



# SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

*Legislative Services Agency*  
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## MEETING MINUTES<sup>1</sup>

**Meeting Date:** August 23, 2011  
**Meeting Time:** 10:00 A.M.  
**Meeting Place:** State House, 200 W. Washington St.,  
Senate Chamber  
**Meeting City:** Indianapolis, Indiana  
**Meeting Number:** 1

**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 first meeting of the Select Joint Commission on Medicaid Oversight was called to order by Senator Patricia Miller, Chairperson, at 10:10 AM. Senator Miller introduced the members of the Commission. After discussion of available dates, the next Commission meeting was scheduled to be held at 2:00 PM, following the Health Finance Commission meeting on September 14, 2011.

### I. Update on Hybrid Eligibility System Implementation (See Exhibit A)

Michael Gargano, Secretary, Family and Social Services Administration (FSSA)

Secretary Gargano discussed the planned rollout for the statewide implementation of the hybrid eligibility system, the increase in numbers of Hoosiers receiving benefits, and the number of new applications. He commented that the number of applications being received on-line is increasing, the accuracy as measured by error rates is increasing, and the application processing timeliness is improving while backlogs are decreasing. Representative Welch

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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.

commented that constituent phone calls concerning the application process had decreased and asked the status of the Indiana Client Eligibility System (ICES) and the IBM Work Flow Management System (WFMS). Secretary Gargano responded that planning for an ICES replacement system is dependent upon what happens with regard to the implementation of healthcare reform and the continued rollout of the hybrid eligibility process. Additional questions were concerned with the local office intake process, how clients and staff are adapting to the new process, and the status of the IBM lawsuit.

## **II. Overview of Preparation & Development of Healthcare Exchange (See Exhibit B)**

### Seema Verma, Health Care Reform Lead

Chairperson Miller explained to the Commission members that the Health Finance Commission reviewed this topic in depth at their first meeting and that Ms. Verma was asked to review key points only for the Commission. Ms. Verma reported that FSSA has received a preliminary response from the Centers for Medicare and Medicaid Services (CMS) regarding the use of the Healthy Indiana Plan (HIP) model for healthcare reform Medicaid expansion populations. The CMS response asked questions of clarification and for additional information. The Office of Medicaid Policy and Planning (OMPP) staff addressed the questions leaving CMS with 90 days to respond.

Ms. Verma briefly explained the court cases and the options for states with regard to establishing a qualifying insurance exchange. Commission questions and discussion involved progress on plans for the exchange, the function of the exchange, and how the exchange and the HIP would fit together in a final program. There was more discussion regarding whether CMS will approve the HIP as the model for implementing the Medicaid expansion associated with the implementation of federal healthcare reform.

The Commission asked for the status of the HIP waiting list for noncustodial adults. Ms. Verma reported that the waiting list for this group is in excess of 59,000. OMPP continues to take applications. She added that enrollment has been opened to add up to 8,000 noncustodial adults. Members requested this subject be discussed at a future meeting.

Additional questions were asked regarding the impact of healthcare reform on the insurance market and the ongoing role of the Department of Insurance in the implementation of healthcare reform provisions. Commission members also expressed concern with regard to the lack of legislative involvement in the process of implementing federal healthcare reform. Ms. Verma suggested that updates could be given to the Commission. She further reported that the federal exchange rules have been published and are now available. She added that the question of the ongoing operating cost of the exchange to the state will need to be addressed since federal support for the exchange will be discontinued after a defined period of time.

## **III. Overview of the Medicaid Family Planning State Plan Amendment (See Exhibit C)**

### Pat Casanova, Director, OMPP, FSSA

Ms. Casanova reported that OMPP will need approximately \$1.1 M to make system changes and implement a State Plan Amendment (SPA) to add family planning services to the Medicaid Plan. She stated that the time line for the process has been established for the submission of the SPA to CMS by January 1, 2012, and provision of the services to begin on October 1, 2012. The program will become obsolete under federal healthcare reform on January 1, 2014. Ms. Casanova cautioned that no savings could be anticipated for the new service during the first

year and added that benefits will be open-ended for all Medicaid eligibles including men and women. Commission questions and discussion followed with regard to the advantages of a State Plan Amendment over the waiver application process. Commission members requested an update on this project during the session.

#### **IV. Provider Reimbursement Rates & Cost Initiatives (See Exhibit C)**

##### Pat Casanova, Director, OMPP, FSSA

Ms. Casanova referred Commission members to the list of cost savings initiatives in Exhibit C. She commented that implementation of the items on the list was estimated to achieve 75% of the \$212 M savings target for the 2012-2013 budget biennium. In response to Commission questions concerning the rate reductions affecting optometry and podiatry services, she indicated that the decision was made to apply the reductions to the provider of the service rather than the actual service so that MDs providing the same services would not be impacted. That is, an ophthalmologist would receive higher reimbursement than an optometrist for the same service. There was some discussion of how the savings target of \$212 M was determined. Senator Miller explained that the Medicaid appropriation was \$212 M less than the budget projection of needed funds.

Additional discussion involved the effect of individual cuts on various services included on the list. Members asked for the projected savings associated with each cut to be added to the list of cost savings initiatives and also for the dollar amount of the FY 2011 Medicaid reversion. Ms. Casanova explained that the projections were very early estimates.

##### Jim Zieba, Indiana Optometric Association (See Exhibit D)

Mr. Zieba explained that optometrists have four years of post-graduate training to earn a doctorate - an O.D. is a doctor. See Mr. Zieba's written comments in Exhibit D. Commission discussion followed.

##### Pat McGuffy, Indiana State Chiropractic Association (See Exhibit E)

See Ms. McGuffy's written comments in Exhibit E.

##### Glenna Shelby, Indiana Podiatric Medical Association

Ms. Shelby stated that podiatrists are also educated to the doctorate level, and the 5% reimbursement cuts were discriminatory since they were targeted to the specific provider type and not the service-related codes.

##### Grant Monahan, Indiana Retail Council

Mr. Monahan commented on the 38% cut in the dispensing fee. The fee was to be reduced to \$3.00 from \$4.90. He stated that there is a temporary restraining order issued by the court delaying this reimbursement reduction.

##### Bill Cowan, Indiana Pharmacy Alliance

The Indiana Pharmacy Alliance filed a lawsuit to stop the implementation of the emergency rule reducing the dispensing fee. Mr. Cowan stated that he believes there was no extended notice of the rate cut and commented that the change to the emergency rule-making procedure that allowed the limited notice was made in the budget bill. He said that independent pharmacies

cannot absorb such a large cut and that \$4.20 rather than \$3.00 would have been acceptable. Commission questions and discussion followed.

Ms. Casanova was asked to respond to comments made regarding the cost savings initiatives. She stated that the pharmacy matter was in federal court and she really could not address that issue. She said that the cost savings target was \$212 M and that the process of reaching the target would make no one happy. Ms. Casanova commented that OMPP had requested the ability to eliminate chiropractic, optometry, and podiatry services from Medicaid covered services during the session and that a rate reduction for these services has less impact on the providers than elimination of the service. She added that to date there have been no complaints from individual Medicaid eligibles while there have been multiple complaints from providers.

## **V. Contract Performance Reports**

### John Barth and Jackie Shearer, MHS (See Exhibit F)

Mr. Barth commented that for the third year in a row, MHS had the largest provider network with over 1,000 primary providers and over 6,000 specialists enrolled. He discussed claims payment statistics and denials. In response to Commission questions regarding coordination of benefits (COB), Mr. Barth commented that the number one reason for MHS claims denial is that the primary insurer should be billed first before resubmitting the claim to MHS. He stated that MHS is seeing an increased number of Medicaid eligibles with other insurance. In response to a Commission question regarding Medicaid payments to providers of abortion services, Mr. Barth explained that MHS had developed a list of Hoosier Healthwise members with Planned Parenthood claims but due to the court injunction, has not implemented any further actions. He also commented that members do not respond to notices or required information updates in response to a question on whether churning of members in Hoosier Healthwise was related to the auto-assignment function.

### Katherine Wentworth, MDWise (See Exhibit G)

Ms. Wentworth reviewed the number of primary medical providers in the MDWise network by region and explained that the dip in claims payment timeliness was due to data issues. She commented that no providers were impacted by the data problems as MDWise extended the time limits for the filing of claims. In response to a Commission question regarding COB, she commented that MDWise gets insurance information from its providers and also contracts with a vendor to do "pay and chase". Ms. Wentworth commented that MDWise had identified Hoosier Healthwise members that had Planned Parenthood claims in order to do outreach, but that further activities were on hold due to the injunction. In response to a Commission question regarding denials for behavioral health services, she explained that the behavioral services providers tend to have a lower level of billing volume, less staff to do billing, and tend to use the paper process more than other providers - all factors that may impact the number of denials.

### Tina Hurt, Anthem (See Exhibit H)

Ms. Hurt explained that the dip in claims timeliness was due to a processing change for high volume claims. The dip demonstrated in the HIP data was due to a systems problem. In response to a Commission question regarding denials of behavioral health claims she explained that there had been a change in the contractor for these services and the providers submitting claims have changed. Commission members requested a report on the denial of behavioral claims services at a later meeting of the Commission. In response to the Commission question regarding COB, she stated that Anthem has an internal process to

identify other payers and that providers also report the availability of other insurance. Anthem also has an outside vendor that does "pay and chase". In response to the question concerning payment to providers of abortion services, Ms. Hurt said that Anthem had identified members with claims, referred them to their primary provider, and had started outreach to affected members.

Trish Hunter, HP/(EDS) (See Exhibit I)

Ms. Hunter stated that the decrease in claims for risk-based managed care was due to the carve-out of pharmacy claims from the managed care contracts. She added that the pharmacy claims carve-out was also responsible for changes in the claims adjudication days as well. She reported that electronic claims filing has increased and HP routinely meets or exceeds the claims processing time frames. In response to the Commission's question regarding COB, she said that HP has a contractor for COB in order to avoid "pay and chase activities".

## **VI. Update on Developmental Disabilities Home and Community-based Services Waiver Revisions (HEA 1001-2011, SECTION 144) (See Exhibit J)**

Julia Holloway, Director, Division of Disability and Rehabilitative Services (DDARS), FSSA

Ms. Holloway reviewed the legislative charge to DDARS and discussed the work group that has been established along with the meeting frequency and progress reporting. The workgroup's draft proposal is due to DDARS by December 31, 2011. In response to a Commission question, she stated that the DDARS is meeting with families and providers as well as contacting advocacy groups around the state.

John Dickerson, The ARC of Indiana

Mr. Dickerson commented that the ARC is committed to work with DDARS. He emphasized that the dollars available for home and community-based services need to be stretched in order to provide services to as many individuals as possible since there are 19,000 individuals on the waiver waiting lists. In response to Commission questions, he stated that rates were cut 7% in the waiver and 3% for group homes. He also explained that DDARS has implemented a needs assessment instrument that is used by numerous states. DDARS has attached a budget to the needs assessment as an attempt to bring equity to the allocation of services within the waiver program. The process is referred to as Objective Budget Allocation (OBA). He added that the DDARS administration has been open with regard to implementation of OBA holding weekly meetings.

Rylin Rodgers, Family Voices Indiana (See Exhibit K)

See Ms. Rodgers's written comments in Exhibit K.

Sharon Overley

Ms. Overley introduced herself as the parent of a disabled daughter who is currently receiving waiver services. Her comments addressed the need to cut waste within the system and to focus on quality services that assist the disabled to remain in their homes.

The meeting was adjourned at 1:40 PM.



August 23, 2011

FSSA Secretary Michael A. Gargano

# HYBRID UPDATE



Exhibit A  
Select Joint Commission on  
Medicaid Oversight  
Meeting #1 August 23, 2011



# DFR Regions

## Hybrid Implementation

**Vanderburgh (7)** – January 2010

**Vigo (6)** – June 2010

**Clark (8)** – September 2010

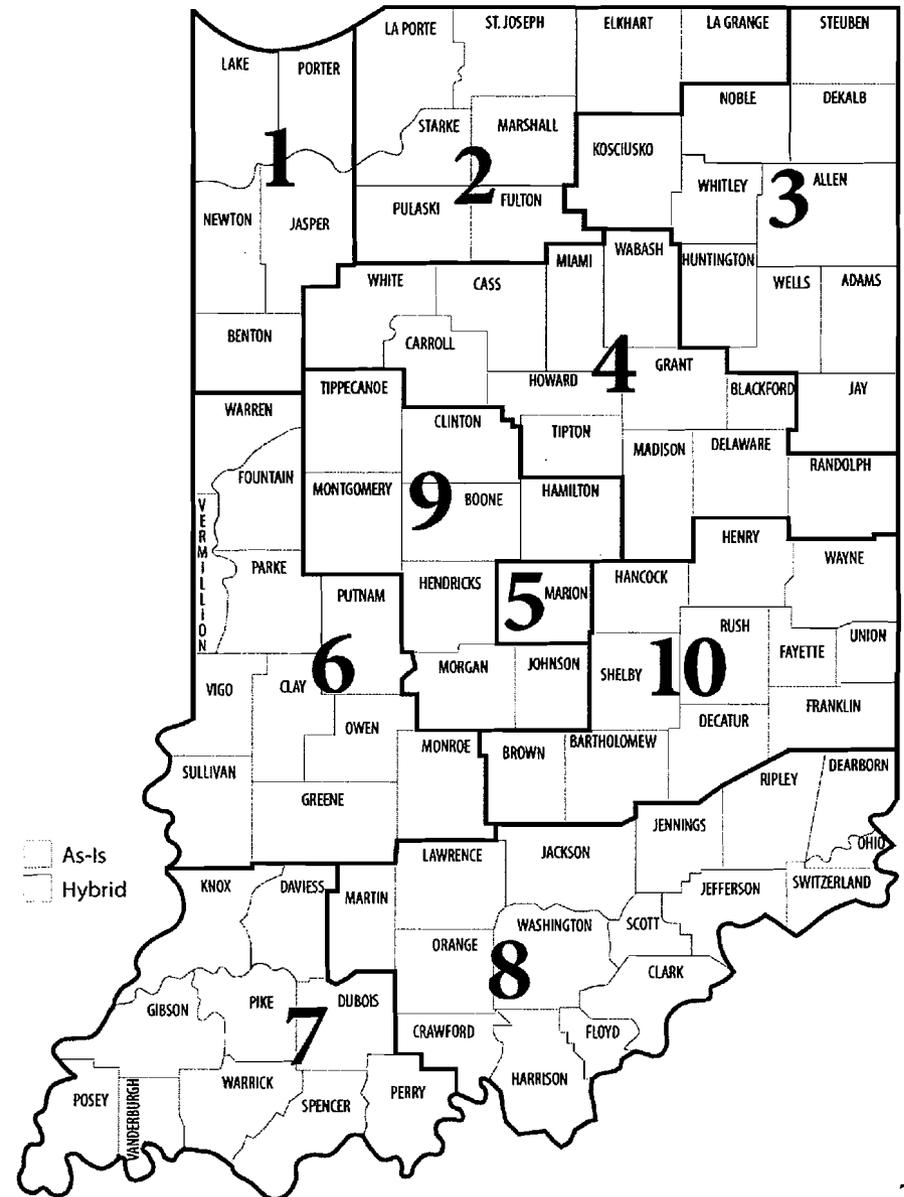
**Allen & Grant (3 & 4)** – February 2011

**Lake & St. Joe (1 & 2)** – June 2011

**Tippecanoe & Wayne (9 & 10)** – Scheduled for late October 2011\*\*

**Marion (5)** – Scheduled for late February 2012\*\*

\*\* Pending FNS approval





## Number of Hoosiers Receiving Benefits Increases Since 2002

With the economic downturn, FSSA program enrollment has increased by 44% since 2005.

### Enrollees by Program (as of June 30 annually)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Medicaid*</b>	756,904	777,170	822,344	847,625	857,599	877,933	920,332	1,017,571	1,088,637	1,110,188
<b>Food Stamp Recipients</b>	428,089	487,197	532,402	557,206	575,602	586,156	639,470	721,155	828,604	887,851
<b>Food Stamp Households</b>	180,457	205,208	228,218	241,177	249,914	253,443	273,876	306,562	355,626	388,271
<b>TANF</b>	151,269	146,783	148,788	141,055	135,206	117,311	122,743	119,912	104,004	69,906
<b>Number of Hoosiers enrolled in at least one program**</b>	<b>776,121</b>	<b>810,694</b>	<b>866,103</b>	<b>899,701</b>	<b>922,434</b>	<b>943,343</b>	<b>1,013,429</b>	<b>1,114,950</b>	<b>1,250,774</b>	<b>1,295,799</b>

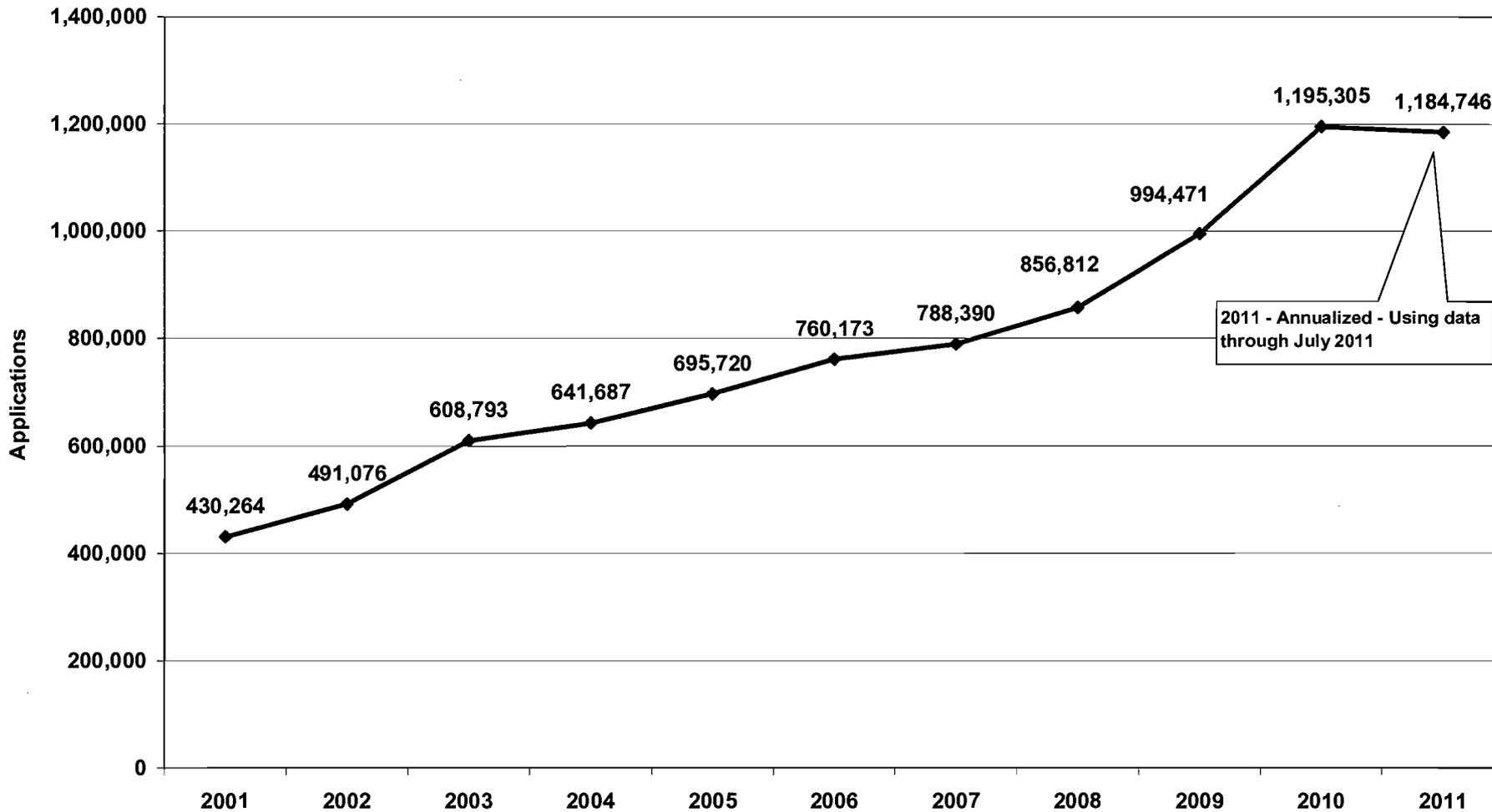
\* Medicaid increase in 2008 & 2009 affected by addition of HIP program (18,903 members in 2008 & 50,115 members in 2009). Medicaid numbers are from ICES and do not include retroactive coverage; numbers are slightly higher in actuality.

\*\* Program totals are comprised of only unique cases, and not a sum of individual program data.

