

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7370 SENATE HEALTH EDUCATION & SOCIAL SERVICES



RECORDS



CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

Jim Butler

Signature of Camera Operator

8/15/95

Date

1991-1992
SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
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API 2000 PRESENTATION 2/12/92

COMMITTEE CORRESPONDENCE

CONFIRMATION - BOARD OF EDUCATION

CONFIRMATION - BOARD OF REGENTS

CONFIRMATION - L. HAMES, COMMISSIONER
DEPARTMENT OF CORRECTIONS

CONFIRMATION - T. MALA, COMMISSIONER
DEPARTMENT OF HEALTH & SOCIAL SERVICES

DEPARTMENT OF CORRECTIONS - OVERVIEW,
10/4/91

DEPARTMENT OF CORRECTIONS - OVERVIEW,
1992

DEPARTMENT OF EDUCATION - OVERVIEW

DEPARTMENT OF HEALTH & SOCIAL
SERVICES - OVERVIEW, 10/4/91

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SB 3

SB 16

SB 19

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HB 511

HB 512

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HJR 57

HJR 70

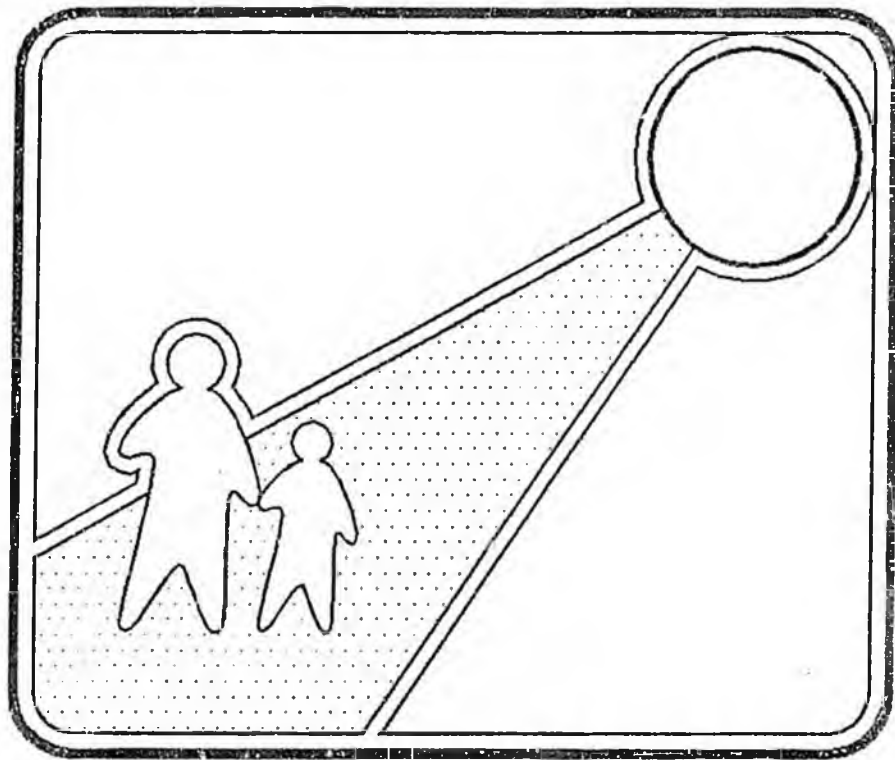
HJR 73

A P P I

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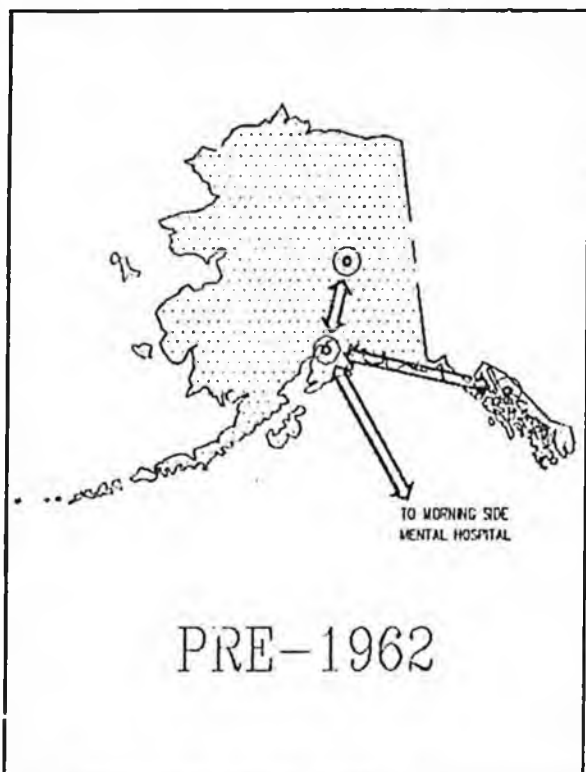
Presentation

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
API 2000



API 2000:
MENTAL
HEALTH
ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 API 2000: SYSTEM CHANGES, 1962-2000+



THREE MENTAL HEALTH CLINICS:
 JUNEAU-ANCHORAGE-FAIRBANKS
 INPATIENTS SENT TO MORNINGSIDE
 HOSPITAL IN OREGON

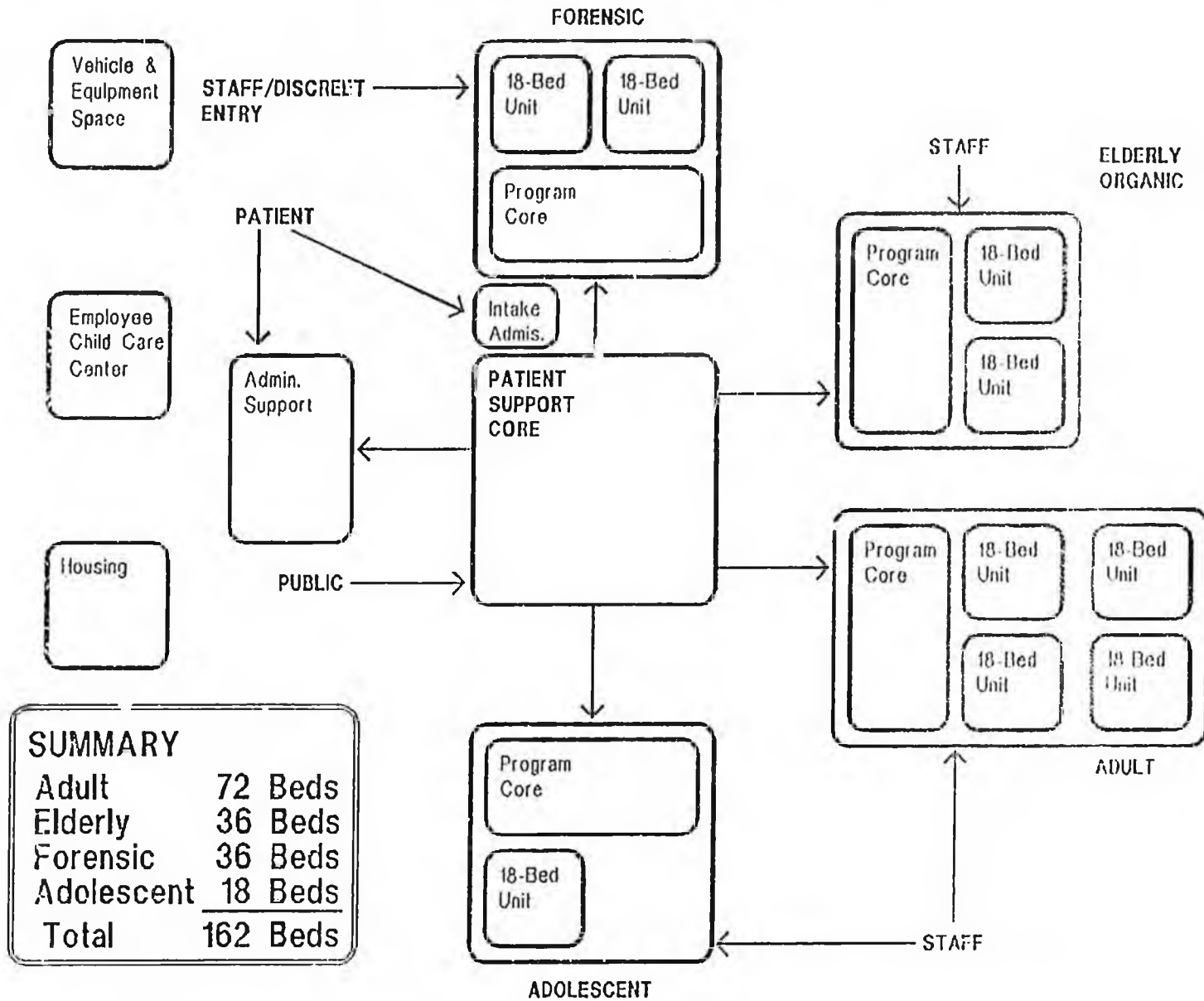


DEVELOPMENT OF:
 LOCAL COMMUNITY MENTAL
 HEALTH SERVICES/CENTERS
 SUPPORT SERVICES (EG. SUBSTANCE ABUSE)
 SUPPORT INFRASTRUCTURE

