

Members

Rep. William Crawford, Chairperson  
Rep. Charlie Brown  
Rep. Peggy Welch  
Rep. Timothy Brown  
Rep. Suzanne Crouch  
Rep. Don Lehe  
Sen. Patricia Miller  
Sen. Ryan Mishler  
Sen. Luke Kenley  
Sen. Sue Errington  
Sen. Vi Simpson  
Sen. Connie Sipes



# SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

*Legislative Services Agency*  
200 West Washington Street, Suite 301  
Indianapolis, Indiana 46204-2789  
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Kathy Norris, Fiscal Analyst for the Commission  
Al Gossard, Fiscal Analyst for the Commission  
Casey Kline, Attorney for the Commission

Authority: IC 2-5-26

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

**Meeting Date:** October 25, 2010  
**Meeting Time:** 10:00 A.M.  
**Meeting Place:** State House, 200 W. Washington St.,  
Room 404  
**Meeting City:** Indianapolis, Indiana  
**Meeting Number:** 3

**Members Present:** Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Peggy Welch; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Don Lehe; Sen. Patricia Miller; Sen. Ryan Mishler; Sen. Sue Errington; Sen. Vi Simpson.

**Members Absent:** Sen. Connie Sipes; Sen. Luke Kenley.

The third meeting of the Select Joint Commission on Medicaid Oversight was called to order by Chairperson Crawford at 10:10 AM. He noted that while this would be the final meeting of the Commission for the interim, he had concerns that the Commission did not have sufficient time this interim session to address all items that required attention. After Commission members introduced themselves, the Chairperson called for an explanation of the recently released revision of the Milliman report that details estimated state costs associated with the federal Affordable Care Act (ACA).

### Milliman Report Revision

Mr. Rob Dahmler, Principal and Consulting Actuary, Milliman, Inc., the state Medicaid program's actuary, stated that there are two versions of the Milliman report; the first, dated May 6, 2010, is the original estimate of the cost of the ACA if all estimated new Medicaid eligibles enrolled. At the request of the Budget Committee, Milliman added an estimate of what actual participation might be expected. The two estimates resulted in a cost range of \$2.9 B to \$3.6 B for state fiscal years 2011 through 2020. This was the version of the report discussed at the first Commission meeting.

---

<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.

The revised report, dated October 18, 2010, (Exhibit A) reflects a change in the treatment of the Medicaid prescription drug rebate provisions and an update of the FFY 2012 federal matching percentage. Mr. Dahmler explained that after working with the directors of state Medicaid programs, the federal Centers for Medicare and Medicaid Services (CMS) revised how Medicaid prescription drug rebate changes required by the ACA would be captured by CMS. (See Exhibits B, C, and D.) Mr. Dahmler commented that the rebate provision was originally estimated by the Congressional Budget Office to result in \$38 B in federal revenue to help provide funding for the ACA for the period 2014 through 2020. The change made by CMS is anticipated to result in fewer dollars coming from the states. Milliman estimates that the impact on the Indiana Medicaid program for the same period will reduce the cost of the ACA by \$298 M. The revised report also includes a savings of \$35 M over the life of the estimate attributable to the recently published increased FMAP rate for FFY 2012.

Commission discussion and questions followed. In response to questions regarding why a general physician fee increase is included in the estimate when it is not required by the ACA, Mr. Dahmler explained that the act requires a two-year primary care fee increase that is to be reimbursed with 100% federal dollars; it does not require a general physician fee increase. However, Milliman included an adjustment to the physician fee schedule because in the actuary's judgement, it will be necessary in order to maintain access to services for the expanded Medicaid population. The questioned adjustment would increase physician fees from approximately 60% to 65% of the Medicare fee schedule to 80% of the Medicare rate. An additional concern was raised as to why a recent mailing to state employees attributed an increase in medical expenses to the ACA. Mr. Dahmler explained that Milliman does not work on state employee healthcare benefits. He did suggest that some changes required by the ACA, such as insurance coverage for children to age 26, would impact costs right away. In response to questions regarding whether the Healthy Indiana Plan participants would be eligible for the 100% federal match for the expansion population, FSSA reported that there has been no clarification on this subject from CMS.

#### Medicaid Mental Health Issues

Gina Eckart, Director of the Division of Mental Health and Addictions (DMHA), reported on the history and trends of state-operated psychiatric facilities and the Division's transition plans for the state-operated facilities. (Ms. Eckert's slide presentations are included as Exhibits E and F, respectively.) Ms. Eckart emphasized that the administration is complying with the Olmstead decision and moving to shift care to community-based settings. Developmentally disabled populations will be moved to community-based settings, allowing for the closure of some units in state-operated facilities while additional mental illness beds will be opened where most needed. In addition, DMHA is closing the addictions inpatient unit at Richmond State Hospital and preparing to provide addictions treatment as a community-based service throughout the state. The net impact of the plan will be the closure of 355 beds, a decrease in capacity of about 30%; 110 beds will be converted to serve persons with serious mental illness.

Discussion and questions followed the presentations. (See Exhibit G for discussion topics and questions distributed by the Chairperson.) There was considerable discussion focused on the workforce capacity to provide home and community-based services and the availability of services from the community mental health center (CMHC) network. Commission members expressed concern with regard to whether patients would have sufficient funding following them to community-based settings and if the community providers would have sufficient and appropriate staff to provide the services needed by deinstitutionalized individuals. There were additional questions regarding the availability of services at the Marion County community mental health centers.

### Medicaid Rehabilitation Option (MRO) Update

Ms. Eckart provided an update on changes to the MRO that were implemented on July 1, 2010. (See Exhibit H for the slide presentation.) In response to a question regarding the difference between day treatment and partial hospitalization, Ms. Eckart explained that the less intensive day treatment services are billed through the MRO, while partial hospitalization services are reimbursed by Medicaid to providers that must be CMHCs or affiliates.

Sarah Jagger, Policy Director, Office of Medicaid Policy and Planning, addressed prior authorization (PA) statistics and issues within the MRO service package and responded to Commission questions regarding PA denials.

The Commission recessed at noon and reconvened at 1:20 PM.

### Residential Living Allowance Update

Julia Holloway, Director of the Division of Developmental Disability and Rehabilitative Services (DDARS), updated the Commission on the changes to the Residential Living Allowance (RLA). Ms. Holloway explained that the RLA is a 100% state supplement that may be paid in addition to all other services. She stated that Indiana is one of a few states that still provide a state supplement. The recent policy modification to the RLA was in response to a lawsuit in which judicial review offered the opportunity for the state to revise and review the policy. Ms. Holloway stated that the RLA is paid for about 440 individual consumers. DDARS revised the definition of household expense that can be met using the RLA, effectively removing food from the budgets since consumers receive federal Food Stamp benefits. The amount of the allocated RLA benefit did not change; more money is now available to assist in paying for housing. In response to Commission questions, Ms. Holloway noted that the budget for the program did not change and that the number of eligible individuals has remained about the same.

Scott Duke, Esq., Office of the General Counsel, FSSA, assisted with responses to questions associated with the lawsuit concerning these changes.

Mr. Steven Dick testified regarding the impact of the RLA policy change on recipients of the state supplemental payments. (See his written testimony in Exhibit I.)

Rep. Crawford also distributed a copy of an e-mail from Marvin and Lois Ross concerning the impact of the RLA policy change on their son. (See their e-mail in Exhibit J.) Rep. Crawford asked FSSA for a cost-benefit analysis of the policy change.

### First Steps Program Modifications

Ms. Dawn Downer, Director of the First Steps Program, reviewed program population and services statistics for FY 2010. (See Exhibit K.) She then explained the actions taken to eliminate a \$15 M deficit. The program has already implemented a change in prior authorization policy - requiring PA for higher intensity services. Additionally, in an effort to improve communications between providers and the state, a proposed rule has been issued that requires providers to be affiliated with networks or supporting agencies. The program does not anticipate providers leaving the program as a result of the proposed rule, but they do anticipate that it will take time for independent single providers to revise their employment.

Commission discussion and questions followed regarding why the program has a \$15 M deficit and what happens when families do not pay the required copayments. Additional questions focused on the types of services provided and how they are reimbursed under the First Steps program. Rep. Crawford commended FSSA for their presentation and responses on this issue. He also requested a cost-benefit analysis of increasing the reimbursement to the First Steps providers.

PD 3351 - Indiana Check-up Plan

Upon proper motion, the Commission voted 8 to 0 to recommend PD 3351, which specifies that interest accruing from the investment of funds in the Indiana Check-up Plan Trust Fund must be deposited in the fund and requires the Office of Medicaid Policy and Planning to post certain information on the Indiana Check-up Plan's website before the office may place individuals on a waiting list or stop enrollments in the plan.

Final Report

Upon proper motion, the Commission voted 7 to 0 to approve the final report, understanding that staff would include information provided at the October 25, 2010, Commission meeting.

Update on Nursing Home Staff Turnover and Retention

Mr. Jim Leich, Indiana Association of Homes and Services for the Aging, emphasized that staffing turnover rates should not be used in isolation as a quality measure; staff retention rates also need to be considered. He noted that certain positions may turn over multiple times while other staff is retained. He testified that the FSSA reimbursement system, Phase 2, contains good incentives and penalties for facilities to strive to provide quality care. Phase 3 is expected to enhance and reinforce the quality expectations. He commented that the Civil Money Penalty Fund (CMP) can be used for education and training to facilitate quality care in facilities and mentioned that the subject of nursing supervisory skills training courses was being discussed as a possible initiative with the Indiana State Department of Health (ISDH). Mr. Leich stated that recommendations to improve the quality of care in nursing facilities have been implemented or are under development; consequently, no legislation is needed at this time. (See Exhibit L.)

Mr. Bob Decker, Hoosier Owners and Providers for the Elderly, and Mr. Scott Tittle, President, Indiana Health Care Association, responded to Commission questions regarding patient satisfaction surveys and federal regulations concerning the training of certified nursing assistants.

FSSA distributed an update on volume and claims statistics for the Indiana Health Coverage Programs. (See Exhibit M.)

There being no further business, the meeting was adjourned at 2:55 PM.

# **Fiscal Impact of Affordable Care Act on Medicaid Assistance Budget**

**State of Indiana  
Family and Social Services Administration  
Office of Medicaid Policy and Planning**

*Robert M. Damler, FSA, MAAA  
Principal and Consulting Actuary*

**October 25, 2010**

**Exhibit A**  
Select Joint Commission on  
Medicaid Oversight  
October 25, 2010

# Impact of Prescription Drug Rebate

- Effective January 1, 2010, Affordable Care Act increased the minimum rebate on brand name drugs under the OBRA '90 federal rebate program from 15.1% of AMP to 23.1% of AMP and from 11% of AMP to 13% of AMP for generic drugs.
- The increase in the minimum rebate will accrue 100% to the federal government, rather than shared with the State of Indiana at the current match rate of 66.96% federal share / 33.04% state share.
- State of Indiana currently receives total pharmacy rebates under the federal rebate program in excess of 30% of prescription drug spending.
- Comparison of Milliman estimates of fiscal impact to the State of Indiana

## Fiscal Impact

May 21, 2010 Letter

\$298.0 million

October 18, 2010 Letter

\$0.0 million

# Why the Change in Estimate?

- In a September 28, 2010 letter, CMS modified the instructions originally outlined in an April 22, 2010 letter on how the increased pharmacy rebate will be captured from the total Medicaid rebates.
- April 22, 2010 State Medicaid Director Letter from Department of Health and Human Services RE: Medicaid Prescription Drug Rebates
  - Page 3, Changes in Non-Federal Share of Rebates: *“For brand name drugs subject to the 23.1 percent minimum rebates, we plan to offset an amount equal to the non-Federal share of 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price.”*
  - **Impact:** Since the State of Indiana receives a significant portion of pharmacy rebates on brand name drugs at the difference between AMP and best price, the State of Indiana would lose 8 percent of AMP or approximately 25% of the rebates received.

# National Association of State Medicaid Directors

- May 18, 2010 letter from State Medicaid Directors to Ms. Cynthia Mann, Director, Center for Medicaid, CHIP and Survey & Certification
- Letter outlined the Medicaid Directors' concern regarding the treatment of the recapture of the non-Federal Share of Rebates
- Page 2, *“The application of this provision to a rebate that is unaffected by the increase in the minimum rebate violates both the letter and the apparent intent thereof. By its terms, this provision applies only to ‘amounts received by the State ... that are attributable ... to the increase in the minimum rebate percentage.’ ”*
- CMS worked with State Medicaid Directors, including Ms. Pat Casanova, Director, OMPP, and other organizations, including the American Academy of Actuaries Medicaid Committee, to understand their concerns.

# Department of Health & Human Services, CMS Updated Letter

- September 28, 2010 State Medicaid Director Letter RE: Medicaid Prescription Drugs
  - Page 1 – 2, Revised Policy on Federal Offset of Rebates: “ ... However, after further consideration of the offset provisions in section 2501 of the Affordable Care Act, we have decided to reconsider our instructions regarding the calculation of the offset provisions to reflect the lesser of the difference between the increased minimum rebate percentage and the AMP (Average Manufacturers Price) minus BP (Best Price). We plan to offset the amount equal to the increased amount of rebates resulting from the Affordable Care Act.’ ”
  - **Impact:** Since the federal offset will only be on the increased rebate value for brand name drugs, there will not be an expected loss of pharmacy rebates to the State of Indiana.

# Other Changes to Fiscal Analysis?

- An updated Federal Medicaid Assistance Percentage (*i.e.*, Federal Share or FMAP) was published on September 24, 2010
- Indiana FMAP increased from prior analysis of 66.53% to 66.96% or the State share has decreased from 33.47% to 33.04%.
- **Impact:** The overall fiscal impact for SFY 2014 to SFY 2020 of the Affordable Care Act decreases by approximately \$35 million (State share).

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid, CHIP, and Survey & Certification**

SMDL#10-006  
PPACA# 2

April 22, 2010

**Re: Medicaid Prescription Drug Rebates**

Dear State Medicaid Director:

This letter is one in a series to provide guidance on the health reform legislation, the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010, together called the Affordable Care Act.

Specifically, this letter provides information on section 2501 of PPACA and section 1206 of HCERA concerning the increased rebate percentages for covered outpatient drugs dispensed to Medicaid patients, the extension of prescription drug rebates to covered outpatient drugs dispensed to enrollees of Medicaid managed care organizations (MCOs) and the rebate offset associated with the increase in the rebate percentages.

**Increase in Rebate Percentages for Covered Outpatient Drugs**

In general, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for covered outpatient drugs that are dispensed to Medicaid patients. The rebates are calculated based on formulas described in section 1927(c) of the Social Security Act (the Act). Effective January 1, 2010, the changes are as follows:

- Except as noted below, for single source and innovator multiple source (brand name) drugs, the minimum rebate percentage is increased from 15.1 percent of the average manufacturer price (AMP) to 23.1 percent of AMP (section 1927(c)(1)(B)(i)(VI), as added by section 2501(a) of PPACA).
- For the following brand name drugs, the minimum rebate percentage is increased from 15.1 percent of AMP to 17.1 percent of AMP (section 1927(c)(1)(B)(iii), as added by section 2501(a) of PPACA):
  - clotting factors for which a separate furnishing payment is made under Medicare Part B (section 1842(o)(5) of the Act) and which is included on a list of such factors specified and updated regularly by the Secretary; and

**Exhibit B  
Select Joint Commission on  
Medicaid Oversight  
October 25, 2010**

- drugs approved by the Food and Drug Administration exclusively for pediatric indications.
- For non-innovator multiple source (generic) drugs, the rebate percentage is increased from 11 percent of AMP to 13 percent of AMP (section 1927(c)(3)(B)(iii), as added by section 2501(b) of PPACA).
- For a drug that is a new formulation (line extension) of a brand name drug that is an oral solid dosage form, the rebate is the amount computed under section 1927 of the Act or, if greater, the product of:
  - the AMP for the line extension drug,
  - the highest additional rebate for any strength of the original brand name drug, and
  - the total number of units of each dosage form and strength of the line extension drug (section 1206 of HCERA, which replaced section 1927(c)(2)(C) as added by section 2501(d) of PPACA).

In addition, section 2501(e) of PPACA established a limit on the rebate amount for each brand name drug at 100 percent of the AMP.

We will issue additional guidance to manufacturers and other stakeholders concerning the process that will be used to identify clotting factors, drugs with pediatric indications, and line extensions of existing drugs.

### **Rebates for Medicaid MCO Drugs**

The new legislation requires manufacturers that participate in the drug rebate program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010 (section 1927(b), as amended by section 2501(c) of PPACA). To facilitate the collection of these rebates, States must include utilization data reported by each Medicaid MCO to the States when requesting quarterly rebates from manufacturers as well as in their quarterly utilization reports to the Centers for Medicare & Medicaid Services.

This section also amends section 1903(m)(2)(A) of the Act, effective March 23, 2010, by adding new conditions for Federal financial participation for MCO contracts including that:

- any covered outpatient drug provided by the MCO is eligible for the rebates authorized under section 1927 of the Act;

- MCO capitation rates shall be based on actual cost experience related to rebates and subject to Federal regulations at 42 CFR 438.6 regarding actuarial soundness of capitation payments; and
- The MCO shall report to the State information on the total number of units of each dosage form, strength and package size by National Drug Code of each covered outpatient drug dispensed to Medicaid MCO enrollees and such other data that the Secretary determines necessary for the State to access the rebates authorized by this provision.

Section 2501(c) also made a conforming amendment to section 1927(j)(1) of the Act, effective March 23, 2010, to specify that certain covered outpatient drugs in this section are not subject to the rebate requirements only if such drugs are both dispensed by health maintenance organizations, including Medicaid MCOs that contract under section 1903(m), and subject to discounts under section 340B of the Public Health Service Act.

#### **Changes in Non-Federal Share of Rebates**

Section 2501(a)(2) of PPACA added section 1927(b)(1)(C) that provides that, effective January 1, 2010, the amount of the savings resulting from the increases in the rebate percentages described above will be remitted to the Federal government.