Source: ICES

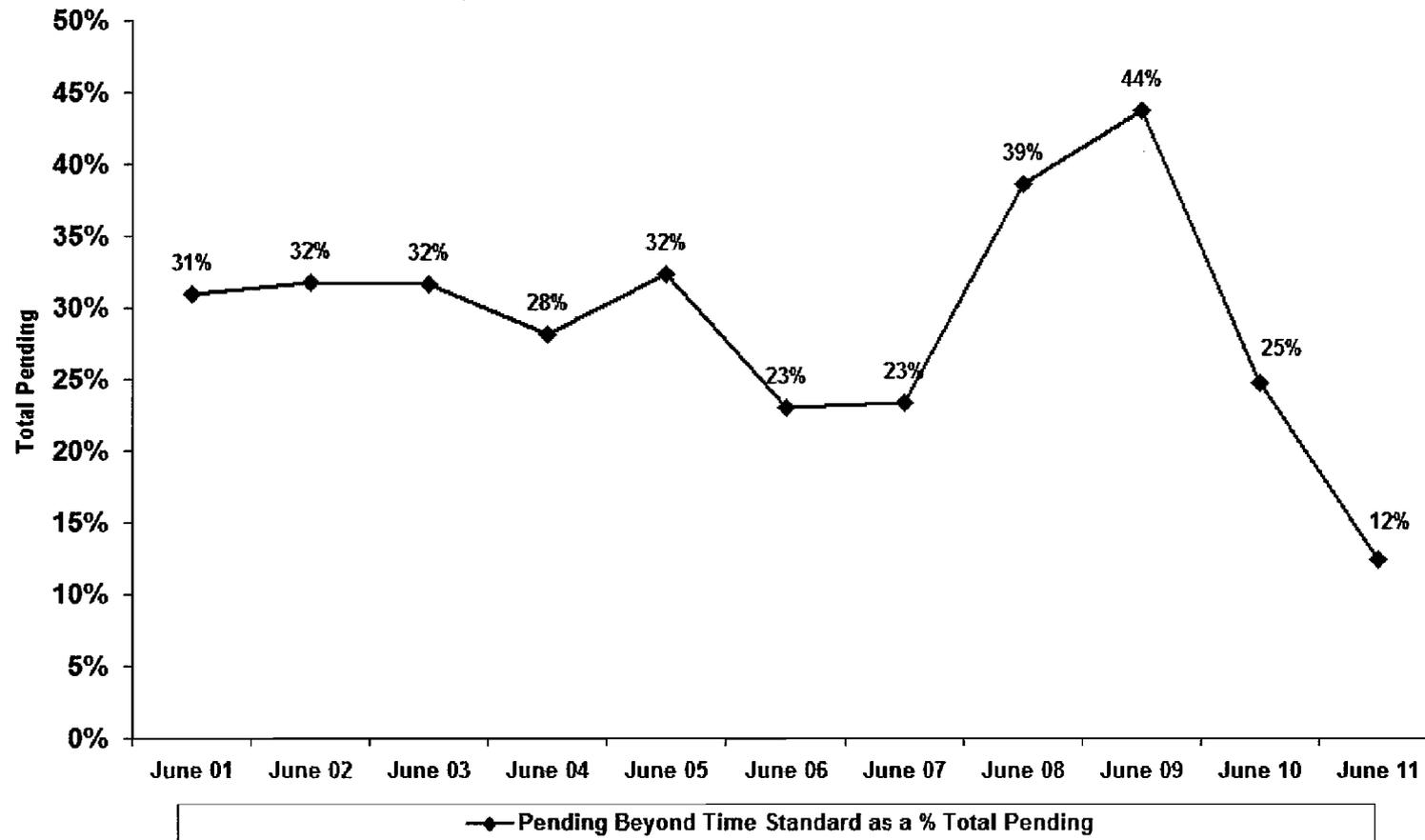


## New Applications for Assistance Groups Received in ICES Statewide





## Applications Pending Beyond Time Standard as a % Total Pending Applications Statewide





## Regional Application Backlog 12/5/09 to 8/1/11

Applications Pending and Late Excluding HIP											
	Lake	St. Joseph	Allen	Grant	Marion	Vigo	Vanderburgh	Clark	Tippecanoe	Wayne	State
Week Ending	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Total
12/05/09	1,309	830	3,941	3,468	3,907	2,338	2,427	3,053	3,357	1,389	26,019
07/30/11	467	402	1,219	661	1,098	159	122	400	163	66	4,757
Increase/Decrease	-64%	-52%	-69%	-81%	-72%	-93%	-95%	-87%	-95%	-95%	-82%

Source: Cognos Application Tracking Dashboard  
 Note: The change shown is relative to the 12/5/09 backlog



# SNAP Error Rates

- In June, FSSA received a bonus payment of **\$1.6M** from FNS for its reduction in positive error rate during FFY10. The bonus was for achieving 2<sup>nd</sup> most improved in the nation.
- FNS also released national rankings for FFY10.
  - #10 in the nation for positive error rates compared to #53 in the nation in FFY09.
  - #12 in the nation for negative error rates compared to #45 in the nation in FFY09.
- FFY11 error rates are on target – both positive and negative error rates are better than the national averages.



# Performance Improvements

- Timeliness.
  - Statewide timeliness in December 2009 was 71.8%. All program timeliness in July 2011 was 88.7%.
  - Recent 6 month timeliness for SNAP applications was 95.97%, as reported by FNS. By comparison for the same period in 2009, SNAP application timeliness was 79.91%.
- Call abandonment rates.
  - The abandonment rate for calls offered in the Hybrid Regions remains below the industry standard of 5%.
    - Locals office calls (in Hybrid regions) answered year to date are 205,602 with an abandonment rate of 2.6%.
    - Regional change center calls answered year to date are 549,880 with an abandonment rate of 4.3%.
- Medicaid Disability Applications (Thornton Lawsuit).
  - The percentage of pending Medicaid Disability applications over 90 days old continues to decline.
    - April 2009: 41.7%.
    - July 2011: 11.7% (Below upper allowable threshold of 13-16%).
- Client inquiries have been reduced by 40% since 2009.



## Performance: Pre, During & Post IBM

	<b>Pre-IBM (2006)</b>	<b>IBM (2009)</b>	<b>Post-IBM (current)</b>
<b>New Applications</b>	760,173	994,471	1,184,746 (annualized)*
<b>Total Enrollment</b>	922,434	1,114,950	1,295,799
<b>Application Backlog - ICES</b>	10,603	31,796	4,757
<b>All-Program Timeliness – ICES</b>	77.2%	66.4%	88.7%
<b>Error Rates - FNS</b>			
<b>Indiana Positive</b>	6.64%	7.13%	2.49% (FFY10)
<b>National Positive</b>	5.99%	4.63%	3.64% (FFY10)
<b>Indiana Negative</b>	6.37%	13.69%	3.81% (FFY10)
<b>National Negative</b>	8.02%	9.41%	8.43% (FFY10)

\*Annualized through end of 2011

# Update on Exchanges

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**SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT  
SEEMA VERMA  
AUGUST 23, 2011**

**Exhibit B  
Select Joint Commission on  
Medicaid Oversight  
Meeting #1 August 23, 2011**

# Recent Progress

- Healthy Indiana Plan (HIP).
  - State Plan Amendment.
    - Response expected from CMS by October 19.
  - Preparation of 1115 waiver.
- Other Initiatives:
  - Rules on new insurance regulations 9/10.
  - Correct Coding Initiative (CCI).
  - Provider credentialing.
  - MLR waiver phase-in.
  - Adequate authority.

# Recent Progress Continued

- Medical Loss Ratio (MLR):
  - Asked for MLR adjustment from HHS.
    - Phased-in approach.
    - Consideration of CDHPs.
  - Responding to questions from the federal government.
- Rate Review:
  - Deemed adequate by federal government.
  - Enhanced reporting requirements to HHS.
- External Review:
  - In compliance through 2014.
  - July 31, 2011 – federal government will make a determination regarding whether the State is compliant beyond 2014.

# Grants

- State applied for:
  - Grants to States for Health Insurance Premium Review.
  - Expansion of MIPPA.
  - ADRC Options for Counseling and Assistance Programs.
  - ADRC Evidence-Based Care Transition Programs.
  - ADRC Nursing Home Transition and Diversion Program.
  - Maternal, Infant and Early Childhood Visiting Program.
  - Strengthening Public Health Infrastructure for Improved Health Outcomes.
  - Exchange Planning Grant.
  - Exchange Level One Grant.
  - Coordinated Care for People with Medicaid and Medicare.\*
- Areas where grants and/or demonstrations will become available: Medicaid/Medicare payments, physician access, public health and education.

# Constitutionality of the Individual Mandate

Case	District Court	Appellate Court	Next Steps
<i>State of Florida et al. v. Secretary of Dept. of HHS</i> – Filed on behalf of 25 states and the NFIB (includes Indiana Attorney General).	January 31, 2011: Judge Robert Vinson deemed individual mandate <b>unconstitutional and non-severable.</b>	On appeal in 11 <sup>th</sup> Circuit Court of Appeals. Oral arguments held on June 8 <sup>th</sup> . <b>Deemed individual mandate unconstitutional. Reversed severability ruling.</b>	Widely accepted that case will go to Supreme Court.
<i>Commonwealth of Virginia v. Sebelius.</i>	December 13, 2010: Judge Henry Hudson deemed individual mandate <b>unconstitutional but did not strike down entire ACA.</b>	On appeal in 4 <sup>th</sup> Circuit Court of Appeals. Oral arguments held on May 10 <sup>th</sup> .	Appellate Court ruling is pending.
<i>Thomas More Law Center v. Barack Obama.</i>	<b>Upheld individual mandate</b> under the commerce clause.	Appealed to 6 <sup>th</sup> Circuit Court of Appeals. <b>Upheld validity of individual mandate.</b>	Thomas More Law Center has petitioned Supreme Court for review.

# Exchange Functions

***Expedia* for health insurance: a tool with which individuals or small employers can find, compare and enroll in health insurance.**

- Eligibility for Medicaid and tax credits.
- Place to go to compare cost and quality of health plans.
- Enrollment in health plans.
- Certify, recertify and decertification of plans offered on Exchange.
- Assign quality ratings to plan, per HHS guidelines.
- Customer support.
- Education and outreach.
- Small Business Options Program (SHOP) – small business exchange.
- Stop loss & risk adjustment for plans.

# ACA & Healthcare Exchanges

- Only place to purchase insurance with tax subsidies.
- Options:
  - State or federally operated.
    - Fully state.
    - Federal.
    - Federal/state partnership – Exchange cedes some functions to the feds.
  - State or regional or multi-state Exchange.
  - State agency, not-for-profit or quasi-governmental.
- Funded through 2015 by feds; after that must be self-sustaining.

# Tentative Exchange Implementation Timeline

June 2012 (estimated)	Federal assessment of State readiness.
January 2013 (final, per ACA)	Federal decision whether State or Federal Government will operate the Exchange.
October 2013 (estimated)	Potential go-live.
January 1, 2014	ACA implementation date.

# Update on Indiana's Efforts

- **Executive Order was issued by Governor Daniels on January 14, 2011.**
  - Does not commit the State to an Exchange.
  - Allows the State to plan for an Exchange and to study the implications of the Exchange.
  - State can stop if ACA is unconstitutional or for other reasons.
  - Conditionally establishes a not-for-profit entity to operate an Indiana-based Exchange.
  - Leverages current agencies (IDOI and FSSA) without creating new agencies.
- **Exchange Grants.**
  - No obligations if State decides to let the federal government run the Exchange for Indiana.
  - Planning Grant (October 2010).
  - Level 1 Establishment Grant (May 2011).

## Status of Activities

- Stakeholder input – Ongoing.
- Market Impact – actuarial analysis – In progress.
- IT gap analysis –Completed.
- IT plan to support Exchange – In progress.
- Business requirements – In progress.
- Budget Financing plan – In progress.
- Legal issues – Impact on IDOI and FSSA – In progress.

# Indiana Insurance Market

Market	2010 Covered Lives <sup>1</sup>	Carriers >100 Lives <sup>1</sup>	Market Share Largest Carrier <sup>2</sup>	Market Share Top 5 Carriers <sup>1</sup>
Individual	200,000	30	59.6%	85%
Insured Small Group (2-50 employees)	300,000	30	50.5%	79%
Insured Large Group (51+ employees)	475,000	25	62%	88%

<sup>1</sup>Source: Milliman. Indiana Supplemental Health Exhibits, December 31, 2010 Annual Statement data submitted by Indiana insurance carriers. Collected using Insurance Analyst Pro®, Highline Data LLC. July 26, 2011.

<sup>2</sup>Source: Noble. Indiana Supplemental Health Exhibits, December Annual Statement data submitted by Indiana insurance carriers. August 4, 2011.

Note: Values are based upon the most recent information obtained from carriers as they work to make the Supplemental Health Care Exhibits more accurate. The fluctuation (as compared to July 15, 2011 presentation to Health Finance), results from: specific information regarding what needed to be filed and how it is calculated not being divulged until very shortly before deadline, lack of training from the federal government regarding the new forms, and a new requirement imposed upon carriers for 2011 reporting. The IDOI continues to reach out to carriers to encourage complete and accurate filing. This information is only reflective of the market on 12/31/2010.

# Hoosiers with Employer Sponsored Insurance (ESI)

Employer Size	Number of Establishments	Percent of Employees in Establishments	Percent of Employees in ESI, in Establishments	Enrolled Employees
< 50 Employees	96,236	51.3%	57.3%	184,227
50 to 99 Employees	4,768	93.4%	54.1%	96,896
> 99 Employees	32,642	99.5%	61.3%	975,018
All Employer Sizes	133,646	86.5%	60.1%	1,256,141

\*Active private sector employment only. Does not include early retirees, public employees or individuals receiving COBRA.

Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – Agency for Healthcare Research and Quality, MEPS Insurance Component 2008 and 2009

# How Will the Market Change by 2019: Size

Source of Health Insurance	2010 Estimate	2019 Projection
<b>Uninsured</b>	875,000	300,000 – 525,000
<b>Public Programs</b>	950,000	1,450,000 – 1,625,000
<b>Individual Insurance</b>	200,000	450,000 - 875,000
<b>Employer-Sponsored Insurance</b>		
Insured Small Group (2-50 employees)	300,000	225,000 – 300,000
Insured Large Group(51+ employees)	475,000	350,000 - 475,000
Self-Funded (All employer sizes)	2,825,000	2,850,000 – 3,125,000
<b>Total Indiana Residents Ages 0 to 64</b>	5,625,000	6,200,000 – 6,500,000

Source: Herbold, Jill S. and Paul R. Houchens. Milliman, Inc. "2019 Health Insurance Enrollment Projections for Indiana." May 2011.

Assumes that Indiana does not offer a federal basic health program.

# How Will the Market Change by 2019: Cost

- Milliman estimates-

- Individual market:

- Total 75% to 95% increase.

- Merging high risk pool with individual market – 35% to 45%.

- Essential benefits/benefit expansion – 20% to 30%.

- Additional factors:

- Risk pool composition changes.

- Provider cost shifting.

- Manufacturer and carrier pass-throughs.

- Small group market:

- Total 5% to 10% premium increase.

- Risk pool composition due to items such as:

- Employers dropping coverage.

- Inclusion of employers up to 100 in small group market.

- Election of self-funded plans in community rating environment.

Source: Herbold, Jill S. and Paul R. Houchens. Milliman, Inc. "Individual and Small Group Premium Changes Under the ACA." May 2011.

# How many Hoosiers may use an Exchange?

## Potential Users of a Health Insurance Exchange: Individuals

Individuals	Households	People
Currently Uninsured, 139-399% FPL	259,077	376,212
Currently with Individual Coverage, 139-399% FPL	76,734	123,993
Uninsured, above 400% FPL	38,343	90,089
Individual Coverage above 400% FPL	54,980	110,181
Total	429,134	768,133

Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – American Community Survey, Public Use Microdata Sample, 2009; MEPS Insurance Component, 2008-09 average; data on businesses with fewer than 25 employees and average wages less than \$50,000 per year from Department of Workforce Development.

**Potential Users of a Health Insurance Exchange:  
Small Businesses Currently Offering Employer Sponsored Insurance (ESI)**

	Employees	Dependents	Total enrollees
Offering ESI with fewer than 50 Employees			
Potentially Eligible for a tax credit	96,431	69,353	165,784
Not eligible for tax credit	87,795	69,682	157,477
*ESI with 50-99 Employees	96,896	72,788	169,684
Total	281,122	211,823	492,945

**Potential Users of a Health Insurance Exchange: Other Businesses**

Businesses with fewer than 50 employees, not currently offering health insurance	Number of employees	Number of establishments
Potentially Eligible for a tax credit	244,301	52,771
Not eligible for tax credit	60,917	10,841
50-99 employees, currently not offering insurance	12,656	687
Over 100 employees, currently offering insurance	1,590,568	32,054
Over 100, currently not offering insurance	7,993	588
Total	1,916,435	96,941

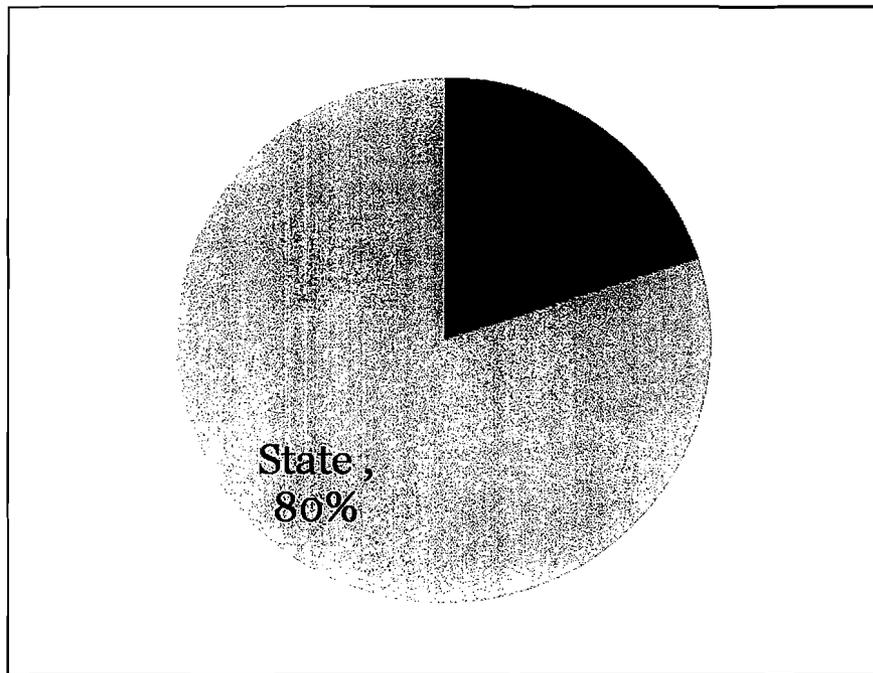
Source: State Health Access Data Assistance Center. "Memorandum." March 10, 2011. – American Community Survey, Public Use Microdata Sample, 2009; MEPS Insurance Component, 2008-09 average; data on businesses with fewer than 25 employees and average wages less than \$50,000 per year from Department of Workforce Development.

**Exchange Design Options**

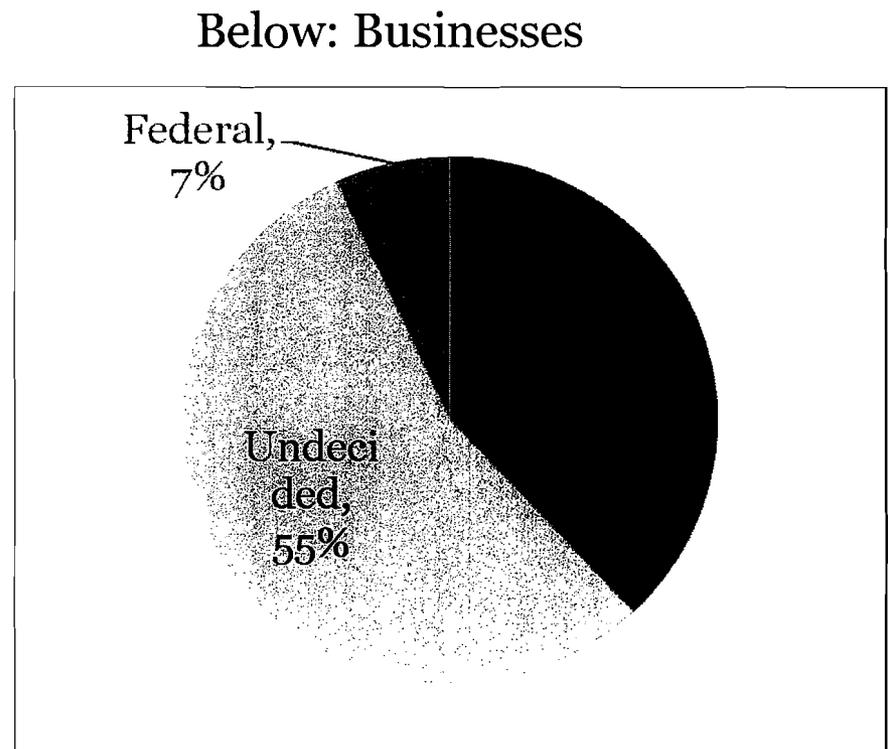
	<b>Farmer's Market – "Orbitz"</b>	<b>Evaluator Model – "Amazon"</b>	<b>Active Purchaser – "MA Model"</b>	<b>Federal Option</b>
Characteristics	<ul style="list-style-type: none"> <li>•Required functions only</li> <li>•Does not influence the market in any meaningful way</li> </ul>	<ul style="list-style-type: none"> <li>•Rates plan</li> <li>•Identifies "Top Tier" plans by HIX criteria</li> <li>•Market Catalyst</li> </ul>	<ul style="list-style-type: none"> <li>•Negotiates Prices</li> <li>•Bulk Purchaser</li> <li>•May include Medicaid &amp; Public Employees</li> </ul>	Unknown
Consumer Impact	Choices maximized	Choices maximized	Limited choice	Unknown
Small & Individual Market	Maintains separation	Maintains separation Authority to combine	Combines markets	Unknown
External Market	Yes - Exchange rules don't apply externally Benefits of the plan may vary	Yes - Level playing field inside and outside the Exchange	No - None allowed	Unknown
Users	People eligible for tax credits Some additional users	People seeking tax credits Could attract users over time for ease of comparison	High (requires participation)	Unknown
Operational Cost	\$	\$\$ Rating system will create increased administrative tasks	\$\$\$ RFP process	Unknown
Advantages	<ul style="list-style-type: none"> <li>•Preserves competition</li> <li>•Preserves choices</li> <li>•Minimal market disruption</li> </ul>	<ul style="list-style-type: none"> <li>•Competition based on Exchange defined criteria</li> <li>•Preserves choices</li> <li>•Minimizes market disruption but can act quickly to address issues</li> <li>•Influences external market to price variation inside/outside Exchange</li> </ul>	<ul style="list-style-type: none"> <li>•Lowest price products</li> </ul>	Unknown
Disadvantages	<ul style="list-style-type: none"> <li>•Passive to the market</li> <li>•Exchange attracts only high risk or subsidized individuals only</li> <li>•Limited # of plans participate</li> </ul>	<ul style="list-style-type: none"> <li>•Rating protests</li> </ul>	<ul style="list-style-type: none"> <li>•Could decrease number of insurers</li> <li>•Limited choices of plans &amp; networks</li> <li>•Fewer insurers may ultimately lead to higher prices</li> </ul>	Unknown
Small Business	Options: Defined contributions, promote HSA plans, Section 125 plans, wellness programs, HRA/HSA			
Quality	Provide a centralized location to obtain quality data for plans & providers			
Financing	Dependent on model. Options: advertising, fees to insurers, consumers, employers. Licenses/certifications for navigators/brokers.			