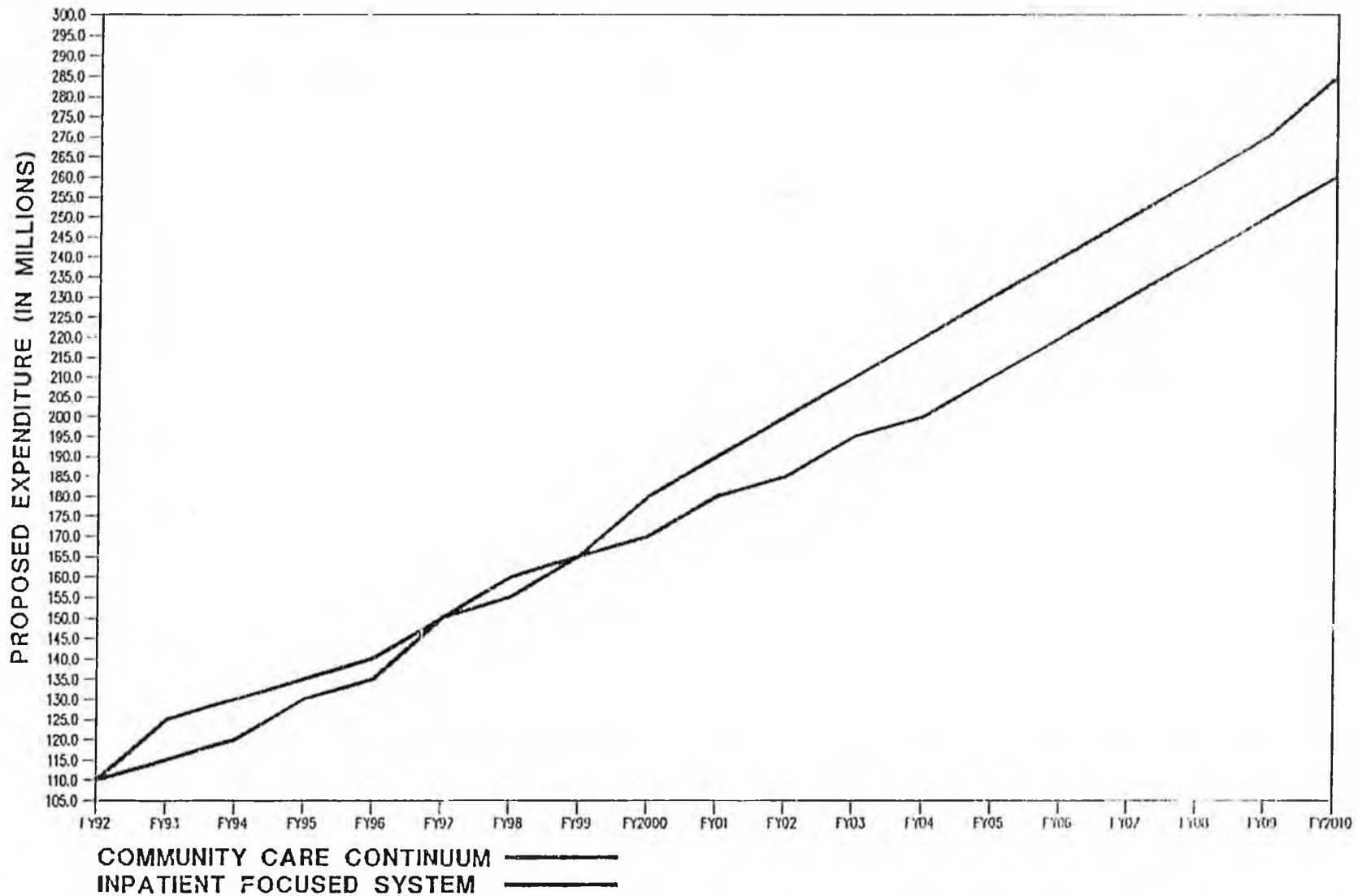


FULL MENTAL HEALTH COMMUNITY
 BASED CONTINUUM OF CARE
 REGIONAL HOSPITALIZATION/TREATMENT

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 API 2000



DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 API 2000: COMMUNITY VS INPATIENT BASED CARE

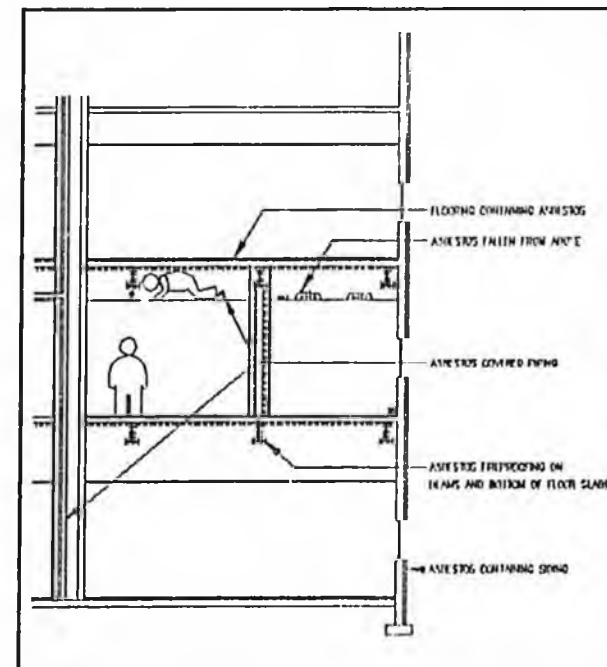
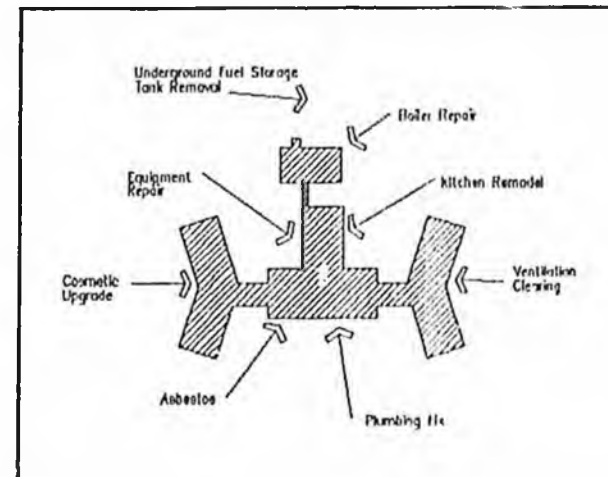


COMMUNITY CARE CONTINUUM ———
 INPATIENT FOCUSED SYSTEM ———

SOURCE: 1) "API - NEEDS ASSESSMENT & PLANNING" MAY, 1986; 2) "FINANCIAL ALTERNATIVES ANALYSIS; 12/2/91 REPORT", IRIBROOK III.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
API 2000

	FUNDING SINCE FY91	ESTIMATED 1992 NEED
FIRE/LIFE SAFETY - FIRE DAMPERS, ALARMS, ASBESTOS, ETC.	\$192.4	\$300.0
BUILDING INTEGRITY - VENTILATION UPGRADE, ETC.	\$808.3	\$400.0
STANDARDS COMPLIANCE - ADA; JCAHO REQUIREMENTS, ETC.	\$802.1	\$275.0
CLIENT ACTIVITY - ACTIVITY THERAPY, ETC.	\$100.0	\$100.0
PROGRAM EFFICIENCY - CRISIS RESPITE REMODEL, ETC.	\$289.1	\$150.0
STAFF ACTIVITY - SPACE REMODELLING	\$ 75.0	\$ 75.0
CONTINGENCY/EMERGENCY	\$400.0	\$100.0
TOTALS		\$1,400.0



DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 API 2000: MAINTAINING LOWEST RESPONSIBLE STATE INPATIENT CAPACITY

MAINTAINING:

REQUIRES: (In the Community)

State Inpatient Capacity

Inpatient/Residential

Other

Adults : 72 Beds

Elderly : 36 Beds
 (plus Harborview)

Children &
 Adolescents : 18 Beds

Forensics : 36 Beds*

TOTAL 162 Beds

86 (+ Designated
 Evaluation Beds)

"26"

25 (RDT)

23*

160

Full Array of Services
 (see AMHB Plan)

Full Array of Services

Full Array of Services

Full Array of Services
 (DOC Plan pending)

*under review

SYSTEM CHARACTERISTICS

Emphasis on Community Based Care
Regional Distribution of Services
Lowest Responsible Inpatient Capacity
Build for 2000; Plan for 2010
Flexible Inpatient Services

Committee

Correspondence



OFFICIAL BUSINESS

Alaska State Legislature
Senate
Office of the Secretary

STATE CAPITOL
JUNEAU, ALASKA 99801-1182
(907) 465-3701
FAX: 465-2832

April 27, 1992

M E M O R A N D U M

TO: Senator Sturgulewski, Chair
Health, Education and Social Services Committee

FROM: Nancy Quinto
Secretary of the Senate

SUBJECT: SENATE CONCURRENT RESOLUTION NO. 110 from the Iowa
General Assembly.

President Eliason referred the attached resolution to your committee for your information and consideration.

NQ/ps

Attachment



The Senate
STATE OF IOWA
Statehouse
Des Moines, Iowa 50319

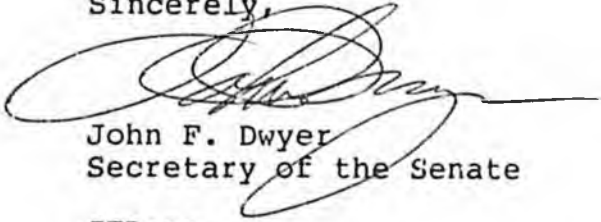
April 10, 1992

Richard Eliason
President of the Senate
Alaska State Capitol
Juneau, AK 99811

Dear President Eliason:

Enclosed is a copy of Senate Concurrent Resolution No. 110, adopted by the 74th Session of the Iowa General Assembly on March 26, 1992, urging the Congress of the United States to enact legislation to ensure adequate funds to find a cure and effective preventive measures for breast cancer.

Sincerely,



John F. Dwyer
Secretary of the Senate

JFD:an



PR 2526

SENATE CONCURRENT RESOLUTION NO. 110
BY SZYMONIAK, LIND, KERSTEN, McLAREN, RITTMER,
TINSMAN, DELUHERY, FUHRMAN, GETTINGS, PETERSON,
MURPHY, ROSENBERG, KIBBIE, GRONSTAL, DIELEMAN,
LLOYD-JONES, HEDGE, SLIFE, CONNOLLY, HANNON,
BUHR, RIORDAN, HORN, HUSAK, and KINLEY

A Concurrent Resolution to support efforts to promote early detection of and effective treatment modalities for breast cancer and to urge the Congress of the United States to enact legislation to ensure adequate funds to find a cure and effective preventive measures for breast cancer.

WHEREAS, breast cancer strikes one in nine women in the United States today, and it is estimated that breast cancer has taken the lives of 44,500 women in 1991 alone; and

WHEREAS, in 1992, an estimated 2,300 women in Iowa will be diagnosed with breast cancer and 600 will die; and

WHEREAS, there has been a 3 percent increase in the incidence of breast cancer since 1980; and

WHEREAS, while the incidence of breast cancer is highest among older women, the incidence is rapidly increasing in women under 40, making breast cancer a concern for women of all ages; and

WHEREAS, while it is known what characteristics place some women at greater risk for developing breast cancer, experts still do not completely understand the cause of breast cancer or how to prevent its occurrence; and

WHEREAS, despite advancements in detection and treatment methods, the mortality rate from breast cancer has remained essentially unchanged; and

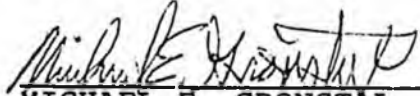
WHEREAS, screening mammography plays a vital role in early diagnosis when breast cancer is in the most curable state; and

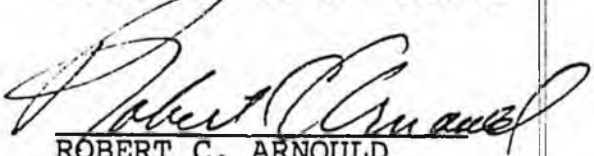
WHEREAS, low income, minority status, and lack of health insurance affect the ability of many women to obtain screening services, making it more likely they will not be diagnosed until in the advanced stages of breast cancer, significantly reducing their chances of survival; NOW THEREFORE,

BE IT RESOLVED BY THE SENATE, THE HOUSE OF REPRESENTATIVES CONCURRING, That the General Assembly supports efforts to promote early detection of and effective treatment modalities for breast cancer in Iowa.


