HOUSE BILL No. 1194

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15-1.3-25; IC 12-15-12-11.6.

Synopsis: Risk based managed care and integrated care. Requires the office of the secretary of family and social services (office of the secretary) to apply to the United States Department of Health and Human Services for a Medicaid waiver or state plan amendment to implement, not earlier than January 1, 2024, a fee for service integrated care model program for specified category of Medicaid recipients. Sets forth requirements of the program. Sets forth certain requirements, including contract requirements for any contract between the office of the secretary and specified entities, in the operation of a risk based managed care program or integrated care model program for the specified covered population.

Effective: Upon passage.

Karickhoff, Lehman, Barrett, Clere

January 6, 2022, read first time and referred to Committee on Public Health.

Introduced

Second Regular Session of the 122nd General Assembly (2022)

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 2021 Regular Session of the General Assembly.

HOUSE BILL No. 1194

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

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

SECTION 1. IC 12-7-2-1.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.1. "Accountable care organization", for purposes of IC 12-15-1.3-25, has the meaning set forth in IC 12-15-1.3-25(b).**

SECTION 2. IC 12-7-2-48.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 48.8. "Covered population", for purposes of IC 12-15-12-11.6, has the meaning set forth in IC 12-15-12-11.6(b).**

SECTION 3. IC 12-7-2-77.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 77.3. "Entity", for purposes of IC 12-15-12-11.6, has the meaning set forth in IC 12-15-12-11.6(c).**

SECTION 4. IC 12-7-2-103.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 103.4. "Health plan", for**

purposes of IC 12-15-1.3-25, has the meaning set forth in IC 12-15-1.3-25(c).

SECTION 5. IC 12-7-2-144.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 144.8. "Primary care case management entity", for purposes of IC 12-15-1.3-25 and IC 12-15-12-11.6, has the meaning set forth in IC 12-15-1.3-25(d).**

SECTION 6. IC 12-15-1.3-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 25. (a) This section does not apply to the following Medicaid recipients:**

(1) A recipient participating in the Program of All-Inclusive Care for the Elderly described in IC 12-15-43.

(2) A recipient participating in any Medicaid waiver administered by the office of the secretary in conjunction with the division of disability and rehabilitative services.

(3) A recipient participating in the residential care assistance program described in IC 12-10-6.

(4) A recipient who is either participating in the traumatic brain injury Medicaid waiver or is receiving traumatic brain injury services out of state.

(5) A recipient enrolled in the Medicare shared savings program (42 CFR 425).

(6) A recipient who is only eligible for emergency services.

(b) As used in this section, "accountable care organization" means a legal organization formed under Indiana law that is comprised of any type or combination of health care providers enrolled in the Medicaid program, including:

(1) physicians licensed under IC 25-22.5;

(2) advanced practice registered nurses licensed under IC 25-23;

(3) hospitals licensed under IC 16-21;

(4) hospices licensed under IC 16-25;

(5) home health agencies licensed under IC 16-27;

(6) health facilities licensed under IC 16-28; or

(7) intermediate care facilities for individuals with intellectual disabilities;

and may include a health plan.

(c) As used in this section, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1), excluding coverage described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(d) As used in this section, "primary care case management entity" has the meaning set forth in 42 CFR 438.2.

(e) The office of the secretary shall apply to the United States Department of Health and Human Services for any state plan amendment or any Medicaid waiver necessary to implement a fee for service integrated care model for a Medicaid recipient who:

(1) is eligible to participate in the federal Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services; or

(2) is:

(A) over sixty (60) years of age;

(B) blind, aged, or disabled; and

(C) receiving services through one (1) of the following:

(i) The aged and disabled Medicaid waiver.

(ii) A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate in the federal Medicare program.

(iii) State Medicaid plan services.

The office of the secretary may not implement a state plan amendment or Medicaid waiver applied for under this section and approved before January 1, 2024.

(f) In developing an integrated care model program applied for in subsection (e), the office of the secretary shall do the following:

(1) Coordinate with the division of aging to incorporate services currently available on the aged and disabled Medicaid waiver in a new integrated care model.

(2) Coordinate with and engage Medicaid recipients, area agencies on aging, and health care providers, including health care providers that provide services to Medicaid recipients described in subsection (e), in the implementation and administration of the program.

(3) Contract with primary care case management entities or accountable care organizations in each designated geographical region or on a statewide basis to deliver services and perform activities.

(g) A contract with a primary care case management entity or an accountable care organization required under subsection (f)(3) may include quality incentive payments or shared savings payments based on defined performance periods. Primary care

case management entities and accountable care organizations may engage with health plans in contracting with the office of the secretary under this section.

