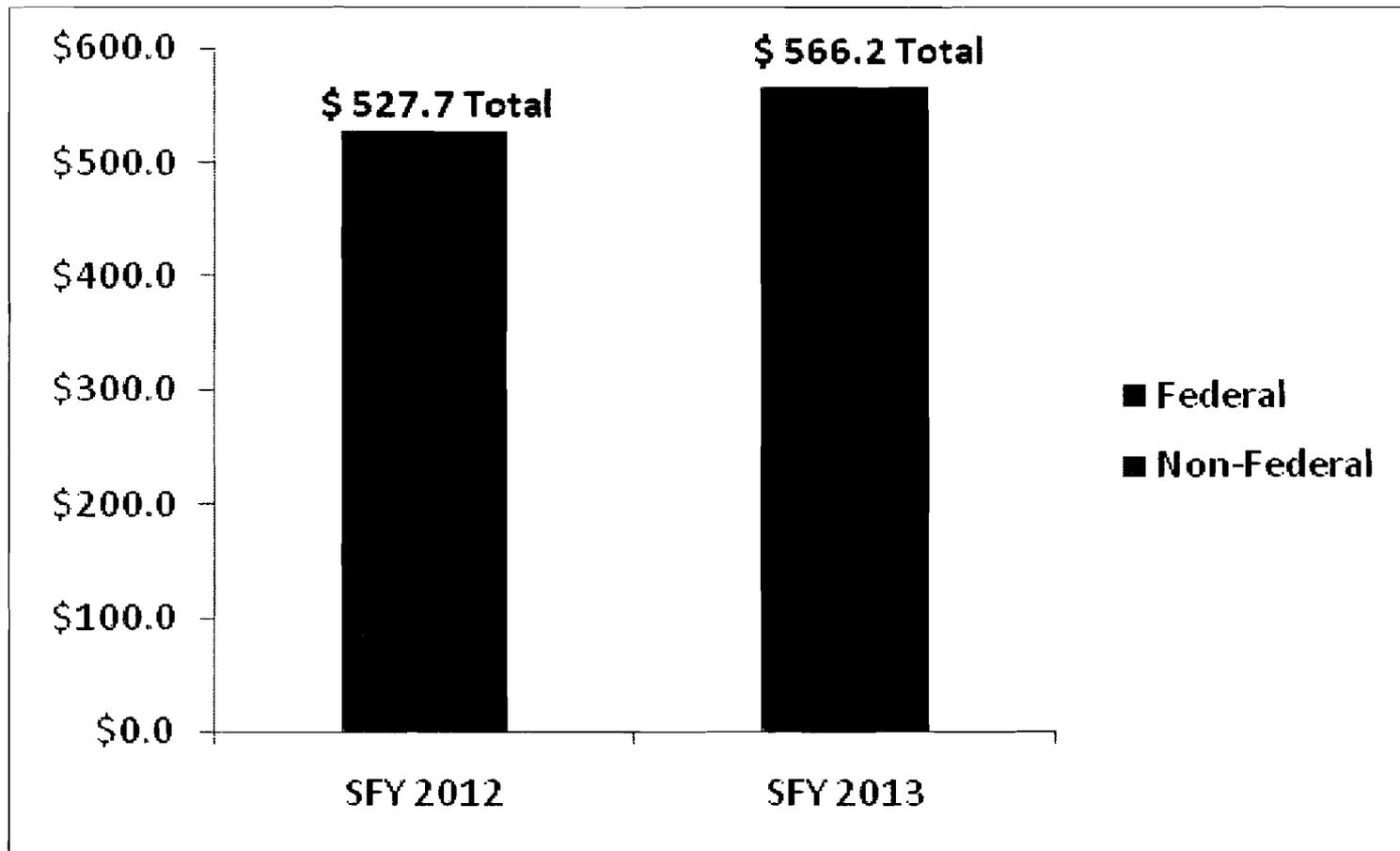


Hospital Assessment Fee Current Proposal

- Funds collected from fees will be used to support:
 - Enhanced payments
 - State share DSH payments
 - Additional revenue to the state for general Medicaid costs
- Hospitals will continue to receive Disproportionate Share (DSH) payments during the assessment fee period based on the determination and distribution methodology developed by the Hospital Association.



Hospital Assessment Fee Projected Managed Care Hospital Reimbursement Increase





Timeline of Actions to Date

- Over the last four months the Indiana Hospital Association worked to develop a model for a Hospital Assessment Fee
- As required in Section 281 of HEA 1001 the following actions have been completed:
 - July 28: FSSA submitted written report to State Budget Committee
 - September 28: Hospital Assessment Fee Committee reviewed & approved all state plan and waiver documents
 - September 30: FSSA submitted written report to State Budget Committee
 - September 30: FSSA submitted state plan amendment and waiver documents to CMS
- FSSA will notify State Budget Committee and the Hospital Assessment Fee Committee of CMS' decision on the state plan amendment and waiver



QUESTIONS?



PRELIMINARY DRAFT
No. 3225

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2012 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 12-7-2-1.8; IC 12-13-14-4.5; IC 12-15-35-28.