BE IT FURTHER RESOLVED, That the General Assembly urges the Congress of the United States to enact legislation to ensure adequate funds to advance efforts to find a cure and effective preventive measures for breast cancer.

BE IT FURTHER RESOLVED, That the Secretary of the Senate send copies of this Resolution to the Governor of the State of Iowa, to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, to the Secretary of the United States Senate, to the Chief Clerk of the United States House of Representatives, to each member of the Iowa congressional delegation, and to the presiding officer of each house of the legislature in each state in the union.


MICHAEL E. GRONSTAL
President of the Senate


ROBERT C. ARNOULD
Speaker of the House

I hereby certify that this Resolution originated in the Senate and is known as Senate Concurrent Resolution 110, Seventy-fourth General Assembly.


JOHN F. DWYER
Secretary of the Senate

FAX COVER SHEET

Date: 24 April 1992

To: Alison Reardon
277-5206

From: Melissa Fouse
PLEASE GIVE TO ALISON RIGHT
AWAY.

Senator Arliss Sturgulewski
State Capitol, Room 427
Juneau, Alaska 99801

(907) 465-3818
Fax (907) 465-3810

Cover Sheet Plus 2 Pages

24 April 1992

Alison Reardon
Business Agent
Alaska State Employees Association
AFSCME Local 52, AFL-CIO
3510 Spenard Road, Suite 110
Anchorage, Alaska 99503

Dear Alison:

Thank you for the opportunity to comment on Christian Ulmann's job performance as it relates to this office. The Senate Health, Education, and Social Services Committee is charged with oversight of issues relating to and legislation regarding the health and welfare and the education of Alaska's citizens.

During the committee's consideration of legislation having to do with the insurance industry, there were a number of technical questions raised that the committee felt appropriate to ask the division of insurance in the Department of Commerce and Economic Development.

As committee aide, I called the director of the division to request assistance with these bills and was told that because of the director's absence, Chris Ulmann would be sent from Anchorage to Juneau to work on the legislation with the committee and to answer technical questions.

Mr. Ulmann did come to Juneau and we discussed the two bills: Senate Bill 74 and Senate Bill 242. In doing so we discussed the legislation section by section where I had indicated that either staff or members of the committee had questions about the technical or regulatory aspects of the legislation. When the discussions veered into policy issues, Mr. Ulmann was very clear to say that he was not authorized to discuss policy issues and later when testifying before the committee he declined to answer policy questions from members of the committee.

The letter regarding suggestions for wording changes to Senate Bill 74 was considered by this office as an enumeration of discussion points and not as the official position of the department since those official positions come to the committee signed by the commissioner of the department.

Mr. Ulmann responded professionally during informal discussions and when testifying on the record during hearings on the legislation. Please feel free to contact me again if you have any further questions.

Sincerely yours,

Melissa Aber Fouse
Committee Aide



ALASKA STATE EMPLOYEES ASSOCIATION
AFSCME Local 52, AFL-CIO

VIA FAX
April 21, 1992

Melissa Fouse, Legislative Aid
Office of Senator Arliss Sturgulewski
State Capital Building, room 427
Juneau, Alaska 99811-1182

Dear Melissa:

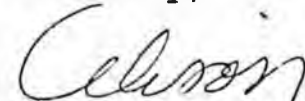
Please find attached to this letter the documentation Christian Ulmann, Insurance Market Analyst has received from the Division Director David Walsh. As I explained to you on the telephone this morning Chris is on administrative leave pending investigation of the charges detailed in the April 15, 1992.

Chris is being represented by the Union in this matter, and we are requesting your assistance in clarifying his role with your office. Specifically, his April 10, 1992 letter to you regarding SB 74, see attached.

It is the Union's position that Chris has not exceeded his authority regarding the technical assistance he provided to your office, under the direction he received from his supervisors, see attached. We would appreciate your assistance in this matter. If you have any questions please do not hesitate to call me, in the Anchorage office.

Thank you again for your willingness to help Chris. As you can well imagine, Chris is extremely upset about the charges and Director Walsh's accusations of inappropriate communication with the Senator's office.

Sincerely,


Alison Reardon
Business Agent

cc: Ulmann

ANCHORAGE OFFICE
3510 Spward Road, Suite 110
Anchorage, AK 99503
(907) 277-5300 FAX (907) 277-5206
TOLL free: 800-478-ASFA

JUNEAU OFFICE
641 West Willoughby, Suite 100
Juneau, AK 99801
(907) 463-4949 FAX (907) 463-4950
TOLL free: 800-478-ASFA

FAIRBANKS OFFICE
315 Barnette Street, Suite 104
Fairbanks, AK 99701
(907) 452-2300 FAX (907) 452-2307
TOLL free: 800-478-2305

M E M O R A N D U M

TO: David J. Walsh, Director
Division of Insurance

DATE: April 17, 1992

RE: Response to April 15, 1992 Memo

FROM: Christian Ulman

In response to your memo requesting information regarding:

1. My projects are too numerous to remember. Due to not having access to my workplace, I can only mention a very few:
 - a. Aetna: Closing the report, including finalizing the modification procedure;
 - b. Blue Cross: By this summer, to establish new regulation regarding permissible loss ratios and finalizing rate action on the traditional programs;
 - c. HMOs: Create new regulation regarding open ended HMOs;
 - d. AMS: Starting regulatory actions after the claims have been paid.

This list is not complete as explained previously.

2. My function was the Joint Committee as described in Section 4, Subsection B2 of the General Government Unit Bargaining Agreement, "The joint committee shall have access to analysis of current plan administration, claim payment administration, benefits plan design and utilization conducted by or for the Division of Retirement and Benefits."

As a result of various inquiries by the Union to the Division of Retirement and Benefits, Aetna provided to them statistical analysis and reports the Union was seeking. This information was provided to the Union by the Division of Retirement and Benefits according to the above paragraph. No Division of Insurance equipment, time nor documentation was ever part of such analysis. The Union action was to read and discuss such matters. Therefore, the Division of Insurance was not involved in these matters.

3. In January when Gordon Laing, Corporate Actuary, contacted me

Chris Ulman

regarding a potential meeting with Blue Cross in Seattle, he indicated it would be cheaper for Blue Cross if I went to Seattle. I informed my supervisor of the potential trip.

When Mr. Laing reported that the project was completed, he wanted to get together as fast as possible because he was operating under a time constraint.

When Blue Cross asked me which airline to be booked on, I responded "Mark Air" knowing the two for one ticket cost the same as a single ticket on Alaska Airlines. Both tickets had to be used at once, on the same flight. The price was identical to Alaska Airlines single fare. It did not cost Blue Cross any money for the extra ticket.

This instance of a companion ticket is the equivalent of accruing free air mileage while on State business. Therefore, I considered choosing Mark Air appropriate.

4. In this instance, I had been instructed to work with the Legislators in regard to the bills. This letter to Ms. Fouse was only to confirm our discussions and not intended to present a position held by the Division. I did not submit the letter for your review because it was a confirmation and reminder of our discussions, nothing more.

I have never disregarded your directives, not in this instance nor in any other.

The new items are merely an extension of an existing matter; and, namely under additional funding, example pull tabs and fund raisers, etc., and clarifying on the medicare eligibility that people on Medicare for reasons of disability not age would be eligible for coverage.

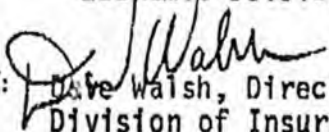
Again, all these matters were technical discussions and served no other purpose than stated.



11233

MEMORANDUM**State of Alaska**

TO: Chris Ulmann, Insurance Market Analyst DATE: April 15, 1992
Division of Insurance, Anchorage
Department of Commerce and FILE NO:
Economic Development

FROM:  Dave Walsh, Director TELEPHONE NO:
Division of Insurance SUBJECT:
Department of Commerce and
Economic Development

As requested by Diane Hodges from ASEA you are hereby provided with a list of projects that you agreed to complete and submit to Thelma Walker, no later than April 17, 1992:

1. A list of current projects with a short status report, two or three sentences on each will suffice.
2. A full explanation of what research and statistics were provided to ASEA, detailing what State documents, equipment and State time were used. A statement as to whether this information was solicited by ASEA in the form of a public information request. Please provide a copy of the information request. A statement indicating whether the information existed or had to be generated.
3. Explain the events that led up to the two (2) for one (1) ticket and why you felt it was an appropriate thing to do.
4. Explain why you issued the April 10, 1992 letter to Melissa Foust, Sturgulewski's aide on behalf of the division in total disregard to directives from me. Explain why you told me there were no new items in the memorandum and later admitted there were new items.

Chris, if you need any more information call me or Thelma directly.

DW/DE/mm6112c
041592a
cc: Personnel File

April 14, 1992

Melissa Fouse, Staff Aid
Office of Senator Sturglewski
State Capitol
Juneau, AK 99801-1182

RE: Letter and Memo in regard
to SB 74 and SB 242

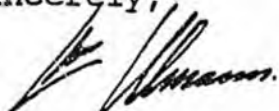
Dear Ms. Fouse:

On April 10, 1992, I provided you with one letter in regard to SB 74 and a memo in regard to SB 242 which confirmed our discussions on these bills.

Due to my error, Director Dave Walsh did not review or approve those documents. Therefore, such documents should not be viewed to reflect the position of the Division of Insurance or the Administration.

Please accept my apologies for any inconveniences this situation may have caused you.