# Exchange: State v. Federal

The September 2010 questionnaire asked respondents to identify who should operate the Exchange.



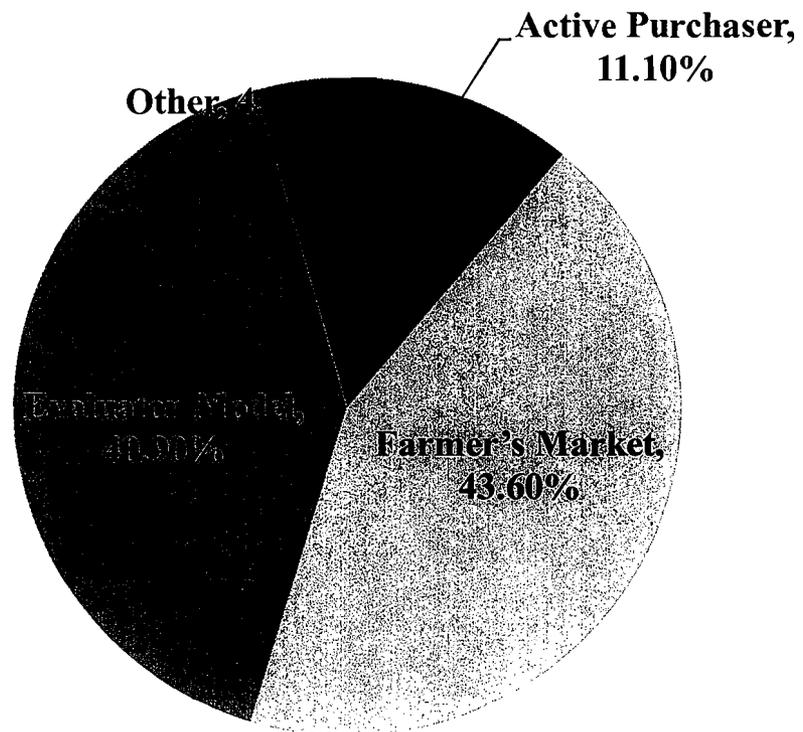
Above: Insurers



Source: Affordable Care Act Questionnaire. State of Indiana. December 1, 2010. <[http://www.in.gov/aca/files/Affordable\\_Care\\_Act\\_Questionnaire\\_Report.pdf](http://www.in.gov/aca/files/Affordable_Care_Act_Questionnaire_Report.pdf)>

# Exchange Model

**Respondent average: Which model do you think would work best for Indiana?**



# Implications of a Federal Exchange

- No federal model has been offered.
- Cheaper for the State.
- Plan offerings:
  - Could limit plan choices for Hoosiers.
  - Geographic carrier/plan issues.
- Would require carriers to interface with two tiers of government for plan certification: State and federal.
- Federal government would be responsible for risk adjustment and reinsurance which redistribute dollars among plans.
- Medicaid eligibility:
  - Federal government making eligibility determinations on behalf of the State.
  - Multiple entry doors.
- Loss of control over customer experience.
- Limited influence over policy.

## Requirements for Health Plans to Offer on an Exchange

- July 15<sup>th</sup> Notice of Proposed Rulemaking.
- Administrative requirements significant, such as:
  - IT system must be compatible with HIX.
    - Eg. Accept enrollment files.
    - Eg. Report enrollment back to HIX monthly.
    - Eg. Potentially accept payment.
  - Additional rules for plan certification and new requirement to become accredited with federal government.
  - Readiness assessment.
  - Review of all marketing materials by HIX or IDOI.
  - Provider list given to Exchange.

# Implications for a State-based Exchange

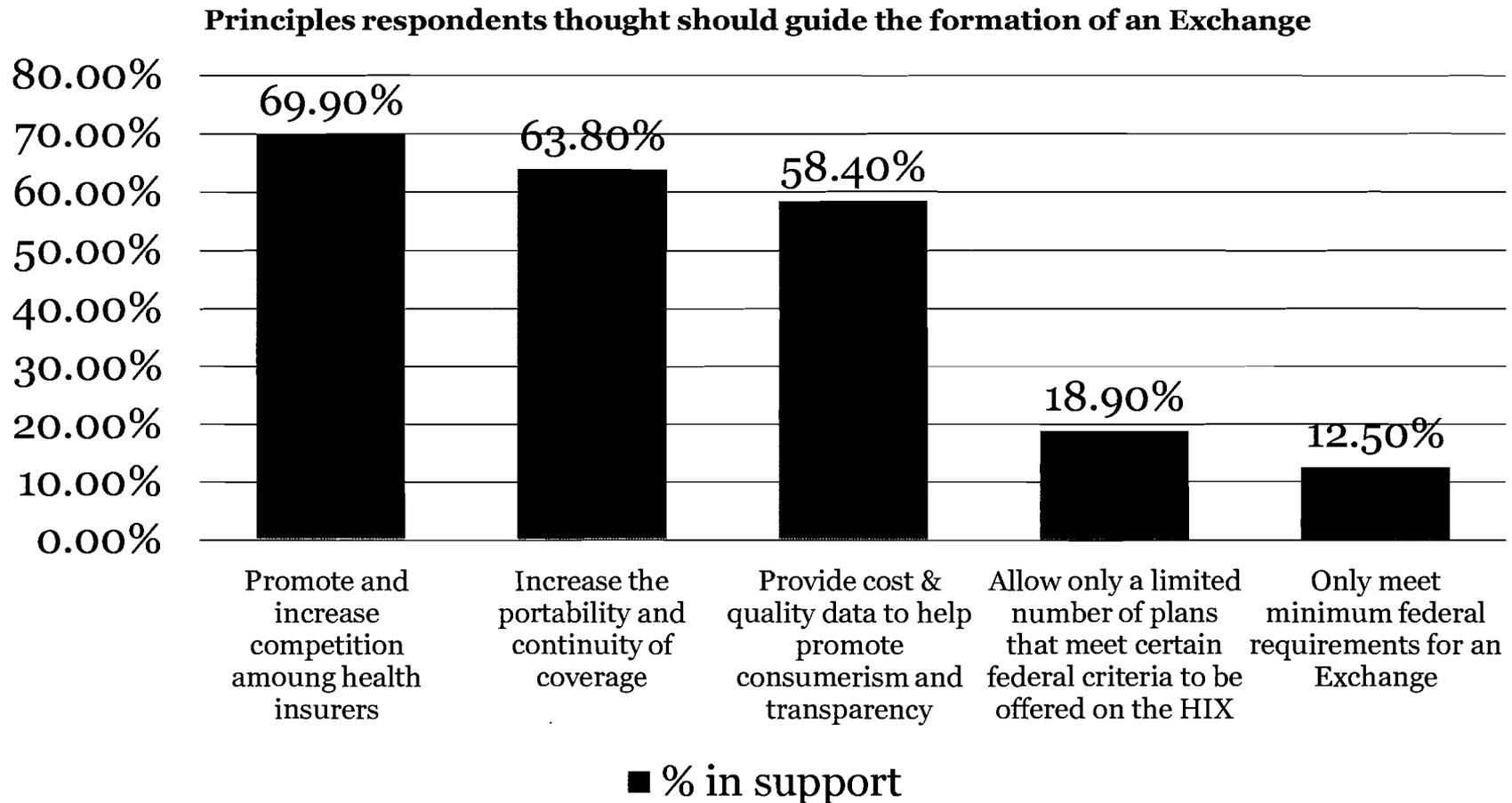
- **Exchange:**

- On-going costs: could these costs increase premiums for the State?
- Complexity.
- Large number of Hoosiers that will use the Exchange.
- State would be responsible for ambitious federal deadline.
- Could create instability in the market.

# Exchange Questionnaire

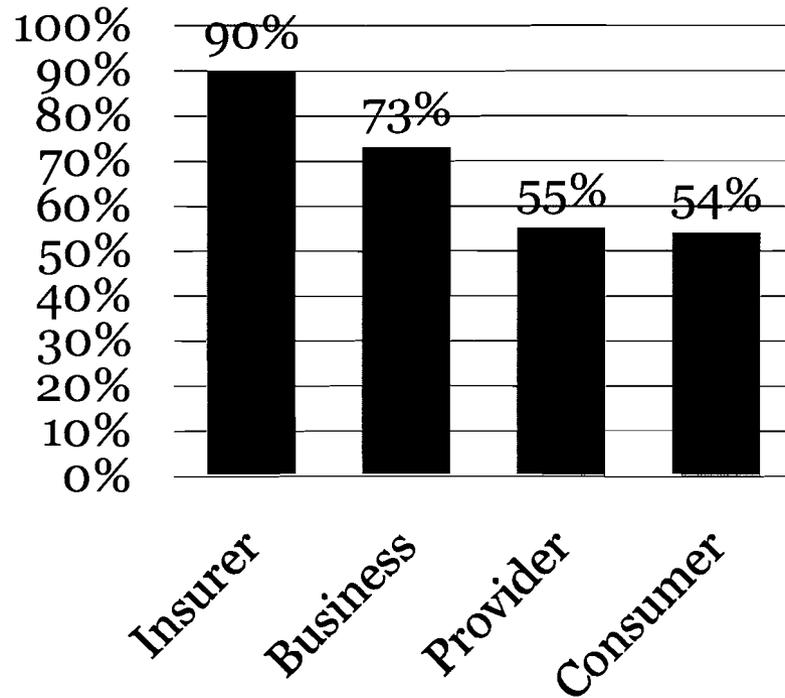
- 4 tracks.
  - Insurer/Broker.
  - Consumer.
  - Business.
  - Healthcare Provider.
- Exchange Design Topics.
- ~2,600 Respondents.
  - 1461 Consumers, 524 Businesses, 414 Insurers/Brokers, 213 Healthcare Providers.

# Exchange Questionnaire: Exchange Goals



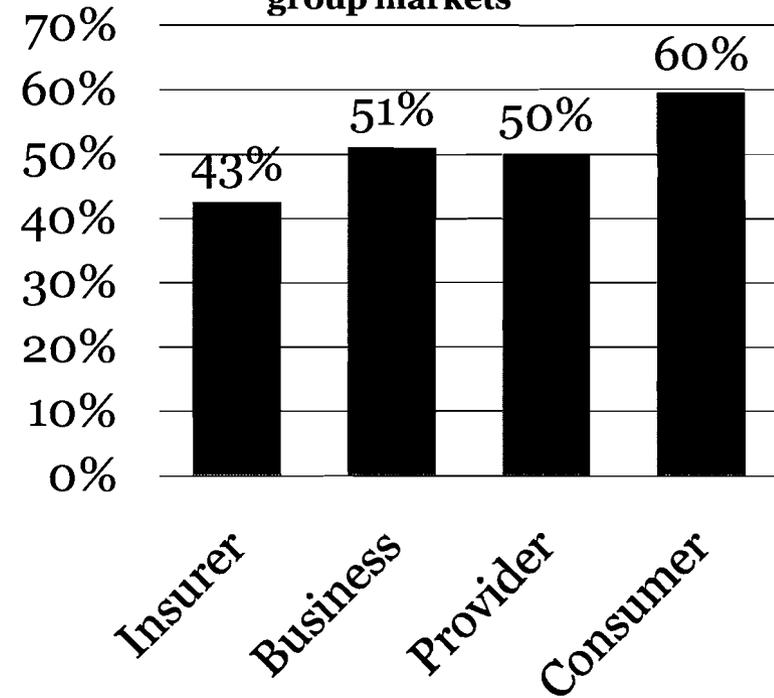
# Exchange Questionnaire: Insurance and Exchange Marketplace

**The HIX should not be the sole avenue  
to purchase insurance**



■ % in agreement

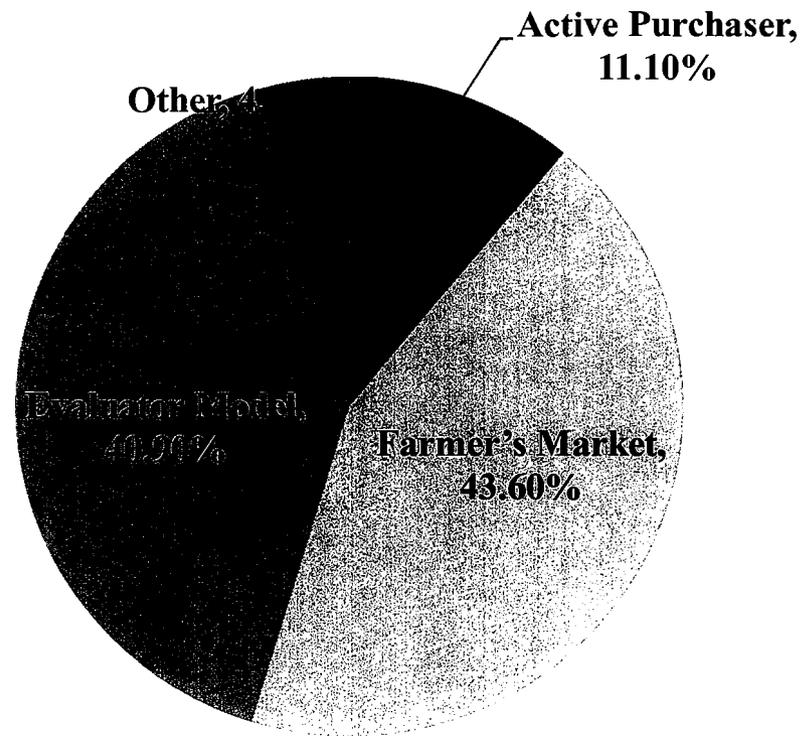
**The rules should be the same in and  
out of the HIX for individual and small  
group markets**