Synopsis: Cash assistance point of service and drug reports. Prohibits the distribution of cash assistance benefits at a point of sale terminal that is located on the premises of an adult entertainment establishment. Requires the drug utilization review board to prepare and submit a preferred drug list report to the select joint commission on Medicaid oversight one time per year. (Current law requires the report twice a year.)

Effective: July 1, 2012.



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 12-7-2-1.8 IS ADDED TO THE INDIANA CODE
2 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2012]: **Sec. 1.8. "Adult entertainment establishment", for**
4 **purposes of IC 12-13-14-4.5, means a place that provides**
5 **adult-oriented entertainment in which performers disrobe or**
6 **perform in an unclothed state for entertainment.**

7 SECTION 2. IC 12-13-14-4.5, AS AMENDED BY P.L.91-2006,
8 SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
9 JULY 1, 2012]: Sec. 4.5. (a) Except as provided in this section, the
10 division may distribute cash assistance benefits to a person who is
11 eligible for assistance under the Title IV-A assistance program through
12 an automated teller machine or a point of sale terminal that is
13 connected to the EBT system.

14 (b) The division may approve or deny participation in the EBT
15 system by a retailer that is not a food retailer.

16 (c) The division may not approve participation by a retailer or
17 financial institution in the EBT system for distribution of cash
18 assistance under the Title IV-A assistance program through an
19 automated teller machine or a point of sale terminal located on the
20 premises of any of the following:

21 (1) A horse racing establishment:

22 (A) where the pari-mutuel system of wagering is authorized;
23 and

24 (B) for which a permit is required under IC 4-31-5.

25 (2) A satellite facility:

26 (A) where wagering on horse racing is conducted; and

27 (B) for which a license is required under IC 4-31-5.5.

28 (3) An allowable event required to be licensed by the Indiana
29 gaming commission under IC 4-32.2.

30 (4) A riverboat or other facility required to be licensed by the
31 Indiana gaming commission under IC 4-33.



- 1 (5) A store or other establishment:
 2 (A) where the primary business is the sale of firearms (as
 3 defined in IC 35-47-1-5); and
 4 (B) that sells handguns for which a license to sell handguns is
 5 required under IC 35-47-2.
 6 (6) A store or other establishment where the primary business is
 7 the sale of alcoholic beverages for which a permit is required
 8 under IC 7.1-3.
 9 (7) **An adult entertainment establishment.**
 10 (d) An establishment described in subsection (c)(1) through ~~(c)(6)~~
 11 **(c)(7)** shall post a sign next to each automated teller machine or point
 12 of sale terminal located in the establishment informing a potential user
 13 that the automated teller machine or point of sale terminal may not be
 14 used to receive cash assistance benefits under the Title IV-A assistance
 15 program.
 16 (e) An:
 17 (1) establishment that does not post the sign required under
 18 subsection (d); or
 19 (2) individual who attempts to use an automated teller machine or
 20 point of sale terminal **with a sign posted as required under**
 21 **subsection (d)** to access cash assistance benefits under the Title
 22 IV-A assistance program; ~~in violation of subsection (d);~~
 23 commits a Class C misdemeanor.
 24 (f) The division shall adopt rules under IC 4-22-2 to carry out this
 25 section.

26 SECTION 3. IC 12-15-35-28, AS AMENDED BY P.L.101-2005,
 27 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 28 JULY 1, 2012]: Sec. 28. (a) The board has the following duties:

- 29 (1) The adoption of rules to carry out this chapter, in accordance
 30 with the provisions of IC 4-22-2 and subject to any office
 31 approval that is required by the federal Omnibus Budget
 32 Reconciliation Act of 1990 under Public Law 101-508 and its
 33 implementing regulations.
 34 (2) The implementation of a Medicaid retrospective and
 35 prospective DUR program as outlined in this chapter, including
 36 the approval of software programs to be used by the pharmacist
 37 for prospective DUR and recommendations concerning the
 38 provisions of the contractual agreement between the state and any
 39 other entity that will be processing and reviewing Medicaid drug
 40 claims and profiles for the DUR program under this chapter.
 41 (3) The development and application of the predetermined criteria
 42 and standards for appropriate prescribing to be used in
 43 retrospective and prospective DUR to ensure that such criteria
 44 and standards for appropriate prescribing are based on the
 45 compendia and developed with professional input with provisions
 46 for timely revisions and assessments as necessary.