Sincerely,



Christian Ulman
1602 West 14th Avenue
Anchorage, AK 99501

CC: Senator Jalmar Kerttula
Senator Virginia Collins
Director David J. Walsh, Division of Insurance
Deputy Director Thelma Snow Walker, Division of Insurance

03523

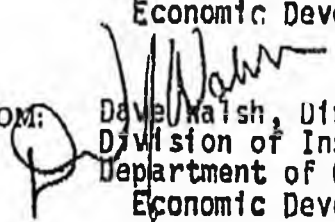
MEMORANDUM**State of Alaska**

TO: Chris Ulman, Insurance Market Analyst
Division of Insurance, Anchorage
Department of Commerce and
Economic Development

DATE: April 13, 1992

FILE NO:

TELEPHONE NO:

FROM:  Dave Walsh, Director
Division of Insurance
Department of Commerce and
Economic Development

SUBJECT: Suspension

Our preliminary investigation indicates that you may have engaged in misconduct involving the use of your official position. Specifically, there is significant evidence of misconduct involving use and distribution of confidential and analytical information, potential violations of the state travel regulations, failure to follow supervisory directives and conflict of interest in the conduct of your official duties. If sustained, these allegations warrant discipline up to and including dismissal.

You will be required to submit to an interview regarding these allegations at the Anchorage Division of Insurance Office on April 27, 1992 at 1:00 p.m. You may have union representation if you so desire. You are directed to answer all questions fully and honestly. If you fail or refuse to answer all questions fully and honestly, you may be subject to discipline up to and including dismissal.

During the pendency of this investigation you are suspended from duty with pay. You are directed to turn in your office keys to Thelma Walker no later than 3:00 p.m. today and refrain from acting or representing yourself in any official capacity during this period of suspension. You are further directed to remain accessible by phone during normal working hours during this period of suspension.

DW/rs2841s

041392a

cc: ASEA
Personnel File

ALASKA
DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE (907) 465-2515

April 10, 1992

MS MELISSA FOUSE, STAFF AID
OFFICE OF SENATOR STURGULEWSKI
STATE CAPITOL
JUNEAU AK 99801-1182

Dear Ms. Fouse:

Re: Testimony for HSS Health
Committee on April 8, 1992

The Division of Insurance suggests the following changes in regard to SB 74.

1. Sec. 21.55.040. Plan of Operation. We suggest that language be added stating:
 - (a) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective.
 - (b) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.
 - (c) The board shall make an annual report to the director of Insurance which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.
2. Sec. 21.55.100. Types of Insurance Plans
Amend section (b) to read: The association shall make available to residents who are high risk and are obtaining Medicare, a Medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060. X

3. Sec. 21.55.130(1). Preexisting Condition

Line 19 and line 23, increase to six months.

4. Sec. 21.55.150. State Plan Premiums

Line 17, amended to read: The premium for a state plan may not exceed 150 percent of the average of those five estimates.

5. Sec. 21.55.220. Operation of Plan. Subsection (f) is added.

The association has the right to generate additional funds in the form of fundraisers, pull-tabs and to obtain private and public donations, etc. X

6. Sec. 21.55.300. Eligibility for State Health Insurance. By extending subsection (b).

(b) The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance pursuant to subsection (a). Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection (a). The list shall be effective on the first day of the operation of the plan and may be amended from time-to-time as may be appropriate.

(c) Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

(d) A person shall not be eligible for coverage under the plan if:

(1) the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it except that:

(A) A person may maintain other coverage while satisfying any preexisting condition waiting period under a plan policy; or

(B) A person may maintain plan coverage while satisfying a preexisting condition waiting period under another health insurance policy.

(2) the person is determined to be eligible for health care benefits under [reference state Medicaid law];

- (3) the person has previously terminated plan coverage unless twelve (12) months have lapsed since such termination;
 - (4) the plan has paid out \$ (Lifetime maximum) in benefits on behalf of the person;
 - (5) the person is an inmate or resident of a public institution;
 - (6) the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.
- (e) coverage shall cease:
- (1) on the date a person is no longer a resident of this state;
 - (2) on the date a person requests coverage to end;
 - (3) upon the death of the covered person;
 - (4) on the date state law requires cancellation of the policy; or
 - (5) at the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.
- (f) Except under the circumstances described in subsection (d), a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

Sincerely,



Chris Ulmann
Insurance Market Analyst

CU/ems6333W
041092c

MEMORANDUM

State of Alaska

TO: Thelma Snow Walker
Deputy Director
Division of Insurance

DATE: August 16, 1991

FILE NO:

TELEPHONE NO:

THRU:

SUBJECT: Position With the
Statewide Union Health
Insurance Committee

FROM: Christian Ulmann
Insurance Market Analyst
Life, Health & Disability
Division of Insurance

This serves as a clarification regarding my activity with the statewide Union Health Insurance Committee. After a discussion with the Business Manager office of our Union, I learned, that the enclosed document was only delivered in Anchorage and that after the date, that Mr. Sykes made his comments. But to satisfy your inquiry I can report the following:

This committee is established according to the Collective Bargaining Agreement, Article 19, Section 4. Such committee consists of members of the union and members of the administration. According to Section 4 of the Bargaining Agreement, Subsection B3, "The Joint Committee may review and make recommendations to the Commissioner of the Department of Administration covering provision of efficient, effective health care benefits within the level of employer contribution, including, but not limited to: utilization review, hospital pre-certification, cost containment measures, etc." The term "representative" is issued as representing the union to such joint committee.

My function is according to Section 4, Subsection B2, which states: "The Joint Committee shall have access to analyses of current plan administration, claims payment administration, benefit plan design and utilization conducted by or for the Division of Retirement and Benefits. A representative of the Insurance carrier shall be available to the Committee."

Again, the representation consists of representing the union to the Joint Task Force. My part in this is to review and analyze information provided by the Division of Retirement and Benefits to the Joint Committee. This is addressed in the Newsletter.

Nothing in the focus of the Joint Committee on Health Benefits discusses negotiations with the state or choosing provider for services. The negotiation of Benefits between the Union and the State Administration occurred prior to the inception of the Bargaining Agreement, and I was never part of such.

Closing Statement

Mr Sykes made a distinctive comment to the Assistant Attorney General, Alexis Gabay, stating that I was a member of the negotiation team and assisted in choosing VSP as a provider and the therefore he stated. I would have a conflict of interest by dealing with VSP. He went as far as saying that he had seen my name on a List of Union negotiators.

Again I would like to repeat my demands:

I request, that Mr. Sykes, as instructed by the Director,

- 1) Admit what he said (he made those accusations even in front of the Director).
- 2) Explain what led him to make such an allegation, with an explanation of the source of such faulty information.
- 3) Apologize in writing as instructed by the Director.

Sykes' failure to write a memo in this matter could, for all intents and purposes, be viewed as a matter of insubordination. He did not comply with a clear order by the Director to send a written apology. Further, it amazes me that Mr. Sykes, after committing a serious imprudent and unethical act, believes he can BS himself out of this situation.

Your immediate attention to this matter is highly appreciated.

Thank you.

MEMORANDUM

19 March 1992

TO: Senator Jim Duncan
Senator Jay Kerttula
Senator Virginia Collins

FROM: Senator Arliss Sturgulewski
Chairman, Senate HESS Committee

It is the intent of the Senate HESS Committee to have an overview of the work of the Health Resources and Access Task Force and it's recommendations on Wednesday, March 25 th.

The committee will then be reviewing legislation currently in the committee congruent with the recommendations of the Task Force. In the process of our committee work, we will be examining the legislation for consistency with those recommendations. We will also look for consistency among the different bills as well.

On Monday, March 30, 1992 at 3:30 pm in the Butrovich room, we will have a public hearing on Senate Bills 74, 83, 242, and 290. It is my intention at that time to hear from the sponsors of the bills scheduled to be heard. We would appreciate having back-up information as complete as possible by that hearing.

Any assistance you can offer in accomplishing these goals will be greatly appreciated. Please call Melissa Fouse of my staff if you have any questions.

- Melissa / see HSS
① need to comply
by 1/1/93?

② Penalties for
not complying

③ Other Bd type
requirements for
Medicaid

④ J+Bd action
current Bds?

A Few Policy Issues of DUR to be Addressed in 1992

Key Issues:

- 1) State medical associations must address numerous policy issues in 1992 session to ensure that DUR remains a *state* issue and that policy areas are enacted properly in state statute/regulation.

Examples:

- DUR *Board* controls DUR, not HCFA, and not Medicaid departments.
 - Criteria and standards are established at *state* level with professional input (consensus) in an ongoing and public fashion.
 - How will DUR Board be selected? What will be the specific duties and powers?
 - Definitions need to be clear and concise.
 - Where does SURS/DUR begin and end?
 - How will the DUR Board "interact" with boards of pharmacy or medicine? What are the lines of jurisdiction?
 - Will pharmacists need to be protected under professional liability statutes?
 - Will DUR Boards be protected from civil liability under peer review statutes?
 - Will pharmacy records and information collected from patients be protected under health records statutes?
 - How will pharmacists "counseling" of patients be defined in statute?
2. Medical societies must take the lead on the issue. This does not *negate* a consensus building approach among the key players in the development of DUR.
 - 3) The initial focus should be on "policy" points (the skeleton).

The details of DUR such as defining outliers, how an intervention is conducted, etc., (the guts and organs) can be filled in after the policy "skeleton" has been built.

Summary of Federal Medicaid Drug Utilization Review Law (OBRA '90)

Intent

- To establish a retrospective and a prospective (point of sale) drug utilization review program for covered outpatient drugs in the state Medicaid program.

Effective Date

- The program is to be in place by January 1, 1993.

Scope:

The DUR program must be designed to:

- a) Ensure that prescriptions are
 - Appropriate
 - Medically necessary
 - Not likely to result in adverse medical outcomes

- b) Educate physicians and pharmacists on
 - Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients
 - Potential or actual severe/adverse reactions to drugs
 - Therapeutic appropriateness
 - Over utilization and under utilization
 - Appropriate use of generics
 - Therapeutic duplication
 - Drug - disease contraindications
 - Drug - drug interactions
 - Incorrect drug dosage/duration of drug treatment
 - Drug allergy interactions
 - Clinical abuse/misuse

Sources for Development of
Predetermined Standards on Drug Use

Compendia consisting of:

- American Hospital Formulary Services Drug Information
- U.S. Pharmacopeia - Drug Information
- AMA Drug Evaluations
- Peer-Reviewed Medical Literature

Retrospective DUR

Must use the mechanized drug claims processing and information retrieval system to analyze claims data to:

- Identify patterns of fraud, abuse, gross overuse, or inappropriate or medically-unnecessary care.
- Assess data on drug use against EXPLICIT PREDETERMINED STANDARDS (using compendia identified previously as the SOURCE OF STANDARDS) to monitor the following:
 - o Therapeutic appropriateness
 - o Over utilization and under utilization
 - o Therapeutic duplication
 - o Drug - disease contraindications
 - o Drug - drug interactions
 - o Incorrect drug dosage or duration of drug treatment
 - o Clinical abuse/misuse.
- Must implement remedial strategies to improve the quality of care and to conserve program funds or personal expenditures.

