HOUSE BILL No. 1191

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-1.6; IC 12-15.

Synopsis: Medicaid matters. Allows a provider that has entered into a contract with a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, to request an independent review of the managed care organization's action with an independent third party provider selected by the office of Medicaid policy and planning. Establishes a procedure for an independent third party provider to review an action of a managed care organization. Prohibits a provision in a contract between a provider and a managed care organization that would negate or restrict the right of a provider to an independent review and provides that such a contract provision is void and unenforceable. Provides that if the office of the secretary of family and social services (office) or a contractor of the office fails to pay or denies a clean claim for any eligible Medicaid service within certain time limits due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or managed care organization, the office or contractor may not assert that the provider failed to meet the timely filing requirements for the claim. Changes the membership of the Medicaid advisory committee (committee). Allows a member of the committee whose position was eliminated to continue to serve until the member's term expires. Establishes co-chairs for the committee and provides that the elected co-chair of the committee serves for a two year term. Requires the office to prepare a report that describes every type of report that must be prepared by a Medicaid contractor or managed care entity and submitted to the office or the office of Medicaid policy and planning.
(Continued next page)

Effective: July 1, 2024.

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January 9, 2024, read first time and referred to Committee on Public Health.

Digest Continued

Specifies the information that must be contained in the report. Requires the office to submit the report to the committee and the general assembly. Requires the committee to hold public hearings on the report. Makes technical changes.

Introduced

Second Regular Session of the 123rd General Assembly (2024)

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

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

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2023 Regular Session of the General Assembly.

HOUSE BILL No. 1191

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

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

SECTION 1. IC 12-7-2-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 1.6. "Administrator of the office" refers to the administrator of the office of Medicaid policy and planning appointed under IC 12-8-6.5-2.**

SECTION 2. IC 12-15-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 11. (a) As used in this section, "action" means:**

(1) a denial of reimbursement for claims submitted for covered services to an applicant, a pending applicant, a conditionally eligible individual, or a member; or

(2) a reduction in reimbursement for claims submitted for covered services to an applicant, a pending applicant, a conditionally eligible individual, or a member.

(b) As used in this section, "contracted provider" means a provider that has entered into a contract with a managed care organization or a contractor of the office.

(c) As used in this section, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6.5-1.

(d) Except as provided in this section, the right of a provider contracting with a managed care organization to dispute an action by the managed care organization is governed by the provider's contract with the managed care organization.

(e) A contracted provider that is directly affected by an action of a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, may file a request for an independent review of the managed care organization's action with an independent third party provider selected by the office.

(f) The office shall establish the procedures and protocols for an independent review under this section, which must include the following:

(1) The review must be initiated by the filing of a request for an independent review by the contracted provider.

(2) The independent review shall be conducted by an independent third party provider that:

(A) is not related to or affiliated with the contracted provider or the managed care organization;

(B) has the medical knowledge necessary to review the medical issues presented in the review; and

(C) shall write a final decision concerning the action of the managed care organization.

(3) The primary focus of the independent review must be the medical necessity and other medically appropriate issues concerning the action of the managed care organization.

(4) The final decision of the independent third party provider is binding on the parties and may not be appealed. However, if the contracted provider or managed care organization proves to the office's satisfaction that the independent third party provider did not materially follow the office's policies and procedures, the office, in its sole discretion, may allow a new review by a different independent third party provider.

(g) The office shall establish a fee schedule, based on the level of review that is required, for the independent review under this section. The fee must be paid to the independent third party provider upon completion of the provider's responsibilities under

this section.

(h) The procedure, time limits, and other provisions set forth in 405 IAC 1.1-1 for appeals concerning applicants and recipients of Medicaid apply to reviews under this section.

(i) Notwithstanding subsection (e), a contracted provider may not file for an independent review under this section until after December 31, 2025. This subsection expires January 1, 2026.

SECTION 3. IC 12-15-11-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12. (a) A contract between a provider and a managed care organization shall not negate or restrict the right of a provider to an independent review under section 11 this chapter.**

(b) A contract provision that violates subsection (a) is void and unenforceable.

SECTION 4. IC 12-15-13-1.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1.7. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(c) If:

(1) the office fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the office or a contractor of the office under IC 12-15-30 subsequently pays the claim;

the office shall pay the provider that submitted the claim interest on the Medicaid allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c) shall:

(1) begin accruing:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stop accruing on the date the claim is paid.

(e) In paying interest under subsection (c), the office shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

(f) If the office or a contractor of the office denies or fails to pay a clean claim for any eligible Medicaid service within the time allowed by subsection (b) due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or a managed care organization, the office or contractor may not assert that the provider failed to meet the timely filing requirements for the claim.

SECTION 5. IC 12-15-33-3, AS AMENDED BY P.L.140-2019, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) The committee shall be appointed as follows:

(1) One (1) member shall be appointed by the administrator of the office to represent each of the following organizations:

(A) Indiana Council of Community Mental Health Centers.

(B) Indiana State Medical Association.

(C) Indiana State Chapter of the American Academy of Pediatrics.

(D) Indiana Hospital Association.

(E) Indiana Dental Association.

(F) Indiana State Psychiatric Association.

(G) Indiana State Osteopathic Association.

(H) Indiana State Nurses Association.