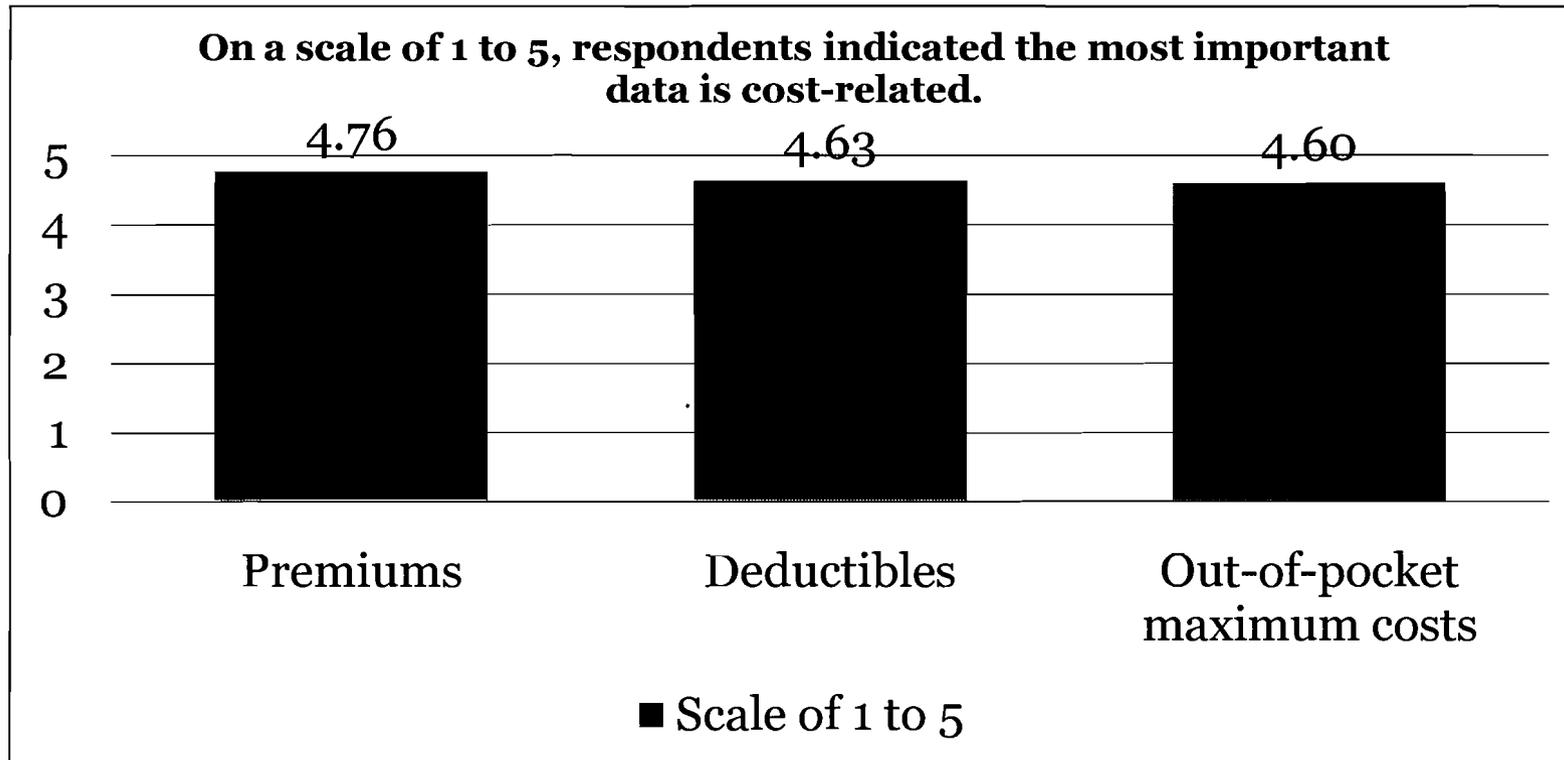
■ % in agreement

# Should all Indiana insurers be required to sell on the Exchange?

**Respondent average: Which model do you think would work best for Indiana?**

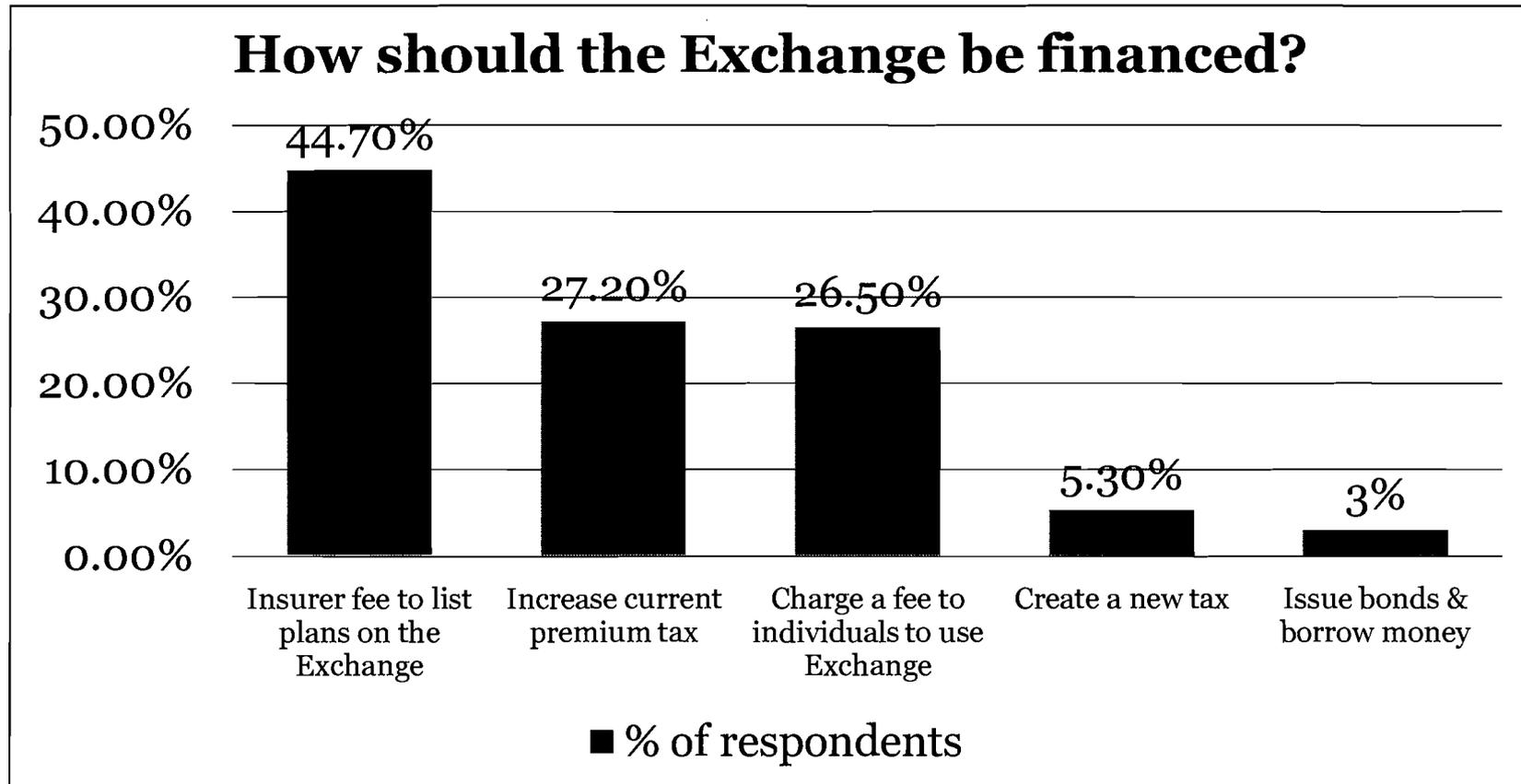


# Exchange Questionnaire: Exchange Data



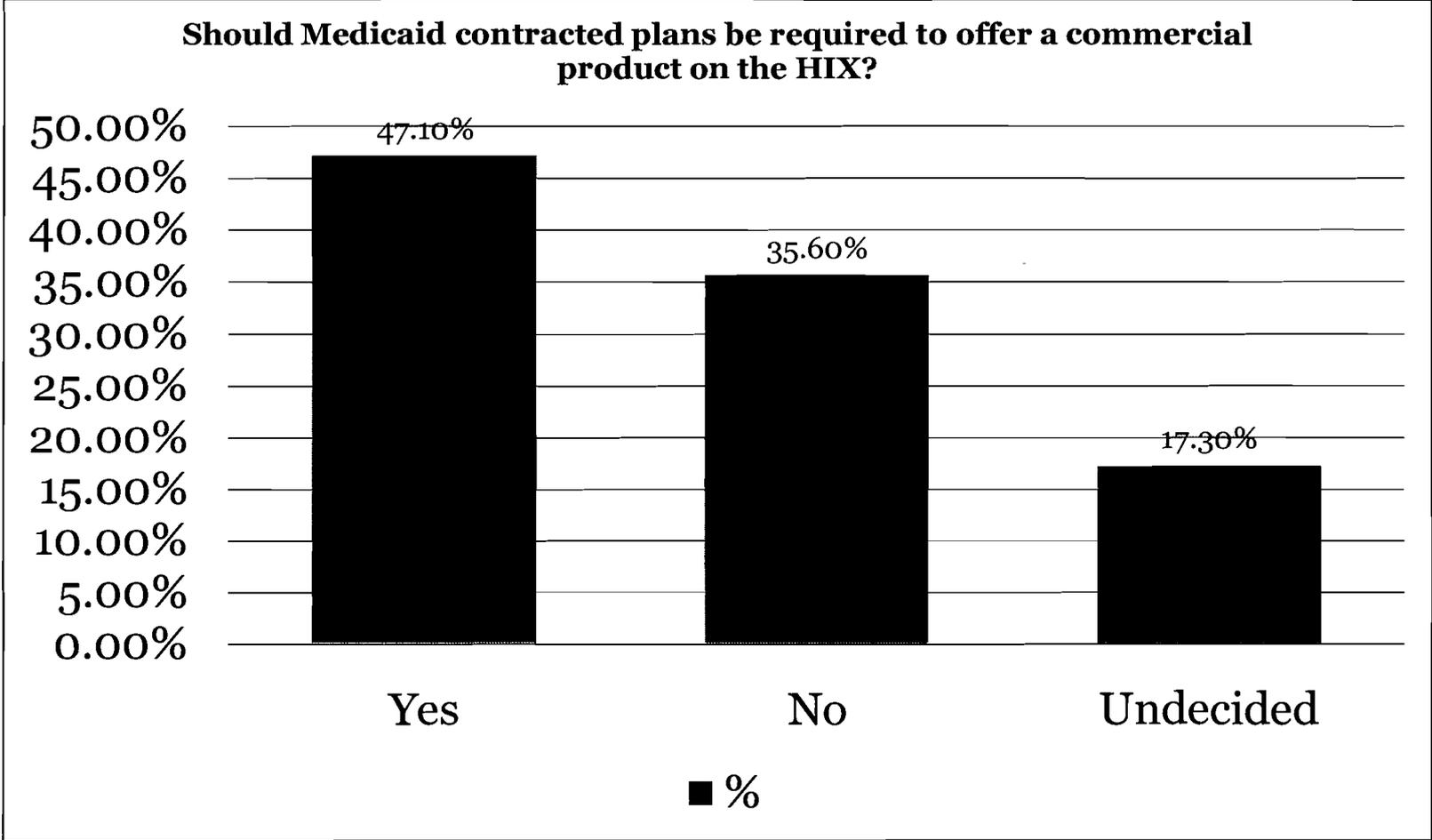
- 41% of respondents are not willing to pay any increase in premium cost for quality data reporting that goes above and beyond the federal requirements.

# Exchange Financing



- Respondents commented that if the Exchange was going to cost additional tax payer funds, then the State should not consider implementing it.

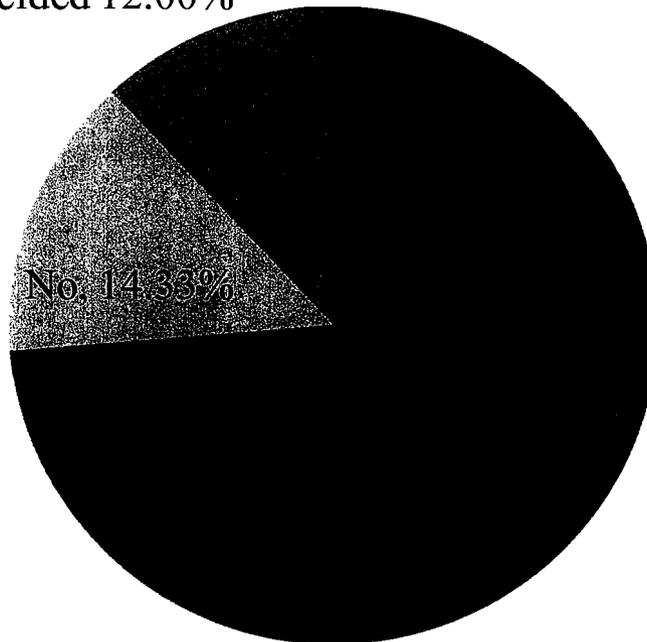
# Exchange Questionnaire: Exchange and Medicaid



# Exchange Questionnaire: SHOP Exchange

**Should the Exchange consider offering a defined contributions option for employers?**

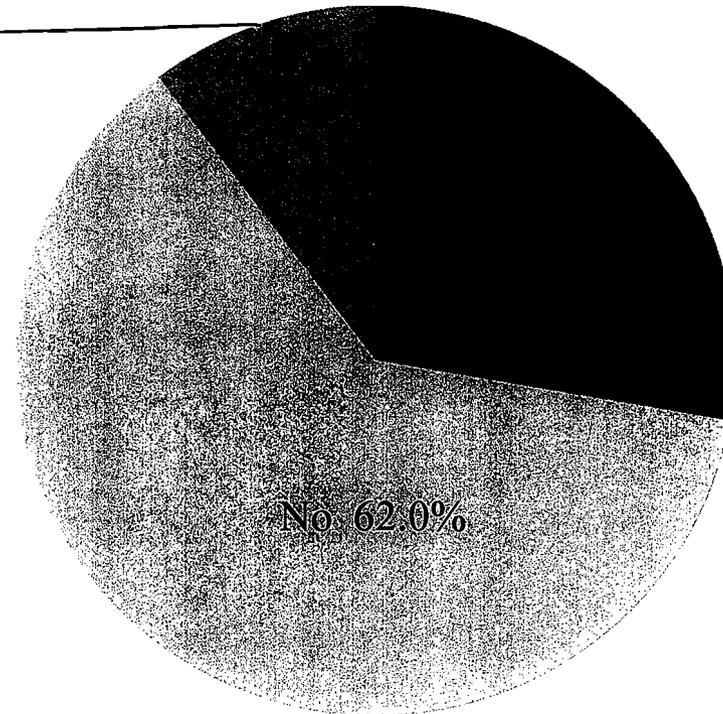
Undecided 12.00%



# Exchange Questionnaire: Premiums and Health Plan Enrollment

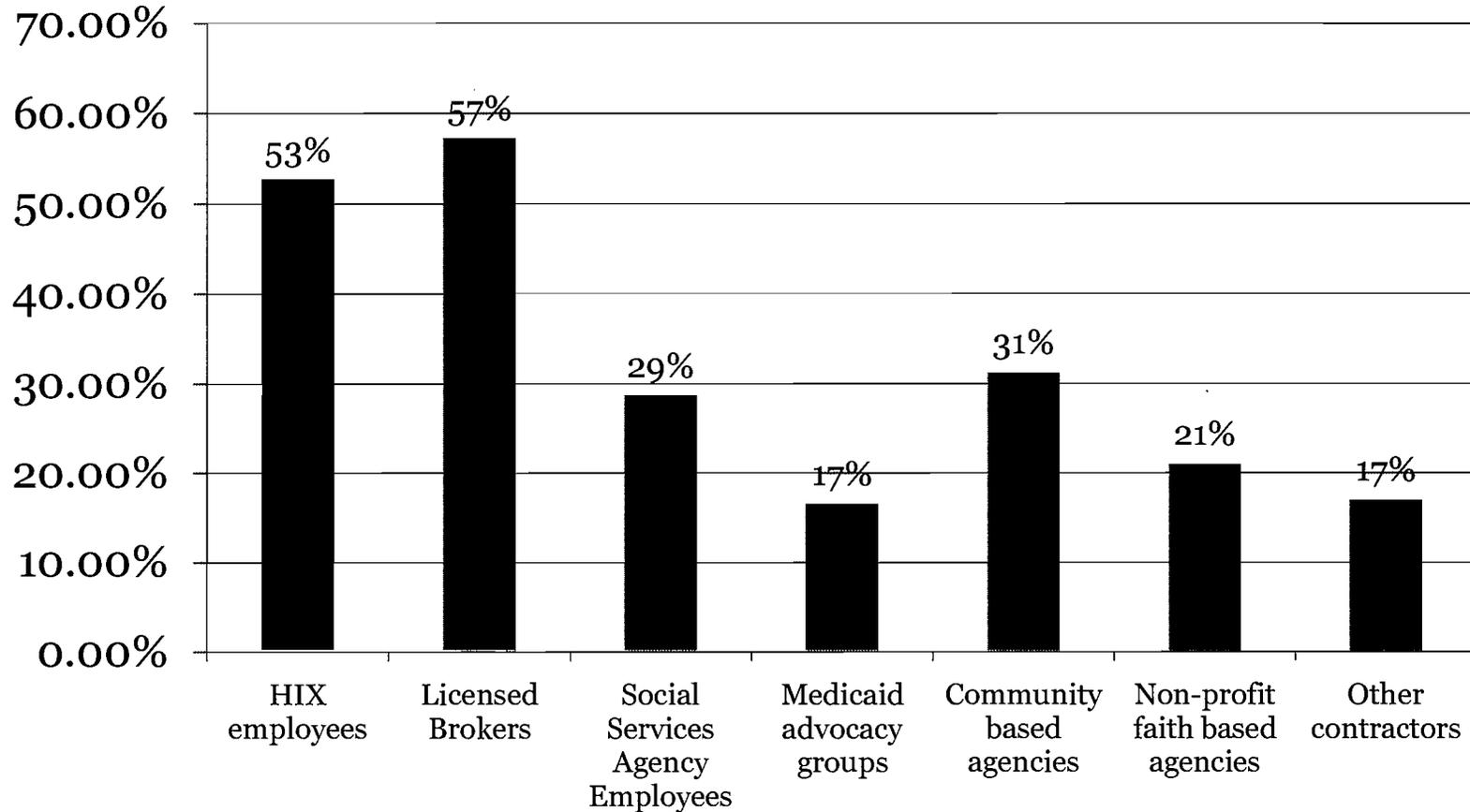
**Should the Exchange collect premiums for individuals?**

Undecided 10.4%



# Exchange Questionnaire: Brokers and Navigators

**What role should the Exchange Navigators play?**



Respondents could select multiple options; this is the average among all four respondent groups.

More information available at  
[Nationalhealthcare.in.gov](http://Nationalhealthcare.in.gov)

Select the “Resources” page.



# OFFICE OF MEDICAID POLICY AND PLANNING UPDATE

Select Joint Commission on Medicaid Oversight  
August 23, 2011



Exhibit C  
Select Joint Commission on  
Medicaid Oversight  
Meeting #1 August 23, 2011



# SEA 461

## Chapter 45. Medicaid Waivers and State Plan Amendments

**(d) Before January 1, 2012, the office shall do the following:**

**(1) Apply to the United States Department of Health and Human Services for approval of a state plan amendment to expand the population eligible for family planning services and supplies as permitted by Section 1902(a)(10)(A)(ii)(XXI) of the federal Social Security Act (42 U.S.C. 1315). In determining what population is eligible for this expansion, the state must incorporate the following:**

**(A) Inclusion of women and men.**

**(B) Setting income eligibility at one hundred thirty-three percent (133%) of the federal income poverty level.**

**(C) Adopting presumptive eligibility for services to this population.**



# Operational Requirements

- Amend Medicaid application and train eligibility staff
- Design and implement system changes
  - Eligibility systems (\$1.1M start-up estimate)
  - Claims system (Estimate in progress)
- Develop presumptive eligibility application
- Enroll and train Qualified Providers
- Outreach to potential eligible population



## Timeline

- Submit state plan amendment—January 1, 2012
  - Work with CMS to obtain approval
- Design new aid category and presumptive eligibility process—In progress
- Training and Outreach—Summer 2012
- Implementation target—October 1, 2012
- Family planning option aid category becomes obsolete—Health Reform 2014



# Cost Savings Initiatives

<b>Program Change</b>	<b>Effective Date</b>	<b>Expiration Date</b>
Inpatient Hospital 5% Rate Reduction	1/1/2010	6/30/2013
Outpatient Hospital 5% Rate Reduction	1/1/2010	6/30/2013
Home Health 5% Rate Reduction	4/1/2010	6/30/2013
Dental 5% Rate Reduction	4/1/2010	6/30/2013
Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Community Residential Facilities for the Developmentally Disabled (CRF/DD) 3% Rate Reduction	4/1/2010	6/30/2013
Developmental Disabilities Waiver Residential Habilitation 7% Rate Reduction	6/1/2010	Permanent
Elective inpatient prior authorization; all ages except newborns	1/1/2011	Permanent
Adult Therapy Service Limits	1/1/2011	6/30/2011
Transportation Rate Reduction (5% ambulance and 10% non-ambulance)	1/1/2011	6/30/2013
Chiropractic 5% Rate Reduction	1/1/2011	6/30/2013
Podiatry 5% Rate Reduction	1/2/2011	6/30/2013
Dental Cap Changed to \$1000	1/1/2011	Permanent
Aged and Disabled Waiver Attendant Care 5% Rate Reduction	1/1/2011	Permanent
Nursing Facility Leave Days Benefit Elimination	2/1/2011	Permanent



# Cost Savings Initiatives cont'd

<b>Program Change</b>	<b>Effective Date</b>	<b>Expiration Date</b>
Nursing Facility 5% Rate Reduction	7/1/2011	6/30/2013
Dispensing fee lowered to \$3.00	7/1/2011	6/30/2013
Lab and Radiology 5% Rate Reduction (non-hospital only)	7/1/2011	6/30/2013
Speech and Hearing Therapy 5% Rate Reduction	7/1/2011	6/30/2013
Durable Medical Equipment/Prosthetics 5% Rate Reduction and Manually Priced Updates	7/1/2011	5% Rate Reduction Ends 6/30/2013; Manual Pricing Updates are Permanent
Medical Supplies 5% Rate Reduction and Manually Priced Updates	7/1/2011	5% Rate Reduction Ends 6/30/2013; Manual Pricing Updates are Permanent
Hearing Aids Rate Updates for Manually Priced Items	7/1/2011	Permanent
Vision 5% Rate Reduction	7/1/2011	6/30/2013
Freestanding Dialysis 5% Rate Reduction	7/1/2011	6/30/2013
Targeted Case Management Benefit Elimination	7/1/2011	Permanent
Prior Authorization Required for Brand Medically Necessary Drugs	7/1/2011	Permanent

## Indiana Medicaid's 5% Reimbursement Cut for Optometrist-Provided Eye Care and Vision Wear

### Issue:

Indiana Medicaid has established a rule to reimburse Optometrists (ODs) 5% less than Ophthalmologists for providing for eye care and vision wear to Medicaid patients. The new policy means that ODs will be reimbursed less for the SAME EXACT – not similar - services as provided by an Ophthalmologist and will receive less for providing the SAME EXACT frames and lenses as an Ophthalmologist.

### Facts:

There are approximately 1400 ODs and 325 Ophthalmologists in Indiana. ODs practice in ALL 92 INDIANA counties, ophthalmologists do not. Ophthalmologists tend to be concentrated in suburban areas near larger cities.

Due to their numbers and locations, ODs are more accessible to Medicaid patients and are able to provide cost-effective and timely care in the communities where Medicaid patients live. They provide access to care for most Medicaid patients.

OD's provide the bulk of vision care and eye wear to Medicaid patients. Few Ophthalmologists provide primary eye care to Medicaid patients and very few Ophthalmologists dispense eyeglasses to Medicaid patients.

ODs, like most physicians and other Medicaid providers have not seen an increase in Medicaid reimbursement rates since the late 1990's. Medicaid reduced coverage for adult vision wear in January 2011. The January cut applied to both OD's and Ophthalmologists.

Tobacco tax funds were used to provide a slight increase to primary care physicians and dentists in the 2000's to ensure access to primary care and avoid the higher costs of specialty care for untreated conditions and diseases. Indiana Medicaid says that this increase established the policy of physicians being a "protected class" with regard to reimbursement cuts. Medicaid's discriminatory cuts of OD-provided eye care runs counter to the rationale the legislature used to increase reimbursement using tobacco tax funds.

Timely eye care not only helps correct vision so children can learn and the elderly can be independent, it can also detect more serious and costly diseases and conditions such as diabetes, hypertension and other problems that can lead to blindness.

Indiana Medicaid's policy appears to be aimed at reducing access to vision care and eye wear for the children and elderly patients on Medicaid by reducing the number of Optometrists who see Medicaid patients. The agency appears to be attempting to cut costs by cutting access.

A study by The New England Journal of Medicine published on June 16, 2011, said: "Children covered by Medicaid are more likely than those covered by private insurers to be denied treatment by medical specialists (ophthalmologists included) and to face wait times of more than one month for an appointment."

A US Gov't Accountability Office (GAO) study published in June 2011 found that physicians had difficulty referring Medicaid and CHIP covered children for specialty care, such as vision care.

**Studies finding inadequate physician-provided specialty care to children on public assistance:**

*New England Journal of Medicine (June 16, 2011):*

<http://www.nejm.org/doi/full/10.1056/NEJMsa1013285>

*US Gov't Accountability Office (June 30, 2011):*

<http://www.gao.gov/products/GAO-11-624?source=ra>

**Medicaid policy should be focused on access and its payments should be based on what services are provided. It should not be based making one class of providers a "protected class" or by giving preferred treatment to a very few providers who provide a particular type of care over others who provide the bulk of it.**

**Request:**

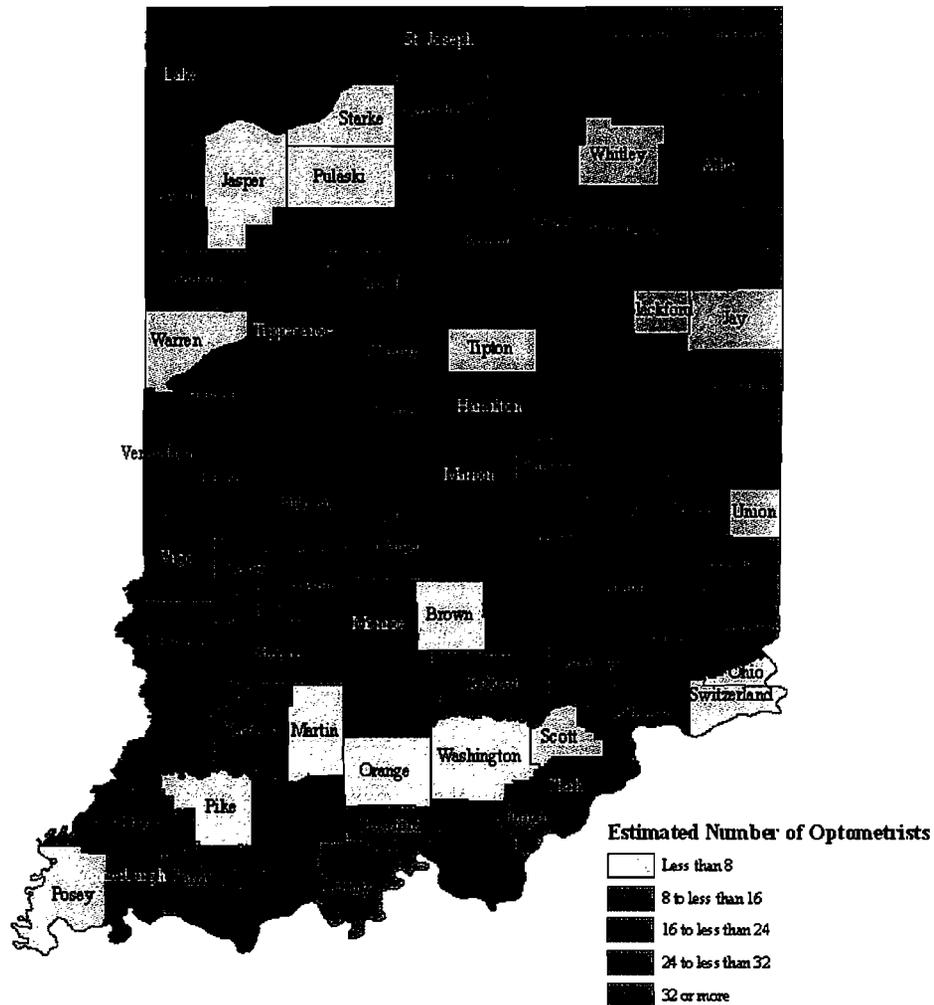
- **PLEASE HELP REVERSE INDIANA MEDICAID's POLICY OF DISCRIMINATING AGAINST ODs.**
- **PLEASE REVERSE THE POLICY THAT SEEKS TO REDUCE MEDICAID COSTS BY REDUCING ACCESS TO CARE.**