Prospective Drug Review
(point-of-sale or distribution)

1) Prior to the prescription being filled or delivered, a review will be conducted at the point of sale to:

-- Screen for potential drug therapy problems resulting from:

- o Therapeutic duplication
- o Drug - drug interactions
- o Incorrect dosage/duration of treatment
- o Drug - allergy interactions
- o Clinical abuse/misuse

-- States must use the compendia previously listed as SOURCE OF STANDARDS.

-- Provide under state law standards for pharmacists to counsel individuals receiving outpatient drugs under the Medicaid program. The pharmacist **MUST OFFER TO DISCUSS** matters which the pharmacist deems significant, including:

- o The name and description of the medication
- o Administration, form, duration of therapy
- o Special directions/precautions for use
- o Common severe side effects or interactions and therapeutic interactions, and how-to avoid such occurrences

- Techniques for self-monitoring drug therapy
- Proper storage
- Prescription refill information
- Action to be taken in the event of a missed dose.

2) Pharmacists must make a reasonable effort to record information on the individual including:

- Name
- Address
- Age
- Gender
- Individual history where significant, including disease state, known allergies/drug reactions, and comprehensive list of medications and relevant devices
- Pharmacist's comments on the individual's drug therapy.

3) The patient may refuse the consultation.

DUR Board

- State must provide a DUR Board either directly or through private contract

Membership of DUR Board

- At least one-third, but no more than 51 percent licensed and actively practicing physicians
- At least one-third licensed and actively practicing pharmacists
- Must have knowledge and expertise in one or more of:
 - a. Clinically appropriate prescribing of outpatient drugs
 - b. Clinically appropriate dispensing and monitoring of outpatient drugs
 - c. Drug use review, evaluation, and intervention

Activities of DUR Board

Include, but not limited to:

- a. Retrospective DUR
- b. Application of predetermined standards to be used in DUR
- c. Ongoing interventions for physicians and pharmacists that include:
 - Information dissemination to ensure the availability to physicians and pharmacists on the Board's duties and powers
 - Written, oral, or electronic reminders of patient-specific or drug-specific information, and suggested changes in prescribing or dispensing practices designed to ensure patient confidentiality
 - Use of face-to-face discussions between experts in drug therapy and the prescriber/pharmacist who has been targeted for educational intervention
 - Intensified reviews or monitoring of selected prescribers or dispensers
- d. Educational program
- e. Evaluation of interventions to determine if interventions improved quality of care

Educational Program of DUR Board

The DUR Board shall (either directly or through contract with health care educational institutions, professional societies, etc):

- Use data provided through DUR to provide for active and ongoing educational outreach programs to improve prescribing and dispensing practices

Electronic Claims Management

- 1) Each state will be encouraged to establish as its principal means of processing claims a point-of-sale electronic claims management system for performing on-line eligibility verifications, claims data capture, and claims payments.
- 2) During FY91 and FY92, the claims management systems developed by the states shall be paid for by the federal government at a rate of 90 percent.

Federal Reimbursement to States

- 1) For electronic claims management at point of sale
-- 90 percent (FY91-92)

- 2) For adoption of statewide DUR
-- 75 percent (FY92-93)

- 3) For approved PILOT programs (on prospective DUR
(with on-line claims management)
-- 100 percent

Annual Report of DUR Board

Each DUR Board must prepare an Annual Report to HHS on:

- The activities of the Board
- An overview of the DUR programs
- A summary of interventions used
- An assessment of the impact of the educational interventions on quality of care
- An estimate of the cost savings

Other Reports

- 1) Annual May 1
Report from HHS to Congress on rebate program
- 2) Annual May 1
Report from Comptroller General on prices of drugs to Veterans Affairs, federal programs, retail and hospital pharmacies, and purchasing groups
- 3) May, 1991
Report from Comptroller General on drug purchasing and billing practices of hospitals, health facilities, and managed care plans
- 4) November, 1991
HHS study on availability and reimbursement for vaccines
- 5) November, 1991
Comptroller General study on discounting drugs under Medicaid

Other Reports

- 6) December, 1991
HHS and Comptroller General shall study prior approval procedures
- 7) December, 1991
HHS study on reimbursement rates to pharmacists under Medicaid
- 8) January, 1994
Report from HHS to Congress on the DUR pilots
- 9) January, 1995
Report from HHS to Congress on results of pilot studies on payment to pharmacists for cognitive services

ENGROSSED HOUSE BILL No. 1337

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-1-34.

Synopsis: Medicaid drug utilization review. Establishes the drug utilization review board. Requires the board to: (1) adopt rules; (2) implement a Medicaid retrospective and prospective drug utilization review (DUR) program; (3) develop predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR programs; (4) develop, select, and assess interventions for physicians, pharmacists, and patients; and (5) publish an annual report. Requires information to be kept confidential.

Effective: Upon passage.

**Brown, Turpin, Crawford,
S. Wolf**

(SENATE SPONSORS - RIEGSECKER, HUNT, K. SMITH)

January 7, 1992, read first time and referred to Committee on Public Health.
January 10, 1992, amended, reported - Do Pass.
January 16, 1992, read second time, ordered engrossed. Engrossed.
January 27, 1992, read third time, passed. Yeas 99, nays 0.

SENATE ACTION

January 28, 1992, read first time and referred to Committee on Health and Human Services.
January 31, 1992, amended, reported favorably - Do Pass.
February 5, 1992, read second time, amended, ordered engrossed.

Reprinted
February 6, 1992

Second Regular Session 107th General Assembly (1992)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in this style type. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

ENGROSSED HOUSE BILL No. 1337

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

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

1 SECTION 1. IC 12-1-34 IS ADDED TO THE INDIANA
2 CODE AS A NEW CHAPTER TO READ AS FOLLOWS:

3 Chapter 34. Drug Utilization Review

4 Sec. 1. As used in this chapter, "appropriate and
5 medically necessary" means drug prescribing, drug
6 dispensing, and patient medication usage in conformity
7 with the criteria and standards developed under this
8 chapter.

9 Sec. 2. As used in this chapter, "board" refers to the
10 drug utilization review board created under this chapter.

11 Sec. 3. As used in this chapter, "compendia" means
12 those resources widely accepted by the medical profession
13 in the efficacious use of drugs, including the following
14 sources:

15 (1) The American Hospital Formulary Services Drug

1 Information.

2 (2) The U.S. Pharmacopeia-Drug Information.

3 (3) The American Medical Association Drug
4 Evaluations.

5 (4) The peer-reviewed medical literature.

6 Sec. 4. As used in this chapter, "counseling" means the
7 activities conducted by a pharmacist to inform Medicaid
8 recipients about the proper use of drugs as required by
9 the board under this chapter.

10 Sec. 5. As used in this chapter, "criteria" means the
11 predetermined and explicitly accepted elements that are
12 used to measure drug use on an ongoing basis to
13 determine if the use is appropriate, medically necessary,
14 and not likely to result in adverse medical outcomes.

15 Sec. 6. As used in this chapter, "drug-disease
16 contraindication" means an occurrence in which the
17 therapeutic effect of a drug is adversely altered by the
18 presence of another disease condition.

19 Sec. 7. As used in this chapter, "drug-drug interaction"
20 means an occurrence in which at least two (2) drugs taken
21 by a recipient leads to clinically significant toxicity that:

22 (1) is characteristic of one (1) or any of the drugs
23 present; or

24 (2) leads to the interference with the effectiveness of
25 one (1) or any of the drugs.

26 Sec. 8. As used in this chapter, "drug utilization
27 review" or "DUR" means the program designed to measure
28 and assess on a retrospective and a prospective basis the
29 proper use of outpatient drugs in the Medicaid program.

30 Sec. 9. As used in this chapter, "intervention" means
31 an action taken by the board with a prescriber or
32 pharmacist to inform about or to influence prescribing or
33 dispensing practices or utilization of drugs.

34 Sec. 10. As used in this chapter, "overutilization or
35 underutilization" means the use of a drug in such
36 quantities where the desired therapeutic goal is not
37 achieved.

38 Sec. 11. As used in this chapter, "person" means an
39 individual, an association, a partnership, a governmental
40 unit, or a corporation.

41 Sec. 12. As used in this chapter, "pharmacist" means an
42 individual who is licensed as a pharmacist in Indiana
43 under IC 25-28.

44 Sec. 13. As used in this chapter, "physician" means an
45 individual who is licensed to practice medicine in Indiana

1 under IC 25-22.5.

2 Sec. 14. As used in this chapter, "prospective DUR"
3 means the part of the drug utilization review program
4 that:

- 5 (1) is to occur before the drug is dispensed;
6 (2) is designed to screen for potential drug therapy
7 problems based on explicit and predetermined
8 criteria and standards that are developed on an
9 ongoing basis with professional input; and
10 (3) is to provide for the counseling of recipients
11 about the proper use of drugs.

12 Sec. 15. As used in this chapter, "retrospective DUR"
13 means the part of the drug utilization review program
14 that assesses or measures drug use based on an historical
15 review of drug use data against predetermined and
16 explicit criteria and standards that are developed on an
17 ongoing basis with professional input.

18 Sec. 16. As used in this chapter, "standards" means the
19 acceptable range of deviation from the criteria that
20 reflects local medical practice and that is tested on the
21 Medicaid recipient database.

22 Sec. 17. As used in this chapter, "SURS" refers to the
23 surveillance utilization review system of the Medicaid
24 program.

25 Sec. 18. As used in this chapter, "therapeutic
26 appropriateness" means drug prescribing based on
27 rational drug therapy that is consistent with the criteria
28 and standards developed under this chapter.

29 Sec. 19. As used in this chapter, "therapeutic
30 duplication" means the prescribing and dispensing of:

- 31 (1) the same drug; or
32 (2) at least two (2) drugs from the same therapeutic
33 class;

34 where overlapping periods of drug administration are
35 involved and where such prescribing or dispensing is not
36 medically indicated.