- 1 (4) The development, selection, application, and assessment of
- 2 interventions for physicians, pharmacists, and patients that are
- 3 educational and not punitive in nature.
- 4 (5) The publication of an annual report that must be subject to
- 5 public comment before issuance to the federal Department of
- 6 Health and Human Services and to the Indiana legislative council
- 7 by December 1 of each year. The report issued to the legislative
- 8 council must be in an electronic format under IC 5-14-6.
- 9 (6) The development of a working agreement for the board to
- 10 clarify the areas of responsibility with related boards or agencies,
- 11 including the following:
- 12 (A) The Indiana board of pharmacy.
- 13 (B) The medical licensing board of Indiana.
- 14 (C) The SURS staff.
- 15 (7) The establishment of a grievance and appeals process for
- 16 physicians or pharmacists under this chapter.
- 17 (8) The publication and dissemination of educational information
- 18 to physicians and pharmacists regarding the board and the DUR
- 19 program, including information on the following:
- 20 (A) Identifying and reducing the frequency of patterns of
- 21 fraud, abuse, gross overuse, or inappropriate or medically
- 22 unnecessary care among physicians, pharmacists, and
- 23 recipients.
- 24 (B) Potential or actual severe or adverse reactions to drugs.
- 25 (C) Therapeutic appropriateness.
- 26 (D) Overutilization or underutilization.
- 27 (E) Appropriate use of generic drugs.
- 28 (F) Therapeutic duplication.
- 29 (G) Drug-disease contraindications.
- 30 (H) Drug-drug interactions.
- 31 (I) Incorrect drug dosage and duration of drug treatment.
- 32 (J) Drug allergy interactions.
- 33 (K) Clinical abuse and misuse.
- 34 (9) The adoption and implementation of procedures designed to
- 35 ensure the confidentiality of any information collected, stored,
- 36 retrieved, assessed, or analyzed by the board, staff to the board, or
- 37 contractors to the DUR program that identifies individual
- 38 physicians, pharmacists, or recipients.
- 39 (10) The implementation of additional drug utilization review
- 40 with respect to drugs dispensed to residents of nursing facilities
- 41 shall not be required if the nursing facility is in compliance with
- 42 the drug regimen procedures under 410 IAC 16.2-3.1 and 42 CFR
- 43 483.60.
- 44 (11) The research, development, and approval of a preferred drug
- 45 list for:
- 46 (A) Medicaid's fee for service program;



- 1 (B) Medicaid's primary care case management program;
2 (C) Medicaid's risk based managed care program, if the office
3 provides a prescription drug benefit and subject to IC 12-15-5;
4 and
5 (D) the children's health insurance program under IC 12-17.6;
6 in consultation with the therapeutics committee.
7 (12) The approval of the review and maintenance of the preferred
8 drug list at least two (2) times per year.
9 (13) The preparation and submission of a report concerning the
10 preferred drug list at least ~~two (2) times~~ **one (1) time** per year to
11 the select joint commission on Medicaid oversight established by
12 IC 2-5-26-3.
13 (14) The collection of data reflecting prescribing patterns related
14 to treatment of children diagnosed with attention deficit disorder
15 or attention deficit hyperactivity disorder.
16 (15) Advising the Indiana comprehensive health insurance
17 association established by IC 27-8-10-2.1 concerning
18 implementation of chronic disease management and
19 pharmaceutical management programs under IC 27-8-10-3.5.
20 (b) The board shall use the clinical expertise of the therapeutics
21 committee in developing a preferred drug list. The board shall also
22 consider expert testimony in the development of a preferred drug list.
23 (c) In researching and developing a preferred drug list under
24 subsection (a)(11), the board shall do the following:
25 (1) Use literature abstracting technology.
26 (2) Use commonly accepted guidance principles of disease
27 management.
28 (3) Develop therapeutic classifications for the preferred drug list.
29 (4) Give primary consideration to the clinical efficacy or
30 appropriateness of a particular drug in treating a specific medical
31 condition.
32 (5) Include in any cost effectiveness considerations the cost
33 implications of other components of the state's Medicaid program
34 and other state funded programs.
35 (d) Prior authorization is required for coverage under a program
36 described in subsection (a)(11) of a drug that is not included on the
37 preferred drug list.
38 (e) The board shall determine whether to include a single source
39 covered outpatient drug that is newly approved by the federal Food and
40 Drug Administration on the preferred drug list not later than sixty (60)
41 days after the date on which the manufacturer notifies the board in
42 writing of the drug's approval. However, if the board determines that
43 there is inadequate information about the drug available to the board
44 to make a determination, the board may have an additional sixty (60)
45 days to make a determination from the date that the board receives
46 adequate information to perform the board's review. Prior authorization



1 may not be automatically required for a single source drug that is newly
2 approved by the federal Food and Drug Administration, and that is:

3 (1) in a therapeutic classification:

4 (A) that has not been reviewed by the board; and

5 (B) for which prior authorization is not required; or

6 (2) the sole drug in a new therapeutic classification that has not
7 been reviewed by the board.

8 (f) The board may not exclude a drug from the preferred drug list
9 based solely on price.

10 (g) The following requirements apply to a preferred drug list
11 developed under subsection (a)(11):

12 (1) Except as provided by IC 12-15-35.5-3(b) and
13 IC 12-15-35.5-3(c), the office or the board may require prior
14 authorization for a drug that is included on the preferred drug list
15 under the following circumstances:

16 (A) To override a prospective drug utilization review alert.

17 (B) To permit reimbursement for a medically necessary brand
18 name drug that is subject to generic substitution under
19 IC 16-42-22-10.