Accordingly, we plan to offset the non-Federal share of the difference between the rebate percentages in effect on December 31, 2009, and the new rebate percentages in effect on January 1, 2010. For brand name drugs subject to the 23.1 percent minimum rebate, we plan to offset an amount equal to the non-Federal share of 8 percent of the AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price. For brand name drugs subject to a rebate percentage of 17.1 percent of AMP, we plan to offset an amount equal to the non-Federal share of 2 percent of the AMP (the difference between 17.1 percent and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price. In both of the above instances, we do not plan to offset amounts attributable to the additional inflation-based rebates described in section 1927(c)(2)(A) or (B) of the Act. Further, we do not plan to offset the non-Federal share of any supplemental rebates States may receive above the increased Federal rebate percentages. For generic drugs, we plan to offset an amount equal to the non-Federal share of 2 percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to offset the non-Federal share of 8 percent of the AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP for the line extension drug) as well as the additional rebate for those drugs.

Page 4 – State Medicaid Director

For covered outpatient drugs that are dispensed to Medicaid MCO enrollees, we plan to offset the non-Federal share limited to the difference between the rebate percentages in effect outside of the MCO context on December 31, 2009 and the rebate percentages in effect on January 1, 2010, as described previously. Specifically, we plan for States to retain the non-Federal share of rebates below the 15.1 percent rebate percentage for brand name drugs and 11 percent for generic drugs as in effect on December 31, 2009. In addition, we plan for States to retain the non-Federal share of the amount above the 17.1 percent for clotting factors and drugs exclusively for pediatric indications, and 23.1 percent for all other brand name drugs.

We will issue additional guidance regarding the process that will be used to offset these amounts due to the increase in the rebate percentages.

We intend to issue additional letters to State Medicaid Directors and other guidance and regulations as necessary to assure the proper and timely implementation of these and related provisions, and we look forward to working with you as you implement PPACA and HCERA. In addition, some of the requirements addressed in this letter contain information collections that are subject to the Paperwork Reduction Act and we are working to obtain a valid Office of Management and Budget control number for these collections.

If you have general questions regarding Medicaid drug provisions in the new legislation, please send them to our drug policy e-mail box at [RxDrugPolicy@cms.hhs.gov](mailto:RxDrugPolicy@cms.hhs.gov). If you have specific questions regarding the guidance described in this letter, please contact Larry Reed, Director, Division of Pharmacy at (410) 786-3325 or via e-mail at [larry.reed@cms.hhs.gov](mailto:larry.reed@cms.hhs.gov).

Sincerely,

/s/

Cindy Mann  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health

Ann C. Kohler  
NASMD Executive Director  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Page 5 – State Medicaid Director

Matt Salo  
Director of Health Legislation  
National Governors Association

Debra Miller  
Director for Health Policy  
Council of State Governments

Christine Evans, M.P.H.  
Director, Government Relations  
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.  
Executive Director  
National Academy for State Health Policy

# NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

May 18, 2010

Cynthia Mann  
Director  
Center for Medicaid, CHIP and Survey & Certification  
7500 Security Blvd.  
Baltimore, MD 21244

Re: Rebates

Dear Ms. Mann:

I am writing to you on behalf of the National Association of State Medicaid Directors (hereinafter "NASMD") as our member states have a number of concerns about the guidance regarding Medicaid prescription drug rebates. Specifically, I would like to draw your attention to the following concern. The State Medicaid Director's letter of April 22, 2010, regarding Medicaid prescription drug rebates under the Affordable Care Act (SMDL #10-006) provides that for brand name drugs now subject to a 23.1% or 17.1% minimum rebate, CMS plans to offset an amount equal to the non-Federal share of the increase in the minimum rebate, "regardless of whether States received a rebate amount based on the difference between AMP and best price." NASMD believes that any such offset from a rebate based on the difference between AMP and best price would be a clear violation of the Affordable Care Act.

Under section 1927(c)(1)(A)(ii) of the Social Security Act, both before and after the Affordable Care Act, federally required drug rebates are based on the greater of:

1. The difference between AMP and best price, or
2. The applicable minimum rebate percentage of AMP.

Under section 1927(c)(2)(A), inflation-based increases may apply to either base – the difference between AMP and best price, or the applicable minimum. The only piece of this formula changed by the Affordable Care Act is the minimum rebate percentages. Therefore, if the difference between AMP and best price for a particular drug exceeds both the old and the new minimum, the rebate for that drug will be unaffected by the Affordable Care Act. In such cases, both the old and the new rebates are based on the difference between AMP and best price, not on the minimums. In other words, the rebate applicable after the Affordable Care Act is unaffected by the change in the minimum and unchanged from the rebate paid prior to the Affordable Care Act.

After providing for the increases in the minimum rebates for brand-name drugs, in section 2501(a)(1), the Patient Protection and Affordable Care Act goes on to provide as follows in section 2501(a)(2):

***Recapture of total savings due to increase.***--Section 1927(b)(1) of such Act (42 U.S.C. 1396r-8(b)(1)) is amended by adding at the end the following new subparagraph:

(C) Special rule for increased minimum rebate percentage.—

- (i) In general.--In addition to the amounts applied as a reduction under subparagraph (B), ... the Secretary shall reduce payments to a State ... in an amount equal to the product of—

- (I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

# NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

(II) ***the amounts received by the State*** under such subparagraph ***that are attributable*** (as estimated by the Secretary based on utilization and other data) ***to the increase in the minimum rebate percentage*** effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act

....

(Emphasis added.) The application of this provision to a rebate that is unaffected by the increase in the minimum rebate violates both the letter and the apparent intent thereof. By its terms, this provision applies only to “amounts received by the State ... that are attributable ... to the increase in the minimum rebate percentage.” There is no such amount if a rebate is unaffected by the change in the applicable minimum. Further, the application of this provision to an unchanged rebate is not a federal “recapture” of any new “savings due to increase.” Rather, it is a shift of existing savings, due to the current rebate formula, from the states to the federal government. To illustrate this point, we cite the example given by Larry Reed on the Managed Care TAG call May 5, 2010. Staff from various states asked Mr. Reed how they could begin to estimate the effect of the recaptured rebates. In explaining that all rebates would not be affected by the Affordable Care Act, Mr. Reed gave these two examples:

(1) Rebate for Drug A is based on 15.1% of AMP minimum rebate, plus 14.9% CPI rebate for a total of 30% of AMP. Under PPACA, this drug’s rebate will now be 23.1% as the minimum base rebate plus 14.9% CPI, for a total of 38% of AMP.

(2) Rebate for Drug B is based on Best Price and equates to 23.1% of AMP, plus 6.9% CPI rebate for a total of 30% of AMP. Under PPACA, this drug’s rebate will not change.

Despite the fact that the rebate for drug B is unchanged, Mr. Reed indicated that the federal rebate offset or recapture would apply to that portion of the unchanged rebate equal to 8% of AMP. As explained above, we believe that violates the Affordable Care Act. NASMD respectfully requests that CMS reconsider its position in regard to the application of the federal rebate offset or recapture to rebates that are unaffected by the increase in the minimum rebate.

CMS also stated on the May 5, 2010, Managed Care TAG conference call that States would be responsible for calculating the recapture amount based on AMP data disseminated by CMS. Initially, States had several concerns on this option, including information that will not be available to the States, such as Best Price and CPI data and identification of drugs falling under the line extension, clotting factor drugs and drugs for pediatric use rebate carve-out. Additional factors that will cause considerable administrative challenges for a State-calculated recapture amount and will potentially result in inaccurate and inconsistent outcomes include retroactive adjustments to the AMP reported by manufacturers (hence Prior Period Adjustments to the Unit Rebate Amount [URA]), and various methods of calculations among States, rebate Contractors, claims processors, manufacturers, and CMS. Lastly, fundamental legal questions arise when looking at how the Affordable Care Act outlines that the “***the amounts received by the State... (as estimated by the Secretary based on utilization and other data)***” (emphasis added). However, on a subsequent May 13, 2010, Pharmacy TAG call, there was a detailed discussion related to the possibility of two options:

- 1) The recapture amount being calculated by CMS: In this option, CMS stated they would be prohibited from sharing the AMP data with the States for recapture amount validation purposes, and the recapture amount would be immediately applied prior to States invoicing manufacturers.
- 2) The recapture amount being calculated by the States: In this option, CMS stated the AMP data would be shared with States for the sole purpose of recapture amount calculation and validation.

# NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

There was a discussion that the released AMP data would only be available for rebate recapture amount, and not any other purpose (ie reimbursement). The recapture amount would be applied after the States invoiced manufacturers and received payments for those invoices.

Due to the vast issues related to each option, coupled by the fact that not all States have been in attendance for all CMS conference calls, NASMD respectfully requests that CMS develops written guidance for each option, to include details on how CPI penalties, Best Price, line extensions, clotting factor drugs, pediatric drugs, retroactive AMP changes, NDC-level reporting, ongoing and prospective litigation regarding the release of AMP data, and other factors can affect the calculation *in each scenario*. In addition, specific calculation instructions on the calculation are requested; in Option 1) it would benefit States to gain a detailed understanding of how CMS anticipates the calculation to be applied, and in Option 2) States need the detailed instructions to perform the calculation so that the States' procedures would not be subject to repeated questions from auditors and increased demand on already limited staffing resources. Consistent with our request above regarding application of the federal rebate recapture to rebates that are unaffected by the increase in the minimum rebate, we request that both options allow for the exclusion of such rebates from the calculation of the recapture amount. We also request that CMS reconsider its stated position that CMS's calculation of the recapture amount would require that the amount be applied immediately, as recovery of an overpayment, prior to invoicing of manufacturers for rebates. The Affordable Care Act provides that the recapture amount will be "deemed an overpayment" only as a "manner of payment reduction." (New section 1927(b)(1)(C)(ii).) And the recapture amount is defined as a portion of "the amounts received by the State" as rebates from manufacturers. Thus, there can be no recapture amount to be collected as an overpayment until a rebate is "received by the State." With this additional guidance, the states will be able to make an informed decision and a collective recommendation to CMS (through NASMD) regarding responsibility for calculation of recapture amounts.

Lastly, given the retroactive nature of this provision, it is vitally important for states to be able to calculate what the impact is on their budgets. Currently, as your pharmacy staff has stated, states are unable to make these calculations as they do not have the necessary information to do these calculations. Therefore we are requesting that you assist the states with this information so that the appropriate calculations for both FY 2010 and FY 2011 can be made.

In addition to the concerns outlined above there are a number of additional questions the state Medicaid programs have with regard to the information that has been provided thus far and we are attaching them to this letter. Some of these concerns include questions regarding line extensions, managed care organizations, & pediatric indications, as well as requests for more information as to the timeline for your future guidance on this topic.

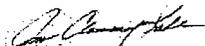
# NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

Thank you very much for your time and attention to these matters. States have a number of overarching concerns and questions that require additional written guidance. States would greatly appreciate receiving this guidance as soon as possible. We look forward to our continued work and discussions with you to ensure that guidance is disseminated to all the states in a timely manner.

Sincerely,



Ann Clemency Kohler  
NASMD Director

Cc: Kathleen Nolan, NGA  
Brian Webb, NAIC  
Alan Weil, NASHP  
Paul Dioguardi, HHS  
Jennifer Ryan, CMS  
Matt Salo, NGA

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26 12  
Baltimore, Maryland 21244-1850



**Center for Medicaid, CHIP and Survey & Certification**

---

SMDL#10-019  
ACA# 9

September 28, 2010

**Re: Medicaid Prescription Drugs**

Dear State Medicaid Director:

This letter is one of a series intended to provide guidance on the implementation of the Patient Protection and Affordable Care Act (P.L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act.

Specifically, this letter revises the previous instructions concerning the Federal offset of Medicaid prescription drug rebates, and further specifies the process we will use for the estimation and collection of these offsets. It also provides information on rebates for Medicaid managed care organization (MCO) drugs, MCO formularies, and the treatment of MCO physician-administered drugs. Finally, this guidance addresses manufacturer reporting requirements, the treatment of discounts under the Medicare Coverage Gap Discount Program for purposes of the determination of best price (BP), and the changes to the excluded drug provisions in Medicaid.

**Revised Policy on Federal Offset of Rebates**

Section 2501 of the Affordable Care Act increased the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs), noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts "attributable" to these increased rebates be remitted to the Federal government.

In the April 22, 2010 State Medicaid Director (SMD) letter, #10-006, CMS indicated that we were planning to offset the non-Federal share of the entire difference between the minimum rebate percentages in effect on December 31, 2009, and the new minimum rebate percentages in effect under the Affordable Care Act, regardless of whether States received a rebate amount based on the difference between the average manufacturer price (AMP) and best price (BP). For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we planned to offset the entire non-Federal share of the increase in the minimum, as well as the additional rebate for those drugs. However, after further consideration of the offset provisions in section

**Exhibit D  
Select Joint Commission on  
Medicaid Oversight  
October 25, 2010**

2501 of the Affordable Care Act, we have decided to reconsider our instructions regarding the calculation of the offset provisions to reflect the lesser of the difference between the increased minimum rebate percentage and the AMP minus BP. We plan to offset the amount equal to the increased amount of rebates resulting from the Affordable Care Act.

In light of this reconsideration, we plan to calculate the offset as described below.

Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications<sup>1</sup> are subject to a minimum rebate percentage of 23.1 percent of AMP:

- If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP).
- If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP.
- If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount.

Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP:

- If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP).
- If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP.

---

<sup>1</sup> Guidance and list of blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are posted on the CMS website at [http://www.cms.gov/Reimbursement/08\\_MedicaidPrescriptionDrugsundertheAffordableCareAct.asp](http://www.cms.gov/Reimbursement/08_MedicaidPrescriptionDrugsundertheAffordableCareAct.asp).

- If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount.

For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of rebates for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount.

We have not reconsidered our guidance with respect to generic drugs, given that rebates are not calculated based on best price. Thus, we plan to continue to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

As indicated in our April 22, 2010 guidance, we do not plan to offset the non-Federal share of any supplemental rebates States may receive above the increased Federal rebate percentages.

### **Offset Rebate Methodology**

When determining the best approach to calculating the offset amount, we considered States, as well as CMS's data and systems capabilities. Some States suggested that it would be more efficient for CMS to perform this offset calculation in a manner similar to the calculation of the unit rebate amount (URA). States also suggested that CMS calculate a second URA identifying the amount of offset to be returned to the Federal Government.

After considering these suggestions and to avoid the potential burden on States, we have decided that it would be more efficient for CMS to determine the offset amount. Accordingly, we plan to calculate a unit rebate offset amount (UROA) that will identify the offset amount per unit of a drug at the 9-digit national drug code (NDC) level on a quarterly basis for States. States will then be able to apply the UROA to the number of units of each drug for which they receive payment from a manufacturer to determine the Quarterly Rebate Offset amount (QROA) for each drug of all manufacturers to determine the total QROA. This amount will be offset and reported on the Quarterly Expenditure reports.

We are in the process of implementing the systems changes necessary to include the UROA with the quarterly rebate data submissions to the States. We believe States will also need more time to modify their respective systems to accept this new UROA data element. Therefore, we are developing an interim process to calculate an estimated quarterly rebate offset amount (EQROA) that will be used to approximate this offset until our UROA systems changes are finalized. We plan to apply the UROA for the basic rebate to an estimation of units for which the State has made payment under the Medicaid State plan and reduce that estimate by the amount of rebates we expect the State would have received in the quarter. We further plan to make this estimate available to the State and record it on behalf of each State on the form CMS-64 as an offset. The

EQROA amount will be reconciled with the total QROA when CMS provides States with the UROAs. Attached to this letter is a detailed description of the methodology we plan to use for the EQROA interim process for estimating the total offset.

Because we do not currently have the capability to systematically identify reformulated drugs, the additional rebate for those drugs is not included for the purpose of this calculation, and no offset will be taken from the States at this point. Once these drugs are identified, we will include them in the EQROA or UROA process, and will make necessary retroactive adjustments.

#### **Rebates for Medicaid Managed Care Organization (MCO) Drugs – MCO Formularies and MCO Physician-Administered Drugs**

We have received questions on whether the legislation also requires Medicaid MCOs to revise their current formularies. As noted in the April 22, 2010 SMD letter, the new legislation requires manufacturers to provide rebates for drugs dispensed to individuals enrolled in a Medicaid MCO. The changes made by section 2501(c) of the Affordable Care Act do not specifically revise the requirements concerning the provision of drugs by an MCO to its members, but they do provide that utilization information concerning covered outpatient drugs dispensed by an MCO to its Medicaid enrollees are to be reported to the State. This reporting will enable the State to include MCO utilization data with its fee-for-service utilization data for covered outpatient drugs, so that the manufacturers can pay rebates on these drugs. Accordingly, we do not plan to require that an MCO modify its formulary provisions in light of this provision of the Affordable Care Act. MCOs may continue to have some flexibility in maintaining formularies of drugs regardless of whether the manufacturers of those drugs participate in the drug rebate program. State Medicaid agencies may continue to establish requirements regarding MCOs' formularies.

We also received questions related to State responsibility for collecting rebates for physician-administered drugs provided in an MCO and MCO responsibility for collecting and reporting rebate data on such drugs (e.g., NDCs and number of units of each covered outpatient drug dispensed) for transmission to the State. In light of the requirements of section 1927(a)(7) regarding the collection of information for physician administered drugs, MCOs are responsible for submitting utilization data for these covered outpatient drugs to the State.

#### **Exemptions for Discounts under the Medicare Coverage Gap Discount Program from Best Price**

In accordance with section 1927(c)(1)(C)(i)(VI) of the Social Security Act, as revised by section 3301(d) of the Affordable Care Act, effective July 1, 2010, discounts provided by manufacturers under the Medicare Coverage Gap Discount Program under section 1860D-14A of the Act are also exempt from a manufacturer's BP calculation.

### **Reporting Units**

Beginning with October 2010, section 2503(b) of the Affordable Care Act requires manufacturers to report the total number of units that are used to calculate the monthly AMP for each covered outpatient drug no later than 30 days after the last day of the month. We plan to require manufacturers to report these units by the same unit type used to calculate the AMP and we plan to use these units to calculate the weighted AMP-based FULs prices. We plan to have the data field necessary for manufacturers to report this data and will provide instructions to manufacturers regarding the reporting of units to facilitate timely reporting in advance of the deadline.