37 Sec. 20. The drug utilization review board is
38 established.

39 Sec. 21. The board is composed of the following:

- 40 (1) Four (4) individuals licensed and actively
41 engaged in the practice of medicine or osteopathic
42 medicine in Indiana under IC 25-22.5.
43 (2) Four (4) individuals licensed under IC 25-26 and
44 actively engaged in the practice of pharmacy in
45 Indiana.

1 (3) One (1) individual with expertise in therapeutic
2 pharmacology who is neither a physician or a
3 pharmacist.

4 (4) A representative of the office of Medicaid policy
5 and planning who shall serve as an ex-officio
6 nonvoting member of the board.

7 Sec. 22. (a) The members of the board shall be
8 appointed by the governor and serve a term of three (3)
9 years.

10 (b) The governor shall fill a vacancy on the board by
11 appointing a new member to serve the remainder of the
12 unexpired term.

13 (c) The governor may remove a member for cause.

14 Sec. 23. Board members must have expertise in one (1)
15 or more of the following:

16 (1) Clinically appropriate prescribing of outpatient
17 drugs.

18 (2) Clinically appropriate dispensing and monitoring
19 of outpatient drugs.

20 (3) Drug utilization review, evaluation, and
21 intervention.

22 (4) Medical quality assurance.

23 Sec. 24. In making the physician appointments, the
24 governor shall provide for geographic balance.

25 Sec. 25. An individual appointed to the board may be
26 reappointed upon the completion of the individual's term.

27 Sec. 26. (a) The board shall annually elect a chairman
28 from the members of the board.

29 (b) The chairman may be re-elected to serve
30 consecutive terms as chairman.

31 (c) A member of the board who is not a state employee
32 is entitled to the minimum salary per diem as provided by
33 IC 4-10-11-2.1(b). Each member of the board is entitled to
34 reimbursement for traveling expenses and other expenses
35 actually incurred in connection with the member's duties
36 as provided in the state travel policies and procedures
37 established by the Indiana department of administration
38 and the budget agency.

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

45 Sec. 27. The secretary of the family and social services

1 administration shall provide staff to the board.

2 Sec. 28. The board is responsible for the oversight of
3 the retrospective and prospective DUR program.

4 Sec. 29. The board has the following duties:

5 (1) The adoption of rules to carry out this chapter, in
6 accordance with the provisions of IC 4-22-2 and
7 subject to any Office of Medicaid Policy and
8 Planning approval that is required by the federal
9 Omnibus Reconciliation Act of 1990 under Public
10 Law 101-508 and its implementing regulations
11 adopted under the Act.

12 (2) The implementation of a Medicaid retrospective
13 and prospective DUR program as outlined in this
14 chapter, including the approval of software
15 programs to be used by the pharmacist for
16 prospective DUR and recommendations concerning
17 the provisions of the contractual agreement between
18 the state and any other entity that will be processing
19 and reviewing Medicaid drug claims and profiles for
20 the DUR program under this chapter.

21 (3) The development and application of the
22 predetermined criteria and standards for
23 appropriate prescribing to be used in retrospective
24 and prospective DUR to ensure that such criteria
25 and standards for appropriate prescribing are based
26 on the compendia and developed with professional
27 input with provisions for timely revisions and
28 assessments as necessary.

29 (4) The development, selection, application, and
30 assessment of interventions for physicians,
31 pharmacists, and patients that are educational and
32 not punitive in nature.

33 (5) The publication of an annual report that must be
34 subject to public comment before issuance to the
35 Federal Department of Health and Human Services
36 by December 1 of each year.

37 (6) The development of a working agreement for the
38 board to clarify the areas of responsibility with
39 related boards or agencies, including the following:

40 (A) The Indiana Board of Pharmacy.

41 (B) The Medical Licensing Board of Indiana.

42 (C) The SURS staff.

43 (7) The establishment of a grievance and appeals
44 process for physicians or pharmacists under this
45 chapter.

- 1 (8) The publication and dissemination of educational
 2 information to physicians and pharmacists
 3 regarding the board and the DUR program,
 4 including information on the following:
 5 (A) Identifying and reducing the frequency of
 6 patterns of fraud, abuse, gross overuse, or
 7 inappropriate or medically unnecessary care
 8 among physicians, pharmacists, and recipients.
 9 (B) Potential or actual severe or adverse
 10 reactions to drugs.
 11 (C) Therapeutic appropriateness.
 12 (D) Overutilization or underutilization.
 13 (E) Appropriate use of generic drugs.
 14 (F) Therapeutic duplication.
 15 (G) Drug-disease contraindications.
 16 (H) Drug-drug interactions.
 17 (I) Incorrect drug dosage and duration of drug
 18 treatment.
 19 (J) Drug allergy interactions.
 20 (K) Clinical abuse and misuse.
- 21 (9) The adoption and implementation of procedures
 22 designed to ensure the confidentiality of any
 23 information collected, stored, retrieved, assessed, or
 24 analyzed by the board, staff to the board, or
 25 contractors to the DUR program that identifies
 26 individual physicians, pharmacists, or recipients.
- 27 (10) The implementation of additional drug
 28 utilization review with respect to drugs dispensed to
 29 residents of nursing facilities shall not be required
 30 if the nursing facility is in compliance with the drug
 31 regimen procedures under 410 IAC 16.2-3-8 and 42
 32 CFR 483.60.
- 33 Sec. 30. (a) A quorum consists of five (5) voting
 34 members of the board.
- 35 (b) DUR criteria and standards for appropriate
 36 prescribing may only be implemented with the approval
 37 of a majority of the quorum of the board. The majority
 38 vote must include at least three (3) of the four (4)
 39 physician members of the board and may allow the board
 40 to accept deviations from the standards on a case-by-case
 41 basis.
- 42 Sec. 31. The criteria and standards developed under
 43 section 29(3) of this chapter for appropriate prescribing
 44 that are implemented must reflect the local practices of
 45 physicians to monitor the following:

- 1 (1) Therapeutic appropriateness.
- 2 (2) Overutilization or underutilization.
- 3 (3) Therapeutic duplication.
- 4 (4) Drug-disease contraindications.
- 5 (5) Drug-drug interactions.
- 6 (6) Incorrect drug dosage or duration of drug
- 7 treatment.
- 8 (7) Clinical abuse and misuse.

9 Sec. 32. (a) An intervention developed under section
10 29(4) of this chapter that involves a physician must be
11 approved by at least three (3) of the four (4) physician
12 members of the board before implementation.

13 (b) An intervention that involves a pharmacist must
14 be approved by at least three (3) of the four (4)
15 pharmacist members of the board before implementation.

16 (c) Interventions include the following:

- 17 (1) Information disseminated to physicians and
18 pharmacists to ensure that physicians and
19 pharmacists are aware of the board's duties and
20 powers.
- 21 (2) Written, oral, or electronic reminders of
22 recipient-specific or drug-specific information that
23 are designed to ensure recipient, physician, and
24 pharmacist confidentiality, and suggested changes in
25 the prescribing or dispensing practices designed to
26 improve the quality of care.
- 27 (3) Use of face-to-face discussions between experts in
28 drug therapy and the prescriber or pharmacist who
29 has been targeted for educational intervention.
- 30 (4) Intensified reviews or monitoring of selected
31 prescribers or pharmacists.
- 32 (5) The creation of an educational program using
33 data provided through DUR to provide for active
34 and ongoing educational outreach programs to
35 improve prescribing and dispensing practices.
- 36 (6) The timely evaluation of interventions to
37 determine if the interventions have improved the
38 quality of care.
- 39 (7) The review of case profiles before the conducting
40 of an intervention.

41 Sec. 33. (a) The annual report under section 29 of this
42 chapter shall:

- 43 (1) be submitted to the legislative council, the
44 governor, and the secretary of family and social
45 services; and

1 (2) be made available to the public before December
2 1 of each year.

3 (b) The annual report must include information on the
4 following:

5 (1) An overview of the activities of the board and the
6 DUR program.

7 (2) Interventions used and their effectiveness.
8 However, the information may not disclose the
9 identities of individual physicians, pharmacists, or
10 recipients. Intervention information should specify
11 if the intervention was as a result of
12 underutilization or overutilization of drugs.

13 (3) The costs of administering the DUR program.

14 (4) Any fiscal impact resulting from the DUR
15 program.

16 (5) An overview of the fiscal impact of the DUR
17 program to other areas of the Medicaid program
18 such as hospitalization or long term care costs.

19 (6) A quantifiable assessment of how DUR has
20 improved the recipient's quality of care.

21 (7) A summary of the total number of prescriptions
22 reviewed by drug therapeutic class.

23 (8) An assessment of the impact of the educational
24 programs or interventions on the prescribing or
25 dispensing practices.

26 Sec. 34. The board and the Office of Medicaid Policy
27 and Planning shall provide to the General Assembly
28 before January 1, 1993, a report on the federal regulations
29 interpreting the drug utilization review requirements of
30 the Omnibus Budget Reconciliation Act of 1990 under
31 Public Law 101-508, and any recommendations for changes
32 in this Act required by those regulations.

33 Sec. 35. (a) Information that identifies an individual
34 collected under this chapter is confidential and may not
35 be disclosed by the board.

36 (b) The board may have access to identifying
37 information for purposes of carrying out intervention
38 activities. The identifying information may not be
39 released to anyone other than a member of the board.

40 (c) The board may release cumulative non-identifying
41 information for purposes of legitimate research.

42 Sec. 36. Before the approval or implementation of a
43 prior approval program for outpatient drugs, the program
44 must meet the following conditions:

45 (1) A prior approval program may not be applied to

1 a single drug entity.

2 (2) An outpatient drug may not be placed on prior
3 approval for other than medical reasons.

4 (3) Before a therapeutic drug class is placed on prior
5 approval, the board must hold a public hearing at
6 least ninety (90) days before taking the action.

7 (4) The board must provide evidence that placing a
8 drug class on prior approval will not impede quality
9 of patient care and that the drug class is subject to
10 clinical abuse or misuse before the board
11 recommends that the drug class be placed on prior
12 approval.

13 (5) Any drug class placed on prior approval will be
14 reconsidered for removal by the board from prior
15 approval no later than six (6) months after the drug
16 is placed on prior approval.

17 (6) Any prior approval program must provide either
18 telephone or FAX approval or denial Monday
19 through Friday, twenty-four (24) hours a day. The
20 office of Medicaid policy and planning must provide
21 the approval or denial within twenty-four (24) hours
22 after receipt of a prior approval request. The
23 program must provide for the dispensing of at least
24 a seventy-two (72) hour supply of the drug in an
25 emergency situation or on weekends.