### Chapter 3: Location of Optometrists by County in Indiana

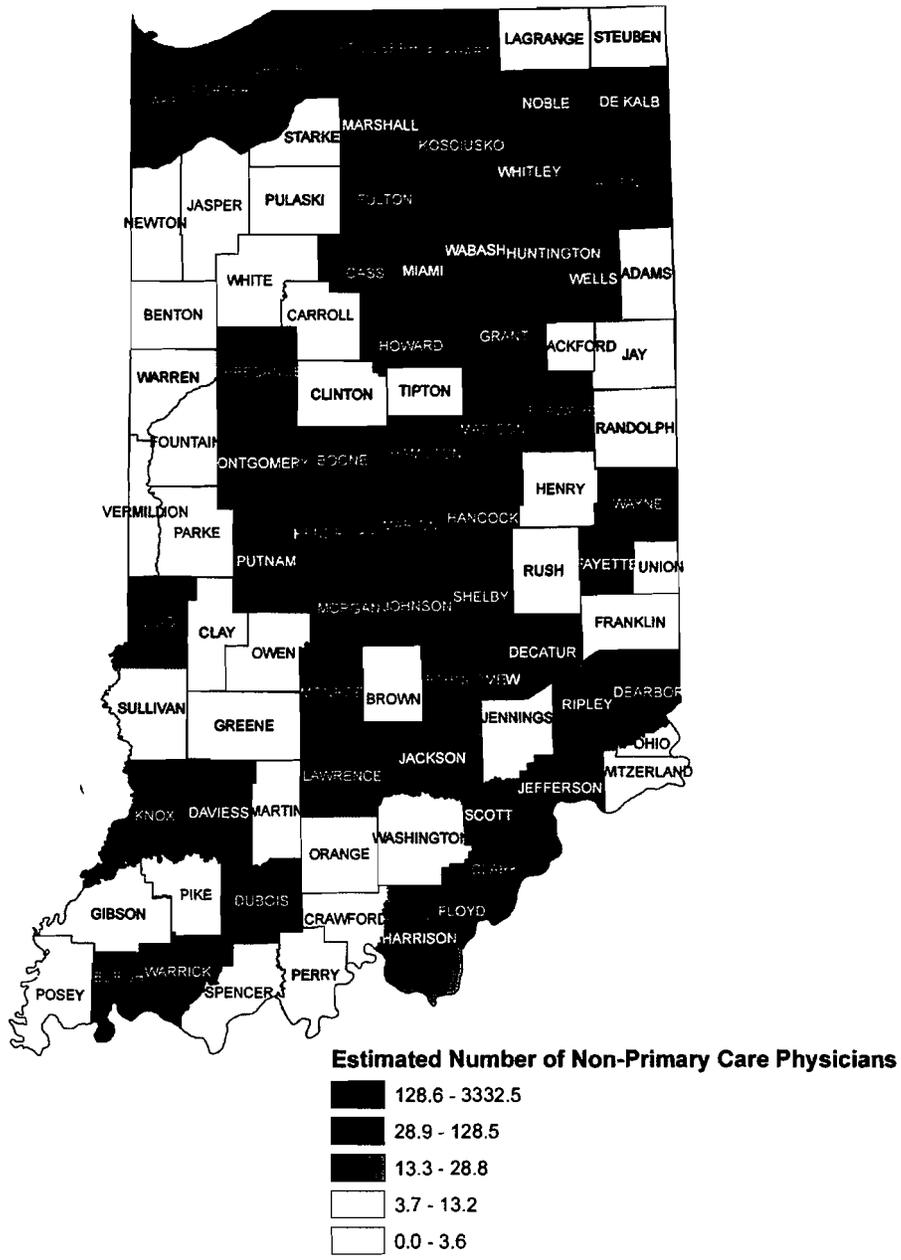
The following maps display the estimated number of optometrists by county and the ratio of optometrists per 10,000 residents based on the respondents' principal practice location. In order to illustrate the data as representative of the actual optometrist population in each county, the number of optometrists in each county was adjusted (weighted) per the response rate (86.6%) for the 2010 optometrist re-licensure survey. *Thus, the counts of optometrists and ratio are estimates of the actual number of optometrists in each county and not the number of respondents in each county.*

Map 3.1 shows that the number of optometrists in Indiana counties is distributed roughly by population. As expected, the counties with the largest populations have the greatest number of optometrists. These counties include Allen, Clark, Hamilton, Lake, Marion, Monroe, St. Joseph, Tippecanoe, Vanderburgh, and Vigo.

Map 3.1 Estimated Number of Optometrists by County, 2010



**Map 4.3 Estimated Number of Non-Primary Care Physicians by County, 2009**



Map 4.3 shows that the urban counties with the largest populations have the greatest number of non-primary care physicians. The counties include Allen, Bartholomew, Clark, Delaware, Elkhart, Hamilton, Hendricks, La Porte, Lake, Madison, Marion, Monroe, Porter, St. Joseph, Tippecanoe, Vanderburgh, and Vigo.

**Emergency Rule**  
LSA Document #11-379(E)

DIGEST

Temporarily amends 405 IAC 1-11.5-2 and 405 IAC 5-16-6 to modify Medicaid reimbursement formulas by reducing rates that are currently paid to speech therapists, audiologists, optometrists, opticians, independent laboratory providers, independent radiology providers, and freestanding renal dialysis clinics by five percent. Authority: IC 4-22-2-37.1(a)(37); IC 12-8-1-9(b)(2). Effective July 1, 2011.

SECTION 1. (a) This SECTION is supplemental to 405 IAC 1-11.5-2.

(b) Notwithstanding all other provisions of 405 IAC 1-11.5, for the period July 1, 2011, through June 30, 2013, reimbursement shall be reduced by five percent (5%) for speech therapists, audiologists, optometrists, opticians, independent laboratory providers, and independent radiology providers for services that have been calculated pursuant to 405 IAC 1-11.5.

SECTION 2. (a) This SECTION is supplemental to 405 IAC 5-16-6.

(b) Notwithstanding all other provisions of 405 IAC 5-16, for the period July 1, 2011, through June 30, 2013, reimbursement shall be reduced by five percent (5%) for freestanding renal dialysis clinics for services that have been calculated pursuant to 405 IAC 5-16.

SECTION 3. SECTIONS 1 through 2 of this document take effect July 1, 2011.

SECTION 4. SECTIONS 1 through 2 of this document expire June 30, 2013.

*LSA Document #11-379(E)*  
*Filed with Publisher: June 23, 2011, 2:05 p.m.*

*Posted: 06/29/2011 by Legislative Services Agency*  
An [html](#) version of this document.



# Evansville Eyecare Associates, Inc.

Dr. Roger Haywood • Dr. Kim Haywood-Pfender • Dr. Michelle Egenmaier • Dr. Kyle King  
*Family Eyecare • Contact Lenses • Treatment of Ocular Disease*

The Honorable Mitchell F. Daniels, Jr.  
Office of the Governor  
Indiana Statehouse  
Indianapolis, IN 46204

13 June 2011

Governor Daniels,

I write to you today as a concerned Hoosier optometrist. Recently a bill was passed that would reduce reimbursements to optometrists to 5% less than that paid to Indiana ophthalmologists for the same care rendered to Indiana Medicaid patients. I understand that our current economic climate forces cuts in many areas, including physician reimbursements. I do not, however, feel that discrimination against our doctors of optometry is appropriate. If cuts are to be made, they should be made across the board.

As optometrists we provide the same level of care and products to our patients as our ophthalmology colleagues. The exam coding is the same, but Indiana Medicaid will pay optometry less than ophthalmology based on the degree we have earned, not the services provided.

Indiana has one of the best schools of optometry in the country and is often considered a great place to practice optometry because of our favorable laws regarding the practice thereof. It would be a shame for the great State of Indiana to begin discriminating against optometry in favor of ophthalmology.

I have been a supporter of yours in both of your elections and during your time in office as Governor. I have proudly displayed My Man Mitch shirts, bumper stickers, and even signed RV1 during your re-election campaign. I hope you will revisit this issue with the understanding that optometrists should be treated as equals when performing equal care and treatment for our Hoosier neighbors. I would greatly appreciate a response on this matter.

Sincerely yours,

A handwritten signature in cursive script that reads "Kyle W. King O.D." with a stylized flourish at the end.

Kyle W. King, O.D.



"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor  
State of Indiana

Office of Medicaid Policy and Planning  
MS 07, 402 W. WASHINGTON STREET, ROOM W382  
INDIANAPOLIS, IN 46204-2738

June 22, 2011

Evansville Eyecare Associates  
Kyle W. King  
213 Main Street  
Evansville, IN 47708-1445

Dear Mr. King;

Thank you for your recent inquiry regarding 5% reduction in reimbursement paid to optometrists and opticians. Your message was forwarded to the Family and Social Services Administration (FSSA) which oversees the Office of Medicaid Policy and Planning (OMPP).

In April 2011, the Indiana General Assembly passed a budget bill that included an allocation to FSSA for the next two state fiscal years. The FSSA allocation required the agency to find \$212M in administrative savings. In order to remain within our fiscal allocation and achieve our administrative savings target for the biennium, FSSA is making changes to provider reimbursement rates and member benefits. Information on this and other reductions was presented during the 2011 Legislative Session to the House Ways and Means Committee and the Senate Appropriations Committee. The 5% reduction in reimbursement paid to optometrists and opticians will be effective July 1, 2011 and sunset at the end of the biennium, June 30, 2013.

*Inaccurate*

*Nonrespon*

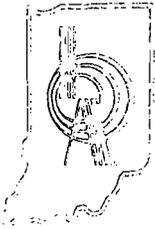
Again, thank you for your inquiry and for this opportunity to be of service.

Sincerely,

Kristina Moorhead  
Office of Medicaid Policy and Planning  
Family and Social Services Administration

Cc: Governor Mitch Daniels





# INDIANA OPTOMETRIC ASSOCIATION

---

June 21, 2011

Patricia Casanova  
Director  
Office of Medicaid Policy and Planning  
Family and Social Services Administration  
402 W. Washington Street  
PO Box 7083  
Indianapolis, IN 46207-7083

RE: Public Records Request  
Sent via Facsimile to 317.233.4693

Dear Ms. Casanova:

On behalf of the members of the Indiana Optometric Association and pursuant to the Access to Public Records Act (Ind. Code 5-14-3), I respectfully request the following information:

- The number of licensed optometrists currently enrolled as Indiana Medicaid Providers to provide vision services.
- The number of licensed ophthalmologists enrolled as Indiana Medicaid Providers to provide vision services.

I understand that you may assess a fee for a copy of appropriate records and am willing to pay said fee in advance. As you are aware, the statute provides that you have seven (7) days to respond to this request. If you choose to deny the request, you are required to respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.

I can be reached at the address and phone number on the letterhead or via email at [bmcnutt@ioa.org](mailto:bmcnutt@ioa.org). Your assistance is appreciated.

Sincerely,

Barbara Marvel McNutt  
General Counsel



"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor  
State of Indiana

**Indiana Family and Social Services Administration**  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

June 29, 2011

Barbara McNutt  
251 N. Illinois St., #980  
Indianapolis, IN 46204

Dear Ms. McNutt,

This letter responds to your June 21, 2011 request for reports within the possession or control of the Indiana Family and Social Services Administration (FSSA). Your request was received on June 23, 2011 by the Office of Medicaid Policy and Planning (OMPP). You have requested:

- The number of licensed optometrists currently enrolled as Indiana Medicaid Providers to provide vision services.
- The number of licensed ophthalmologists enrolled as Indiana Medicaid Providers to provide vision services.

The data that you have requested will not be provided to you at this time for the following reason. The Indiana Access to Public Records Act does not require state agencies to reprogram computers to provide requested data, according to Indiana Code §§ 5-14-3-2 and 5-14-3-6(d)(1), which would be a requirement in order to facilitate the data that is being requested.

The OMPP does have a report that was generated for normal business with the number of optometrists and ophthalmologists for calendar year 2010. These counts represent a distinct number of LPs. A provider may render services under multiple LPs or multiple providers may bill under one LP, thus this is not a distinct provider count.

Medicaid Enrolled Optometrists for CY2010	1,049
Medicaid Enrolled Ophthalmologists for CY2010	779

*IN has  
1400 OOs  
325 OMDs*

Thank you for your inquiry.

Sincerely,

Kristina Moorhead  
Office of Medicaid Policy and Planning



**Jim Zieba**

---

**From:** Mills, Lawren K. [lmills@gov.IN.gov]  
**Sent:** Friday, July 01, 2011 10:27 AM  
**To:** Jim Zieba  
**Subject:** RE: Meeting Request - Indiana Optometrists

Hi, Jim—

Our office was briefed on this policy before implementation. I was also briefed by FSSA after your meeting with them this week.

I understand that your issue is not about the 5% cut per se, but that ophthalmologists will not be cut as well. As I believe FSSA mentioned, there is specific money set aside in the budget to maintain physician reimbursement rates. The general assembly made a clear choice to ensure that physician rates not be lowered, and therefore, FSSA is forced to find cost savings from other sources.

As we do with any cut or reduction, we will monitor access closely, and if a substantial situation arises, we will re-evaluate at that time.

Respectfully,  
Lawren

**Lawren Mills**

Senior Policy Director and Legislative Director  
Office of Governor Mitch Daniels  
State House; Room 206  
200 West Washington Street  
Indianapolis, Indiana 46204  
Office: 317.232.3515  
Fax: 317.232.3443  
[lmills@gov.in.gov](mailto:lmills@gov.in.gov)

---

**From:** Jim Zieba [mailto:jzieba@ioa.org]  
**Sent:** Wednesday, June 29, 2011 2:48 PM  
**To:** Mills, Lawren K.  
**Subject:** Meeting Request - Indiana Optometrists

Lawren,

I am writing to request a meeting with you concerning an ill-conceived policy decision that was made by the Families and Social Services Administration. I have attempted to meet with Secretary Gargano, but he will not meet with me. I have had conversations with OMPP Director Pat Casanova and am scheduled to meet with her this afternoon, but I am not convinced that she appreciates the gravity of the situation.

Specifically I want to discuss the proposed FSSA rule that will reduce Medicaid reimbursement for Optometrists who provide care and eye wear to Medicaid patients. While my members understand the proposed 5% cut, they are understandably furious that the same exact care and eye wear provided by Ophthalmologists will not be cut. Again, we are talking about the exact same services and eye wear.

Indiana has approximately 1400 Optometrists located in all 92 counties and approximately 300 Ophthalmologists located largely in suburban areas. Very few Ophthalmologists provide primary vision care and eye wear. Ophthalmologists concentrate on surgeries where the money is. Optometrists provide the overwhelming majority of vision care and eye wear to Indiana's Medicaid patients.

I've heard from members who have written letters to Governor Daniels that were forwarded on to FSSA for answering. One member faxed a copy of a letter from FSSA which was completely nonresponsive and which contained a major inaccuracy. The letter was nonresponsive in that it failed to address the discrimination issue at all. Instead, it talked about the need for a 5% cut (which is not what the member wrote about). The letter was inaccurate in that it said that the optometric cuts were discussed in the

8/16/2011

House Ways and Means Committee and the Senate Appropriations Committee. I attended and monitored the meetings to both committees this session and cuts to vision care and eye wear were NEVER discussed.

Ms. Casanova was informed how offensive this ill-conceived policy is to Indiana's Optometrists when we first heard of the proposed rule. By proceeding with the proposed discrimination, it appears that the Daniels Administration is looking to cut costs by reducing access to care for the children and elderly patients that are on Medicaid.

Again, I would like to meet with you to discuss this matter. Indiana's Optometrists have been very cooperative with the Administration and did not publically object to the cuts that were made concerning vision wear in January. That will certainly not be the case this time. I am attaching additional information to this email for your consideration.

Jim

**Jim Zieba**  
**Executive Director**

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*A response(s) to a request for information by a member or staff of the Indiana Optometric Association is the member's or staff member's understanding or interpretation. The Indiana Optometric Association, its members, and staff do not render legal advice or opinions. The response should not be relied upon solely in taking action regarding the practice of optometry in the State of Indiana. The IOA highly encourages individuals to retain counsel to advise them on such matters.*

8/16/2011



# State of Indiana

# Senate

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Committees:  
Chair, Courts & Juvenile Justice Subcommittee  
Elections  
Judiciary  
Public Policy  
Tax & Fiscal Policy

July 20, 2011

Raymond Hopper Jr. O.D.  
Midwest Eye Consultants, P.C.  
935 West Main St.  
Peru, IN 46970

Dear Raymond,

Thank you for your correspondence regarding a reduction in Medicaid reimbursements for optometrists. My office has checked into this issue and we have been told that the Family and Social Services Administration (FSSA) has made a policy decision to exclude physicians from rate reductions. We have also been told that FSSA has kept that a policy consistently throughout the cost containment implementation. Further, we have been told that FSSA will monitor access closely, and if a substantial situation arises, FSSA will re-evaluate the situation at that time.

As you can tell, it appears that only a change in circumstances will remedy the reimbursement issue. Until then, I do not believe that FSSA will not budge on this. I will continue to stay in contact with FSSA to hopefully resolve this issue.

Please let me know if you have any further questions on this or any other issue and thank you again for informing me on issues that matter to you the most.

Sincerely,

Randy Head  
State Senator

Not so  
for  
Adult  
glasses  
cut o.  
1/1/11

SPECIAL ARTICLE

## Auditing Access to Specialty Care for Children with Public Insurance

Joanna Bisgaier, M.S.W., and Karin V. Rhodes, M.D.

### ABSTRACT

#### BACKGROUND

From the School of Social Policy and Practice (J.B., K.V.R.) and the Division of Emergency Care Policy Research, Department of Emergency Medicine, School of Medicine (K.V.R.) — both at the University of Pennsylvania, Philadelphia. Address reprint requests to Dr. Rhodes at the School of Social Policy and Practice, University of Pennsylvania, 3815 Walnut St., Rm. 201, Philadelphia, PA 19104, or at [kvr@sp2.upenn.edu](mailto:kvr@sp2.upenn.edu).

Health care reform has expanded eligibility to public insurance without fully addressing concerns about access. We measured children's access to outpatient specialty care to identify disparities in providers' acceptance of Medicaid and the Children's Health Insurance Program (CHIP) versus private insurance.

#### METHODS

Between January and May 2010, research assistants called a stratified, random sample of clinics representing eight specialties in Cook County, Illinois, which has a high proportion of specialists. Callers posed as mothers of pediatric patients with common health conditions requiring outpatient specialty care. Two calls, separated by 1 month, were placed to each clinic by the same person with the use of a standardized clinical script that differed by insurance status.

#### RESULTS

We completed 546 paired calls to 273 specialty clinics and found significant disparities in provider acceptance of Medicaid–CHIP versus private insurance across all tested specialties. Overall, 66% of Medicaid–CHIP callers (179 of 273) were denied an appointment as compared with 11% of privately insured callers (29 of 273) (relative risk, 6.2; 95% confidence interval [CI], 4.3 to 8.8;  $P<0.001$ ). Among 89 clinics that accepted both insurance types, the average wait time for Medicaid–CHIP enrollees was 22 days longer than that for privately insured children (95% CI, 6.8 to 37.5;  $P=0.005$ ).

#### CONCLUSIONS

We found a disparity in access to outpatient specialty care between children with public insurance and those with private insurance. Policy interventions that encourage providers to accept patients with public insurance are needed to improve access to care.

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**E**XPANSIONS OF MEDICAID AND THE CHILDREN'S Health Insurance Program (CHIP) are designed to extend access to high-quality medical care to all U.S. children.<sup>1-3</sup> However, evidence suggests that the 37 million children covered by Medicaid-CHIP<sup>4,5</sup> are less likely to receive specialty care than children covered by commercial insurance.<sup>6-13</sup> Children covered by Medicaid-CHIP may face greater barriers to specialist care as a result of fewer resources within their families, including lower levels of income, education, language proficiency, and health literacy.<sup>14</sup> Another possible explanation for disparities is that specialists choose not to accept public insurance.<sup>15</sup> In contrast to patient-related or family-related barriers, which are less malleable to change, provider-related barriers are potentially modifiable through health care policies.<sup>16</sup> To date, research on children's access to specialty care has not adequately distinguished between provider-related barriers and patient-related ones.

Unraveling the contributions of clinical need and patient-related versus provider-related barriers is a vital first step in constructing effective policies that improve children's access to specialty care. Given the association between socioeconomic disadvantage and poor health status, children covered by Medicaid-CHIP may have a greater need for specialty care.<sup>17</sup> However, most studies to date have been unable to directly control for children's clinical need for specialty services.<sup>6,18</sup> Audit methodology, traditionally used for detecting "real life" discriminatory behavior in housing and labor markets, can be used to assess insurance-related disparities in health care access.<sup>19</sup> Using this approach in a 1994 study, the Medicaid Access Study Group found that adult patients with Medicaid had poor access to outpatient care.<sup>20</sup> Subsequent studies in which this approach was used did not sufficiently examine physicians' willingness to provide needed specialty care for publicly insured children.<sup>7,13,21,22</sup> In light of the pending expansions of public insurance programs, we sought to identify whether—and if so, to what extent—provider acceptance of Medicaid-CHIP coverage is an independent barrier to outpatient specialty care for children in the current health care market, while controlling for patient factors and the clinical urgency of the referral.