### **Excluded Drug Provision Changes**

Section 2502 of the Affordable Care Act requires that over the counter (OTC) and prescription smoking cessation drugs, barbiturates, and benzodiazepines be removed from the list of drugs that States may exclude from coverage, effective January 1, 2014. States will generally be required to cover these products to the extent that States provide coverage of prescribed drugs. Please note that because Medicare Part D does not require the coverage of OTC smoking cessation drugs, States are responsible for coverage of such drugs for Medicaid dual-eligible individuals, provided that the State provides a prescription drug benefit under its State plan for such Medicaid beneficiaries.

We intend to issue further guidance and regulations as necessary to ensure the proper and timely implementation of these and related provisions of the Affordable Care Act. We look forward to our continuing work together to implement this legislation. Questions regarding Medicaid drug provisions can be submitted through the drug policy resource mailbox at [RxDrugPolicy@cms.hhs.gov](mailto:RxDrugPolicy@cms.hhs.gov) or may be directed to Larry Reed, Director, Division of Pharmacy, Disabled and Elderly Health Programs Group at (410) 786-3325.

Sincerely,

/s/

Cindy Mann  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health

Richard Fenton  
Acting Director  
Health Services Division  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Matt Salo  
Director of Health Legislation  
National Governors Association

Debra Miller  
Director for Health Policy  
Council of State Governments

Carol Steckel  
President  
National Association of Medicaid Directors

Christine Evans, M.P.H.  
Director, Government Relations  
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.  
Executive Director  
National Academy for State Health Policy

## Enclosure

### **METHODOLOGY FOR CALCULATING THE ESTIMATED QUARTERLY REBATE OFFSET AMOUNT**

Effective January 1, 2010, the Affordable Care Act increased the minimum rebate amounts that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs) and noninnovator multiple source drugs (generic drugs). The Affordable Care Act also required that amounts “attributable” to these increased rebates be returned to the Federal Government.

We have provided a detailed description below of CMS’ methodology for the estimated quarterly rebate offset amount (EQROA) interim process for estimating the total offset amount that will be remitted to the Federal Government for this provision. The EQROA amount will be reconciled with the total quarterly rebate offset amount (QROA) when CMS provides States with the unit rebate offset amounts (UROAs).

Using the most complete available data, we plan to calculate the EQROA using the following methodology. We note the limitations in using the data for this calculation in the data limitations section at the end of this paper.

#### **ACRONYMS AND ASSOCIATED FORMULA**

UROA = Unit Rebate Offset Amount = Quarterly AMP x Offset Rebate Percentage per NDC

QROA = Quarterly Rebate Offset Amount = UROA x Average Total Units per NDC

Total QROA = Sum of the QROA of all NDCs

EQROA = Estimated Quarterly Rebate Offset Amount = Total QROA x Discount Factor  
Percentage Specified Below

#### **DATA SOURCES**

- Quarterly AMP Data, Begins with 1Q2010 (1<sup>st</sup> quarter of calendar year 2010)
- 3Q2008 – 2Q2009 Total Number of Units Reimbursed by States Obtained from the Medicaid State Drug Utilization Data

#### **METHODOLOGY and EXAMPLE –**

##### **Step 1 – Extract the Units Reimbursed by Each State from the Medicaid State Drug Utilization Data File for 3Q2008 to 2Q2009**

Each State’s utilization data file is due to CMS no later than 60 days after the end of each quarter and is posted and updated on the CMS Web site on quarterly basis at:

<http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp>. The data elements included in this file are State, NDC, quarter and year, product name, units reimbursed, number of prescriptions, total amount reimbursed by State, amount reimbursed under Medicaid, and amount reimbursed by non-Medicaid. Although the drug utilization data is due to CMS no later than 60

days after the end of each quarter, it does not appear that this data is reliable until sometime after that since States often initially revise these submissions. Therefore, to better estimate utilization, we plan to use the past quarters' data, 3Q2008 to 2Q2009, in the calculation. Units reimbursed by NDC per State are then downloaded for each of the four quarters from 3Q2008 to 2Q2009.

**Step 2 – Calculate the Average Total Units from 3Q2008 to 2Q2009**

The Average Total Units are calculated by taking the average of the units reimbursed per NDC by State from 3Q2008 to 2Q2009. As with this step and all the following steps in this methodology, we are providing example to highlight the methodology. We are providing the following example for steps 2-9 to highlight the methodology.

NDC	3Q2008	4Q2008	1Q2009	2Q2009	Calculating the Average Total Units = Sum of Units / 4 Quarters	Average Total Units
00001-0001	150	50	90	110	= (150+50+90+110) ÷ 4	100
00002-0111	100	200	250	150	= (100+200+250+150) ÷ 4	175
00003-0222	500	300	100	350	= (500+300+100+350) ÷ 4	312.5

For the purpose of continuing this calculation into future quarters (e.g., 2Q2010 EQROA, 3Q2010 EQROA, and future quarters as necessary), we plan to calculate the average total units using quarters with the best available data on the total number of units reimbursed. Data will be moved forward one quarter for each subsequent EQROA. Thus for 2Q2010 EQROA, the average total units will be calculated using units reimbursed per NDC by State from 4Q2008 to 3Q2009. For 3Q2010 EQROA, the average total units will be calculated using units reimbursed per NDC by State from 1Q2009 to 4Q2009. And for 4Q2010 EQROA, the average total units will be calculated using units reimbursed per NDC by State from 2Q2009 to 1Q2010.

**Step 3 – Identify the Drug Category of Each NDC**

CMS posts the drug product data file on the CMS Web site on a quarterly basis at [http://www.cms.gov/MedicaidDrugRebateProgram/09\\_DrugProdData.asp](http://www.cms.gov/MedicaidDrugRebateProgram/09_DrugProdData.asp). This file can be downloaded to identify whether an NDC is a single source (S) drug, innovator multiple source (I) drug, or noninnovator multiple source (N) drug. The drug product information that goes into this file is based on manufacturer submissions to CMS. This file includes information such as NDC, drug category, DESI indicator, drug type, product name, etc. The most recent file posted on the CMS Web site is for 1Q2010. Please note that we plan to use the most updated drug product data file available for the quarter when we perform the calculation. For the purpose of calculating 1Q2010 EQROA, we are using 1Q2010 drug product data file.

**Step 4 – Match the Drug Product Data File Against the 1Q2010 Quarter AMP File**

Thirty days after the end of each rebate period, manufacturers are required to report to CMS their quarterly AMP and best price (BP) for each NDC on record with CMS. The most complete AMP and BP file that CMS has at this time is for 1Q2010. We plan to use the most updated

AMP and BP data received this quarter and all future quarters, as we believe this best represents the amount manufacturers will use as the basis for their increased rebate payments. Because 1Q2010 quarterly AMP and BP files and the drug product data file are two separate files that include separate information we need for each NDC, we plan to match both files by NDC in order to have both the quarterly AMP and BP and the drug category appear for each NDC to appear on the same file.

<b>1Q2010 Quarterly AMP and BP File:</b>		
NDC	Quarterly AMP	Quarterly BP
00001-0001	0.750000	0.650000
00002-0111	1.000000	0.800000
00002-0222	0.500000	0.000000

<b>1Q2010 Drug Product Data File</b>	
NDC	Drug Category
00001-0001	S
00002-0111	S
00002-0222	N

<b>Matched Quarterly AMP File and Drug Product Data File</b>			
NDC	Drug Category	Quarterly AMP	Quarterly BP
00001-0001	S	0.750000	0.650000
00002-0111	S	1.000000	0.800000
00002-0222	N	0.500000	0.000000

**Step 5 – Determine Where AMP Minus BP Falls**

Once we have matched the 1Q2010 drug product data file against the 1Q2010 quarterly AMP and BP file, we need to determine where the difference between AMP and BP falls. See details and example below.

For brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications:

- A. If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP).
- B. If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP.
- C. If the difference between AMP and BP is greater than or equal to than 23.1 percent of AMP, then we do not plan to take any offset amount.

For brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications that are subject to a rebate percentage of 17.1 percent of AMP:

- D. If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP).
- E. If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP.
- F. If the difference between AMP and BP is greater than or equal to than 17.1 percent of AMP, then we do not plan to take any offset amount.

For generic drugs, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP), since these drugs are unaffected by best price.

Because we currently do not have the capability to systematically identify reformulated drugs, the additional rebate for those drugs is not included for now for the purpose of this calculation and no offset will be taken from the States at this point. Once these drugs are identified, we will include them in the EQROA for future quarters or the UROA process consistent with the provisions of section 2501 of the Affordable Care Act.

NDC	Drug Category	Quarterly AMP	Quarterly BP	AMP-BP	AMP x 15.1%	AMP x 23.1%	Determination of Where AMP-BP Falls
00001-0001	S	0.750000	0.650000	<b>0.100000</b>	0.113250	0.173250	Less than AMPx15.1% - use Step 5A above
00002-0111	S	1.000000	0.800000	<b>0.200000</b>	0.151000	0.231000	Greater than AMPx15.1% and less than AMPx23.1% - use Step 5B above
00002-0222	N	0.500000	0.000000	N/A	N/A	N/A	N/A – Generic drug

**Step 6 – Identify the Offset Rebate Percentage to be Applied to Each NDC**

Based on the identification of where AMP minus BP falls in Step 5, the following offset rebate percentage is applied to each NDC.

NDC	Drug Category	Determination where AMP-BP falls	Offset Rebate Percentage
00001-0001	S – brand	Less than AMPx15.1% - see Step 5A above	8%
00002-0111	S – brand	Greater than AMPx15.1% and less than AMPx23.1% - see Step 5B above	3.1%
00002-0222	N – generic	N/A	2%

**Step 7 – Calculate UROA per NDC**

Once AMP minus BP is determined (using the matched file with the 1Q2010 quarterly AMP and BP data and the drug category indicator for each NDC), we calculate the UROA by multiplying AMP by the offset rebate percentage determined in Step 5 for each of the category of drugs where that AMP minus BP is applicable. For generic drugs, the UROA is calculated by multiplying AMP by two percent.

NDC	Drug Category	Quarterly AMP	Offset Rebate Percent Applied	Calculating the UROA = Quarterly AMP x Offset Rebate Percent	UROA per NDC
00001-0001	S – brand	0.750000	8%	= 0.750000 x 8%	0.060000
00002-0111	S – brand	1.000000	3.1%	= 1.000000 x 3.1%	0.031000
00002-0222	N – generic	0.500000	2%	= 0.500000 x 2%	0.010000

**Step 8 – Calculate QROA and Total QROA**

To calculate the QROA, the average total units of an NDC are multiplied by UROA of that NDC. The total QROA is then calculated by taking the sum for all NDCs.

NDC	Average Total Units	UROA per NDC	Calculate QROA = Average Total Units x UROA	QROA
00001-0001	100	0.060000	= 100 units x 0.060000	\$6.00
00002-0111	175	0.031000	= 175 units x 0.031000	\$5.425
00002-0222	312.5	0.010000	= 312.5 units x 0.010000	\$3.125
<b>Total QROA for All NDCs</b>				<b>\$14.55</b>

**Step 9 – Discount Factor on Actual Payment Received from Manufacturers by State**

When a State invoices a manufacturer, State may not receive the full payment from the manufacturer based on the amount the State invoices the manufacturer for that quarter in the following quarter. CMS has no current data to estimate the amount States received in payment from the manufacturers. Additionally, because of the zero URAs for 1Q2010, CMS is aware that States and manufacturers are attempting to develop a process to implement the new Affordable Care Act rebate provisions, and that States may have invoiced the manufacturers late, causing States to receive late payments from manufacturers. As a result, we plan to offset 25 percent of

the total QROA for 1Q2010 and 50 percent of the total QROA for 2Q2010, 3Q2010, and 4Q2010. We believe that this is the best estimation that we can propose at this time to avoid over-estimating the offset amount for States and inappropriately reducing rebates not related to this Affordable Care Act provisions. Since the EQROA will be reconciled with the total QROA for these quarters, the accurate offset amount will be determined ultimately.

**Step 10 – Calculate EQROA per State**

The EQROA is calculated by multiplying the total QROA by 25 percent for 1Q2010. For 2Q2010, the EQROA will be calculated by multiplying 2Q2010 total QROA by 50%. This will be the same for 3Q2010 and 4Q2010 EQROA.

1Q2010 EQROA = 1Q2010 Total QROA x Discount Factor of 25% = \$14.55 x 25% = \$3.64  
2Q2010 EQROA = 2Q2010 Total QROA x Discount Factor of 50% = \$X x 50%  
3Q2010 EQROA = 3Q2010 Total QROA x Discount Factor of 50% = \$Y x 50%  
4Q2010 EQROA = 4Q2010 Total QROA x Discount Factor of 50% = \$Z x 50%

**Step 11 – Delivery of EQROA to State**

We are aware that States are still developing a process to implement the new rebate provisions and adjust their systems to accommodate the new data. To minimize the burden for States, we plan to provide each State with their individual EQROA based on our calculation from the above methodology via a letter for each of the four quarters in 2010.

**Step 12 – EQROA on CMS-64**

To minimize the administrative work for States, CMS plans to populate the EQROA that CMS provides to each State on the CMS-64. This amount will be available for the State to view by September 30, 2010. Specific instructions on reporting rebate expenditures, including the line item number in which the EQROA will be populated, will be provided in the near future.

**Step 13 – EQROA Reconciliation**

Once CMS is able to provide States with the UROA based on the new rebate percentage, including the identification of the blood clotting factors, drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications, and the reformulated drugs, States will be able to reconcile the EQROA with the total QROA based on the units that States actually reimbursed for during the specific quarter.

**TIMELINE**

Our proposed timeline for these activities follows below. Please note that the dates and deliverables are only estimated and may be subject to change.

<b>Estimated Date</b>	<b>Estimated Deliverable</b>
September 7, 2010	Run most recently updated 1Q2010 AMP and BP data against most recently updated average units from 3Q2008 to 2Q2009.
September 28, 2010	Provide each State with their 1Q2010 EQROA via a letter.
September 30, 2010	CMS to populate State's 1Q2010 EQROA on the CMS-64.
October 1, 2010	Each State should be able to view their State's 1Q2010 EQROA in the CMS-64. This amount should be the same as the amount provided to the State in the letter.
November 15, 2010	Run most recently updated 2Q2010 AMP and BP data against most recently updated average units from 4Q2008 to 3Q2009.
December 1, 2010	Provide each State with their 2Q2010 EQROA via a letter.
December 30, 2010	CMS to populate State's 2Q2010 EQROA on the CMS-64.
January 1, 2011	Each State should be able to view their State's 2Q2010 EQROA in the CMS-64. This amount should be the same as the amount provided to the State in the letter.
February 15, 2011	Run most recently updated 3Q2010 AMP and BP data against most recently updated average units from 1Q2009 to 4Q2009.
March 1, 2011	Provide each State with their 3Q2010 EQROA via a letter.
March 30, 2011	CMS to populate State's 3Q2010 EQROA on the CMS-64.
April 1, 2011	Each State should be able to view their State's 3Q2010 EQROA in the CMS-64. This amount should be the same as the amount provided to the State in the letter.
May 3, 2011	CMS' systems ready to calculate the updated URAs based on the increased rebate percentage under the Affordable Care Act and the UROAs for 1Q2011.
May 4, 2011	CMS provides States with the 1Q2011 the Affordable Care Act URAs and UROAs.
May 16, 2011	Run most recently updated 4Q2010 AMP and BP data against most recently updated average units from 2Q2009 to 1Q2010 to calculate 4Q2010 EQROA.
June 1, 2011	Provide each State with their 4Q2010 EQROA via a letter. This will be the last EQROA CMS will provide to each State.
June 30, 2011	CMS to populate State's 4Q2010 EQROA on the CMS-64.
July 1, 2011	Each State should be able to view their State's 4Q2010 EQROA in the CMS-64. This amount should be the same as the amount provided to the State in the letter.
July 1, 2011	States may begin to report their 1Q2011 total QROA on the CMS-64.
August 1, 2011	Deadline for States to report their 1Q2011 total QROA on the CMS-64.
August 3, 2011	CMS calculates 2Q2011 URAs and UROAs. States should begin to reconcile the EQROA that CMS sends to States' against the total QROA based on actual units that States have received payment from manufacturers.
August 4, 2011	CMS provides States with the 2Q2011 URAs and UROAs.
October 31, 2011	Deadline for States to report their 2Q2011 total QROA on the CMS-64.

## DATA LIMITATIONS

Please note the following EQROA data limitations:

- We used four quarters of utilization data rather than eight quarters to estimate utilization data as the shorter time period reduced the States' offset liability.
- We excluded S/I NDCs that did not have AMP and BP reported and N NDCs that did not have AMP reported. Despite the fact that the manufacturers did not report their data in a timely manner to CMS, they still are required to pay timely rebates to the States. Because their data are not reflected, the offset amount is underestimated.
- We excluded NDCs that do not have units reported. Similar to late reporting by manufacturers, where there were units billed to the manufacturers, this underestimates the offsets.
- We have identified the blood clotting factors and exclusively approved pediatric drugs with the best available data at the time the calculation is performed; therefore, the offset amount may change as more data become available. We believe this will have a minimal effect on the offsets.
- We have yet to identify reformulated drugs; therefore, we did not apply the increased additional rebate amount to the EQROA. This action underestimates the offsets for those drugs, provided that the manufacturer made reasonable assumptions for reformulated drugs.
- The EQROA does not include rebates and units from MCOs as we do not yet have that utilization data. To the extent that most States have been unable to provide the MCO utilization data to the manufacturers, these data are not accounted for in the estimated offsets. For any States that were able to provide utilization data, the offsets will be underestimated. While more States will be able to report this utilization data for subsequent quarters, we will not include these data until they are included in the States utilization data that we use to calculate the EQROA, or until the QROA process is in place.
- We do not have current estimates of rebates collected by quarter since the rebates reported in any given quarter always include amounts for past quarters. As a result, we are not able to estimate the amount States will actually receive in rebates for 1Q2010 or when they will receive them. We assumed that, in accordance with guidance we provided, manufacturers calculated and submitted their URAs to the States based on the Affordable Care Act rebate percentage. We believe we conservatively estimated a minimal percentage of 25 percent for 1Q2010 EQROA and 50 percent for 2Q2010, 3Q2010, and 4Q2010 EQROA. To the extent that the States receive timely rebates for these quarters at a greater or lesser rate, this approach will underestimate or overestimate the offset.