26 (7) Any prior approval program may not be applied
27 to prevent acceptable medical use for appropriate
28 off-label indications.

29 **Sec. 37.** The board may establish advisory committees
30 to assist the board in carrying out the board's duties
31 under this chapter.

32 **Sec. 38.** The board shall, in cooperation with the
33 secretary of family and social services, include in the
34 Medicaid state plan the creation and implementation of a
35 retrospective and prospective DUR program for Medicaid
36 outpatient drugs to ensure that the prescriptions are
37 appropriate, medically necessary, and not likely to result
38 in adverse medical outcomes.

39 **Sec. 39.** The retrospective and prospective DUR
40 program shall be operated under the guidelines and
41 procedures established by the board under section 29 of
42 this chapter.

43 **Sec. 40. (a)** Retrospective DUR must:

44 (1) be based on the guidelines established by the
45 board; and

1 (2) use the mechanized drug claims processing and
 2 information retrieval system to analyze claims data
 3 to do the following:

4 (A) Identify patterns of fraud, abuse, gross
 5 overuse, and inappropriate or medically
 6 unnecessary care.

7 (B) Assess data on drug use against explicit
 8 predetermined standards that are based on the
 9 compendia and other sources to monitor the
 10 following:

11 (i) Therapeutic appropriateness.

12 (ii) Overutilization or underutilization.

13 (iii) Therapeutic duplication.

14 (iv) Drug-disease contraindications.

15 (v) Drug-drug interactions.

16 (vi) Incorrect drug dosage or duration of
 17 drug treatment.

18 (vii) Clinical abuse and misuse.

19 Sec. 4L. Prospective DUR must be based on the
 20 guidelines established by the board and must provide that
 21 prior to the prescription being filled or delivered a review
 22 will be conducted by the pharmacist at the point of sale
 23 to screen for potential drug therapy problems resulting
 24 from the following:

25 (1) Therapeutic duplication.

26 (2) Drug-drug interactions.

27 (3) Incorrect dosage and duration of treatment.

28 (4) Drug-allergy interactions.

29 (5) Clinical abuse and misuse.

30 Sec. 42. The activities of the board in carrying out this
 31 chapter are covered under IC 34-4-12.6.

32 Sec. 43. (a) The board may meet in an executive
 33 session for purposes of reviewing DUR data or to conduct
 34 or to discuss activity as provided for in IC 5-14-15-6.1.

35 (b) The board shall also conduct regular public
 36 meetings to gather input from the public on the operation
 37 of the DUR program.

38 Sec. 44. Confidential data or information obtained by
 39 pharmacists as part of prospective DUR are confidential
 40 but may be released to prescribers or others according to
 41 procedures established by the board.

42 Sec. 45. A person who does not comply with the
 43 confidentiality provisions under section 34 of this chapter
 44 commits a Class A misdemeanor.

45 SECTION 2. IC 25-26-13-4 IS AMENDED TO READ AS

- 1 FOLLOWS: Sec. 4. (a) The board may:
2 (1) promulgate rules and regulations under IC 4-22-2 for
3 implementing and enforcing this chapter;
4 (2) establish requirements and tests to determine the
5 moral, physical, intellectual, educational, scientific,
6 technical, and professional qualifications for applicants for
7 pharmacists' licenses;
8 (3) refuse to issue, deny, suspend, or revoke a license or
9 permit or place on probation or fine any licensee or
10 permittee under this chapter;
11 (4) regulate the sale of drugs and devices in the state of
12 Indiana;
13 (5) impound, embargo, confiscate, or otherwise prevent
14 from disposition any drugs, medicines, chemicals, poisons,
15 or devices which by inspection are deemed unfit for use or
16 would be dangerous to the health and welfare of the
17 citizens of the state of Indiana; the board shall follow those
18 embargo procedures found in IC 16-1-28-22 through IC
19 16-1-28-35, and persons may not refuse to permit or
20 otherwise prevent members of the board or their
21 representatives from entering such places and making such
22 inspections;
23 (6) prescribe minimum standards with respect to physical
24 characteristics of pharmacies, as may be necessary to the
25 maintenance of professional surroundings and to the
26 protection of the safety and welfare of the public;
27 (7) subject to IC 25-1-7, investigate complaints, subpoena
28 witnesses, schedule and conduct hearings on behalf of the
29 public interest on any matter under the jurisdiction of the
30 board;
31 (8) prescribe the time, place, method, manner, scope, and
32 subjects of licensing examinations which shall be given at
33 least twice annually; and
34 (9) perform such other duties and functions and exercise
35 such other powers as may be necessary to implement and
36 enforce this chapter.
- 37 (b) The board shall adopt rules under IC 4-22-2 for the
38 following:
39 (1) ~~establishing~~ Establishing standards for the competent
40 practice of pharmacy.
41 (2) Establishing the standards for a pharmacist to
42 counsel individuals regarding the proper use of
43 drugs.
- 44 SECTION 3. (a) The drug utilization review board

1 established by IC 12-1-34, as added by this act, shall adopt
2 the rules required by IC 12-1-34-29 before January 1, 1993.

3 (b) This SECTION expires January 2, 1993.

4 SECTION 4. (a) Notwithstanding IC 12-1-34-22, as added
5 by this act, the governor shall appoint the initial members
6 of the drug utilization review board established by this
7 act for terms expiring as follows:

8 (1) Two (2) members for terms expiring June 30, 1995.

9 (2) Four (4) members for terms expiring June 30,
10 1996.

11 (3) Four (4) members for terms expiring June 30,
12 1997.

13 (b) This SECTION expires July 1, 1997.

14 SECTION 5. (a) The state may not approve a contract
15 for services to implement the retrospective drug
16 utilization review program under IC 12-1-34 before July 1,
17 1993.

18 (b) This SECTION expires July 1, 1993.

19 SECTION 6. (a) Notwithstanding IC 12-1-34-26, as added
20 by this act, the governor shall appoint the initial
21 chairperson of the drug utilization review board.

22 (b) This SECTION expires January 1, 1993.

23 SECTION 7. Because an emergency exists, this act
24 takes effect upon passage.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1337, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 3, line 30, after "ex-officio" insert in bold "nonvoting".

Page 3, line 32, after "Sec. 22." insert in bold "(a)".

Page 3, between lines 33 and 34, begin a new paragraph insert in bold the following:

"(b) The governor shall fill a vacancy on the board by appointing a new member to serve the remainder of the unexpired term.

(c) The governor may remove a member for cause."

Page 4, line 3, delete "if" and insert in bold "of".

Page 4, between lines 5 and 6, begin a new paragraph insert in bold the following:

"(c) A member of the board who is not a state employee is entitled to the minimum salary per diem as provided by IC 4-10-11-2.1(b). Each member of the board is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties as provided in the state travel policies and procedures established by the Indiana department of administration and the budget agency.

(d) Each member of the board who is a state employee is entitled to reimbursement for traveling expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency."

Page 8, line 34, after "include" insert in bold "in".

Page 10, between lines 15 and 16, begin a new paragraph and insert the following:

"SECTION 4. (a) The drug utilization board established by IC 12-1-34, as added by this act, may not enter into a contract for services to implement the retroactive drug utilization review program under IC 12-1-34.

(b) This SECTION expires July 1, 1993."

Page 10, line 16, renumber SECTION 4 as SECTION 5.
and when so amended that said bill do pass.

(Reference is to House Bill 1337 as introduced.)

BROWN, Chair

Committee Vote: yeas 10, nays 0.

COMMITTEE REPORT

Mr. President: Your Committee on Health and Human Services, to which was referred Senate Bill 1337, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be amended as follows:

Page 3, line 2, delete "and".

Page 3, line 6, delete "." and insert in bold "; and

(3) is to provide for the counseling of recipients about the proper use of drugs."

Page 4, line 45, delete "to carry out" and insert in bold "required by".

Page 5, line 1, delete "this chapter" and insert in bold "the federal Omnibus Reconciliation Act of 1990 under Public Law 101-508 and any regulations adopted under the Act".

Page 5, line 6, delete "approval of" and insert in bold "recommendations concerning".

Page 6, line 17, delete "The approval or disapproval of the" and insert in bold "The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities may not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 433.60."

Page 6, delete lines 18 through 21.

Page 8, between lines 14 and 15, begin a new line block indented and insert in bold the following:

"(9) A report on the federal regulations interpreting the drug utilization review requirements of the federal Omnibus Reconciliation Act of 1990 under Public Law 101-508 and any recommendations for changes in this chapter required under the Act."

Page 8, line 24, delete "(a) The office of Medicaid policy and planning".

Page 8, delete lines 25 through 27.

Page 8, line 28, delete "(b)".

Page 8, run in lines 24 and 28.

Page 8, line 41, after "the" insert in bold "board recommends that the".

Page 8, line 41, delete "is" and insert in bold "be".

Page 9, delete lines 14 through 17.

Page 9, delete lines 21 through 22.

Page 9, line 23, delete "38." and insert in bold "37."

Page 9, line 30, delete "39." and insert in bold "38."

Page 9, line 34, delete "40." and insert in bold "39."

Page 10, line 10, delete "41." and insert in bold "40."

Page 10, line 21, delete "42." and insert in bold "41."

Page 10, line 23, delete "43." and insert in bold "42."

Page 10, line 29, delete "44." and insert in bold "43."

Page 10, line 33, delete "45." and insert in bold "44."

Page 10, between lines 35 and 36, begin a new paragraph and insert the following:

"SECTION 2. IC 25-26-13-4 IS AMENDED TO READ AS FOLLOWS: Sec. 4. (a) The board may:

- (1) promulgate rules and regulations under IC 4-22-2 for implementing and enforcing this chapter;
- (2) establish requirements and tests to determine the moral, physical, intellectual, educational, scientific, technical, and professional qualifications for applicants for pharmacists' licenses;
- (3) refuse to issue, deny, suspend, or revoke a license or permit or place on probation or fine any licensee or permittee under this chapter;
- (4) regulate the sale of drugs and devices in the state of Indiana;
- (5) impound, embargo, confiscate, or otherwise prevent from disposition any drugs, medicines, chemicals, poisons, or devices which by inspection are deemed unfit for use or would be dangerous to the health and welfare of the citizens of the state of Indiana; the board shall follow those embargo procedures found in IC 16-1-28-22 through IC 16-1-28-35, and persons may not refuse to permit or otherwise prevent members of the board or their representatives from entering such places and making such inspections;
- (6) prescribe minimum standards with respect to physical characteristics of pharmacies, as may be necessary to the maintenance of professional surroundings and to the protection of the safety and welfare of the public;
- (7) subject to IC 25-1-7, investigate complaints, subpoena witnesses, schedule and conduct hearings on behalf of the public interest on any matter under the jurisdiction of the board;
- (8) prescribe the time, place, method, manner, scope, and subjects of licensing examinations which shall be given at least twice annually; and
- (9) perform such other duties and functions and exercise such other powers as may be necessary to implement and enforce this chapter.