(I) Indiana State Licensed Practical Nurses Association.

(J) Indiana State Podiatry Association.

(K) Indiana Health Care Association.

(L) Indiana Optometric Association.

(M) Indiana Pharmaceutical Association.

(N) Indiana Psychological Association.

(O) Indiana State Chiropractic Association.

(P) Indiana ~~Ambulance~~ **Emergency Medical Services** Association.

(Q) Indiana Association for Home **and Hospice** Care.

(R) Indiana Academy of Ophthalmology.

(S) Indiana ~~Speech and Hearing~~ **Speech-Language-Hearing** Association.

(T) Indiana Academy of Physician Assistants.

(U) Indiana Association of Rehabilitation Facilities.

(V) Indiana Association of Health Plans.

(W) Indiana Primary Health Care Association.

(2) Ten (10) members shall be appointed by the governor as follows:

~~(A) One (1) member who represents agricultural interests.~~

~~(B)~~ **(A)** One (1) member who represents business and industrial interests.

~~(C)~~ **(B)** One (1) member who represents labor interests.

~~(D)~~ **(C)** One (1) member who represents insurance interests.

~~(E) One (1) member who represents a statewide taxpayer association.~~

~~(F) Two (2) members who are parent advocates.~~

~~(G) Three (3) members who represent Indiana citizens.~~

(D) A representative nominated by AARP Indiana.

(E) A representative nominated by The Arc of Indiana.

(F) A representative nominated by the Indiana Minority Health Coalition.

(G) A representative nominated by the Indiana Rural Health Association.

(H) A representative nominated by Mental Health America of Indiana.

(I) A representative nominated by an Alzheimer's Association chapter that provides services in at least one (1) county in Indiana.

(J) A representative nominated by a United Way that provides services in at least one (1) county in Indiana.

(3) Six (6) members shall be appointed by the president pro tempore of the senate acting in the capacity as president pro tempore of the senate to represent the senate. Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.

(4) Six (6) members shall be appointed by the speaker of the house of representatives to represent the house of representatives. Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.

(5) The governor shall rotate the appointment of:

(A) a member of a chapter described in subdivision (2)(I) among the chapters described in subdivision (2)(I); and

(B) a member of a United Way described in subdivision (2)(J) among the United Ways described in subdivision (2)(J).

(b) Notwithstanding subsection (a)(3), after consultation with the

minority leader of the senate, the president pro tempore of the senate shall appoint three (3) of the members from the minority party of the senate.

(c) Notwithstanding subsection (a)(4), after consultation with the minority leader of the house of representatives, the speaker of the house shall appoint three (3) of the members from the minority party of the house.

SECTION 6. IC 12-15-33-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 5. **(a)** An appointment to the committee is for a four (4) year term, except the representatives of the senate and house of representatives, whose terms coincide with the representative's or senator's respective legislative terms.

(b) Notwithstanding any other law, an individual:

(1) who was a member of the committee and was appointed under section 3 of this chapter before July 1, 2024;

(2) who on June 30, 2024, had at least one (1) year remaining on the member's term; and

(3) whose position to be appointed on the committee was eliminated on July 1, 2024;

may continue to serve as a member of the committee until the member's original term expires. This subsection expires July 1, 2027.

SECTION 7. IC 12-15-33-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 7. **(a)** The administrator of the office **and a member of the committee who is elected at the last meeting of the committee during an odd-numbered year** shall serve as ~~secretary~~ **co-chairs** of the committee.

(b) The member of the committee who is elected co-chair under this section shall serve as co-chair for a term of two (2) years.

SECTION 8. IC 12-15-33-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9. The committee shall do the following:

(1) Meet at least four (4) times each year, one (1) time in each calendar quarter.

(2) Hold special meetings that the committee or ~~the secretary~~ **a co-chair** requests.

SECTION 9. IC 12-15-33-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 11. (a) The office of the secretary shall prepare a report that describes every type of report that must be prepared by a Medicaid contractor or managed care entity and submitted to the office of the secretary or the office. The report**

must contain the following information:

(1) The name or type of each report that contains only information that is required by federal law or a federal agency.

(2) The name or type of each report that contains information that is required by state law or a state agency.

(b) For the reports that are identified under subsection (a)(2), the report must contain the following information for each type of report:

(1) The purpose of the report.

(2) Entities that use the reported information.

(3) The manner in which the information is being used.

(4) Whether there is information that is required in the report that is not being actively used.

(5) Whether there is information in the report that is duplicated in another report.

(6) Any data from the report or aggregate data that is available to the public.

(c) The report required under this section must contain the following information:

(1) Any process that is used to evaluate the purpose and use of the reports, including consolidating or eliminating reports.

(2) Recommendations on how to make information from the reports and data held by the office of the secretary that is compliant with the federal Health Insurance Portability and Accountability Act (HIPAA) available to the general assembly, Medicaid contractors, managed care entities, and the public to be used for accountability, policymaking, and innovation purposes.

(d) The report required under this section must be submitted before October 1, 2024, to the:

(1) committee; and

(2) general assembly in an electronic format under IC 5-14-6.

(e) The committee:

(1) shall hold public hearings on the report; and

(2) may make recommendations to the office of the secretary and the general assembly.

(f) This section expires July 1, 2025.