# State Psychiatric Hospitals: History and Trends

Gina Eckart

Division of Mental Health and Addiction

**Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.**

Exhibit E  
Select Joint Commission on  
Medicaid Oversight  
October 25, 2010



# Psychiatric Hospitals: State of the States

- In every state, there are state-owned-and-operated psychiatric inpatient beds that are used for persons in need of the most intensive level of mental health services.
- In most states (44), the operation of state psychiatric hospitals is part of the SMHA's responsibilities. In six states (Colorado, New Hampshire, New Mexico, Rhode Island, South Dakota, and Wyoming), a separate state government agency has this responsibility.

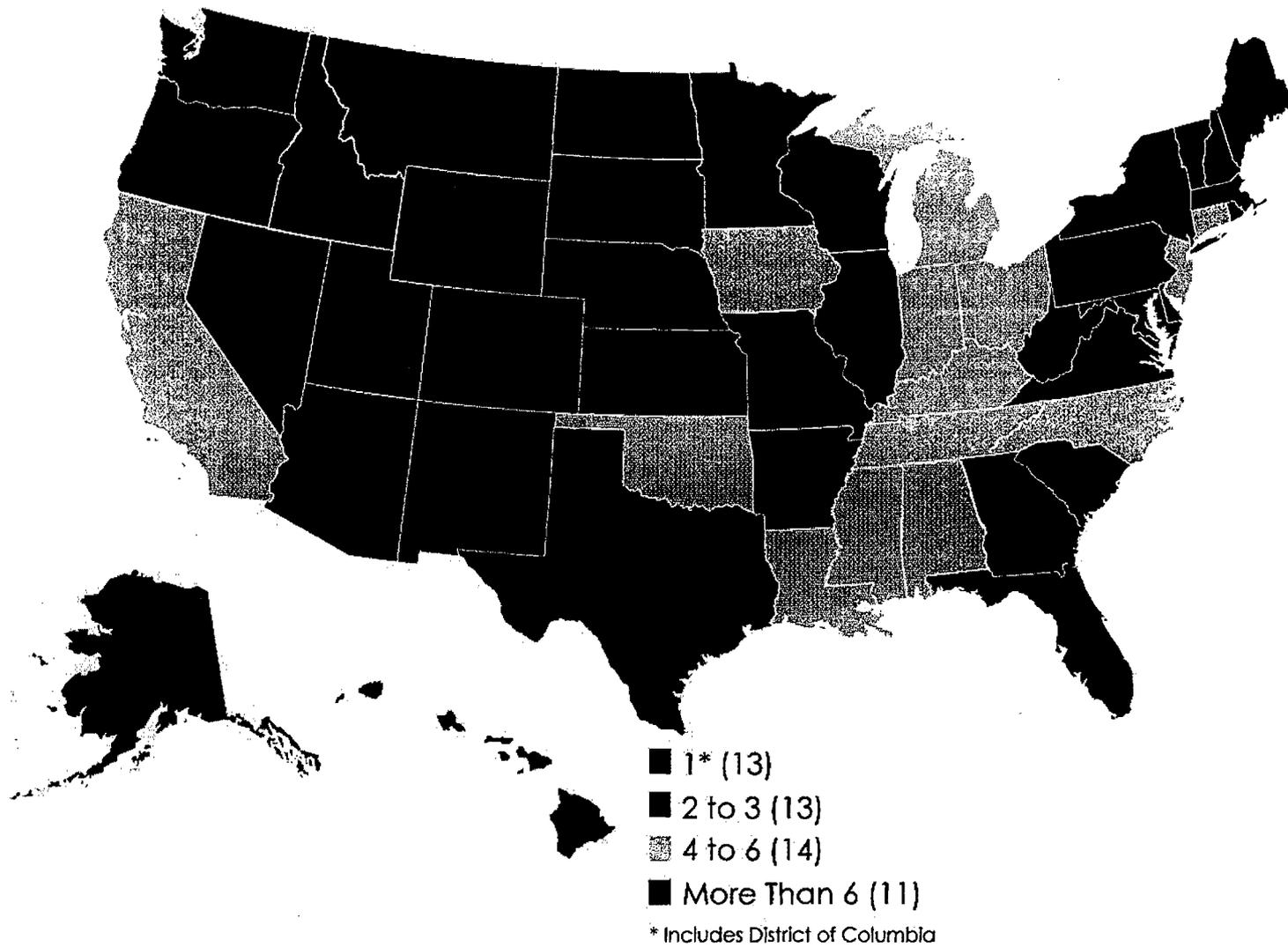
# Psychiatric Hospitals: State of the States

- Forty-nine states and the District of Columbia operate a total of 232 state psychiatric hospitals—hospitals that are operated and staffed by the SMHA that provides specialized inpatient psychiatric care.
- Rhode Island is the only state that does not have a stand-alone state psychiatric hospital

# Psychiatric Hospitals: State of the States

- In over half the states (26), there are 3 or fewer state psychiatric hospitals.
- the 13 states that have only 1 state psychiatric hospital tend to be in the mountain-frontier west and New England.
- The 11 states that have 6 or more state psychiatric hospitals are all larger-population states and are mostly in the east and southern regions of the country

## Number of State Psychiatric Hospitals (2007)



Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

# Psychiatric Hospitals: State of the States

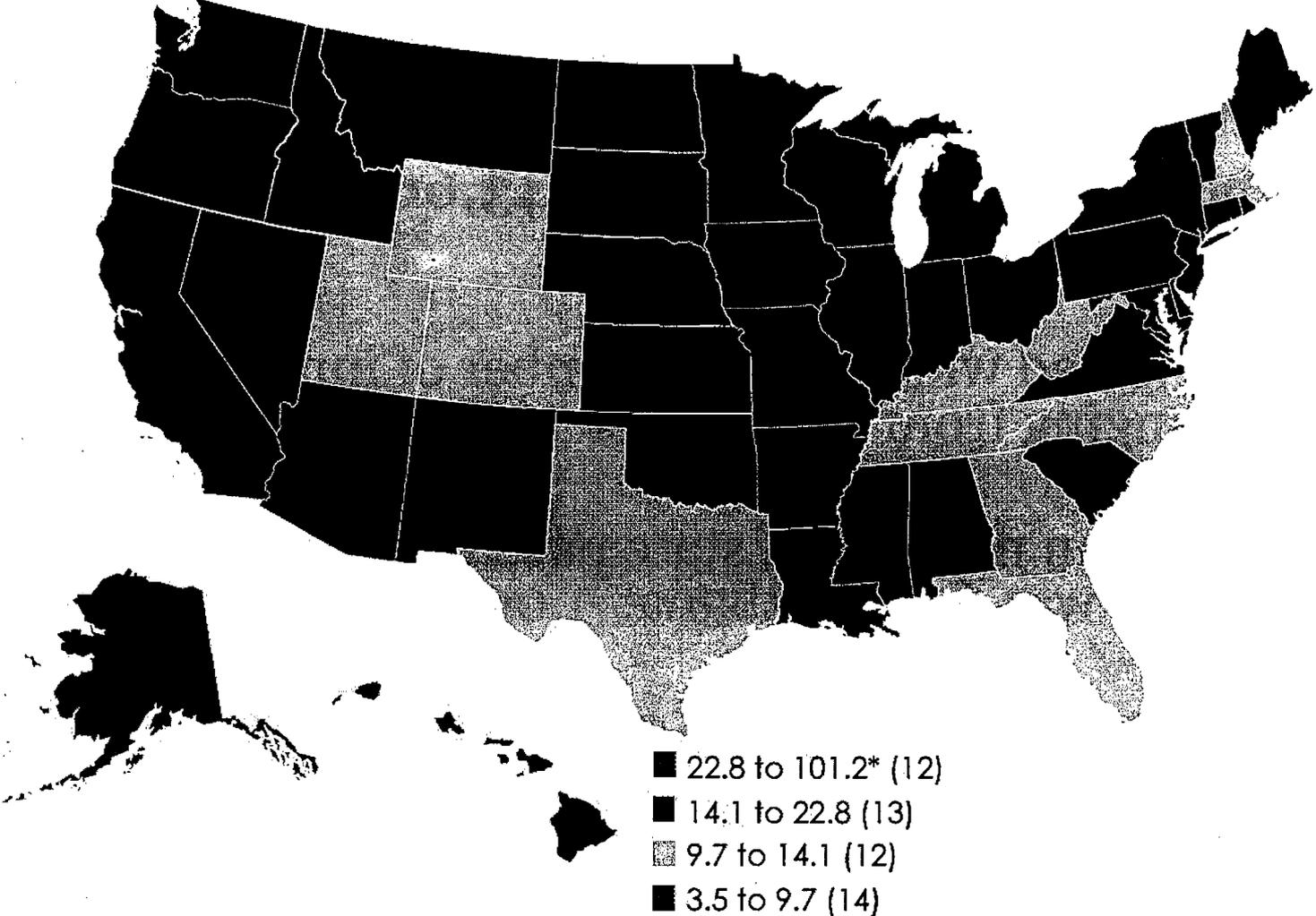
State	Number of State Hospitals (2007)	Population Estimate as of July 1, 2007	Acute, Intermediate, Long Term
Arizona <sup>1</sup>	1	6,338,755	A, I, LT
California	5	36,553,215	I, LT (+ Acute Forensic)
Florida	7	18,251,243	LT (adults only)
Indiana	6	6,345,289	LT*
Massachusetts	10	6,449,755	A, I LT-Adults only
Tennessee	5	6,156,719	A, I (adults only), LT (adults only)
Wisconsin	3	5,601,640	A, I, LT

Source: 2007 SMHA Profiles, unless noted : (1) 2006 NRI State Profiles

Acute (fewer than 30 days)

Intermediate (30-90 days) \* Indiana has intermediate stays for research beds at Larue Carter Hospital Only

# State Psychiatric Hospital Residents per 100,000 Population (2007)



\* Includes District of Columbia

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

# Psychiatric Hospitals: State of the States

- At the end of 2006, there were **43,601** patients residing in state psychiatric hospitals.
- States varied widely in the number of inpatients they had, ranging from **66** in Alaska to **6,327** in California.
- The median number of state psychiatric hospital residents was **655**. Indiana: 1,000-1,050
- On average, states had **14.5** state psychiatric residents per 100,000 population (the median was 13.7). The range was from a low of 3.5 in New Mexico to a high of 41.0 in North Dakota (see Figure 15).

*“Even prior to the 1963 Community Mental Health Centers Act, which established a goal of having a nationwide network of community mental health centers, states were under pressure to reduce the size of state psychiatric hospitals. One of the goals of the Federal Community Mental Health Services Block Grant is to help states minimize their use of state psychiatric inpatient beds. As a result of these policies, there were many fewer state hospitals in 2007 than before, and many fewer patients in them.”*

**Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.**

# State Hospital Trends

- According to CMHS, in **1950**, there were **512,501** patients in state and county psychiatric hospitals. **By 2005**, that number had **declined by 90 percent** to only **49,947** patients
- The number of state psychiatric hospitals has also declined by 37 percent

# State Hospital Trends

- The state psychiatric hospitals of the 1950s and 1960s were much more focused on long-term care, with many patients remaining in the hospital for years.
- At the current time, most state psychiatric hospitals are much smaller but also have much shorter lengths of stay.

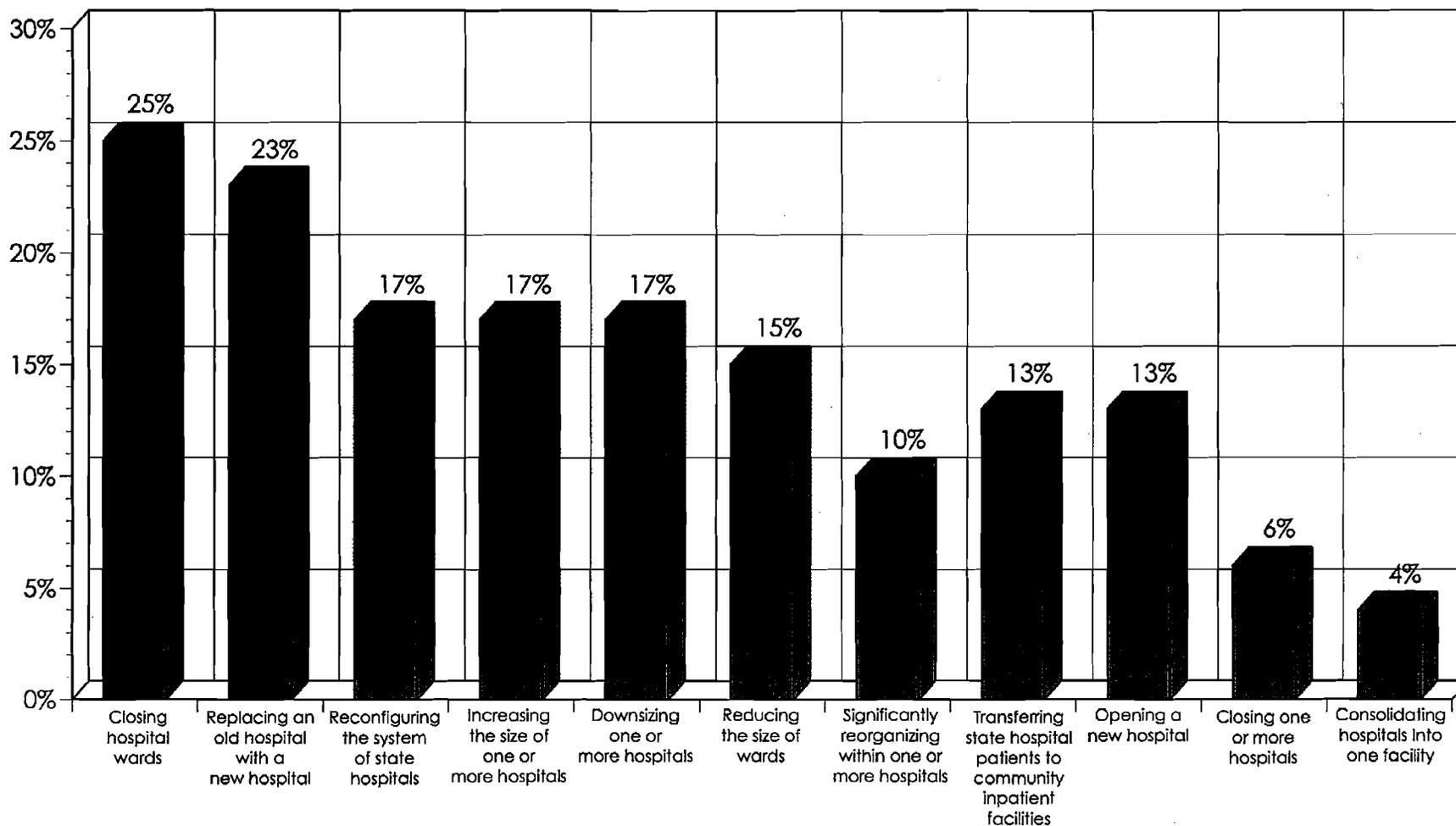
## Number of Hospitals and Resident Patients in State and County Psychiatric Hospitals: 1950-2005

Year	Number of Hospitals	Residents at End of Year
1950	322	512,501
1955	275	558,922
1960	280	535,540
1965	290	475,202
1970	315	337,619
1975	313	193,436
1980	276	132,164
1985	279	116,136
1990	281	92,059
1995	258	69,177
2000	230	54,836
2005	204	49,947

# State Hospital Trends

- As a result of the major decrease in the number and size of state psychiatric hospitals, many states are reorganizing their state psychiatric hospital systems.
- In 2007, just over half of the states (54 percent) reported they were involved in some aspect of reorganization of their state psychiatric hospital system.

## State Psychiatric Hospital Reorganization Activities, 2007



48 States Responding

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

# Closing State Psychiatric Hospitals

- Over the last 55 years, there has been a reported net decrease of 118 state psychiatric hospitals.
- In 2007, five states reported they had closed a total of seven state hospitals over the last 2 years, and three states reported they were currently planning to close a state psychiatric hospital.
- Five states reported they were working on plans to close an additional six state psychiatric hospitals in the next 2 years.
- The data show that although many of the state hospital beds were closed during the 1950s to 1970s, the majority of state psychiatric hospitals have been closed since 1990.

# State Hospital Trends

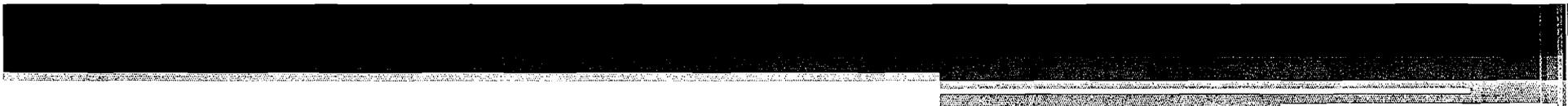
## How States Use Their Psychiatric Hospitals

- Acute vs. Long Term Care
  - Acute=less than 30 days
  - Long Term=greater than 90 days (Indiana)
- Populations Served
  - Adults (Indiana)
  - Youth (Indiana)
  - Forensic (Indiana)

## Number of States Using State Psychiatric Hospitals by Age and Service, 2007

Population	Population 0-17 (100 million U.S. days)		Population 18-64 (100 million U.S. days)		Population 65+ (100 million U.S. days)	
	Number of States	Percent	Number of States	Percent	Number of States	Percent
<b>Children</b>	23	47%	20	41%	15	31%
<b>Adolescents</b>	29	59%	26	53%	20	41%
<b>Adults</b>	41	84%	43	88%	43	88%
<b>Elderly</b>	37	76%	40	82%	40	82%
<b>Forensic</b>	36	73%	41	84%	43	88%

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.



# Population Served and Length of Stay

- All States have inpatient psychiatric beds for treating adult mental health consumers
- In three states, state psychiatric hospitals are focused on providing acute or intermediate-length inpatient services (30-90 days) to adults, i.e. no long term beds.
- Over half of all patients discharged from state hospitals had a length of stay of 30 days or less.
- In a few states (Arkansas, Georgia, and Tennessee), over 90 percent of discharged patients had a length of stay of 30 days or less.
- Indiana had under 10 percent of clients discharged in 30 days or less.