20 (C) To prevent fraud, abuse, waste, overutilization, or
21 inappropriate utilization.

22 (D) To permit implementation of a disease management
23 program.

24 (E) To implement other initiatives permitted by state or federal
25 law.

26 (2) All drugs described in IC 12-15-35.5-3(b) must be included on
27 the preferred drug list.

28 (3) The office may add a drug that has been approved by the
29 federal Food and Drug Administration to the preferred drug list
30 without prior approval from the board.

31 (4) The board may add a drug that has been approved by the
32 federal Food and Drug Administration to the preferred drug list.

33 (h) At least ~~two~~ **two** ~~times~~ **one time** each year, the board shall
34 provide a report to the select joint commission on Medicaid oversight
35 established by IC 2-5-26-3. The report must contain the following
36 information:

37 (1) The cost of administering the preferred drug list.

38 (2) Any increase in Medicaid physician, laboratory, or hospital
39 costs or in other state funded programs as a result of the preferred
40 drug list.

41 (3) The impact of the preferred drug list on the ability of a
42 Medicaid recipient to obtain prescription drugs.

43 (4) The number of times prior authorization was requested, and
44 the number of times prior authorization was:

45 (A) approved; and

46 (B) disapproved.



- 1 (i) The board shall provide the first report required under subsection
- 2 (h) not later than six (6) months after the board submits an initial
- 3 preferred drug list to the office.





PRELIMINARY DRAFT
No. 3260

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2012 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 4-22-2-37.1.

Synopsis: Voiding of certain Medicaid rules. Eliminates emergency rulemaking for the office of the secretary of family and social services (office) or the office of Medicaid policy and planning concerning: (1) federal Medicaid waiver program provisions; and (2) federal programs administered by the office. Voids a final rule and emergency rules concerning the following: (1) five percent reduction in Medicaid reimbursement for chiropractic and podiatric services; (2) five percent reduction of Medicaid reimbursement for speech therapists, audiologists, optometrists, opticians, independent laboratory providers, independent radiology providers, and freestanding renal dialysis clinics; and (3) reduction in Medicaid dispensing fee from \$4.90 to \$3.00.

Effective: Upon passage.



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

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

1 SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.229-2011,
2 SECTION 58, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 UPON PASSAGE]: Sec. 37.1. (a) This section applies to a rulemaking
4 action resulting in any of the following rules:

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

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

11 (3) An emergency temporary standard adopted by the
12 occupational safety standards commission under
13 IC 22-8-1.1-16.1.

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

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

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

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

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

26 (9) A rule adopted under IC 16-19-3-5 or IC 16-41-2-1 that the
27 executive board of the state department of health declares is
28 necessary to meet an emergency.

29 (10) An emergency rule adopted by the Indiana finance authority
30 under IC 8-21-12.

31 (11) An emergency rule adopted by the insurance commissioner



- 1 under IC 27-1-23-7 or IC 27-1-12.1.
 2 (12) An emergency rule adopted by the Indiana horse racing
 3 commission under IC 4-31-3-9.
 4 (13) An emergency rule adopted by the air pollution control
 5 board, the solid waste management board, or the water pollution
 6 control board under IC 13-15-4-10(4) or to comply with a
 7 deadline required by or other date provided by federal law,
 8 provided:
 9 (A) the variance procedures are included in the rules; and
 10 (B) permits or licenses granted during the period the
 11 emergency rule is in effect are reviewed after the emergency
 12 rule expires.
 13 (14) An emergency rule adopted by the Indiana election
 14 commission under IC 3-6-4.1-14.
 15 (15) An emergency rule adopted by the department of natural
 16 resources under IC 14-10-2-5.
 17 (16) An emergency rule adopted by the Indiana gaming
 18 commission under IC 4-32.2-3-3(b), IC 4-33-4-2, IC 4-33-4-3,
 19 IC 4-33-4-14, IC 4-33-22-12, or IC 4-35-4-2.
 20 (17) An emergency rule adopted by the alcohol and tobacco
 21 commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
 22 IC 7.1-3-20-24.4.
 23 (18) An emergency rule adopted by the department of financial
 24 institutions under IC 28-15-11.
 25 (19) An emergency rule adopted by the office of the secretary of
 26 family and social services under IC 12-8-1-12.
 27 (20) An emergency rule adopted by the office of the children's
 28 health insurance program under IC 12-17.6-2-11.
 29 (21) An emergency rule adopted by the office of Medicaid policy
 30 and planning under IC 12-15-41-15.
 31 (22) An emergency rule adopted by the Indiana state board of
 32 animal health under IC 15-17-10-9.
 33 (23) An emergency rule adopted by the board of directors of the
 34 Indiana education savings authority under IC 21-9-4-7.
 35 (24) An emergency rule adopted by the Indiana board of tax
 36 review under IC 6-1.1-4-34 (repealed).
 37 (25) An emergency rule adopted by the department of local
 38 government finance under IC 6-1.1-4-33 (repealed).
 39 (26) An emergency rule adopted by the boiler and pressure vessel
 40 rules board under IC 22-13-2-8(c).
 41 (27) An emergency rule adopted by the Indiana board of tax
 42 review under IC 6-1.1-4-37(l) (repealed) or an emergency rule
 43 adopted by the department of local government finance under
 44 IC 6-1.1-4-36(j) (repealed) or IC 6-1.1-22.5-20.
 45 (28) An emergency rule adopted by the board of the Indiana
 46 economic development corporation under IC 5-28-5-8.