## METHODS

### DATA COLLECTION AND STUDY DESIGN

We designed an audit study in which research assistants posing as mothers made paired calls to the same clinic and attempted to schedule an appointment for a child needing specialty care. The calls were separated by 1 month and varied only by insurance status (private vs. Medicaid-CHIP insurance). Data were gathered by the University of Chicago Survey Laboratory, where trained and supervised graduate students made calls to specialty clinics with the use of a central-computer-assisted telephone interview. (Post-call evaluation forms and the protocol flow chart for audit calls are available in the Supplementary Appendix, available with the full text of this article at NEJM.org.) Our study was conducted in Cook County, Illinois, the second most populous U.S. county (5,194,675 residents),<sup>23</sup> where the ratio of specialists to population is 218 to 100,000; the national median is 32 to 100,000.<sup>24</sup> Although Illinois Medicaid has historically provided care through a fee-for-service structure, it began implementing a primary care case-management program in July 2006, which serves approximately 67% of publicly insured children in Cook County.<sup>25</sup> The remaining children are served in a fee-for-service structure (16%) or voluntary commercial managed-care organizations (18%). Illinois is among 27 states that implement CHIP and Medicaid as a combined program (i.e., identical program name [All Kids] and reimbursements).<sup>26</sup>

### SAMPLING METHODS

We constructed an exhaustive list of providers, using state-provided physician-licensure data, cross-referenced with lists of physicians submitting specialty claims for children in Cook County and lists of specialists provided by children's hospitals and the American Academy of Pediatrics. The final sample included all specialists for whom there was any evidence that they provided care to children (0 to 18 years of age) residing in Cook County. Because several specialists may practice at the same clinic and some specialists practice at several clinics, we did not sample providers; rather, we sampled clinics, defined by unique (unduplicated) telephone numbers used for scheduling appointments. Random samples

of 40 clinics per health-condition scenario were stratified according to two key variables (provider licensure reporting acceptance vs. nonacceptance of Medicaid–CHIP and urban vs. suburban location) with the use of a computer algorithm. During the study, physicians' licensure data regarding Medicaid–CHIP acceptance were not publicly available.

#### SPECIALTY CONDITIONS AND PROTOCOL

From January through May 2010, we investigated eight specialties (allergy–immunology, pulmonary diseases, dermatology, endocrinology, neurology, orthopedics, otolaryngology, and psychiatry) in which providers treat seven pediatric specialty health conditions (Table 1). Allergists–immunologists and pulmonary disease specialists were audited together and sampled in proportion to their representation in the population, because both treat persistent, uncontrolled asthma. Clinical scenarios (involving a diagnosis and symptoms in a patient of a specified age) were chosen by pediatric primary care providers (PCPs) and specialist consultants with the use of an iterative review process to identify conditions that affect a large number of children, warrant timely outpatient specialty evaluation and treatment to achieve optimal health outcomes, are urgent situations but not emergencies, and have a known effective treatment. A pilot study of these scripts with standardized responses to possible questions was conducted between November 2009 and January 2010. (Scripts are available in the Supplementary Appendix.)

Every caller reported having a referral from the child's PCP; three scenarios also involved referral by an emergency department. To avoid geographic discrimination, we geocoded all specialty clinics and generated fake patient and PCP addresses that were in the vicinity of (but more than 1.6 km [1 mi] from) each clinic with the use of ArcGIS software (version 9.3). If asked, callers reported an emergency department located in the general area, cross-checked against specialists' hospital affiliations (from licensure data) to avoid the potential for shared electronic medical records.

We obtained dummy Medicaid–CHIP identification numbers from the state that would appear in the online system as “active” and that were

linked to the demographic characteristics (e.g., name, sex, and race or ethnic group) corresponding to each caller's identity. If asked for the PCP's name, callers gave 1 of the top 10 physician surnames from Medicaid–CHIP claims data for fiscal year 2008. For questions that the caller was unable to answer (e.g., Social Security number or private insurance number), standardized “work-arounds” were developed. To control for the racial or ethnic characteristics of a caller's name and voice, all samples were randomly assigned to one of three groups of callers (black, white, or Hispanic) with the use of a computer algorithm. Clinics were deemed “out of scope” if they reported that they did not provide care for the clinical condition or for children of the reported age (before knowing the child's insurance status). Out-of-scope clinics and nonfunctional telephone numbers were replaced with the next randomly selected clinic providing care for the condition. After three calls without reaching a live person, callers left a voice-mail message with their assigned name, telephone number, and insurance type. If voice mail was not returned, callers placed six additional calls, leaving voice-mail messages.

The same caller called the same clinic twice. The order of reported insurance type, the only variable differing between the two calls, was randomly assigned. If asked, there were minor variations in the patient's and caller's names, the patient's address and date of birth, and the PCP's name and address. For private insurance, callers reported Blue Cross Blue Shield coverage because it has the largest market share in Illinois.<sup>27</sup> Callers did not volunteer their insurance status, but if an appointment was granted without a request for insurance status, callers confirmed the acceptance of their assigned insurance. All calls were kept as short as possible, and all appointments were canceled at the end of the call. Prepaid cell phones allowed callers to provide telephone numbers, leave voice-mail messages, and receive returned calls. Outcomes were the percentage of callers according to insurance status who successfully scheduled an appointment and the wait time (number of days) between the call and the scheduled appointment date. Descriptive data about medical and insurance-related questions asked were collected.

**Table 1. Specialties and Health-Condition Scenarios Included in the Study.\***

Specialty Type	Medical Condition	Age	Referral Source	Symptoms
Dermatology	Severe atopic dermatitis	9 mo	PCP	Severe, itchy rash for 7 months on face, legs, and arms; PCP has tried glucocorticoids
Otolaryngology	Obstructive sleep apnea and chronic bilateral otitis media	5 yr	PCP	Snores every night but getting worse, fluid in both ears, frequent infections
Endocrinology	Type 1 diabetes	7 yr	PCP	Tired, constantly thirsty, PCP tested fasting blood sugar (approximately 200 mg/dl)
Neurology	New-onset afebrile seizures	8 yr	PCP and ED	Had a seizure last week, did not have fever, seen in ED
Orthopedics	Forearm fracture through growth plate	12 yr	PCP and ED	Radiograph in ED showed possible fracture, but doctors were not sure
Psychiatry	Acute, severe depression	13 yr	PCP	Withdrawn, depressed, grades have slipped
Allergy-immunology and pulmonary diseases	Persistent, uncontrolled asthma	14 yr	PCP and ED	Takes many medications but still wheezes, uses inhaler daily, seen in ED

\* Referral source and symptoms were reported by callers only if asked. Standardized responses to questions were prepared through piloting and iterative review to indicate that the conditions were urgent (but not emergencies), common, and warranted specialty care. ED denotes emergency department, and PCP primary care provider.

#### STUDY OVERSIGHT

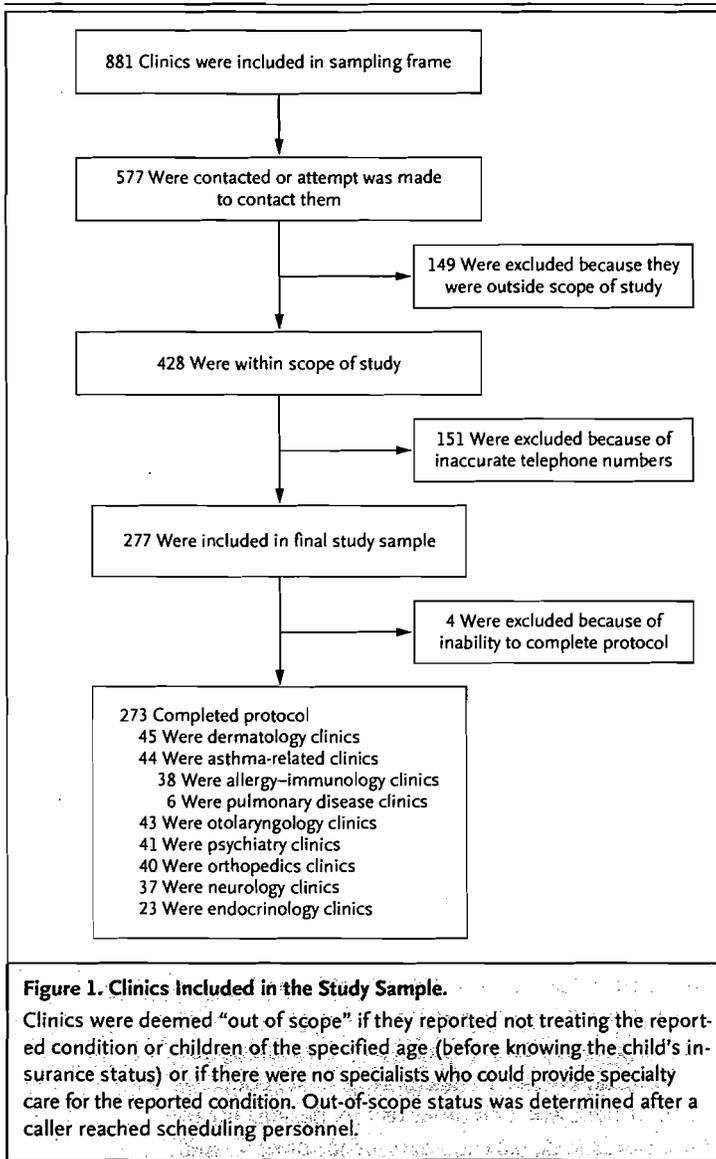
The study was approved, with a waiver of the requirement for informed consent, by institutional review boards at two institutions, with the caveat that debriefing letters be sent to all clinics in the entire sampling frame at the conclusion of the study. The deceptive design was considered necessary to accomplish the primary objective of the study: to identify the existence and extent of any disparities in children's access to specialty care according to insurance status by measuring the real-life behavior of specialty practices contacted for outpatient appointments. The debriefing letters clearly stated that the purpose of the study was to monitor the system rather than individual providers, that individual clinics may or may not have been randomly selected to be studied, and that the identity of those selected will never be disclosed.

#### STATISTICAL ANALYSIS

For all calls, we calculated the relative risk that children with Medicaid-CHIP coverage, as compared with those who had commercial insurance, would not receive a specialty care appointment. For paired calls, we calculated the log-odds probability of a scheduled appointment, using McNemar's test to assess the symmetry of dis-

cordant pairs (i.e., pairs of calls in which public and private insurance were not treated equally), holding constant all other patient and clinical characteristics. For subanalyses according to specialty type, we anticipated extreme splits on the dependent variable and used exact conditional (fixed-effects) logistic regression, which is a generalization of McNemar's test. Sample-size calculations for McNemar's test before the study were based on previous data from audit studies.<sup>21</sup> We calculated that a sample of 20 clinics would provide 80% power to detect a 34% difference and that 32 clinics would be needed to detect a 20% difference in the rate of clinics accepting public versus private insurance, at an alpha level of 0.05.

For specialty clinics that scheduled appointments for both insurance types, we calculated the difference between appointment wait times (in number of days) with the use of paired t-tests. We did not test the significance of wait-time disparities by specialty type because of the small number of clinics that scheduled appointments for both insurance types. All tests were two-sided, and P values of less than 0.05 were considered to indicate statistical significance. All statistical analyses were performed with the use of Stata/SE software (version 11.0).



## RESULTS

### CLINICS

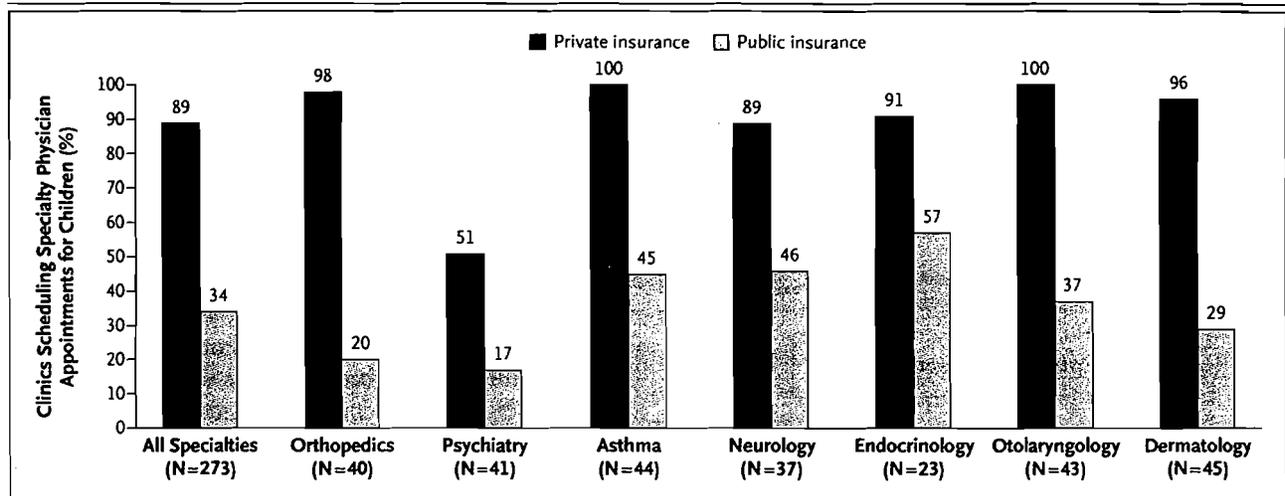
During the 5-month study period, the survey center attempted to contact 577 specialty clinics. As shown in Figure 1, 149 clinics (26%) did not treat patients with the given age or clinical condition, and 151 clinics (26%) were excluded because of nonfunctional telephone numbers. For the 277 clinics in the final sample, callers were unable to complete the study protocol with 4 clinics (1%), which required more medical documentation than we could provide. Two completed calls were made to each of the remaining 273 clinics (546 total calls). Because of the low number of endo-

crinology and neurology clinics with evidence of providers seeing pediatric patients (30 and 66, respectively), we randomly sampled from the broader pool of specialty clinics (68 endocrinology clinics and 99 neurology clinics) in an attempt to identify additional specialists willing to see children.

### OUTCOMES

Of the 546 calls to clinics, 297 (54%) involved a request for information about the child’s insurance type before the caller was told whether an appointment could be scheduled. For 153 (52%) of these 297 calls, the type of insurance coverage was the first question asked. Figure 2 shows the proportions of specialty clinics that scheduled appointments for children with public insurance and for those with private insurance, according to type of specialty. As shown in Table 2, 66% (179) of the callers reporting Medicaid–CHIP coverage were denied an appointment for specialty care, as compared with 11% (29) of the callers reporting Blue Cross Blue Shield insurance (relative risk, 6.2; 95% confidence interval [CI], 4.3 to 8.8;  $P < 0.001$ ). When calls to the same clinic were analyzed as matched pairs, there were 5 discordant pairs (2%) in which children with Medicaid–CHIP obtained an appointment but those with private insurance did not, and 155 discordant pairs (57%) in which the clinic accepted privately insured children but not Medicaid–CHIP enrollees (odds ratio for appointment denial with public insurance, 31.0; 95% CI, 13.0 to 96.8). All relative risks (when calculable) and exact conditional logistic-regression analyses showed that, across all tested specialties, children with Medicaid–CHIP were significantly more likely to be denied an appointment than privately insured children. Among 173 clinics with any providers whose license indicated acceptance of Medicaid–CHIP, 43% scheduled Medicaid–CHIP appointments. Of 100 clinics without licensure-reported Medicaid–CHIP acceptance, 19% granted these appointments.

Among the 89 specialty clinics that scheduled appointments for both Medicaid–CHIP enrollees and privately insured children, children with Medicaid–CHIP had greater delays in obtaining needed specialty care (Table 3). On average, children with public insurance waited 42 days for an appointment with a specialist, whereas privately insured children waited 20 days (mean difference, 22.1 days; 95% CI, 6.8 to 37.5;  $P = 0.005$ ).



**Figure 2. Clinics Scheduling Specialty Care Appointments for Children, According to Type of Insurance.**

Public insurance was reported by callers as the Illinois Medicaid–Children's Health Insurance Program (CHIP) umbrella program; private insurance was reported by callers as Blue Cross Blue Shield. Each of the 273 clinics was called twice (for a total of 546 calls) by the same caller, with only insurance coverage varying between the two calls: once reporting Medicaid–CHIP coverage and once reporting private coverage. Calls were made 1 month apart, and the order of the reported insurance status was randomly assigned. Asthma clinics included 38 allergy–immunology clinics and 6 pulmonary disease clinics.

## DISCUSSION

With the use of an experimental study design involving simulated requests for specialty care, we measured real-world scheduling behavior in an urban area with a high density of medical specialists.<sup>24</sup> The results showed significant disparities in children's access to needed outpatient specialty care, attributable to specialists' reluctance to accept public health insurance. These results held across all audited specialties. Moreover, even when children with Medicaid–CHIP were not denied appointments outright, the appointments were, on average, 22 days later than those obtained for privately insured children with identical health conditions. Notably, even callers claiming to have a privately insured child faced an average wait time of 20 days when urgently requesting an appointment. These findings signal a need to consider refining specialty care delivery processes to more efficiently use the specialist workforce.<sup>28,29</sup>

Two previous audit studies of pediatric specialty care have shown even lower Medicaid acceptance rates: 4%<sup>13</sup> and 8%.<sup>7</sup> However, both studies investigated only one specialty type (orthopedics), and both had weaknesses in their sampling strategies that may have biased their results, including failure to exclude ineligible providers,<sup>7</sup> sampling at the physician level rather than the clinic level (i.e.,

possibly calling the same clinic multiple times),<sup>7</sup> and the exclusion of physicians practicing at tertiary pediatric referral centers,<sup>13</sup> which are key sources of outpatient orthopedic care.<sup>30</sup>

A recent population-based survey by Kogan et al. showed that parents whose children had Medicaid–CHIP coverage were more likely to report that insurance did not allow their child to see needed providers.<sup>31</sup> Our results corroborate and add to this important finding by measuring the real-life experience of attempting to schedule an appointment when all other factors besides insurance status (e.g., parental persistence or savvy and the child's clinical symptoms) are held constant. The strength of the current study stems from its ability to isolate the effect of one dimension of access. Our results indicate that increasing the number of providers who accept public insurance will increase access opportunities. Without correcting this dimension, it is unlikely that disparities in access between public and private insurance can be fully eliminated, even if all other barriers to access (e.g., out-of-pocket costs, referral requirement, and need for language proficiency, transportation, and health literacy) could be addressed.<sup>15,16</sup>

The Affordable Care Act represents an opportunity to remold health care delivery processes in the United States.<sup>32,33</sup> It is well established that

**Table 2. Likelihood of Being Denied a Scheduled Specialty Care Appointment According to Type of Insurance.\***

Specialty	Total Clinics Called†	Both Insurance Types Denied	Both Insurance Types Accepted	Public Insurance Denied and Private Insurance Accepted	Public Insurance Accepted and Private Insurance Denied	Odds Ratio for Appointment Denial with Public Insurance (95% CI)‡	Public Insurance Denied	Private Insurance Denied	Relative Risk of Appointment Denial with Public Insurance (95% CI)‡
				<i>number (percent)</i>		<i>percent</i>			
All specialties	273	24 (8.8)	89 (32.6)	155 (56.8)	5 (1.8)	31.0 (13.0–96.8)	65.6	10.6	6.2 (4.3–8.8)
Orthopedics	40	1 (0.4)	8 (2.9)	31 (11.4)	0	44.2 (7.9–∞)§	80.0	2.5	32.0 (4.6–223.0)
Dermatology	45	2 (0.7)	13 (4.8)	30 (11.0)	0	42.8 (7.6–∞)§	71.1	4.4	16.0 (4.1–62.8)
Otolaryngology¶	43	0	16 (5.9)	27 (9.9)	0	38.5 (6.8–∞)§	62.8	0	—
Asthma¶	44	0	20 (7.3)	24 (8.8)	0	34.1 (6.0–∞)§	54.5	0	—
Neurology	37	2 (0.7)	15 (5.5)	18 (6.6)	2 (0.7)	9.0 (2.2–79.9)	54.1	10.8	5.0 (1.9–13.2)
Endocrinology	23	1 (0.4)	12 (4.4)	9 (3.3)	1 (0.4)	9.0 (1.2–394.5)	43.5	8.7	5.0 (1.2–20.4)
Psychiatry	41	18 (6.6)	5 (1.8)	16 (5.9)	2 (0.7)	8.0 (1.9–71.7)	82.9	48.8	1.7 (1.2–2.4)

\* Public insurance was reported by callers as the Illinois Medicaid–Children’s Health Insurance Program (CHIP) umbrella program; private insurance was reported by callers as Blue Cross Blue Shield.

† All 273 clinics were called twice (for a total of 546 calls), once reporting Medicaid–CHIP coverage and once reporting private coverage.

‡ P<0.05 for all comparisons. Odds ratios were calculated with the use of McNemar’s test to compare proportions of appointments for paired calls to the same clinic for children with public insurance versus those with private insurance. Relative risks, which were calculated for unpaired calls, are based on the overall appointment rates for children with public insurance versus those with private insurance.

§ Because of an extreme split on the dependent variable for orthopedics, asthma, otolaryngology, and dermatology, exact conditional (fixed-effects) logistic-regression odds ratios are medium unbiased estimates with no upper limit of the 95% confidence interval.

¶ Relative risks could not be calculated because there were no denials of care for children with private insurance.

|| The asthma clinics included 38 allergy–immunology clinics and 6 pulmonary disease clinics.