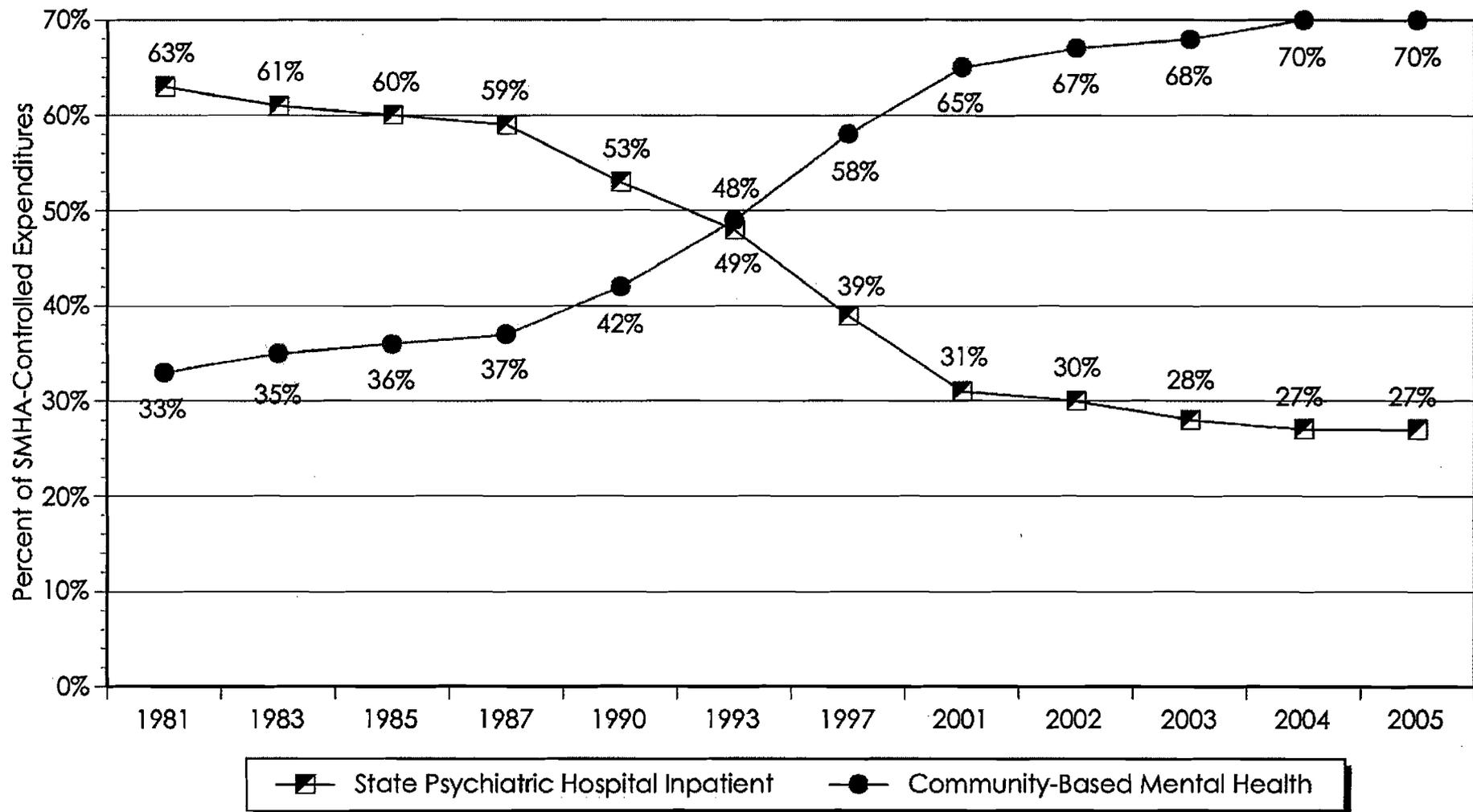
## Populations Served (cont.)

- Some states dedicate their state psychiatric inpatient beds for adults and forensic clients and do not have inpatient beds for children.
- There were 32 states that reported that they serve children and adolescents in state psychiatric hospitals, and for 12 of these states the focus is on acute/ intermediate length of stays for children. (Indiana: long term)

# State Hospital and Community-Based Care

- Over the last 25 years, states have shifted their treatment paradigm to focus on providing comprehensive mental health services in the community.
- In FY 2005, community mental health expenditures accounted for 70 percent of total SMHA-controlled expenditures, and state psychiatric hospital-inpatient expenditures were 27 percent.
- This is an historic shift from FY1981, when community-mental health expenditures accounted for 33 percent of SMHA expenditures and state psychiatric hospitals were 63 percent of expenditures.
- SMHAs also varied widely in the distribution of their mental health expenditures between community-based services and state psychiatric hospitals. The national average was 70 percent on community based programs as opposed to 27% on institutional care.

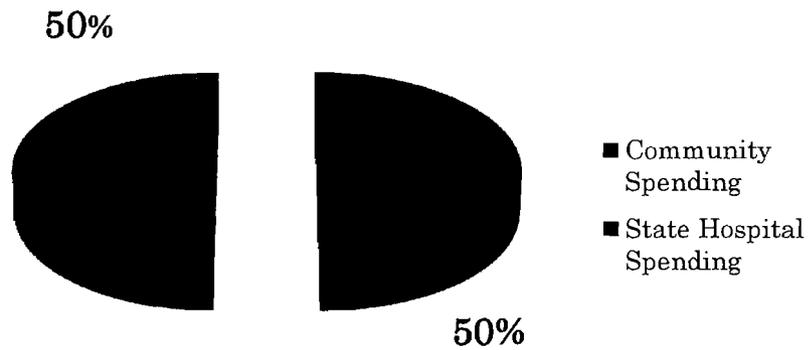
## SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2005



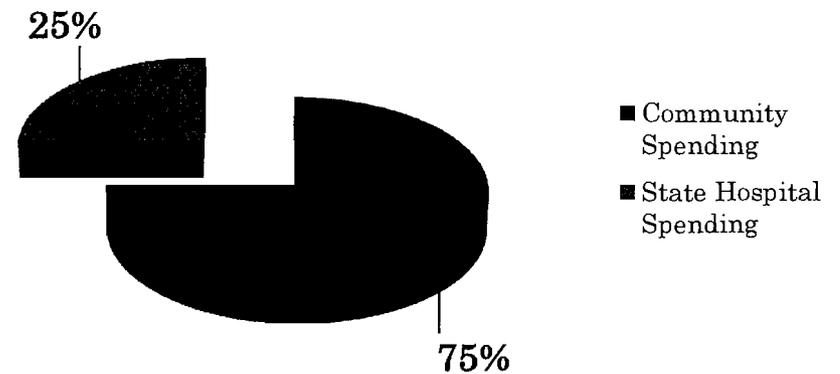
Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

# Institution vs. Community Focus

Current DMHA Spend



National SMHA Trend



# Why the Shift?

- Improvements in the treatment of behavioral health disorders
  - Effective medications with improvements related to efficacy and side effects.
  - Community/evidenced-based practices identified and implemented.
    - Medicaid Rehabilitation Option
    - Assertive Community Treatment
    - Community Alternatives to Psychiatric Residential Treatment Facilities

# Why the Shift?

- Recovery Movement
  - A future in which everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully **in the community**.
  - Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just managing symptoms.

# Why the Shift?

## Olmstead

- On June 22, 1999, the United States Supreme Court held in *Olmstead vs. L.C.* that it is a violation of the civil rights of Americans with disabilities to require a person to be institutionalized in order to receive necessary disability supports and services, if these services are more appropriately provided in the community .

# Why the Shift?

## Efforts Re-energized Around Olmstead

- Multiple “State Director” letters from HHS, SAMHSA, and CMS
  - Increased availability of Home and Community Based Services leads to....
  - Funding focus on HCBS.
  - IMD Exclusion-remove funding as a deterrent to SOF utilization
- Increased enforcement by the Department of Justice
  - Providers and State Agencies will be held accountable- and we should be!

# The Central State Hospital Discharge Study

Indiana Consortium for Mental Health Services  
Research. 2005. "Central State Hospital  
Discharge Study. Tenth Anniversary Public  
Report Series." Bloomington, IN: ICMHSR,  
Indiana University.

- John McGrew, PhD, Bernice Pescosolido PhD, and  
Eric R. Wright, PhD
- April 1993-June 2005

# Indiana Successes

## Closure of Central State Hospital

- Involvement with Criminal Justice
  - *“...there was no evidence that people ended up in the criminal justice system”*
  - *“While there were a small number of clients who had contact with law enforcement officials, including spending some time in jail or prison, this was a relatively uncommon occurrence...”*

# Indiana Successes

## Closure of Central State Hospital

- Mortality data
  - Nearly 1/5 of the consumers released from Central State Hospital died in the decade following the closure.
  - *“many of the deaths of the former patients were the result of diseases that are also common causes of death among older Hoosiers...”*
  - Leading causes of death were cardiovascular disease and cancer.

# Indiana Successes

## Closure of Central State Hospital

- Psychiatric Functioning
  - *“While the group did continue to experience serious psychiatric symptoms and problems in functioning, these data suggests that the mix of services provided to the former patients were successful in maintaining the cohort’s functioning at levels similar to those experienced at Central State Hospital.”*

# Indiana Successes

## Closure of Central State Hospital

- Contact with Law Enforcement
  - 88 clients out of 389 (22.4%) had some type of contact with law enforcement.
  - Only 24.4% resulted in jail time, total number of days “relatively low.”
  - Most contacts under non-violent circumstances
  - Positive outcomes despite the time period occurring before Crisis Intervention Team (CIT) programs had started.

# Indiana Successes

## Closure of Central State Hospital

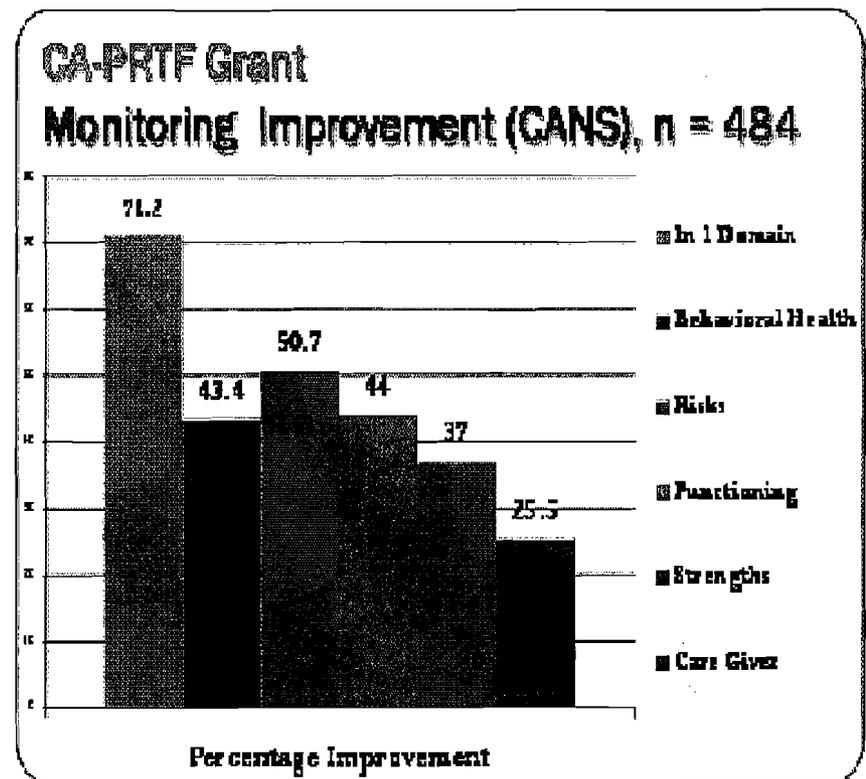
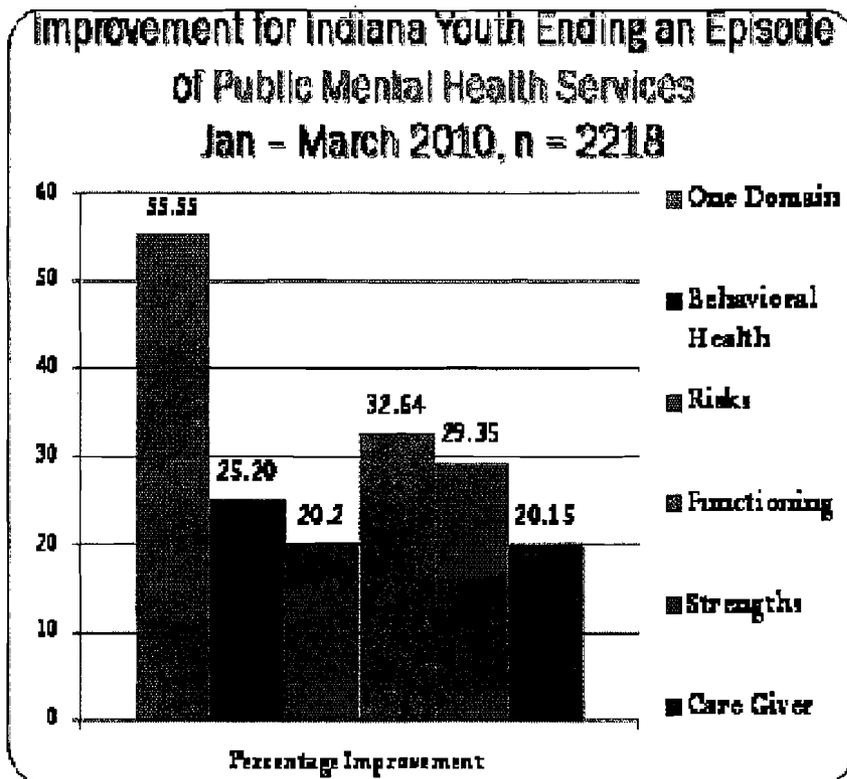
- Quality of Life
  - Based on interviews and completion of the Life Satisfaction Checklist, overall quality of life improved significantly over the 10 years following discharge with the majority of this improvement realized in the first four years and remaining stable thereafter.
  - Trending suggested that a community setting may contribute to positive quality of life across several domains.

# Indiana Successes-Youth

## Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF)

- Demonstration grant to prevent PRTF placement or promote discharge from PRTF
- To date in SFY11 over 600 children served with family and within the community as opposed to out of home placement in PRTF
- Improvement in functioning has been 32.64% for those in usual public services, and 44% for those on the grant. The improvement in any one domain is 55.55% for those in usual public services, and 71.2% for kids on the grant

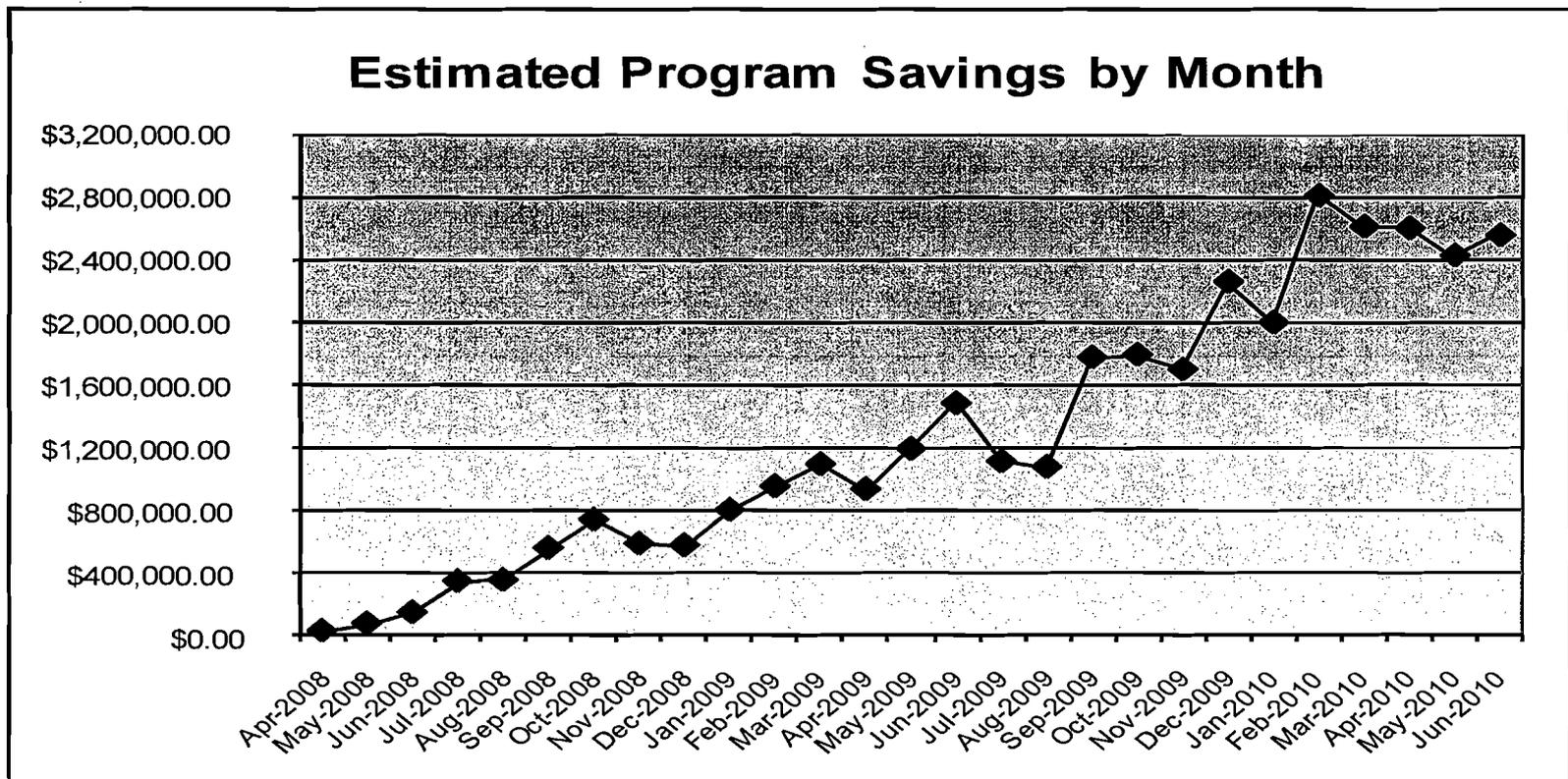
# Improvement in Functioning: CA-PRTF vs. Regular Care