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



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

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

8 (1) accept the rule for filing; and

9 (2) electronically record the date and time that the rule is
 10 accepted.

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

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

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

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

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

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

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

36 (2) IC 13-14-9;

37 as applicable.

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

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

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

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

46 (j) A rule described in subsection (a)(24) or (a)(25) expires not later



1 than January 1, 2006.

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

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

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

10 SECTION 2. [EFFECTIVE UPON PASSAGE] (a) **The following**
11 **are void:**

- 12 (1) **405 IAC 1-11.5-2(g).**
- 13 (2) **LSA Document # 11-379(E).**
- 14 (3) **LSA Document # 11-382(E).**

15 **The publisher of the Indiana Administrative Code and the Indiana**
16 **Register shall remove the provisions described in subsection (a)(1)**
17 **from the Indiana Administrative Code.**

18 (b) **This SECTION expires December 31, 2012.**

19 SECTION 3. **An emergency is declared for this act.**



FINAL REPORT

Select Joint Commission on Medicaid Oversight

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-26) directing the Commission to do the following:

- (1) Determine whether the contractor for the Office of Medicaid Policy and Planning (OMPP) under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.
- (2) Determine whether a managed care organization that has contracted with the OMPP to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state.
- (3) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process Medicaid claims and eliminate reimbursement backlogs, delays, and errors.
- (4) Oversee the implementation of a case-mix reimbursement system developed by the OMPP and designed for Indiana Medicaid-certified nursing facilities.
- (5) Study and investigate any other matter related to Medicaid.
- (6) Study and investigate all matters related to the implementation of the Children's Health Insurance Program established by IC 12-17.6.

In addition, Legislative Council resolution LCR 11-01 provides that the Commission may make an advisory recommendation to the OMPP concerning the proposed family planning services State Plan amendment. (SEA 416 - 2011)

Further, IC 12-15-45 (SEC. 144, HEA 1001-2011) concerning Medicaid Developmental Disability Home and Community-Based Services Waivers provides that before July 1, 2012, the Division of Rehabilitative Services shall report orally and in writing to the Commission for review of a plan to reduce the aggregate and per capita cost of the waiver by implementing certain changes to the waiver.

Finally, SECTION 32 of SEA 88-2011 requires the Family and Social Services Administration (FSSA) to prepare and present to the Commission before November 1, 2011, a report on the availability and use of mental health drugs.

II. INTRODUCTION AND REASONS FOR STUDY

In FY 2011, the Indiana Medicaid program had total expenditures of approximately \$6.5 billion dollars. At the end of FY 2011, the program enrolled approximately 1,110,000 Indiana citizens who were eligible to receive services. Due to the size of this program in the state budget and the number of recipients, the Select Joint Commission on Medicaid Oversight was established as a permanent commission to provide legislative branch oversight of this state function.

III. SUMMARY OF WORK PROGRAM

The Commission met three times during the 2011 interim: August 23, 2011; September 14, 2011; and October 18, 2011. All Commission meetings were held at the State House in Indianapolis.

The first meeting was held August 23, 2011. The Commission heard an update on the implementation of the hybrid eligibility-determination system from Secretary Michael Gargano of the Family and Social Services Administration. Ms. Seema Verma, FSSA Health Care Reform Lead, gave an overview and update of the state's preparation and development of a health insurance exchange for federal healthcare reform. Ms. Pat Casanova, Director of OMPP, presented an overview of the Medicaid State Plan amendment for family planning services and reviewed cost savings initiatives implemented or planned for the Indiana Medicaid program. The Commission heard testimony from advocates for providers affected by the cost-savings initiatives. Ms. Julia Holloway, Director of the Division of Developmental Disabilities and Rehabilitative Services (DDRS), updated the Commission on the process and planning for revisions to the home and community-based services waivers for the developmentally disabled. The Commission also heard testimony on the home and community-based services waiver issue. Medicaid claims processing contractors presented performance reports to the Commission.

The second meeting was held September 14, 2011. The Commission heard a presentation by Ms. Kristina Moorhead, Deputy Director of OMPP, regarding Medicaid program integrity program components and fraud prevention activities. Ms. Pat Casanova returned to give more detailed information on cost-savings initiatives undertaken by OMPP. She also presented additional Healthy Indiana Plan (HIP) enrollment statistics as requested by Commission members at the first meeting. The Commission also heard testimony from providers of targeted case management services that have been eliminated by OMPP as a cost-saving initiative.

The third meeting was held October 18, 2011.

[This Section to be completed after the final Commission meeting on October 18, 2011.]