**Table 3. Wait Times for Appointments for Children with Public versus Private Insurance among Clinics Accepting Both Insurance Types.\***

Specialty	No. of Clinics Accepting Both Insurance Types†	Wait Time with Public Insurance	Wait Time with Private Insurance	Difference	95% Confidence Interval‡	P Value§
		<i>number of days</i>				
All specialties	89	42.0±75.1	19.9±34.0	22.1±72.9	6.8–37.5	0.005
Endocrinology	12	103.4±145.4	47.3±68.8	56.1±148.7		
Otolaryngology	16	52.7±82.9	5.8±5.3	46.9±82.8		
Dermatology	13	47.5±46.8	29.5±42.8	18.0±37.1		
Neurology	15	38.8±60.6	23.3±22.2	15.5±63.5		
Asthma¶	20	16.2±19.1	11.3±11.7	4.9±19.7		
Psychiatry	5	12.8±15.7	8.4±9.9	4.4±19.9		
Orthopedics	8	8.5±10.4	13.4±14.7	–4.9±16.7		

\* Plus–minus values are means ±SD. Public insurance was reported by callers as the Illinois Medicaid–Children's Health Insurance Program (CHIP) umbrella program; private insurance was reported by callers as Blue Cross Blue Shield.

† All 89 clinics were called twice.

‡ We did not calculate 95% confidence intervals or P values according to specialty type because of the small number of clinics for each specialty type that scheduled appointments for both types of insurance.

§ Asthma clinics included 38 allergy–immunology clinics and 6 pulmonary disease clinics. Of the 20 clinics that accepted both types of insurance, 15 were allergy–immunology clinics and 5 were pulmonary disease clinics.

reimbursement levels influence providers' decisions about whether to accept public insurance.<sup>8,34–36</sup> In Illinois, an office consultation visit for a problem of moderate severity (Healthcare Common Procedure Coding System code 99243) is reimbursed at \$99.86 by Medicaid–CHIP,<sup>37</sup> whereas the average reimbursement for the same code by a commercial preferred-provider organization is approximately \$160. Although disparities in insurance-reimbursement rates are important, the literature indicates that additional variables affect physicians' decisions about whether to accept public insurance, such as delays in payment and hassles of payment procedures,<sup>35,36</sup> personal characteristics of providers (e.g., credentials or experience,<sup>34,38,39</sup> race or ethnic group,<sup>34,38–41</sup> and underlying attitudes or prejudices<sup>39,42</sup>), and structural features of the system in which they provide care (e.g., institutional affiliations,<sup>34,43,44</sup> location,<sup>34,38,41</sup> and practice size or type<sup>22,34,38,44</sup>). Further research on the multiple underlying variables associated with provider behavior in our current system can help with workforce planning and inform innovations in service delivery.

More work is needed to understand the benefits or opportunity costs of potential policy changes. For example, is it better to raise reimbursement rates globally for all specialists or to provide targeted incentives to specialists or medical centers

located in low-resource neighborhoods and committed to serving as safety-net specialty providers? Do we need more specialists or should we reorganize the manner in which we provide specialty care? Such information is fundamental to the formation of integrated delivery systems and the configuration of payment methods that can optimize access and decrease disparities.

Caution is needed in generalizing our results to specialists other than those in the specific specialties and region that were audited in this study. In particular, there is no evidence that pediatric specialists working in inpatient or rural settings are unwilling to accept Medicaid–CHIP. Nonetheless, our experimental design affords high internal validity within the context of understanding specialist behavior relative to our simulated children's insurance status, with adequate controls for clinical urgency and other patient-level factors. Our study only assessed access to specialty care for publicly and privately insured children, and it should be noted that access to specialty care may be different for uninsured children and for publicly insured or uninsured adults.

Our study was powered to measure appointment denials and delays across a number of outpatient specialty types, but it was not powered to identify the effect of specific provider or clinic characteristics associated with appointment de-

nials or delays. In addition, we did not identify the causes of interspecialty variation. Nor did we assess whether acceptance of public insurance varies between specialists who provide cognitive consultations and procedural or surgical specialists, who may be more dependent on their affiliated hospitals to provide technologically advanced diagnostic and surgical resources.<sup>29</sup> Finally, although we used the literature and experts in both primary and specialty care to inform the urgency and importance of our clinical scenarios, more work is needed to clarify whether identified disparities are clinically meaningful for children's long-term health and safety.

Overall, we found considerable disparities in access to outpatient pediatric specialty care that were attributable to providers' nonacceptance of public insurance. These findings speak to the imperative for policymakers to identify regulatory mechanisms and incentives that target provider behavior and to explore innovative models of specialty care delivery that have the potential to in-

crease access to specialty expertise.<sup>45-47</sup> As we encounter new opportunities for restructuring the U.S. health care delivery system, there is a need for empirical data on policy mechanisms that can minimize disparities in access to care and deliver on health care reform's commitment to the provision of high-quality care for all Americans.

Supported by the state of Illinois, which provided funding, detailed physician-licensure data, data regarding Medicaid and state-employee health insurance claims, and dummy Medicaid identification numbers as a result of a court-ordered consent decree stemming from class-action litigation on behalf of Cook County children enrolled in Medicaid.

No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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# MEDICAID AND CHIP

## Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care

Highlights of GAO-11-624, a report to congressional committees

### Why GAO Did This Study

Medicaid and the Children’s Health Insurance Program (CHIP)—two joint federal-state health care programs for certain low-income individuals—play a critical role in addressing the health care needs of children. The Children’s Health Insurance Program Reauthorization Act of 2009 required GAO to study children’s access to care under Medicaid and CHIP, including information on physicians’ willingness to serve children covered by Medicaid and CHIP.

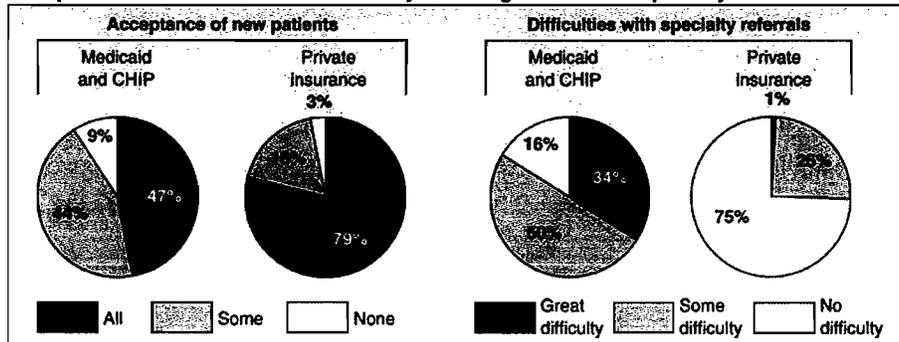
GAO assessed (1) the extent to which physicians are enrolled and serving children in Medicaid and CHIP and accepting these and other children as new patients, and (2) the extent to which physicians experience difficulty referring children in Medicaid and CHIP for specialty care, as compared to privately insured children. GAO conducted a national survey of nonfederal primary and specialty care physicians who serve children, and asked about their enrollment in state Medicaid and CHIP programs, whether they served and accepted Medicaid and CHIP and privately insured children, and the extent to which they experienced difficulty referring children in Medicaid and CHIP and privately insured children to specialty care. GAO also interviewed officials with the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS) that oversees Medicaid and CHIP.

### What GAO Found

Most physicians are enrolled in Medicaid and CHIP and serving children covered by these programs. On the basis of its 2010 national survey of physicians, GAO estimates that more than three-quarters of primary and specialty care physicians are enrolled as Medicaid and CHIP providers and serving children in those programs. A larger share of primary care physicians (83 percent) are participating in the programs—enrolled as a provider and serving Medicaid and CHIP children—than specialty physicians (71 percent). Further, a larger share of rural primary care physicians (94 percent) are participating in the programs than urban primary care physicians (81 percent). Nationwide, physicians participating in Medicaid and CHIP are generally more willing to accept privately insured children as new patients than Medicaid and CHIP children. For example, about 79 percent are accepting all privately insured children as new patients, compared to about 47 percent for children in Medicaid and CHIP. Nonparticipating physicians—those not enrolled or not serving Medicaid and CHIP children—most commonly cite administrative issues such as low and delayed reimbursement and provider enrollment requirements as limiting their willingness to serve children in these programs.

Physicians experience much greater difficulty referring children in Medicaid and CHIP to specialty care, compared to privately insured children. On the basis of the physician survey, more than three times as many participating physicians—84 percent—experience difficulty referring Medicaid and CHIP children to specialty care as experience difficulty referring privately insured children—26 percent. For all children, physicians most frequently cited difficulty with specialty referrals for mental health, dermatology, and neurology.

Acceptance of New Patients and Difficulty Referring Children for Specialty Consultations



Source: GAO.

Note: Numbers may not sum to 100 percent because of rounding.

View GAO-11-624 or key components. For more information, contact Katherine Iritani, (202) 512-7114, iritanik@gao.gov.

In its comments on a draft of this report, HHS stated that CMS is committed to improving physician participation and that this report will be of value as CMS works with the states to ensure beneficiary access to care.



# INDIANA STATE CHIROPRACTIC ASSOCIATION

August 23, 2011

Dear Members of the Medicaid Oversight Committee,

In November of 2010, OMPP promulgated an emergency rule to cut reimbursement to Doctors of Chiropractic (DCs) 5 percent. The stated position was to avoid an anticipated budgetary shortfall and to remain within the available Medicaid appropriation.

The Indiana State Chiropractic Association (ISCA) proposes this action will not save the State money. There are numerous studies that prove that chiropractic treatment is the most cost effective and efficient treatment for uncomplicated back and neck pain. Consequently if additional DCs stop participating in the Medicaid program because of lower reimbursement and patients do not have access to a DC, the patient will go to a more expensive health care provider for treatment. Therefore there will be a cost shift and not a cost savings. In fact, the ISCA proposes Medicaid costs would increase as patients having neck or back pain will simply go to a medical or osteopathic physician that would be substantially more expensive.

Chiropractic is a treatment method that returns about 2/3 of people with acute and chronic pain back to work, lowers their subsequent health care bills and is less expensive than the common medical alternative. Evidence-based, peer reviewed literature across the world singles out chiropractic manipulative therapy as a first line treatment intervention in the back pain patient. Numerous studies support this position and I will highlight a few.

In a 4-year study, researchers found that the 700,000 health-plan members with chiropractic coverage benefit had significant lower annual total healthcare expenditures compared with the 1 million members of the same plan who did not have chiropractic coverage. It offered convincing statistics into possible large-scale economic benefits obtained through access to chiropractic coverage by large groups of insured patients.

- Chiropractic care reduced the cost of treating back pain by 28%
- Chiropractic care reduced hospitalizations among back pain patients by 41%
- Chiropractic care reduced back surgeries by 32%
- Chiropractic care reduced the cost of medical imaging, e.g. X-Rays and/or MRI by 37%

In another study undertaken by the School of Business Administration, Oakland

**Exhibit E**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**Meeting #1 August 23, 2011**

University, Rochester, MI, and published in the Journal of Manipulative and Physiologic Therapeutics, June 1993, a comparison of Health Care Costs for Chiropractic and Medical Patients, of almost 400,000 patients treated for one or more musculoskeletal conditions, 25% were treated by chiropractors, with a significant cost-savings.

In a study printed in the Journal of Occupational Medicine, August 1991, Cost per Case Comparison of Back Injury Claims of Chiropractic versus Medical Management for Conditions with Identical Diagnostic Codes, reviewing over 3,000 Worker's Compensation Claims, chiropractic care was 10-fold less expensive than medical care.

A study appearing in the prestigious British Medical Journal, August 1995, Randomized Comparison of Chiropractic and Hospital Outpatient Management for Low Back Pain: Results from Extended Follow up, concluded that back pain patients treated by chiropractic derive more benefit and long term satisfaction than those treated by hospitals.

Data from 85,000 Blue Cross Blue Shield beneficiaries concludes that insurance companies that restrict access to chiropractic care for low back pain treatment may inadvertently pay more for care than they would if they removed such restrictions. In fact, care for low back pain initiated with a doctor of chiropractic (DC) saves 40 percent on health care costs when compared with care initiated through a medical doctor (MD).<sup>2</sup>

Additionally, a ground-breaking study, published in the Achieves of Internal Medicine entitled Comparative Analysis of Individuals with and Without Chiropractic Coverage: Patient Characteristics: Utilization and Costs compared 2 million members' health care expenditures between those with and those without chiropractic coverage. The study concluded that chiropractic care was more cost effective and cost-efficient.

On the evidence, particularly the most scientifically valid clinical studies, spinal manipulation applied by chiropractors is shown to be more effective than alternative treatments for back pain. The literature suggests that chiropractic manipulation is safer than medical management of low-back pain, plus there is an overwhelming body of evidence indicating that chiropractic management of low-back pain is more cost-effective than medical management.

There would be highly significant cost savings if more management of back pain was transferred to chiropractors. Evidence from Canada, the USA and other countries suggest potential savings of many hundreds of millions annually. The literature clearly and consistently shows that the major savings from chiropractic management comes from fewer and lower costs of auxiliary services, significantly less hospitalizations, and highly significant reduction in chronic problems, as well as in levels and duration of disability. Workers' compensation studies report that injured workers with the same specific diagnosis of lower back pain returned to work much sooner when treated by chiropractic physicians than by other health care professionals. This leads to very significant reductions in direct and indirect costs.<sup>3, 4, 5, and 6</sup>

There is certainly convincing evidence in the scientific literature attesting to the efficacy and cost-effectiveness of chiropractic care over traditional health care interventions. Additionally, there is less risk to the patient from surgical and pharmaceutical measures.

Thank you for allowing me to testify on behalf of ISCA.

Sincerely,  
Pat McGuffey, Ex Dir. ISCA

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Select Joint Commission on  
Medicaid Oversight

John Barth and Jackie Shearer

August 23, 2011

\*All Data Current as of June 30, 2011



**MCE Enrolled HHW Providers By Region**

Region	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	119 1/222	24 1/1101	9 1/2936	4 1/6607	34 1/777	11 1/2402
North Central	178 1/214	24 1/1509	41 1/931	14 1/2727	30 1/1273	11 1/3471
Northeast	117 1/174	45 1/453	11 1/1853	12 1/1699	27 1/755	8 1/2548
West Central	44 1/244	17 1/630	11 1/974	6 1/1787	28 1/383	3 1/3573
Central	290 1/168	108 1/453	54 1/907	30 1/1632	106 1/462	55 1/890
East Central	82 1/234	15 1/1283	15 1/1283	8 1/2406	35 1/550	3 1/6417
Southwest	140 1/121	32 1/529	31 1/546	12 1/1412	25 1/678	25 1/678
Southeast	112 1/173	22 1/880	27 1/717	27 1/717	21 1/922	14 1/1383

**Exhibit F**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**Meeting #1 August 23, 2011**



MCE HIP Enrolled Providers

	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Statewide	683	284	184	104	302	115
	1/2	1/4	1/6	1/11	1/4	1/10



Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region



## Claims Payment Timeliness – Physical Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	98.51%	99.39%
% Electronic Claims Paid Within 21 Days	99.57%	98.92%
% Denied	4.33%	5.96%

5



## Top 10 Claims Denial Reasons – Physical Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB	1. THE TIME LIMIT FOR FILING HAS EXPIRED
2. THE TIME LIMIT FOR FILING HAS EXPIRED	2. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB
3. AUTHORIZATION NOT ON FILE	3. AUTHORIZATION NOT ON FILE
4. COVERAGE NOT IN EFFECT ON DATE OF SERVICE	4. COVERAGE NOT IN EFFECT ON DATE OF SERVICE
5. NOT A MCO COVERED BENEFIT	5. NON COVERED SERVICE FOR PACKAGE B MEMBER
6. NON COVERED SERVICE FOR PACKAGE B MEMBER	6. CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
7. DENIED BY MEDICAL SERVICES	7. THIS IS NOT A VALID MODIFIER FOR THIS CODE
8. CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	8. PROCEDURE CODE Pairs INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
9. MISSING OR INVALID POA INDICATOR (present upon admission) UNCLEAN CLAIM	9. THIS SERVICE IS NOT COVERED
10. THIS SERVICE IS NOT COVERED	10. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION

6



## Claims Payment Timeliness – Behavioral Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	99.21%	99.26%
% Electronic Claims Paid Within 21 Days	99.89%	99.90%
% Denied	5.99%	9.05%

7



## Top 10 Claims Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB	1. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB
2. THE TIME LIMIT FOR FILING HAS EXPIRED	2. BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET
3. REVENUE CODE CAN ONLY BE BILLED ONCE PER DAY	3. SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
4. AUTHORIZATION NOT ON FILE	4. THE TIME LIMIT FOR FILING HAS EXPIRED
5. PLEASE RESUBMIT TO THE MEDICAL PLAN FOR CONSIDERATION	5. COVERAGE NOT IN EFFECT ON DATE OF SERVICE
6. PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY	6. AUTHORIZATION NOT ON FILE
7. OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH, PLEASE RESUBMIT	7. PLEASE RESUBMIT CLAIM TO THE STATE FOR CONSIDERATION
8. COVERAGE NOT IN EFFECT ON DATE OF SERVICE	8. NOT A BEHAVIORAL HEALTH SERVICE CODE
9. REVENUE CODE AND DIAGNOSIS ARE INCOMPATIBLE, PLEASE RESUBMIT	9. DENIED BY MEDICAL SERVICES
10. SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	10. CPT, HCPC and/or REVENUE CODE & LOCATION ARE NOT COMPATIBLE. PLEASE RESUBMIT



## Select Joint Commission on Medicaid Oversight (SJCMO) Presentation

August 23, 2011



### MCO Enrolled Providers By Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	245 1/169	121 1/359	41 1/1000	51 1/2564	51 1/695	20 1/2051
North Central	87 1/173	89 1/169	37 1/406	7 1/2149	36 1/418	18 1/836
Northeast	185 1/203	439 1/85	22 1/1704	22 1/1704	101 1/3715	14 1/2678
West Central	124 1/194	61 1/395	28 1/861	5 1/4821	51 1/473	8 1/3013
Central	434 1/250	1888 1/58	382 1/284	237 1/458	268 1/405	144 1/754
East Central	113 1/230	212 1/123	32 1/812	21 1/1237	67 1/388	12 1/2165
Southwest	92 1/127	77 1/152	33 1/354	41 1/285	137 1/85	11 1/1063
Southeast	99 1/194	100 1/192	24 1/799	24 1/799	112 1/171	59 1/325

**Exhibit G**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**Meeting #1 August 23, 2011**



## Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region



## Claims Payment Timeliness Physical Health: January – June 2010

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	97%	99%
% Electronic Claims Paid Within 21 Days	98%	99%
% Denied	4%	5%



Claims Payment Timeliness  
Behavioral Health: January – June 2010

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	96%	99%
% Electronic Claims Paid Within 21 Days	97%	100%
% Denied	10%	6%



Top 10 Clean Claims Denial Reasons  
HHW Physical Health :  
April – June 2011

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Not covered claim	1. Exceeds claim limits
2. Incorrect Billing	2. Member was not eligible at the time the service was provided
3. Payment Denied/reduced/for absence of, or exceeded per certification/authorization	3. Benefit maximum for this time period of occurrence has been reached
4. Exceeds Filing Limit	4. Payment Denied/reduced/for absence of, or exceeded, per certification/authorization
5. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	5. Duplicate claim/service
6. Member was not eligible at the time the service was provided	6. Incorrect Billing
7. Benefit maximum for this time period of occurrence has been reached	7. Claim/Service lacks information which is needed for adjudication
8. Claim/Service lacks information which is needed for adjudication	8. Charges do not meet qualifications for emergent/urgent care
9. Payment adjusted because this care may be covered by another payer per coordination of benefits	9. Payment adjusted because this care may be covered by another payer per coordination of benefits
10. Charges do not meet qualifications for emergent/urgent care	10. The Provider was not eligible to render the service at the time the service was rendered.



Top 10 Clean Claims Denial Reasons  
HIP Physical Health :  
April – June 2011

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Payment Denied/reduced/for absence of, or exceeded, per certification/authorization	1. Payment Denied/reduced/for absence of, or exceeded, per certification/authorization
2. Exceeds Filing Limit	2. Claim/Service lacks information which is needed for adjudication.
3. Claim/Service lacks information which is needed for adjudication.	3. Exceeds Filing Limit
4. Payment adjusted because this care may be covered by another payer per coordination of benefits	4. Payment adjusted because this care may be covered by another payer per coordination of benefits
5. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5. Non-covered charges
6. Non-covered charges.	6. Incorrect Billing
7. Duplicate claim/service	7. Duplicate claim/service
8. Incorrect Billing	8. The Provider was not eligible to render the service at the time the service was rendered.
9. Member was not eligible at the time the service was provided.	9. Benefit maximum for this time period or occurrence as been reached.
10. Benefit maximum for this time period or occurrence as been reached.	10. N/A



Top 10 Clean Claims Denial Reasons  
Behavioral Health (HHW & HIP):  
April – June 2011

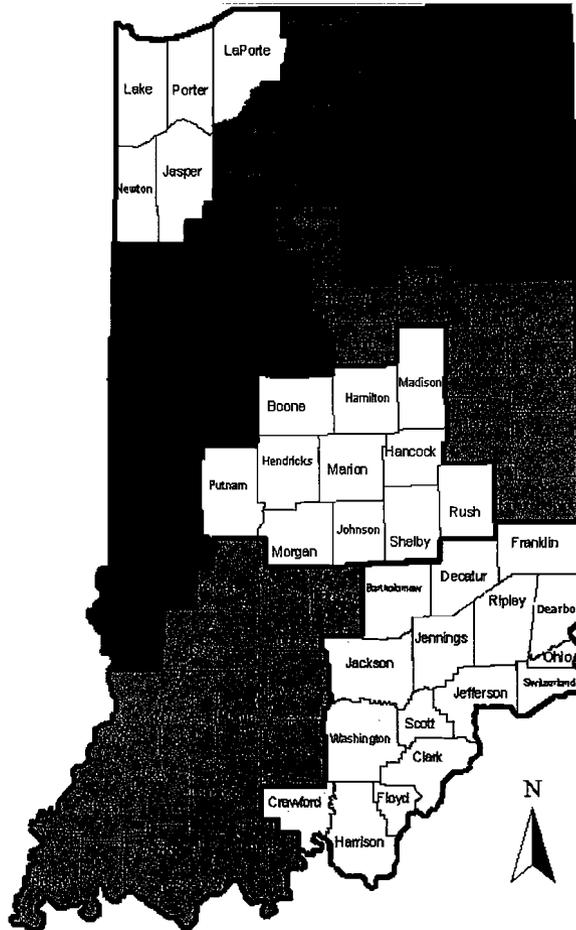
Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Duplicate claim/service	1. Duplicate claim/service
2. Non-covered charges.	2. Duplicate claim/service
3. Benefit maximum for this time period or occurrence as been reached.	3. Exceeds Filing Limit
4. Exceeds Filing Limit	4. Payment Denied/reduced/for absence of, or exceeded, per certification/authorization
5. Incorrect Billing	5. Incorrect Billing
6. Payment Denied/reduced/for absence of, or exceeded, per certification/authorization	6. Non-covered charges.
7. Payment adjusted because this care may be covered by another payer per coordination of benefits	7. Claim/Service lacks information which is needed for adjudication.
8. Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	8. Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
9. Claim/Service lacks information which is needed for adjudication	9. Member was not eligible at the time the service was provided.
10. N/A	10. The Provider was not eligible to render the service at the time the service was rendered.