# SOF/PRTF Cost Comparison

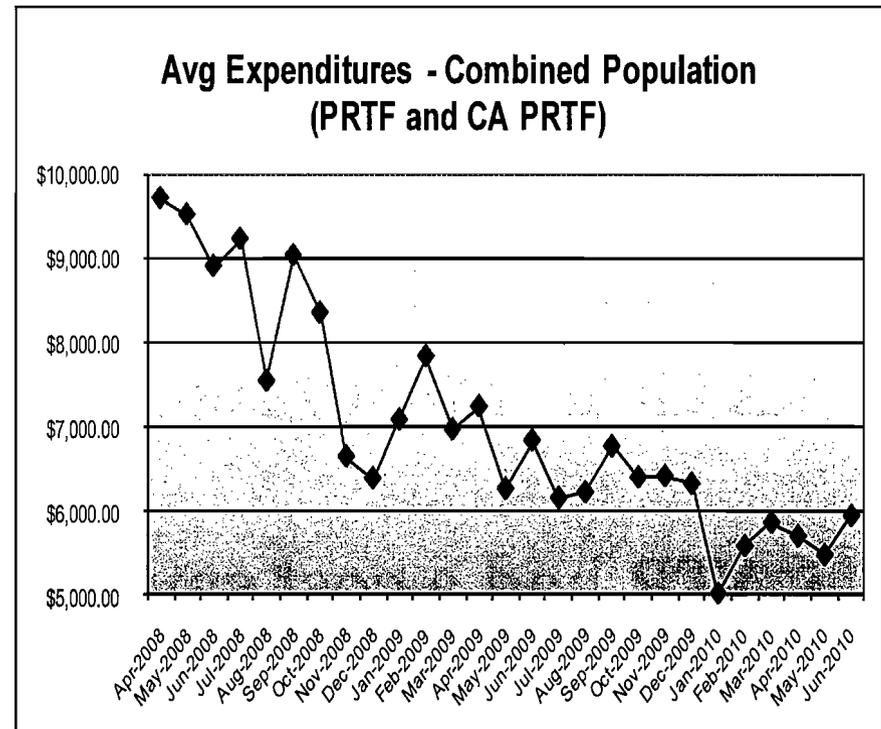
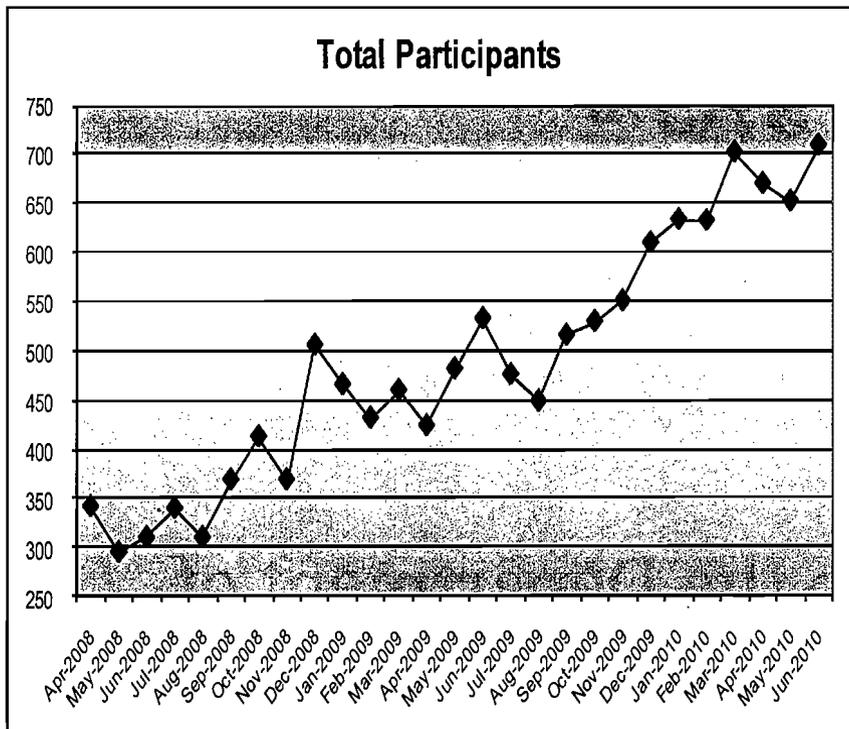
	<b>Cost Per Patient Day</b>	<b>Match Rate</b>	<b>Annual Cost Per Patient</b>	<b>State Portion</b>	<b>Projected Per Patient Annual Savings</b>	<b>Overall Projected Annual Savings</b>
EPCC	\$992	Current SMAP (34.07%)	\$362,080	\$123,360		
PRTF Facility	\$343	Current SMAP (34.07%)	\$125,195	\$42,654	\$80,706	\$968,472
CA-PRTF	\$93	Current SMAP (34.07%)	\$33,945	\$11,565	\$111,795	\$1,341,540

# Indiana Successes-Youth



A basic calculation taking the average cost per client per month difference between PRTF residents and CA PRTF Grant participants, and multiplying by the number of Grant participants per month, illustrates cost effectiveness to the State. This calculation alone estimates a total Program savings of \$34.5 million over the past 27 months. (Provided by HP: PRTF/CA PRTF Activity Analysis-June 2010)

# CA-PRTF & PRTF: Expenditures and Numbers Served



# Indiana Successes-Substance Abuse

## Impact of Indiana Access To Recovery (ATR) on Department Of Correction (DOC)

- DOC rate of recidivism = **37.5%**
- DOC offenders who have been connected to ATR II rate of recidivism = **27.6%**
- ATR had a cost savings to the Department of Correction of **\$13,211,209.20**

This is based on taking the per diem (\$54.28) multiplied by our average length of stay (1.4 years) multiplied by the number of offenders who did not return during the period (475 offenders).

# State Operated Facilities Transition Plan

Recovery and Reinvestment  
Commission on Mental Health  
September 7, 2010

**Exhibit F**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**October 25, 2010**

# What is Happening?

- Public announcement on 7/8/10 of the implementation of the transition plan for patients and staff
- Sequence of events that allow all state hospitals to remain open
- Specific patient populations have been identified to move from hospitalization to community services
- Result is the **net closure of 355 beds** system-wide which represents an approximately **30% decrease** of current capacity.
  - Current capacity: 1205
  - Revised capacity: 850
- Re-deploy 110 beds for persons with SMI
- SOFs will transition to intermediate care facilities and shift from long term residential housing to the greatest extent possible

# Current Picture (84% occupancy as of 8/30/10)

- ESH (95%)
  - Capacity 168
  - Population 160
- Madison (84%)
  - Capacity 150
  - Population 126
- Logansport (77%)
  - Capacity 388
  - Population 299
- Richmond (85%)
  - Capacity 312
  - Population 264
- Carter (97%)
  - Capacity 159
  - Population 154
- EPCC (54%)
  - Capacity 28
  - Population 15

# Transition versus Closing

- Prevents closure of a state hospital
- Maintains statewide service
- Services in the least restrictive setting by moving individuals to community
- No completely vacant assets for State to dispose of or maintain. All bonded structures remain in operation
- Diversity of mental health population & ability of each facility to provide appropriate services
- Minimization of disruption in services and community concerns
- Greater efficiencies than closing a single hospital
- Maintain statutory compliance specific to ESH and Carter

# Logansport

- Remain a high acuity forensic psychiatric hospital with limited civil beds
- Persons with MR/DD will be assessed for transition to the community
- 110 persons with SMI will transfer to other SOFs
- Capacity: 134
- Maintain approximately 500 employees
- **Why such a large impact at LSH?**
  - Large population with MR/DD
  - Expertise with forensic and high acuity patients
  - Significant investment of state funds

# Richmond

- Transition adolescent unit to services for persons with SMI
- Shift CA program to community providers resulting in closure of the addiction services building. RFP has been released for community –based services
- Transition persons with MR/DD to community services and convert unit for persons with SMI
- Capacity: 211
- Maintain approximately 495 employees
  
- Significant impact at RSH is due to the transition of the addiction services program

# Madison

- Transition 30 persons with MR/DD to community services
- Receive 30 persons with SMI
- Capacity: 150

# Evansville

- Transition 30 persons with MR/DD to community services
- Receive 30 persons with SMI
- Capacity: 168

# Larue Carter

- Transition youth from Richmond unit
- Capacity: 159

# Patient Future

- Carefully screened for community assignment
- Coordination with BDDS providers for best fit
- Involvement of patients and families
- Patient needs and community safety are paramount concerns



# Building Usage

- Other state agencies
- County/city opportunities
- School options

# Proposal Details

**Logansport:**

- Close most civil beds (254 beds)

**Larue Carter:**

Youth from Richmond moved to LC (utilization of 20 Existing Beds)

**Evansville:**

- Close 30 bed MRDD unit & transition to community
- Utilize 30 bed unit for persons with SMI



**Richmond:**

- Close substance abuse unit (101 beds)
- Close youth services unit (20 beds)
- Close MRDD unit (30 beds)
- Use 50 beds for persons with SMI

**Madison:**

- Close two MRDD units (30 beds)
- Utilize 30 beds for persons with SMI

# Lay-off Process

- Affected classifications and number of employees needed after the transition have been identified
- Order of layoff in each affected classification is determined by State Personnel Department through the merit employee retention scoring process
- Layoffs will occur over a period of several months and will be concluded by 3/1/2011. Each State employee impacted by this transition will be notified of a specific layoff date as those dates are established in accordance with the transitions of patients to new living arrangements



# Next Steps

- Need to provide continuing quality care for patients throughout and following the transition
- Transition planning with patients and families
- SPD coordinating employee informational sessions with benefits section, PERF and DWD

## **Downsizing of Logansport & Richmond State Hospitals**

**Background & Reason for Medicaid Oversight Committee Coverage: FSSA is going to substantially reduce the mental operations of Richmond State Hospital and Logansport State Hospital by reducing their operational capacity by 30%.**

**Hundreds of individuals currently receiving services will be “transferred” to other settings to receive their services.**

**In addition, hundreds of State workers will lose their jobs as a result of the downsizing of these facilities.**

**Furthermore, NOT as well noticed or highlighted in the discussion of the Richmond and Logansport downsizing is the fact that DD/MR units in Richmond, Logansport AND Evansville State Hospital and Madison State Hospital will be closed.**

**Questions:**

**Has FSSA truly thought of all the consequences of drastically reducing the capacity at these facilities in light of the fact that community capacity might not adequately exist to accommodate the treatment needs of so many individuals in a short period of time (plan is to be implemented by March 1, 2011)?**

**What safeguards are being put in place to ensure that are individuals leaving these facilities will be adequately served in a community setting? Please elaborate for both the State Mental Health facility side and the DD side?**

**It appears that Indiana receives at least \$93 million dollars in Psychiatric DSH for their State Hospital because they are Institutions of Mental Disease. How much DSH money will Indiana lose as a result of the downsizing of Richmond and Logansport?**

**Has FSSA holistically assessed the entire Mental Health provider network to adequately determine if capacity exists to make these changes now, when Community Mental Health Centers are receiving less funding but being asked to take on even more duties such as those that are being contemplated by the Department of Child Services and there planned changes?**

**It appears that CMHC's are going to have to become more involved but they have resource constraints that may not make that realistically possible.**



# Medicaid Rehabilitation Option (MRO) Implementation Update

Gina Eckart, Director

Division of Mental Health and Addiction

Sarah Jagger, Policy Director

Office of Medicaid Policy and Planning

Exhibit H  
Select Joint Commission on  
Medicaid Oversight  
October 25, 2010





# MRO Changes Update

- Implementation on July 1, 2010.
- Mental Health System Transformation framework based on recovery oriented care model.
- Person centered treatment planning and individualized care.



## DMHA Activities in Preparation for MRO Changes

- January and February shared process flow for service package assignments and information about required data elements with all CMHCs.
- Provided information to CMHCs regarding issues with Medicaid RID numbers (March - June).
- Invited CMHCs to send staff to DMHA to work on cleaning their data – 8 CMHCs did so.
- All CMHCs received monthly communications and specific data files that indicated potential issues with diagnoses and assessments (April-July).



## DMHA/OMPP Activities in Preparation for MRO Changes

- Tested the HP system process for service package assignment with four selected CMHCs (May-June).
- Amended MRO Rule after extensive collaboration with stakeholders to ensure changes were clinically and operationally sound.
- Developed public website which housed all master documents, presentations, training materials, and FAQs
- FAQs – 500+ questions collected and answered through [transformation@fssa.in.gov](mailto:transformation@fssa.in.gov).
- Completed 4 “Initial Loads” during July with HP – ensuring as many consumers as possible received packages based on assessments from January 2010 through June 2010.
- Developed and published new MRO Manual.



## DMHA/OMPP Activities in Preparation for MRO Changes - Provider Training and Technical Assistance (TTI Grant)

<b>Activity</b>	<b>Dates</b>
<b>MRO Train-the-Trainer</b> (4 regional trainings) Presenters: Sarah Jagger (OMPP) Debbie Herrmann (DMHA)	March 31 – April 1, 2010 April 5 – 6, 2010 April 12 – 13, 2010 April 26 – 27, 2010
<b>Recovery-Based Care</b> Presenter: Dr. Janis Tondora	July 26, 2010 July 27, 2010 July 28, 2010 July 29, 2010 9 am - 4 pm local time
<b>Assessing and Treating Individuals with Co-occurring Disorders</b> Presenter: Vicki Ley, MA, LMHC, MAC, ICAC II, CADACII	<u>Webinar</u> June 10, 2010 10:00 – 12:00 (Eastern) Repeated from 1:00 – 3:00 (Eastern)
<b>Recovery Outcomes</b> Presenter: Maria O'Connell, Ph.D. Assistant Professor, Yale University, Department of Psychiatry Yale Program for Recovery and Community Health (PRCH)	<u>Webinar</u> September 15, 2010 10:00am — 12:00pm (EST) or 2:00pm — 4:00pm (EST)



# DMHA/OMPP Activities in Preparation for MRO Changes

## **MRO Service Package and PA Process**

Presenters: HP and Advantage

### Webinar

May 18, 2010

10:00am – 3:00pm (Eastern)

## **Community, Consumer and Family focused Town Hall Meetings**

Facilitated by MHA

Presenter: Gina Eckart

May 18, 2010

May 24, 2010

May 27, 2010

June 2, 2010

June 14, 2010

June 17, 2010

July 14, 2010

## **Technical Assistance**

Multiple Presenters

### Webinar

June 8, 2010

July 13, 2010

August 10, 2010

September 14, 2010

October 12, 2010

November 9, 2010

December 7, 2010

January 11, 2011

February 8, 2011

March 8, 2011



# MRO Service Package Assignments

## Preliminary System Wide Results

Total Consumers with an Open Episode in DARMHA*	104,873
Total Medicaid RID Numbers in DARMHA with necessary data*	57,246 (55%)
Total Service Packages Assigned as of 8/27/10**	44,994
Percentage of Medicaid Consumers with a Service Package**	79%

\*Data from DARMHA as of 7/31/2010.

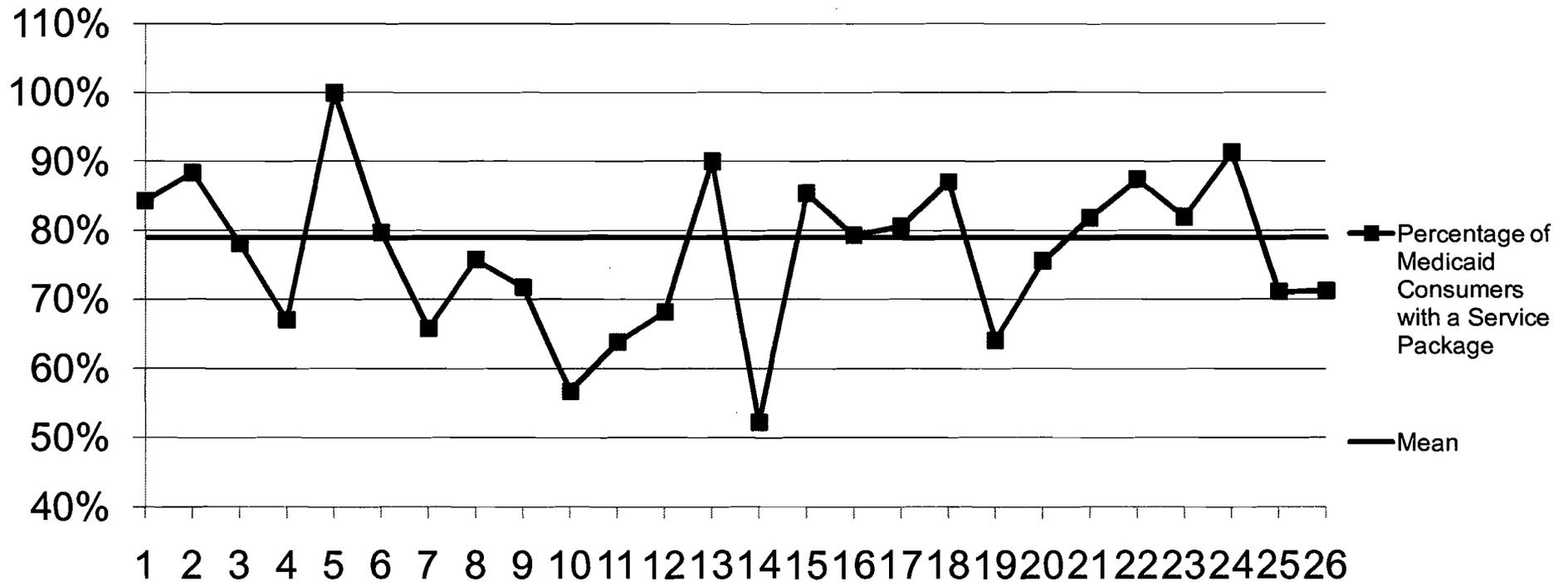
\*\*This data does not include those consumers who have been prior authorized for MRO services.