IV. SUMMARY OF TESTIMONY

Update on the Implementation of the Hybrid Eligibility-Determination System.

Secretary Gargano reported that pending Federal Nutrition Service (FNS) approval, Regions 9 and 10 have been scheduled for conversion to the hybrid eligibility system for late October 2011. Region 5, Marion County, is scheduled for conversion in late February 2012, pending FNS approval. The Secretary reported statewide enrollment statistics, new applications, regional backlogs, and other performance statistics. The statistics demonstrated improved performance in the regions that had been converted to the hybrid system. Regions 9, 10, and 5 are the remaining regions in the state that were never converted to the privatized eligibility system.

Overview of Insurance Exchange Development Activities

Ms. Seema Verma reviewed the progress made towards requirements of the Patient Protection and Affordable Care Act (PPACA). She detailed grants that the administration has applied for and reviewed the current status of the various legal challenges to the federal health care reform statute. She also reviewed the state's progress with regard to establishing an insurance exchange while emphasizing that the actions taken will not obligate the state to run an exchange if it is determined not to do so in the future. Ms. Verma reviewed the state insurance markets and how the market is projected to change by 2019. She reviewed exchange design options and the results of a December 2010 Affordable Care Act Questionnaire. Finally she discussed the issue of how the operations of the exchange could be financed and what products should be offered on the exchange.

Healthy Indiana Plan (HIP)

Pat Casanova, Director of OMPP, reported that the standing of the HIP program is still unknown with regard to the state's ability to use HIP as the vehicle for the Medicaid expansion population under federal health care reform. She stated that the program could potentially continue as a waiver or as a State Plan amendment. She reported that the HIP program had been opened for the enrollment of 8,000 non-caretaker adults and described the process for taking applicants on the waiting list.

Developmental Disability Home and Community-Based Services Waiver Revision

Section 144 of HEA 1001- 2011 requires the Division of Rehabilitative Services to report orally and in writing to the Commission for review of a plan to reduce the aggregate and per capita cost of the waiver by implementing certain changes to the waiver. Ms. Julia Holloway discussed the work group that was established to work on the waiver budget-neutrality issue and described the process the division will use to address the aggregate and per capita costs of services provided for the new waiver application. The work group's draft report is due to the division by December 31, 2011, and a written report is required to be provided to the Commission by July 1, 2012. Mr. John Dickerson of the ARC of Indiana testified that the ARC is committed to work with the division to find ways to provide services to as many individuals as possible. He discussed activities that the division has undertaken to bring equity to the level of

services provided to each individual. Ms. Rylin Rodgers of Family Voices Indiana offered testimony relating to the importance of Medicaid services to families with children with disabilities and the need to provide an adequate level of services to allow children to stay in their own homes. Ms Sharon Overly, the parent of a disabled daughter, addressed the need to cut waste that exists within the system and to provide quality services that allow the disabled to remain in their homes.

The Commission is to review a plan to reduce the aggregate and per capita cost of the developmentally disabled home and community-based services waiver, however, the time line outlined for the development of the waiver does not allow for the Commission's review of the document.

Provider Rate Reductions

Pat Casanova, Director of OMPP, described cost containment actions undertaken by OMPP to achieve savings to address an estimated \$220 M shortfall in state Medicaid appropriations for FY 2012. Representatives of the Indiana Optometric Association, the Indiana Podiatric Medical Association, the Indiana State Chiropractic Association, the Indiana Retail Council, the Indiana Pharmacy Alliance, the Indiana Perinatal Network, and the Indiana AARP commented on proposed cuts that affected the individual provider groups.

Family Planning Services State Plan Amendment

Ms. Pat Casanova reported on the time frame of the process to prepare and submit to the Centers for Medicare and Medicaid Services (CMS) a State Plan amendment to add family planning services to Indiana Medicaid. She stated that the State Plan amendment is to be submitted to CMS by January 1, 2012, with the provision of open-ended benefits to eligible men and women to begin on October 1, 2012. She clarified that the program will become obsolete under the federal healthcare reform on January 1, 2014. Ms. Casanova reported that OMPP will need approximately \$1.1 M to make system changes necessary to implement the new service and that no savings due to the new services could be anticipated during the first year.

The Commission may make an advisory recommendation with regard to the State Plan amendment for family planning services; however, the time line outlined for the development of the amendment does not allow for the Commission's review or consideration of the document.

Claims Processing Contractor's Activity Reports

Representatives of Medicaid managed care contractors and the fee-for-service contractor presented claims processing performance statistics and information on their provider networks.

The Commission received the claims processing performance reports. No determination of the contractors' proper contract performance was made.

Medicaid Program integrity and Fraud Prevention

Ms. Kristina Moorhead presented information regarding Medicaid program integrity activities aimed at detecting improper payments to providers and identifying member misrepresentation and overutilization. She reviewed the recovery of improper payments and the new CMS requirement that states have a Medicaid Recovery Audit Contractor (RAC). These contractors audit payments made to healthcare providers to identify Medicaid payments that may have been improperly made. The contractor is responsible for recovering overpayments or correcting underpayments. Ms. Moorhead also discussed the Right Choices Program that identifies Medicaid members that use an inordinate level of services and places them in a program that restricts their access to certain providers. She emphasized that the program is intended to assist members to utilize resources better - they are not prevented from receiving necessary services.