(b) The board shall adopt rules under IC 4-22-2 for the

following:

(1) ~~establishing~~ **Establishing standards for the competent practice of pharmacy.**

(2) **Establishing the standards for a pharmacist to counsel individuals regarding the proper use of drugs."**

Beginning on page 10, line 36, renumber SECTIONS 2 through 4 as SECTIONS 3 through 5.

Page 11, line 6, delete "drug utilization board established" and insert in bold "state".

Page 11, line 7, delete "by IC 12-1-34, as added by this act,".

Page 11, line 7, delete "enter into" and insert in bold "approve".

Page 11, line 8, delete "retroactive" and insert in bold "retrospective".

Page 11, line 9, after "IC 12-1-34" insert in bold "before July 1, 1993".

Page 11, between lines 10 and 11, begin a new paragraph and insert the following:

"SECTION 6. (a) **Notwithstanding IC 12-1-34-26, as added by this act, the governor shall appoint the initial chairperson of the drug utilization review board.**

(b) **This SECTION expires January 1, 1993."**

Page 11, line 11, renumber SECTION 5 as SECTION 7.

and when so amended that said bill do pass.

(Reference is to House Bill 1337 as printed January 13, 1992.)

BLANKENBAKER, Chairman

Committee Vote: Yeas 8, Nays 0.

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1337 be amended as follows:

Page 5, line 4, delete "under IC 4-22-2" and insert in bold "to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any Office of Medicaid Policy and Planning approval that is".

Page 5, line 5, after "Omnibus" and insert in bold "Budget".

Page 5, line 6, delete "any" and insert in bold "its implementing".

Page 5, delete line 7,

Page 6, line 25, delete "may" and insert in bold "shall".

Page 8, delete lines 22 through 26.

Page 8, between lines 26 and 27, begin a new paragraph and insert in bold the following:

"Sec. 34. The board and the Office of Medicaid Policy and Planning shall provide to the General Assembly before January 1, 1993, a report on the federal regulations interpreting the drug utilization review requirements of the Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508, and any recommendations for changes in this Act required by those regulations."

Beginning on page 8, line 26, renumber "Sec. 34" through "Sec. 44" as "Sec. 35" through "Sec. 45".

(Reference is made to bill printed February 1, 1992.)

RIEGSECKER



Principles of Drug Use Review (DUR)

Adopted by



American Medical Association
American Pharmaceutical Association
Pharmaceutical Manufacturers Association

**Pharmaceutical
Manufacturers
Association**

Summer 1991

PRINCIPLE 1

The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy.

CHARACTERISTICS:

- a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed.
- b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

PRINCIPLE 3

Criteria and standards for DUR must be non-proprietary and must be developed and revised through an open professional consensus process.

CHARACTERISTICS:

- a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted.
- b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings.
- c) The criteria and standards should be reviewed and revised in a timely manner.
- d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

PRINCIPLE 5

Confidentiality of the relationship between patients and practitioners must be protected.

CHARACTERISTICS:

- a) The DUR program must assure the security of its database.

PRINCIPLE 7

DUR program operations must be structured to achieve the principles of DUR.

CHARACTERISTICS:

- a) DUR programs should maximize physician and pharmacist involvement in program development, operation and evaluation.
- b) DUR programs should have an explicit process for system evaluation (e.g. total program costs, validation).
- c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs.
- d) DUR programs should minimize administrative burdens to patients and practitioners.

DEFINITIONS

DRUG UTILIZATION REVIEW (DUR: DRUG USE REVIEW)

FORMAL PROGRAM FOR ASSESSING DATA ON DRUG USE AGAINST EXPLICIT, PROSPECTIVE STANDARDS AND, AS NECESSARY, INTRODUCING REMEDIAL STRATEGIES TO ACHIEVE SOME DESIRED END.

RETROSPECTIVE DUR

REVIEW OCCURS AFTER THE DRUG HAS BEEN DISPENSED; DOES NOT ALLOW OPPORTUNITY TO MODIFY INDIVIDUAL PATIENT'S DRUG THERAPY.

PROSPECTIVE DUR

REVIEW OCCURS BEFORE PRESCRIPTION IS DISPENSED TO PATIENT; ALLOWS OPPORTUNITY TO MODIFY INDIVIDUAL PATIENT'S PRESCRIPTION.

- PHARMACIST DISPENSING LEVEL VS. PHYSICIAN PRESCRIBING LEVEL
- LOCAL REVIEW ONLY VS. ONLINE ELECTRONIC REVIEW

DEFINITIONS (CONTD)

CRITERIA

PREDETERMINED ELEMENTS OF DRUG USE AGAINST WHICH ASPECTS OF QUALITY, MEDICAL NECESSITY, AND APPROPRIATENESS OF DRUG USE MAY BE COMPARED.

- IMPLICIT (UNSTRUCTURED; UNWRITTEN; SUBJECTIVE) VS. EXPLICIT (WRITTEN; OBJECTIVELY DERIVED; AGREED TO BY ALL [EG, DOSE OF DRUG X IS 25 MG]).

NORMS

NUMERICAL OR STATISTICAL DESCRIPTIONS OF OBSERVED PERFORMANCE (EG, AVERAGE DOSE OF DRUG X USED WAS 25 MG).

STANDARDS

PROFESSIONALLY DEVELOPED EXPRESSIONS OF THE RANGE OF ACCEPTABLE VARIATION FROM A CRITERION OR NORM (EG, NO MORE THAN 5% OF PATIENTS ON DRUG X AT GREATER THAN 25 MG DOSE).

GOALS OF DUR

CORRECT INAPPROPRIATE PRESCRIBING, DISPENSING, AND PATIENT
MEDICATION USE TO:

- IMPROVE QUALITY OF CARE
- DECREASE COST
- DECREASE FRAUD AND ABUSE

DUR _ PROCESS

SETTING CRITERIA AND STANDARDS

DATA CAPTURE AND ANALYSIS

- CRITERIA-BASED VS NORMATIVE

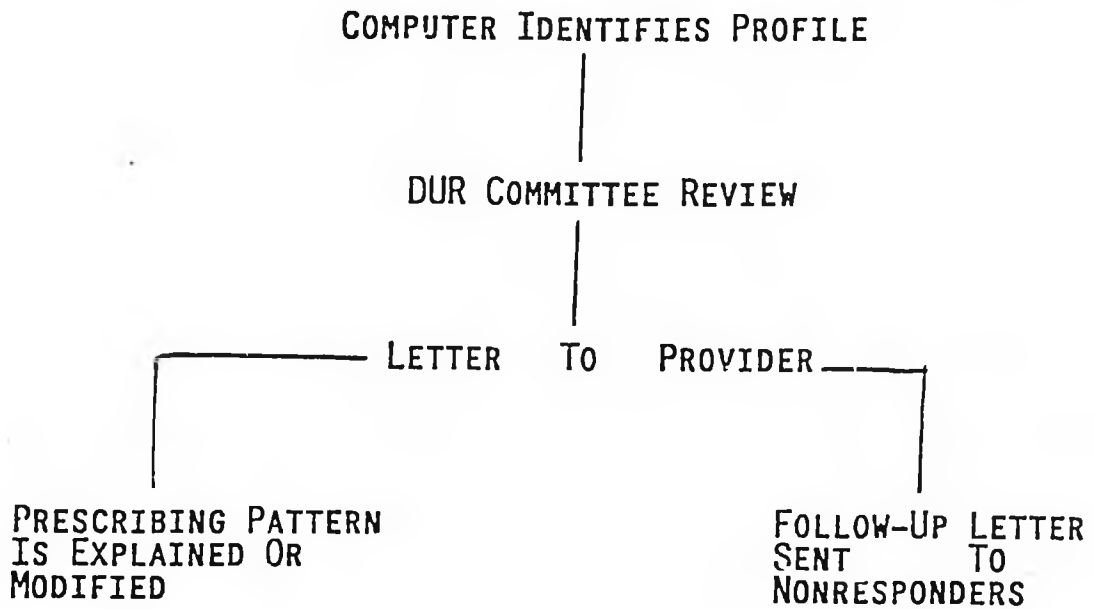
INTERVENTION AND EDUCATION

- LETTERS
- FACE-TO-FACE PEER COUNSELING ("COUNTER DETAILING")
- FOCUSED CME

MEASURE EFFECTIVENESS

- OF INTERVENTIONS (EG, IMPROVED PRESCRIBING)
- OF DUR PROGRAM (EG, HEALTH OUTCOMES; COST-EFFECTIVENESS)

TYPICAL MEDICAID RETROSPECTIVE
DUR PROCEDURE (NPC STUDY)



DUR UNDER OBRA '90

- REQUIRED IN EVERY STATE BY 1/1/93
- ADDRESS QUALITY OF CARE; COST; FRAUD AND ABUSE
- CRITERIA AND STANDARDS FROM THREE COMPENDIA AND PEER REVIEWED LITERATURE (STATUTORY LANGUAGE)
- PROSPECTIVE DUR
 - ELECTRONIC NOT MANDATED
 - BY PHARMACIST AT POS -- MANDATES PHARMACIST COUNSELING OF PATIENT
 - 10 DEMONSTRATION PROJECTS FOR ELECTRONIC ONLINE, REAL-TIME PROSPECTIVE DUR
- RETROSPECTIVE DUR -- WILL ADDRESS INAPPROPRIATE PRESCRIBING!
- INTERVENTION -- EDUCATION (EG, LETTERS, FACE-TO-FACE) PREFERRED; BUT PUNITIVE SANCTIONS PROBABLY WILL BE ALLOWED
- DUR BOARD
 - MANDATED IN EACH STATE
 - RUNS RETROSPECTIVE DUR AND EDUCATION (NOTE: RUN PROSPECTIVE DUR IF TECHNICAL CORRECTION-SCHULKE?)
 - COMPOSITION IS 33% TO 51% PRACTICING PHYSICIANS AND 33% TO 66% PRACTICING PHARMACISTS
 - MAY BE CONTRACTED OUT
 - APPROVE CRITERIA AND STANDARDS (HCFA CONCEPT PAPER)