SECTION 7. IC 12-15-12-11.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.6. (a) This section applies to an entity that seeks to contract with or contracts with the office of the secretary for the following:**

(1) A risk based managed care program authorized under:

(A) Section 1115;

(B) Section 1915(b); or

(C) Section 1915(c);

of the federal Social Security Act, or a combination of any of the waivers described in clauses (A) through (C), for the covered population.

(2) An integrated care model authorized under IC 12-15-1.3-25.

(b) As used in this section, "covered population" means a Medicaid recipient who:

(1) is eligible to participate in the federal Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services; or

(2) is:

(A) over sixty (60) years of age;

(B) blind, aged, or disabled; and

(C) receiving services through one (1) of the following:

(i) The aged and disabled Medicaid waiver.

(ii) A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate in the federal Medicare program.

(iii) State Medicaid plan services.

(c) As used in this section, "entity" refers to either of the following:

(1) A managed care organization that seeks to contract with or contracts with the office of the secretary to provide services for a risk based managed care program described in subsection (a)(1) for the covered population.

(2) An entity that seeks to contract with or contracts with the office of the secretary to provide services in the implementation of an integrated care model described in subsection (a)(2) for the covered population.

(d) Before the office of the secretary may contract with an entity

for a program described in subsection (a), the office of the secretary shall ensure that the entity meets the following:

(1) Has Indiana based staff and leadership with long term services and supports experience, including at least one (1) geriatrician licensed to practice in Indiana.

(2) Employs management with expertise and experience in long term services and supports, including either providing long term services and supports or being employed by a provider of long term services and supports, including the following provider types:

(A) Nursing facilities.

(B) Residential care facilities.

(C) Home health agencies.

(D) Hospices.

(E) Family caregivers.

(F) Social workers.

(G) Nurses.

(H) Behavioral health specialists.

(I) Care and case managers.

(e) The office of the secretary must include the following provisions in any contract with an entity for a program described in subsection (a):

(1) Provider credentialing requirements.

(2) An independent appeals process for the resolution of claims disputes and denials of prior authorization for services for recipients.

(3) A requirement that the tender of a provider agreement occurs at least ninety (90) days before the effective date of the agreement.

(4) Provider agreement termination provisions that include the following:

(A) Health care providers may be terminated by an entity for cause only, and limited to:

(i) termination of the provider from the Medicare program or the Medicaid program by the United States Department of Health and Human Services or the office of the secretary;

(ii) a provider's loss of licensure or certification by a state agency; or

(iii) a regulatory action that has the effect of permanently rendering the provider unable or ineligible to deliver Medicare or Medicaid services.

(B) Termination must:

(i) occur by written notice to the provider that includes any reason for the termination;

(ii) include an explanation of the standards and information used to evaluate the provider;

(iii) include the criteria used in the decision to terminate the provider; and

(iv) include information concerning the provider's right to appeal the determination and an explanation of the appellate procedure.

(5) Prompt payment requirements that comply with IC 12-15-13 and include a liquidated damages provision that contains financial penalties as described in subdivision (6)(B) for failure to meet the prompt payment requirements.

(6) Standardized processes for provider claims appeals, including:

(A) provider claims payment appeals with second level appeals administered by the office of the secretary to ensure unbiased adjudication of the claims payment appeal; and

(B) financial penalties of not less than ten percent (10%) of the total claim allowed charges based on the current:

(i) Medicare fee for service fee schedule; or

(ii) Indiana Medicaid fee schedule;

as applicable, for all claims denials or underpayments overturned at the first or second appeal level.

(7) A description of the medical necessity criteria that must include enhanced protections for the covered population concerning the coverage of services that are more limited or are not addressed in commercially available resources that address utilization management and medical necessity.

(8) A requirement addressing continuation of reimbursement to a provider when a recipient is transferred or discharged from a nursing facility under 410 IAC 16.2-3.1-12 or a residential care facility under 410 IAC 16.2-5-1.2, or any other subsequent rule or statute, concerning transfer or discharge until:

(A) the transfer or discharge is complete, even if an extended stay has not been approved; and

(B) any appeal right has been exhausted or expired.

(9) A requirement to provide a recipient and the recipient's family with:

(A) freedom of choice in selecting a provider of services, including choice of a nursing facility;

(B) individualized information concerning whether the provider network includes the providers with whom the recipient has an established patient relationship, including an attestation or similar documentation from the recipient or the recipient's responsible party concerning the providers and services that were included in the information provided and the provider and services selected;

(C) adequate time for the recipient and the recipient's family to make a decision concerning providers and services; and

(D) a new health care or services provider determined not later than three (3) days from request by the recipient or the recipient's responsible party.