[This Section will be updated to include information added from the final meeting of October 18, 2011.]

V. COMMISSION FINDINGS AND RECOMMENDATIONS

The Commission made the following findings of fact:

[This Section to be revised to include any findings of fact, if any, that may be made at the final meeting of October 18, 2011.]

The Commission made the following recommendations:

[This Section will be revised to include any actions taken on Preliminary Drafts considered by the Commission and the Final Report at the final meeting of October 18, 2011.]

WITNESSLIST

Mr. John Barth, MHS
Ms. Pat Casanova, Director, OMPP
Mr. Paul Chase, IN AARP
Mr. Bill Cowan, Indiana Pharmacy Alliance
Mr. John Dickerson, The ARC of Indiana
Mr. Michael Gargano, Secretary, FSSA
Ms. Julia Holloway, Director, DDRS
Mr. Larry Humbert, Indiana Perinatal Network
Ms. Trish Hunter, HP/EDS
Ms. Tina Hurt, Anthem
Ms. Pat McGuffy, Indiana State Chiropractic Association
Mr. Grant Monahan, Indiana Retail Council
Ms. Kristina Moorhead, Deputy Director, OMPP
Ms. Sharon Overley
Ms. Rylin Rodgers, Family Voices Indiana
Ms. Jackie Shearer, MHS
Ms. Glenna Shelby, Indiana Podiatric Medical Association
Ms. Seema Verma, Health Care Reform Lead
Ms. Katherine Wentworth, MD Wise
Mr. Jim Zieba, Indiana Optometric Association

[This Section to be revised to include any additional witnesses, if any, that may appear before the Commission at the final meeting of October 18, 2011.]



INDIANA MEDICAID SPEND-DOWN PROGRAM

October 18, 2011

Select Joint Commission on Medicaid Oversight

Office of Medicaid Policy and Planning



Exhibit G
Selection Joint Commission on
Medicaid Oversight
Meeting #3 October 18, 2011



Spend-down Federally Required

- In 1974, Indiana elected to use more restrictive standards to determine eligibility for Medicaid disability than most other states.
 - Indiana is one of eleven 209(b) states.
 - All other states operate under 1634 authority and use the more lenient SSI disability standard.
- States that operate under 209(b) must allow individuals to “spend-down” their income to become Medicaid eligible.
 - This requirement can be found in federal law at 42 USC 1396a(f).



Medicaid Disability Changes

SEA461 Section 5 (2011 Session)

(b) The office may request the United States Department of Health and Human Services to approve Indiana's transition, beginning January 1, 2014, as a state that determines eligibility for individuals who are aged, blind, or disabled under Medicaid based on Section 1634 of the federal Social Security Act.



Spend-down and Medicaid Eligibility

- With spend-down, an individual becomes eligible for Medicaid when their qualified medical expenses reduce their income to the SSI level (74% FPL).
- As soon as the individual's medical expenses equal their monthly spend-down obligation, the individual is fully covered by Medicaid.
- Participants must meet their spend-down amount each month in order to obtain full Medicaid benefits.
- There is no upper FPL ceiling for eligibility under spend-down, meaning there are many individuals over 200% FPL receiving some Medicaid benefits.



Spend-down Automated

- Indiana automated spend-down in 2006.
 - Prior to automation, members had to take medical bills to the county office to be entered manually.
- Providers submit claims to Medicaid and the claim amounts are applied toward spend-down based on the date and time of adjudication by IndianaAIM.
- Automation has removed much of the administrative burden on providers, members and the State by reducing paperwork and expediting claims payment.



Billing and Collecting from Spend-down Members

- Providers electronically verify member eligibility and the amount of remaining spend-down for that month.
 - This amount is based on a point in time and is subject to change as claims continue to be processed.
- Providers may bill members for the spend-down amount deducted from the **adjudicated claim**.
- Members are not required to pay the provider until the member receives the *Monthly Medicaid Spend-down Summary Notice*.



Member Protections

- Collecting from a member before the *Monthly Spend-down Summary* is issued puts the member at risk of liability in excess of their obligation.
- A provider may not:
 - refuse service to a Medicaid member pending verification that the member's monthly spend-down obligation has been satisfied.
 - refuse service solely on the basis of the member's spend-down status.
 - apply a more restrictive collection policy to spend-down member than to other patients and customers.



Transition to 1634 Status

- Will require the State to submit a State plan amendment to CMS to authorize the change.
- The State has notified CMS that we will need their assistance in planning the transition.
- The State is awaiting written confirmation from CMS that those who are currently SSI eligible, but not Medicaid eligible (~23,000) will be considered “newly eligible” if the program transitions to a 1634 state.
- State has begun planning around this transition in tandem with health care reform changes.



QUESTIONS?