- **Provider data is approximate due to:**
  - Inclusion of consumers that may be inactive.
  - Issues with the Medicaid RID number or eligibility, missing diagnoses or missing assessments.



# Percentage of Consumers with Medicaid Receiving a Service Package, by Provider

Mean = 79%; Highest = 100%; Lowest = 52%



Updated with July 31, 2010 counts of eligible



# MRO Service Package Assignments by Level of Need

Total Children	Total Adults	TOTAL
20,379	24,615	<b>44,994</b>

Service Package	3	4	5	5A
# Adults	8,929	10,798	3,942	946

Service Package	2	3	4	5
# Children	3,974	9,439	4,838	2,128



## Historical Unduplicated Number of Individuals Served with MRO

July 1, 2009 – December 31, 2009

- 46,096 Medicaid members received at least one MRO service



# Prior Authorization (PA) Scenarios

- **Scenario 1:** A member depletes service units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- **Scenario 2:** A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- **Scenario 3:** A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- **Scenario 4:** A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.



## Prior Authorization (PA) Data

	Jul	Aug	Sept	Total
# of PAs requested	425	1,758	1,412	3,595
Average # of (business) days to process	8.5	7.7	8.7	8.3

Contract requires an average turnaround time of less than 10 days.



# Number of PA Lines, by Status

	Evaluation	Approved	Modified	Suspended	Denied	Total
Sept 2010	0	1,594	148	156	660	2,558



# Prior Authorization Status Definitions

- **Evaluation:** This is a prior authorization that has been received, but no decision has been rendered yet.
- **Approved:** Prior authorization request was approved as submitted.
- **Modified:** Prior authorization request was approved, but required an adjustment to the dates or units requested from the originally submitted request.
- **Suspended:** The prior authorization received did not contain enough information to render a decision, and we need additional information from the provider. Providers will be notified via prior authorization decision letter of specific information needed in order to process request.
  - Additional information must be received within 30 days of suspension or request will automatically be denied.
- **Denied:** This prior authorization request has been denied and cannot be remedied.
  - Specific reason for denial is provided to the member and provider on the prior authorization decision letter.



# Advantage PA Assistance

- Conducted an onsite orientation session for the following CMHCs:

Bowen Center	Warsaw, IN	May 10, 2010
Four County	Logansport, IN	June 17, 2010
Grant Blackford	Marion, IN	July 12, 2010
Gallahue	Indianapolis, IN	August 5, 2010

- In addition, Advantage has conducted outreach to assist the following CMHCs:

Aspire	Cummins
Adult and Child	Centerstone
Park Center	Oaklawn
Southern Hills	Porter Starke
Regional	Howard Regional
Hamilton Center	Madison Center



## Next Steps

- Quality Management
  - Service Package Utilization
  - Service Package Assignments
  - Prior Authorization
- Provider and Stakeholder Education and Support

## **STATEMENT BEFORE HOUSE OVERSIGHT COMMITTEE ON MEDICAID**

Thank you Mr. Chairman, and members of the Committee, for allowing me to appear today. My name is Steven Dick and I am the guardian of and legal advocate for Michael Dick, who is the lead Plaintiff in the class action lawsuit filed against the Family and Social Services Administration (FSSA) over their unlawful practice of offsetting food stamps against the grocery allowance under Residential Living Allowance (RLA) budgets, which has caused the furor and national publicity in the last four months.

This lawsuit was instituted to right a wrong which FSSA refused to recognize administratively, and even publically dismissed as “frivolous and meritless” after it was filed. As subsequent events have shown, the lawsuit was neither frivolous nor meritless, and has resulted in yet another public embarrassment to our State and FSSA’s administration of the Medicaid program. Because of FSSA’s irresponsible actions, a bad situation for seriously handicapped adults has been turned into an even worse situation. The policies and practices of FSSA are flawed and need your review.

According to the most recent data available to me, in this state there are some 12,500 seriously handicapped constituents in Indiana who are receiving benefits under the either Autism/ Developmental Disabilities/ or Support Services Waiver Programs. These constituents do not vote; most cannot even read or write. They have no voice to speak for themselves and no political agenda. The waiver program was instituted to allow the individuals to avoid being institutionalized; and instead to be allowed to live and participate in their community, in those magic words: **in the least restrictive environment.**

FSSA has been tasked with the management of these waiver programs, and this legislature has funded them for that task. There are multiple provisions of the IN Code and even more of the IN Administrative Code setting out how FSSA and providers are to carry out that task. Instead of focusing on helping these adults to live as productive lives as possible, in my opinion, FSSA, thru BDDS, is striving to keep these individuals in sub-poverty and restricted environments.

This lawsuit has illuminated the fact that for the last decade FSSA has clearly violated Federal Food Stamp laws by forcing waiver recipients to apply for food stamps and then offsetting those food stamps from benefits otherwise allowed

under this state's Residential Living Allowance. I understand FSSA's desire that waiver recipients should apply for all possible benefits before the state assists them. But who pays for social security benefits, food stamps, and the like? You and I do; and pushing more costs into those programs is simply pushing the ability to control and distribute those funds from your hands into someone else's hands in Washington. The actions FSSA have taken since their error became public has created even worse conditions for waiver recipients.

Embarrassed by being caught including food stamps in their computation of income and benefits on the Individual Community Living Budgets (ICLB), and offsetting those benefits from the meager grocery allowance being allowed to waiver recipients, they have, in my opinion again, now retaliated against all waiver recipients. In their new RLA Policy Statement issued in mid-September of this year, retroactive to September 1<sup>st</sup>, FSSA has removed food stamps from being counted as income or benefits within the ICLB budget computation. This action is clearly in compliance with Federal law. However, in doing so they have, in knee-jerk fashion, cleverly written a new policy apparently stating "if we cannot offset food stamps as part of your grocery allowance, then waiver recipients cannot include groceries within their computation of basic living expenses."

I say it was written cleverly because, and I believe you would agree, groceries are as basic a necessity as is possible. Yet the new RLA Policy Statement never once includes the words "groceries or grocery allowance"; even though it includes two pages of **non-permissible budget expenses**. This fact almost escapes notice, so much so that BDDS has issued two separate directives to waiver service providers clarifying their position that not only is the existing food stamps line in the RLA income and benefits section to be reported as ZERO; but also the groceries line in the expenses section **must** also be reported as ZERO.

The fight I started 18 months ago with FSSA/BDDS was my attempt on behalf of my son to keep a meager \$1.25 per day increase in his food stamp benefits so as to increase his \$200 maximum monthly grocery allowance; an allowance which has not been increased in a decade. I do not believe any person in this room can say that \$200 can buy the same amount of groceries today as it did 10 years ago. Even the Dept. of Justice's National Standards for individuals who file for bankruptcy protection provide a grocery allowance for a single person of \$293 per month; and this standard is periodically reviewed and updated.

Instead of allowing an increase in my son's grocery allowance, FSSA's new Policy Statement declares that if my son is not satisfied with the \$200 per month grocery allowance; then survive on food stamps alone. The RLA Policy Statement requires that every dime of any waiver recipient's Social Security or other sources of benefits shall be dedicated solely to housing, utilities, and other allowable expenses, excluding groceries, before you will receive any state RLA funds! For waiver recipients, the situation has gone from bad to worse.

This silent population has and is forced to live at a sub-poverty level. The RLA Policy Statement provides that a recipient's income and RLA benefits are not to exceed 150% of the Federal poverty level. In fact, very few recipients even reach the poverty level. According to Health & Human Services Guidelines, the poverty level for a single person is \$10,830 per year, or \$902.50 per month. The vast majority of waiver recipients receive only an SSI payment of about \$674 per month. Very few of the waiver recipients are functional enough to earn any income from employment, and the average RLA benefit under the old policy was less than \$200 per month.

When this new RLA Policy Statement went into effect, it eliminated the entire \$200 per month grocery allowance previously allowed, so the majority of the waiver recipients will not receive any RLA benefits! My son's service provider is one of the largest in the state and they report that virtually all of their clients have lost their RLA benefits under the new policy. So, I again state, that in my opinion, this new RLA Policy has been drafted to punish waiver recipients because of the litigation – litigation which have never occurred had FSSA been in compliance with Federal law.

FSSA/BDDS has repeatedly told me, service providers, and even an Administrative Law Judge that RLA's are a state funded, discretionary distribution, not an entitlement, and that FSSA have the right, even the duty, to limit benefits so as not to exceed their appropriated funding. I agree that RLA's are not an entitlement; but, I assert that FSSA has been less than honest.

FSSA has been systematically limiting benefits to waiver recipients to keep them at a sub-poverty level. Now, FSSA representatives say that the RLA grocery money has "migrated" to other FSSA programs. The truth, however, appears quite different according to the State Budget Agency's own Close-Out Report on Reversions. In their last report, FSSA reverted \$201.7 million of their appropriations back to the general fund; including over \$15 million in line item

funds specifically designated to just DD waiver services. Funding the entire grocery allowance under the old Policy, without offsetting any food stamps, for all 12,500 waiver recipients would have required only \$2.5 million in funding; or only 1.2% of just the funds FSSA returned to the general fund. As a result of the new Policy, FSSA says that only 440 people will now be eligible to receive RLA's.

The latest statements by FSSA as to why they are eliminating grocery allowances are that **“RLA recipients may have misused the program by misstating their incomes”** and that the **“program was just too wide, too confusing, and that confusion was leading to abuse.”** Neither excuse is any justification for removing groceries from budgets within the new RLA Policy Statement. These are public address statements made without any basis in fact. FSSA changed its policy as a direct result of not being able to offset food stamps! No other statement makes sense in light of the actions taken by FSSA.

The service providers across this state are highly qualified, highly supervised, and very experienced in completing the uncomplicated ICLB RLA budgets. They complete doing dozens if not hundreds, every quarter for their clients. The RLA budget computation is less complicated than balancing your checkbook; except for all the expenses which they disallow to waiver recipients. There are 9 lines to be completed which cover all of an individual's income and benefits; of which generally only 2 or 3 are ever completed. There are 8 lines of allowed expenses. If expenses exceed income, an RLA request is submitted. How can a provider abuse a grocery allowance set at a flat \$200 per month (absent extra-ordinary medical justification) unless the provider is simply not feeding the waiver recipient and pocketing the funds! Providers are required to collect and retain all grocery receipts for BDDS to audit upon request.

Although I am here to protest the new policy, and even beg that you mandate that the new RLA Policy Statement be suspended and re-written; I am quite cognizant that you must also be fiscally responsible. The two objectives are not impossible to reconcile. You created a waiver program that already clearly requires an individual be certified as seriously handicapped. You also enacted that they be entitled **to live and participate within the community.**

Appropriations are decided upon in every budget cycle, and boundaries are set as to the number of waiver recipients that can be served. Likewise, apportionment of those funds can be done in a fiscally sound manner which recognizes realistic costs of living, and periodically either reviews those standards, or links those allowances

to established national standards. When those standards change, this legislature will have real time data for review of appropriation requests.

The system already has a massive bureaucracy; from agencies, bureaus, divisions, management coordinators, service coordinators, support teams, and service providers, who all are paid far better than at the poverty level. This silent constituency should not be punished by this new RLA Policy Statement and likewise, should not be forced to live at sub-poverty levels.

I thank you and am willing to answer any questions you may have.



Darren Cummings / AP

In this July 14, 2010 photo, Michael Dick, 26, looks out the front window of his home while playing with a string of beads in Indianapolis. For at least a decade, potentially thousands of Indiana's neediest adults have seen some of their state aid payments slashed simply because they receive food stamps... a practice that advocates and legal experts say is a clear violation of federal law. Dick is enrolled in state programs that provide money to help the developmentally disabled live on their own, including buying groceries. When his food stamp benefits were raised to as much as \$99 a month, Michael Dick's grocery allowance was reduced from \$139 to as low as \$101. Steven Dick said he and his son appealed the decision and lost, then decided to sue. The \$200 cap set by the state is arbitrary and has not been adjusted in at least six years, the lawsuit said. (AP Photo/Darren Cummings)

## Erik Gonzalez

---

**From:** Peter Okefor  
**Sent:** Friday, October 22, 2010 2:38 PM  
**To:** Erik Gonzalez; Hope Tribble  
**Subject:** FW: [QUARANTINE] FW: DDRS Decision to Eliminate State-Line Food/Grocery Funding for many Developmentally Disabled Individuals

**Importance:** Low

---

**From:** Marvin O. Ross [mailto:moross4@comcast.net]  
**Sent:** Friday, October 22, 2010 2:35 PM  
**To:** Peter Okefor  
**Subject:** [QUARANTINE] FW: DDRS Decision to Eliminate State-Line Food/Grocery Funding for many Developmentally Disabled Individuals  
**Importance:** Low

---

**From:** Marvin O. Ross [mailto:moross4@comcast.net]  
**Sent:** Friday, October 22, 2010 2:22 PM  
**To:** 's26@iga.in.gov'  
**Cc:** 'h41@in.gov'; 'h78@in.gov'; 'h15@in.gov'; 's32@in.gov'; 's9@in.gov'; 's20@in.gov'; 's40@in.gov'; 's46@in.gov'; 's15@in.gov'; 's16@in.gov'; 's34@in.gov'; 'h81@in.gov'; 'h85@in.gov'; 'h80@in.gov'; 'h6@in.gov'  
**Subject:** DDRS Decision to Eliminate State-Line Food/Grocery Funding for many Developmentally Disabled Individuals

**Re: SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT---Meeting, Monday, October 25, 2010, 10:00am, Room 404 in the State House**

We are the parents of a 44 year old son who is multiply disabled. He has an intellectual disability, organic brain syndrome, personality disorder (mental illness), Diabetes Type II, Hypertension, Cardiomyopathy and Sleep Apnea. He was approved for community living by the Office of Medicaid Policy & Planning in March 2001. Our son has been enrolled in the DD Waiver Program since the fall of 2002. Because of health issues he has not been able to work or function in a sheltered workshop since mid-2008.

For the past eight years our son has been eligible for a monthly supplemental Residential Living Allowance in order for him to be housed in a one-bedroom unit without a housemate (this due to severe mental illness & his psychiatrist's directive).

We belong to two parent coalitions in Allen County and one that meets on a state-wide basis. Last month's decision by Ms. Julia Holloway, Director of the Division of Disability and Rehabilitative Services, to eliminate state-line funding for food for the developmentally disabled is absolutely devastating---to our family and many parent/guardians of individuals that are developmentally disabled. That decision by DDRS was wrong, wrong, wrong.

WE ASK THAT YOU REVERSE THE ABOVE REFERENCED DECISION OF THE DDRS.

Not all Clients are receiving Federal Food Stamps. Our son is receiving the maximum of \$200 for Food Stamps monthly but that calculates to **an average of \$6.67 for food per day which is inadequate**. This action by DDRS will force many DD Clients to become a ward of the state---Costing the State of Indiana even more. Other Clients will be forced to return to their previous home with elderly parents. This action by DDRS was unconscionable. It needs to be rectified by our State Legislators. Please let us know if you have questions about the adverse affect of the food/grocery decision. Thank you.

Very sincerely,

**Exhibit J**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**October 25, 2010**

Marvin O. & Lois Ross, Parents/Guardians of our DD Waiver Son  
7629 Sunderland Drive  
Fort Wayne, IN 46835-1243  
Phone: 260-485-7432



# Indiana Family & Social Services Administration

## First Steps

### Indiana Statewide Profile Report

Reporting Period: 07/01/2009 - 06/30/2010

#### I. Population Information

Population (U.S. Census Bureau)	6,376,792
Population Growth Percentage (U.S. Census Bureau)	4.0 %

#### II. Child Enrollment & Referral

	Number of Children	Percentage of Children
One-day Count w/IFSP - 0 to 1 year-olds	1,486	
One-day Count w/IFSP - All Children	10,174	
Annual Count of Children w/IFSP	21,291	
Annual Count of Children Served (regardless of IFSP)	25,198	
Average Age at Referral (months)	13	
New IFSP 04/01/2010 - 06/30/2010	2,665	
Children with Referral to IFSP 45+ Days 04/01/2010 - 06/30/2010	6	

#### III. Exits

Children Moving to Preschool Special Education	3,323	35%
Children under 3, Services No Longer Needed	1,025	11%
Eligible Children who Declined Services	415	4%

#### IV. Paid Services

Children w/IFSP Served Primarily in the Natural Environment	21,045	99%
Total Amount Paid on Behalf of Children Served	\$51,550,715.72	
Average Paid on Behalf of Each Child Served	\$2,045.83	

#### V. Race Information

	White	Black or African - American	Hispanic / Latino	American Indian or Alaskan Native	Asian	Native Hawaiian or Other Pacific Islander	2 or More Races Selected	Other Race
Children Served	18,269	2,892	2,449	32	274	1	1,265	8
Percentage	73%	11%	10%	0%	1%	0%	5%	0%

#### VI. Children Receiving Each Service Type

	Number of Children Served	Percent Receiving Service Type		Number of Children Served	Percent Receiving Service Type
Assistive Technology	1,073	4%	Occupational Therapy	11,526	46%
Audiology	3,086	12%	Other Services	137	1%
Developmental Therapy	17,535	70%	Physical Therapy	11,470	46%
Health Services	0	0%	Psychology	594	2%
Interpreter Services	344	1%	Social Work	162	1%
Medical	0	0%	Speech Therapy	14,648	58%
Nursing	7	0%	Vision	96	0%
Nutrition	1,015	4%			

**Exhibit K**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**October 25, 2010**

# **Nursing Home Staff Turnover and Retention**

**Submitted by**  
**Hoosier Owners and Providers for the Elder (HOPE)**  
**Indiana Association of Homes and Services for the Aging (IAHSA)**  
**Indiana Health Care Association (IHCA)**

On September 21, 2010, the Select Joint Commission on Medicaid Oversight (Commission) received testimony from state agencies, the three associations representing Indiana nursing homes, and others on nursing home issues raised by recent Indianapolis Star articles. One of the issues discussed was nursing home staff turnover and retention.

Terry Whitson, Assistant Commissioner of the Indiana State Department of Health (ISDH) provided statistics from a study completed for ISDH by the University of Indianapolis which showed that turnover rates in Indiana were significantly higher than national rates.