**Provider Network Access  
and  
Claims Processing**



Exhibit H  
Select Joint Commission on  
Medicaid Oversight  
Meeting #1 August 23, 2011

# Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region

# Anthem HHW contracted Providers by Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist (	Urologist
Central	474 1/152	731 1/99	288 1/251	127 1/568	76 1/949	122 1/591
East Central	72 1/154	74 1/150	40 1/278	22 1/505	23 1/483	11 1/1,009
North Central	87 1/136	99 1/120	45 1/263	44 1/845	48 1/247	49 1/623
Northeast	121 1/166	171 1/117	29 1/691	37 1/542	33 1/607	53 1/378
Northwest	239 1/109	178 1/147	30 1/870	25 1/1,044	46 1/567	47 1/555
Southeast	105 1/172	100 1/180	51 1/354	53 1/340	23 1/784	59 1/306
Southwest	206 1/172	146 1/243	68 1/521	47 1/754	87 1/422	71 1/869
West Central	84 1/114	49 1/195	25 1/382	7 1/1,365	16 1/597	20 1/478

\*Counts by provider location.



# Anthem Claims Payment Timeliness – Physical Health Hoosier Healthwise

	<b>Facility Claims* (UB-04)</b>	<b>Professional Claims** (CMS 1500)</b>
<b>% Paper Claims Paid Within 30 Days</b>	<b>97.06%</b>	<b>98.94%</b>
<b>% Electronic Claims Paid Within 21 Days</b>	<b>99.08%</b>	<b>99.80%</b>
<b>% Denied</b>	<b>7.99%</b>	<b>11.84%</b>

\*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.

# Anthem Top 10 Claims Denial Reasons – Physical Health Hoosier Healthwise

Facility (UB-04)	Professional (CMS 1500)
1. Claim submitted after filing limit	1. Pricing or benefits issue
2. Other carrier/Medicare payment exceeded amount due	2. Claim submitted after filing limit
3. Pricing or benefits issue	3. Duplicate charges paid
4. Duplicate claim	4. Provider NPI not found
5. Authorization required	5. Other carrier / Medicare payment exceeded amount due
6. Not a covered benefit	6. Not a covered benefit
7. Provider NPI not found	7. Authorization required
8. Diagnosis does not agree with patient age	8. Diagnosis does not agree with patient age
9. Procedure code does not correspond with patient gender	9. Procedure code does not correspond to patient gender
10. The Services are Not Covered Without Consent/Certification Form	10. Pre-post operative service denied

# Anthem Claims Payment Timeliness – Physical Health Healthy Indiana Plan

	<b>Facility Claims* (UB-04)</b>	<b>Professional Claims** (CMS 1500)</b>
<b>% Paper Claims Paid Within 30 Days</b>	<b>78.20%</b>	<b>99.62%</b>
<b>% Electronic Claims Paid Within 21 Days</b>	<b>96.52%</b>	<b>99.29%</b>
<b>% Denied</b>	<b>16.78%</b>	<b>16.87%</b>

\*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.

# Anthem Top 10 Claims Denial Reasons – Physical Health Healthy Indiana Plan

Facility (UB-04)	Professional (CMS 1500)
1. Member's coverage was not in effect on the date services were provided	1. Claim is a duplicate of a previously submitted claim for this member
2. Claim is a duplicate of a previously submitted claim for this member.	2. Service not covered by a Non-network provider
3. Claim submitted after filing limit	3. Member's coverage was not in effect on the date services were provided
4. Member not eligible for benefits	4.. Claim submitted after filing limit
5. No precert obtained; postservice review needed to reprocess claim	5. Member not eligible for benefits
6. Service not covered by a Non-network provider	6. This service is not covered under the member's plan.
7. Healthy Indiana Plan eligibility not met due to other insurance	7. Maternity is not a covered benefit under the Healthy Indiana Plan.
8. Payment was included in the global rate	8. Member's coverage was not in effect on the date services were provided
9. Non-accident related dental services are not covered in an ER setting	9. Healthy Indiana Plan eligibility not met due to other insurance
10. This service is not covered under the members plan	10. Deny-Service is Not Reimbursable or is included in Global Fee

# Claims Payment Timeliness – Behavioral Health (WellPoint Behavioral replaced subcontractor, Magellan)

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

# Top 10 Claims Denial Reasons – Behavioral Health

<b>Facility Claims (UB-04)</b>	<b>Professional Claims (CMS 1500)</b>
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



# Indiana Health Coverage Programs

Update to Select Joint Commission on  
Medicaid Oversight

August 23, 2011

**Exhibit I**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**Meeting #1 August 23, 2011**

# Indiana Health Coverage Programs

## Volume Statistics, July 2007 through June 2011

	SFY 2008 Jul '07 – Jun '08	SFY 2009 Jul '08 – Jun '09	SFY 2010 Jul '09 – Jun '10	SFY 2011 Jul '10 – Jun '11
<b>Dollars Paid <sup>(a)</sup></b>	\$6,427,600,000	\$5,640,700,000	\$6,136,400,000	\$6,581,000,000
<b>Claims</b>				
Risk Based Managed Care	17,609,333	15,080,731	15,242,671	12,170,583
# Fee-for Svc Paid Claims <sup>(b)</sup>	28,591,064	29,590,516	35,474,838	40,519,836
# Fee-for Svc Denied Claims	15,231,873	13,978,353	15,684,009	18,025,774
% Paid	65.2	67.9	69.3	69.2
Adjudication Days <sup>(c)</sup>	2.5	2.3	2.4	1.9
<b>Providers – MCE &amp; FFS Enrolled <sup>(d)</sup></b>	51,610	52,456	46,669	48,046
<b>Recipients at End of Period</b>				
Enrolled (Medicaid)	892,058	965,853	1,028,746	1,043,664
Enrolled (HIP)	12,933	44,621	46,219	41,892
<b>Total Enrolled</b>	<b>904,991</b>	<b>1,010,474</b>	<b>1,074,965</b>	<b>1,085,556</b>

a. SFY 2008 through SFY 2011 reflect auditor of state paid values.

b. Increase in fee for service claims from SFY 2009 to SFY 2010 is result of HP processing MCE pharmacy claims, beginning January 2010.

c. Adjudication is the number of days from submission to payment determination. Payment occurs in the next weekly payment run.

d. Figures include all provider types who were enrolled at any time during the state fiscal year. Enrollment decrease from SFY 2009 to SFY 2010 is due to the October 2009 implementation of automatic termination of providers who have not submitted claims for 18 months.



# Indiana Health Coverage Programs

## SFY 2011 Claim Statistics (July 2010 – June 2011)

### Top 2 Hard Denial Reasons

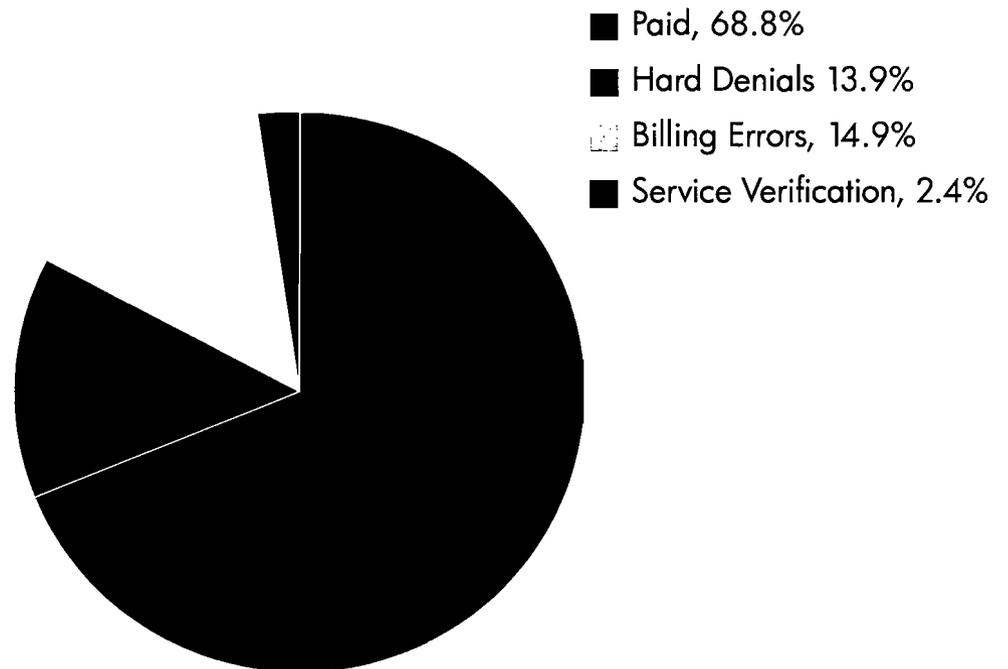
- Other insurance related denials
- Recipient eligibility related denials

### Top 2 Billing Error Reasons

- Missing coinsurance and deductible
- Duplicate billing

### Top 2 Service Verification Reasons

- Prospective Drug Utilization Review (ProDUR) related
- National Drug Code vs. days supply



# Indiana Health Coverage Programs

## Operational Statistics (April 2011 – June 2011)

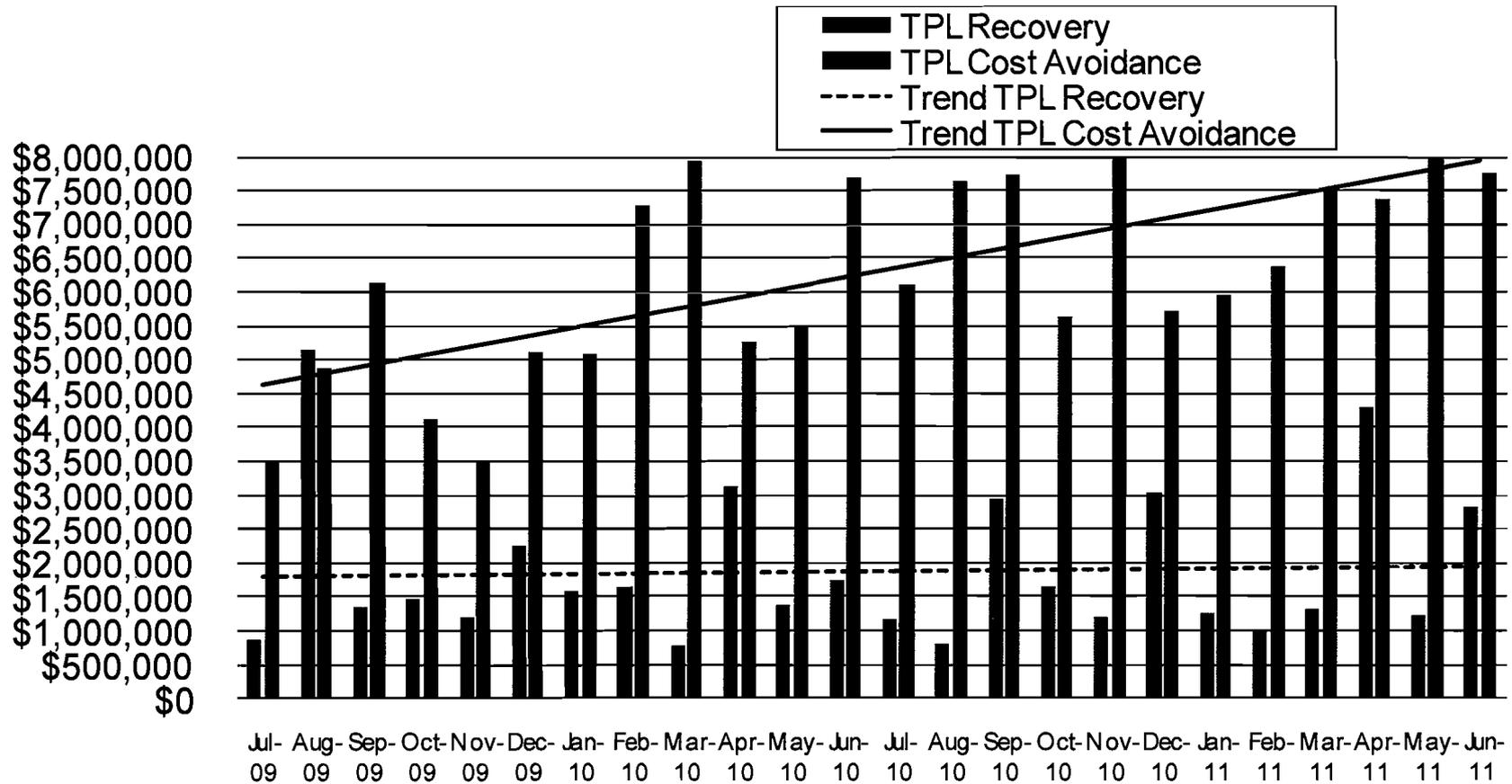
Operational Area	Apr-Jun 2011
<b>Claims Volume</b>	
Fee-for Service (FFS) Electronic	8,346,522
Fee-for Service (FFS) Paper	647,387
Pharmacy	6,008,476
Risk Based Managed Care (RBMC)	<u>2,710,073</u>
Total Claims	17,712,458
Web Claim Volume (included above)	848,696
Percent Electronic Claims	96.3%
<b>Call Center</b>	
Provider Calls	47,911
Recipient Calls	<u>41,881</u>
Total Calls	89,792
Automated Voice Response	145,450
Percent Automated Calls	61.8%
<b>New FFS Provider Enrollments</b>	3,116
<b>Written Correspondence</b>	1,229

Operational Area	Apr-Jun 2011
<b>Claims Inventories: June 2011 Month End</b>	
Suspended for Manual Adjudication	26,021
Received, Awaiting Data Entry	5,487
Received, Awaiting Attachment	<u>2,274</u>
Total Claims in Inventory	33,782
<b>Publications</b>	
Bulletins	28
Banners	11
Newsletters	3
<b>System Availability</b>	
IndianaAIM (23 hours/day)	100.0%
Automated Voice Response (98%)	100.0%
OMNI – eligibility (23 hours/day)	100.0%
Response Time (Inquiry <= 3 sec)	0.17
Response Time (Update <= 3 sec)	0.06
(Numbers in parentheses are contractual required minimums/maximums)	



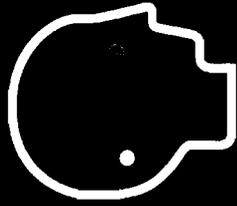
# Indiana Health Coverage Programs

## Third Party Liability Savings, July 2009 – March 2011)



- August 2009 higher than average recovery figure is due to Medicare A/B disallowance recoveries.
- CY 2010 forward increased cost avoidance is the result of HP processing and cost avoiding MCE pharmacy claims, beginning January 2010.





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# HB 1001 Sec. 144

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- **DDRS is required to address the aggregate and per capita spend of it's programs including looking at the following areas:**
  - Calculating budget neutrality on an individual rather than an aggregate basis.
  - Instituting a family care program to provide recipients with another option for receiving services.
  - Evaluating the current system to determine whether a group home or a waiver home is the most appropriate use of resources for placement of the individual.
  - Evaluating alternative placements for high cost individuals to ensure individuals are served in the most integrated setting appropriate to the individual's needs and within the resources available to the state.
  - Migrating individuals from the waiver to a redesigned waiver that provides options to individuals for receiving services and supports appropriate to meet the individual's needs and that are cost effective and high quality and focus on social and health outcomes.
  - Requiring cost participation by a recipient, whose family income exceeds five hundred percent (500%) of the federal income poverty level, factoring in medical expenses and personal care needs expenses of the recipient.

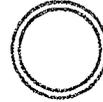
Exhibit J  
Select Joint Commission on  
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## HB 1001 Sec. 144

2

- DDORS has put together a group that includes representatives from stakeholder groups including the Arc of Indiana, INARF and INABC.
- This group exists to take a meaningful look at where we are, create policy, and move toward building a system that serves individuals – through empowerment toward self-sufficiency – in the most meaningful and cost-effective way.
- The group is currently meeting weekly and will be providing regular progress updates throughout the process.

# HB1001, Section 144 Timeline



**July 18th** | **August** | **September** | **October** | **November** | **December 31st**

Weekly meetings held with DD Advocates

Meetings with families and providers

Finalize draft report to SJCMO

Family Voices Indiana represents families raising Children and youth with special health care who have a broad range of chronic illnesses and/or disabilities including *cerebral palsy*, *epilepsy*, and *autism*. Approximately 266,494 children in Indiana – or 16.6 percent of all Hoosier children – have special health care needs. Medicaid is a vital program for many of these children and youth.

For some of these children, Medicaid is the only source of financing for their care. Even for those children who have private insurance, Medicaid often serves as a “wrap-around” to augment their coverage. For example, some medical equipment and assistive devices (such as hearing aids) may not be covered under traditional insurance plans but are available through Medicaid.

Importantly, children with Medicaid have access to Early Periodic Screening, Diagnosis and Treatment (EPSDT), which is designed to identify developmental and health problems early on, so that necessary treatment can be provided before a condition worsens.

Medicaid can also save families from bankruptcy that might otherwise result from high medical bills.

Medicaid as you know is very complicated. CYSCHCN who are eligible or in need are not covered under one type of Medicaid; instead their access to Medicaid varies based on family income, access to private insurance, diagnosis and, too often, wait time.

If access to Medicaid Waivers is further limited in Indiana the health and well-being of many CYSCHCN and their families will be in peril. For example:

- ♥ The Knauffs family in Carmel, Indiana – whose 12 year old son with autism, Sam, would lose the access to medication, therapy and case management that has made it possible for them to navigate and support Sam’s needs.
- ♥ The Kurmay family of Avon, Indiana – whose 5 year old daughter, Makenna, is medically fragile and relies on a feeding tube and whose 4 year old son, Maison, has Down Syndrome, would lose access to the therapy, feeding supplies and nursing services that allow them to meet Makenna’s needs at home.
- ♥ My family in Lebanon, Indiana – with my 11 year old daughter, Laura, and my 14 year old son, Matthew, who have Mitochondrial disease, if we would lose the Medicaid they rely on as secondary coverage; our out-of-pocket medical expenses will exceed our total household income.

Many of you have heard the personal stories of your constituents about the impact of Medicaid waivers. These same families share their knowledge of the complicated web of public and private systems and services, of family and community support and participation that allow them to meet their children’s needs and allows your constituents to live, work and serve in their communities. It is from the knowledge base of these families that we urge you to build solutions to the very real budget and resource limits that our state’s Medicaid program faces. I can assure that families raising CYSCHCN are among the most effective at stretching resources, and at making tough choices about using limited resources. In other words, we are masterfully frugal!

As a starting point we ask that you consider the following

- ♥ The Affordable Care Act makes it possible for families whose children have disabilities and special health care needs to maintain private insurance coverage. Family Voices has urged our members whose children have Medicaid Waivers to maintain their private insurance, leaving Medicaid as the payer of last resort and drastically reducing the cost of these children to the public system while ensuring protection from catastrophic out-of-pocket costs. It may be advisable to require that children with access to private insurance maintain this coverage.
- ♥ The ACA current allowance for young adults maintaining coverage under parents' plans extends the saving impact of private insurance described above.
- ♥ The Family Opportunity Act (FOA) is federal legislation passed as part of the Deficit Reduction Act of 2005. It allows states to create a buy-in program to expand Medicaid coverage to children who meet SSI disability criteria and whose family incomes are too high to be eligible under current regulations. Any reduction in access to Medicaid should include adoption of this option in Indiana, allowing families to contribute to access Medicaid to prevent many families being forced into poverty by their child's needs.
- ♥ Increased coordination between systems and services would ensure reduced duplication, maximized efficiency and address the frustrations currently faced by both families and providers.
- ♥ Self-Directed Care like that is currently available for some using the Aged and Disabled waiver via the Public Partnerships, may allow some families to take on the burden and cost of an administrative role, saving resources
- ♥ Families absolutely want providers to be appropriately compensated. We need to ensure that reimbursement rates are sufficient to ensure system capacity and we do support this vital workforce; however, if provider rates are increased while families face service cuts and reduced access we risk creating greater disparities. Any increase in rates should include some limits on administrative cost to ensure increases are seen by frontline providers.

While limit or cuts to the Medicaid waiver got the most attention during the last legislative session, there was additional language about potential changes that raised concerns due to its ambiguity. Again, we welcome an opportunity to help DRS problem-solve how to be the best stewards of limited resources, but we also want to ensure individuals have their needs adequately met and that they are in the least restrictive environment with meaningful activities. Policies that move Hoosiers to more restrictive options based on category may in fact be both more costly and less appropriate.