Pharmacy Point of Service (POS) Claims

- In a POS transaction, the pharmacy enters the recipient identification number (RID) and the prescription information into the pharmacy computer and transmits the claim using the approved telecommunication or switching vendor and any POS software that supports National Council for Prescription Drug Programs (NCPDP) version 5.1.
- From that information, online and real-time edits and Prospective Drug Utilization Review (ProDUR) alerts occur within a few seconds. The response(s) to the provider are based on the submitted information and historical paid claims information.

Deliverables from 09.14.11 Select Joint Commission on Medicaid Oversight

Sen. Miller/Hershman

- Does FSSA have the ability to remove a member from the Medicaid program?

When a Medicaid member fails to meet the eligibility requirements of any category within the program, assistance is discontinued effective the first day of the month following notice.

Rep. C. Brown

- Requested HIP enrollment/waitlist number by county.
The data is not readily available.
- Requested total number of unique individuals who have been enrolled in HIP during the existence of the program.
The attached reports provide this data.

Sen. Miller

- What is the service provided under Targeted Case Management for prenatal care coordination?

Prior to July 1, 2011, Medicaid reimbursement was available for targeted case management for pregnant women. This service was available through the Indiana State Department of Health's Prenatal Care Coordination Services.

Prior to July 1, 2011, providers could bill for some of the Prenatal Care Coordination Services to Medicaid for Medicaid eligible individuals. Medicaid did not pay for services rendered to individuals who were not Medicaid eligible. The services that could be billed to Medicaid are below:

- H1001 – Initial Assessment – one unit per pregnancy (face to face)
- H1004 – Reassessment (up to two units per pregnancy, can be face to face or telephone)
- 99501 – Home Visit for Postnatal Assessment and Follow-up Care – one unit per child per pregnancy (face to face)
- A0160 U1 - Care coordination, transportation for home visit, initial assessment (Nonemergency transport, per mile, caseworker or social worker)
- A0160 U2 - Care coordination, transportation for home visit, reassessment (Nonemergency transport, per mile, caseworker or social worker)

Prenatal care coordinators could bill Medicaid for up to four visits for individuals who were Medicaid eligible. The Initial Assessment and Postnatal Assessment were required to be face to face with the Medicaid member, and the two Reassessment visits could be face to face or telephone. Records indicate that most Reassessment visits occurred via telephone.

The need to identify \$212M to meet state budget requirements is the reason why OMPP eliminated Targeted Case Management as a covered service under Medicaid. There was relatively small utilization of this program. In 2010, 2,819 women received Targeted Case Management services under Medicaid. That represents only 6.87% of Medicaid births for 2010. For all births in the state, the birth rate is trending downward - around 86,000. That would mean 3.27% received Targeted Case Management.

FSSA has NOT reduced the availability of pre-natal care in any way. Pregnant women can still receive pre-natal care through other avenues in Medicaid:

1. Presumptive Eligibility: which begins pre-natal care payment before Medicare applications are fully processed and approved in order to ensure the most timely availability of services.
2. Notification of Pregnancy: an incentive program for doctors to provide notice to Managed Care Entities about pregnancies so these health care providers and the Managed Care entities can ensure women are receiving education and other necessary services related to their pregnancy. This primarily targets those women who are identified as having a high risk pregnancy which will require additional services.

The data below represents one of our Healthcare Effectiveness Data and Information Set (HEDIS) prenatal care measures that we track each of the MCEs on. This one demonstrates that we are trending upward, demonstrating that women are receiving necessary prenatal care visits.

HEDIS FPC measure for ongoing prenatal care- the percentage of Medicaid deliveries that received >=81% of the expected visits

MCO	HEDIS 2010	HEDIS 2011	Trend
1	82.73	84.18	↑
2	72.99	75.5	↑
3	75.19	82.69	↑

Rep. C. Brown

- How many Medicaid recipients utilized targeted case management services for prenatal care in FY2010?
For SFY 2010, 2,819 unique individuals.
- What percent of the \$440,000 cut to targeted case management represents payments for prenatal care coordination?
The prenatal care coordination portion is \$146k.

Rep. Welch

- Requested additional clarification on FSSA FY2011 reversions.

FSSA reverted \$163.2M from fund 15050 (Medicaid) in FY11. Of this total, \$14.4M was unspent Medicaid administration dollars (not Medicaid Assistance funds). Of this total, \$148.8M was associated with enhanced FMAP made available in the Education Jobs bill (passed in August 2010). The reversion of \$148.8M reflects the actual amount of additional federal funds received between January-June 2011 as a result of the Education Jobs bill that was able to reduce the amount of general fund dollars needed.

Every version of the budget passed by the Indiana General Assembly during the 2011 legislative session assumed these general fund dollars would not be spent. Therefore, the reversion of these funds was not unanticipated nor do they mean that additional funds are available to be spent. Rather, they were needed simply to meet the assumptions of the budget that passed the General Assembly.

These details were made available on July 14, 2011 as a part of FY11 close-out (http://www.in.gov/sba/files/FY_2011_GF_Reversions_7-14-11.pdf)