During the meeting, Commission Chairman Bill Crawford requested HOPE, IAHSA, and IHCA collaborate and develop a report on turnover and present recommendations regarding potential strategies to address the turnover issue. The three associations are pleased to present the following information and recommendations regarding this important issue.

## **OVERVIEW**

Historically, high turnover rates for nursing home staff has been a serious problem. A 2009 study by the University of Indianapolis for ISDH showed that turnover for Certified Nursing Assistants (CNAs) was 98.1%. Turnover for Registered Nurses (RNs) was 74% and for Licensed Practical Nurses (LPNs) was 67%. More recent statistics from Myers & Stauffer, the state's nursing home rate setting contractor, indicates lower turnover rates. The Myers & Stauffer statistics show CNA turnover at 71% and RNs/LPNs turnover at 54%.

Current turnover rates are still high, especially when many facilities have turnover rates above the state average. However, keeping turnover low is possible. In the Myers & Stauffer data, there were facilities that had no turnover of CNAs in the past year.

Turnover rates can be deceiving. A limited number of positions may turnover regularly such as weekend night shifts yet the majority of positions are stable. This is why retention is a statistic that is also important to study. For example, one IAHSA member reported a turnover rate of 50% but a retention rate of 95%.

Not all turnover is negative. There is natural turnover as people obtain more education and move on to other employment, life circumstances change, and some employees don't meet the requirements or standards of the facility. All health care providers struggle with finding RNs given the current RN shortage.

However, high turnover and low retention rates have been associated with quality of care and quality of life issues. It is difficult to have consistent systems and processes of care when staff turns over too quickly. The resident quality of life is impacted since they have different staff members taking care of them who do not know them or their conditions well.

**Exhibit L**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**October 25, 2010**

High turnover can be caused by:

- High management turnover;
- Poor supervisory skills of management staff;
- Lack of qualified and experienced candidates;
- Difficulty and nature of work not previously recognized by an employee prior to being hired;
- Aggressive recruitment efforts of competitors;
- Availability of education and training opportunities;
- Lack of a “career ladder”;
- Relatively low pay and benefits; and
- Inefficient systems for recruitment and hiring and poor job orientation processes;

## **RECOMMENDATIONS**

The overriding objective of policy-makers and long term care providers is to improve the quality of care and services provided to nursing home residents. Staff retention is one component in a complex regulatory system and challenging business climate that influences the quality of care and services. Historically, government has taken a prescriptive approach to improving quality through the 177 federal standards for long term care survey and certification. This prescriptive approach has disappointed all stakeholders with its results. Quality has improved, but slowly.

The most exciting improvements in quality have occurred independently of regulation in organizations that have accepted that it is their responsibility to improve. These facilities have adopted the quality lessons from other industries and adapted them to long-term care. The impact of recent regulatory efforts to incentivize and penalize certain industry behavior in order to improve quality metrics and outcomes will take time to measure and evaluate.

There is no one solution for reducing turnover. There are numerous studies, best practices, and programs that different facilities have used to reduce turnover. Each facility is different and has different labor market circumstances. Rather than prescribing one approach and requiring facilities to implement this approach, we recommend that the State continue to enhance positive financial incentives for improving outcomes and continue negative financial consequences for low performance. We recommend letting individual organizations respond to these incentives and consequences. These are referred to as “Phase 2” and “Phase 3” changes in the long term care Medicaid reimbursement system. In addition, we recommend that the long term care profession and the state build on the excellent work being done by ISDH in quality improvement and training.

1. **Phase 2.** The nursing home associations worked with the Family and Social Services Administration’s Division of Aging (Division of Aging) in 2008 and 2009 to develop and implement changes to the nursing home Medicaid reimbursement system that incorporate strong incentives for quality improvement. Phase 2 incentives update the Quality Add-On and increase the amount available to facilities with the best ISDH survey Report Card Scores. A sliding scale is used to increase reimbursement as Report Card Scores improve. Conversely, the Quality Add-On is eliminated for the facilities with the worst Report Card Scores.

A strong disincentive is also included. Prior to Phase 2, facilities with costs below the direct and indirect care limits have kept a portion of the difference between their costs and the limit as

an efficiency incentive. Under Phase 2, facilities whose survey Report Card Scores fall above the median score will not get this Profit Add-On. Below the median score, facilities can increasingly retain the Profit Add-On as their report card scores improve. (Note: lower Report Card Scores are better than higher Report Card Scores). Facilities which can reduce turnover are much more likely to have improved Report Card Scores, leading to higher Quality Add-Ons and higher Profit Add-Ons.

Phase 2 was implemented on January 1, 2010 and is expected to provide strong financial incentives for facilities to work to improve regulatory compliance, resident satisfaction and staff retention. It is expected that at least two survey cycles will be needed in order to demonstrate the effectiveness of the Phase 2 approach. Only then will we be able to assess the effectiveness of the Phase 2 modifications.

2. **Phase 3.** The survey Report Card Score is only one measure of quality. The Division of Aging currently has a Clinical Expert Panel (CEP) evaluating additional measures of quality that can be incorporated into the Quality Add-On measure and used in determining which facilities qualify for a Profit Add-On. The CEP is comprised of clinical staff, academicians, consumer advocates, and facility administrative staff. Staff retention/turnover statistics are expected to be part of the final Phase 3 proposals. This will provide even stronger financial incentives for facilities to increase staff retention and reduce staff turnover.
3. **Use of Civil Money Penalty (CMP) funds.** ISDH maintains a fund of federal fines derived from nursing homes' noncompliance with federal regulations called the CMP fund. This money is required to be used by states to work on key quality issues seen in their state. ISDH has been effectively utilizing the CMP funds for educational programs directed at key quality issues. Mr. Whitson discussed some of these initiatives at the Commission's last meeting, including a description of the large conferences that ISDH has held addressing clinical care issues.

The three nursing home associations have continued to discuss with Mr. Whitson the use of CMP funds for training and education purposes. The most recent discussions have focused on use of the CMP funds to provide leadership and supervisory training to facility personnel to enhance employee retention and continue progress in clinical quality. These next CMP-funded training programs would be targeted to supervisory and clinical personnel and delivered at small venues to increase effectiveness. Mr. Whitson has indicated his support this proposal.

These three recommendations provide strong financial incentives for improvement in staff retention and key training to help facilities with this improvement. Supervisory training is vital since most clinical staff receive very little management training in their education. Good supervisory and leadership skills are critical for keeping employees regardless of the specific management approach or staff retention approach a facility takes.

Although this is not an exhaustive list, the following reflects some of the approaches that the long term care profession has utilized to reduce turnover:

- Consistent or permanent staffing assignments so the same staff care for the same residents on a day to day basis

- Culture Change is a broad movement that emulates techniques that have been successfully adopted in other industries: Flattening management hierarchies; pushing decision making down to the lowest appropriate staff level; team problem solving and focusing on the customer or Resident Centered Care; management support and appreciation for contribution of all employees
- Career ladders and other opportunities for advancement
- Increased training and educational opportunities
- Better screening of applicants and better orientation programs
- Flexible and self scheduling approaches
- Peer mentoring programs
- Regular reviews of pay and benefit competitiveness
- Consistent policy implementation
- Consistent management staff

Specific examples of implementation by individual facilities or systems of the above approaches include:

- Creation of CNA training centers that require 172 hours of training; 97 more hours than are required by the State. The additional training provides a better understanding to applicants of what it is like to be a CNA in the long term care profession and has led to fewer resignations
- Implementation of a multi-step interview process involving front line staff and management led to a reduction in 90-day terminations (thereby reducing the turnover rate)
- Virtual Campuses (on-line education) provides better access for clinical and professional staff continuing education, as well as training in management, customer service, and specific long term care skills
- Use of advanced leadership training programs for mid-level and upper management, with the goal of improving management techniques and retention that will lead to a reduction in clinical staff turnover
- Consistent monitoring of regional pay scales to ensure that hourly rates are competitive has led to fewer resignations due to low wages
- Implementation a skills test as a screening tool for nurse applicants.
- Increasing the number of orientation shifts from five (5) to ten (10) for new nurses that are recent graduates.
- Implementing a “mentor/mentee” program where the mentor receives a financial bonus if the CNA remains employed after a certain time period.
- Flexible scheduling so that people can change from full-time to part-time as personal issues develop; like wanting to return to school or working part-time due to childcare issues.

## **CONCLUSION**

Indiana’s long term care industry has recognized the importance of reducing turnover and increasing retention. Individual companies and organizations have implemented, and continue to develop, strategies to address turnover and retention. The trade associations representing the profession have worked with FSSA to develop and implement cutting edge reimbursement policies designed to improve quality of care. HOPE, IAHSAs and IHCA are committed to working together and with the legislature and administration to continue to improve the quality of care being delivered to Indiana’s frail and elderly population.



# Indiana Health Coverage Programs

Update to Select Joint Commission on  
Medicaid Oversight

October 25, 2010

**Exhibit M**  
**Select Joint Commission on**  
**Medicaid Oversight**  
**October 25, 2010**

# Indiana Health Coverage Programs

## Volume Statistics, July 2007 through September 2010

	SFY 2008 Jul '07 – Jun '08	SFY 2009 Jul '08 – Jun '09	SFY 2010 Jul '09 – Jun '10	SFY 2011 Jul '10 – Sep '10
<b>Dollars Paid <sup>(a)</sup></b>	\$6,427,600,000	\$5,640,700,000	\$6,136,400,000	\$1,484,100,000
<b>Claims</b>				
Risk Based Managed Care	17,609,333	15,080,731	15,242,671	2,981,390
# Fee-for Svc Paid Claims <sup>(b)</sup>	28,591,064	29,590,516	35,474,838	9,573,503
# Fee-for Svc Denied Claims	15,231,873	13,978,353	15,684,009	4,182,895
% Paid	65.2	67.9	69.3	69.6
Adjudication Days <sup>(c)</sup>	2.5	2.3	2.4	1.9
<b>Providers – MCO &amp; FFS Enrolled <sup>(d)</sup></b>	51,610	52,456	46,669	47,740

a. SFY 2008 through SFY 2010 reflect auditor of state paid values.

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

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

## SFYTD 2011 Claim Statistics (July 2010 – September 2010)

### Top 2 Hard Denial Reasons

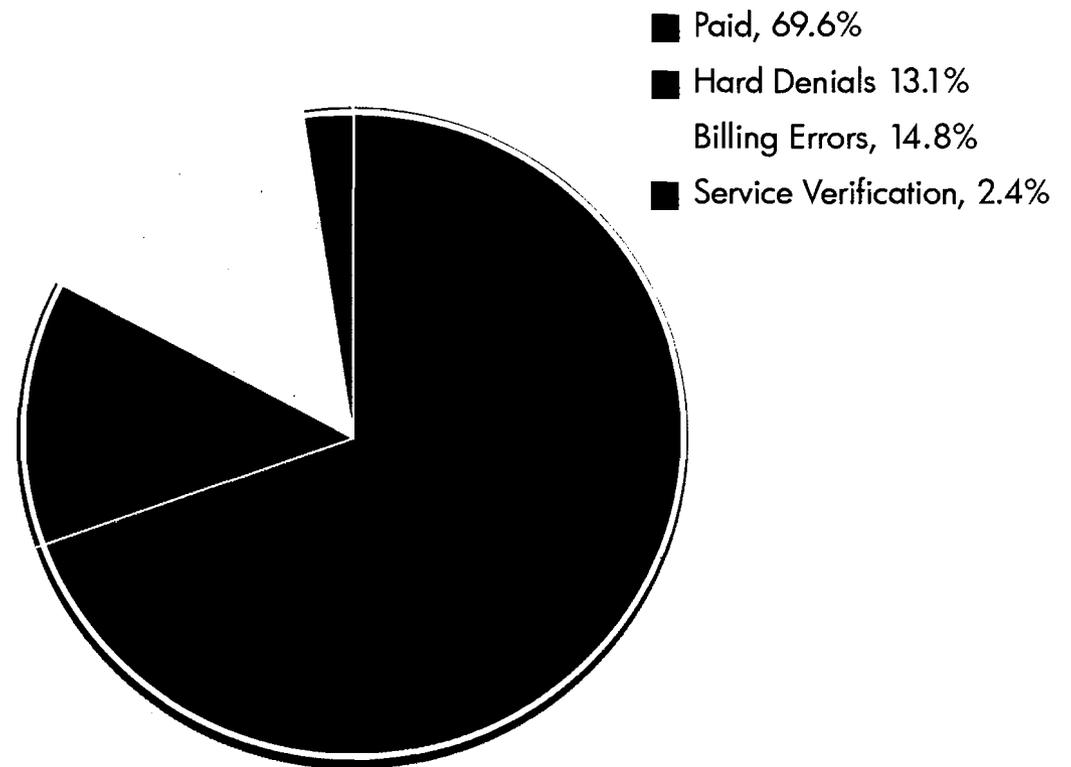
- Other insurance related denials
- Recipient eligibility related denials

### 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 (July 2010 – September 2010)

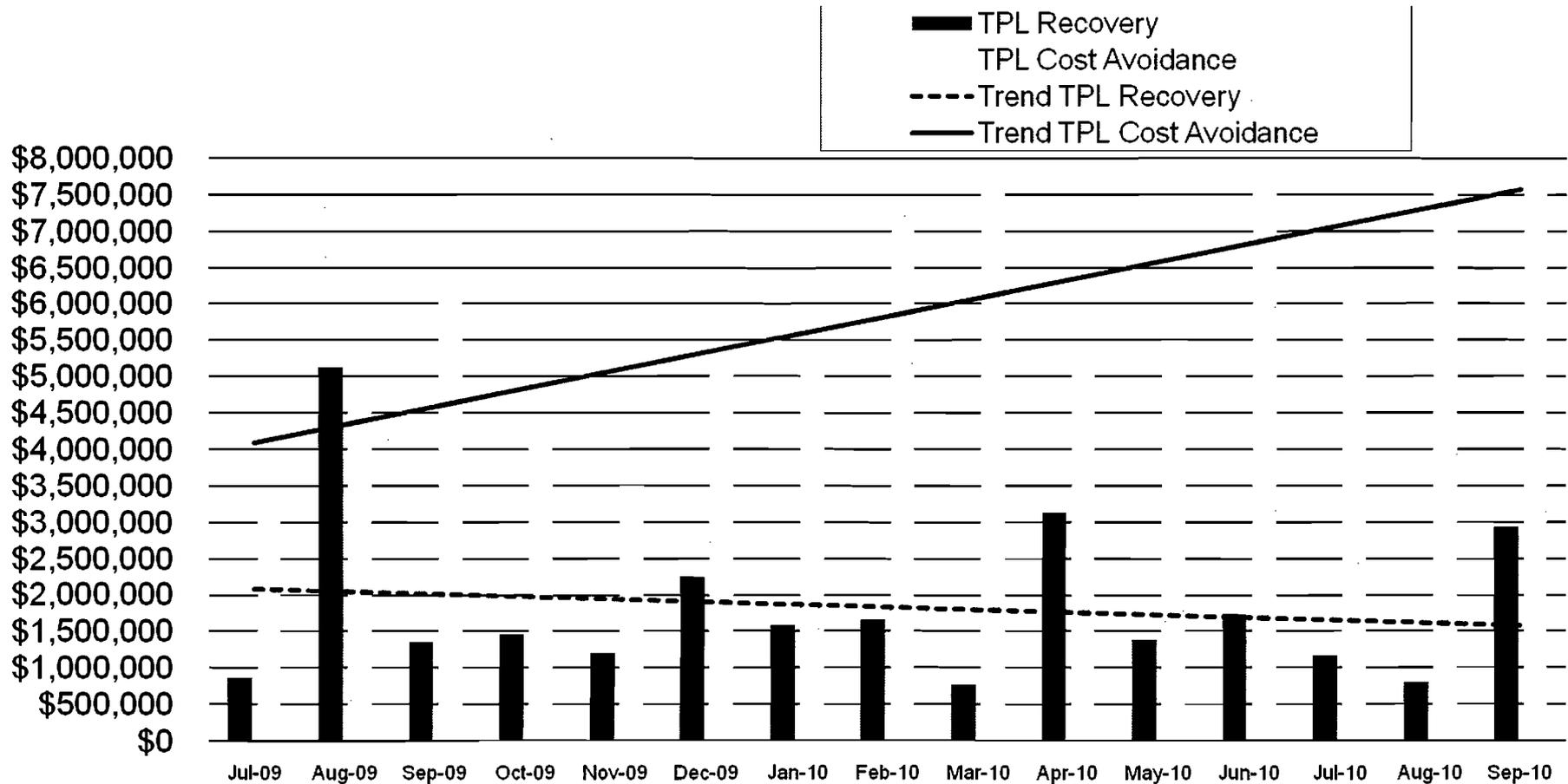
Operational Area	Jul-Sep 2010
<b>Claims Volume</b>	
Fee-for Service (FFS) Electronic	7,373,670
Fee-for Service (FFS) Paper	636,634
Pharmacy	5,746,094
Risk Based Managed Care (RBMC)	<u>2,981,390</u>
Total Claims	16,737,788
Web Claim Volume (included above)	886,814
Percent Electronic Claims	96.2%
<b>Call Center</b>	
Provider Calls	58,507
Recipient Calls	<u>40,438</u>
Total Calls	98,945
Automated Voice Response	148,359
Percent Automated Calls	60.0%
<b>New FFS Provider Enrollments</b>	1,854
<b>Written Correspondence</b>	1,909

Operational Area	Jul-Sep 2010
<b>Claims Inventories: Sep '10 Month End</b>	
Suspended for Manual Adjudication	16,404
Received, Awaiting Data Entry	34,109
Received, Awaiting Attachment	<u>2,308</u>
Total Claims in Inventory	36,417
<b>Publications</b>	
Bulletins	18
Banners	13
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)	0.03
Response Time (Update <= 3 sec)	0.05
(Numbers in parentheses are contractual required minimums/maximums)	



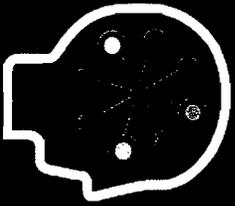
# Indiana Health Coverage Programs

## Third Party Liability Savings, July 2009 – September 2010



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





Technology for better business outcomes

© 2009 Hewlett-Packard Development Company, L.P.  
The information contained herein is subject to change without notice.