(10) A prohibition on payment arrangements or other contract terms that:

(A) reimburse providers at enhanced rates; or

(B) offer other inducements;

in exchange for steering, exclusivity, or other activities that have the effect of limiting consumer choice.

(11) A description of the managed care organization's or entity's role in:

(A) discharge planning;

(B) imposing prior authorization requirements; and

(C) the process for appealing adverse determinations, including the process for expedited appeals and second level appeals of adverse determination.

(12) A requirement that capacity for prior authorization determinations for services must be available twenty-four (24) hours a day, seven (7) days a week, and:

(A) be resolved not later than:

(i) twenty-four (24) hours from the submission of the request for urgent and expedited requests; and

(ii) forty-eight (48) hours for all other requests;

(B) be reviewed and completed by a physician licensed under IC 25-22.5 with:

(i) specialty experience in the primary diagnosis for which the prior authorization is requested;

(ii) demonstrated experience in treating aged or disabled individuals; and

(iii) knowledge of long term services and supports provider operations;

(C) include a requirement that failure to render a prior authorization determination in the time set forth in clause (A) deems the prior authorization approved without retroactive denial, additional documentation requests, or payment denial except as may be required to:

(i) conform with consumer retroactive loss of eligibility or disenrollment;

(ii) address criminal activity or fraud; or

(iii) address waste and abuse investigations promulgated by the federal government, state government, or a law enforcement agency; and

(D) may not be denied for a member of the covered population who is in need of:

(i) hospital services, as determined by the individual's primary care provider; or

(ii) nursing facility service when the member chooses nursing facility services and meets the level of care criteria determined by the office of the secretary under 405 IAC 1-3, or a successor law or regulation.

(13) A requirement to comply with this chapter concerning the coverage of emergency services.

(14) A requirement that care management staff and managers:

(A) meet minimum qualifications, including:

(i) either having a degree in social work or being licensed as a registered nurse under IC 25-23; and

(ii) having at least two (2) years experience in providing care or case management services to older adults;

(B) are based in Indiana and available twenty-four (24) hours a day through telephone or other means; and

(C) have access to case management and medical information systems necessary to facilitate continuity of care to work with the office of the secretary and other agencies on resolving urgent matters impacting recipients, including:

(i) public emergencies;

(ii) fires; or

(iii) severe care deficiencies.

(15) A prohibition on requiring any health care provider to exclusively contract with the primary care case management

entity or a managed care organization.

(16) A requirement for reimbursement for a managed care organization or an entity in an integrated care model to comply with:

(A) 42 CFR 438.206(b)(4) concerning out of network provider access;

(B) the applicable network adequacy requirements; and

(C) 42 CFR 438.206(b)(5) concerning cost sharing for out of network provider access;

at no additional cost to the recipient.

(17) A requirement that all authorized and routine care provided by an out of network provider must be covered and reimbursed at a rate that is at least one hundred percent (100%) of the Medicaid fee for service rate unless a negotiated rate has been agreed upon by all parties. However, an out of network provider may be subject to prior authorization requirements for non self referral or nonemergency services.

(18) Network adequacy requirements that at least meet the requirements of the current guidance from the Centers for Medicare and Medicaid Services and that are applicable to organizations that participate in Medicare Advantage plans.

(19) A requirement that a managed care organization that also offers a dual eligible special needs plan under the Medicare program enter into a subcapitation agreement with an institutional or institutional equivalent special needs plan under the Medicare program for any of the Medicaid services the office of the secretary has contracted to the managed care organization when:

(A) the Medicaid recipient chooses to enroll in an institutional or institutional equivalent special needs plan under the Medicare program; and

(B) the institutional or institutional equivalent special needs plan files a notice with the office of the secretary detailing the Medicaid services that will be subject to a subcapitation agreement with the managed care organization.

(f) The office of the secretary shall determine all eligibility requirements and level of care criteria for a program described in subsection (a) and may not contract out or otherwise delegate this requirement. In determining the eligibility requirements and the level of care criteria under this subsection, the office of the

secretary shall consider input from stakeholders and providers engaged in providing nursing facility care and long term services and supports.

(g) The office of the secretary shall determine the base reimbursement rate structure, methodology, and reimbursement rates that may be paid to a provider for the services performed in a program described in subsection (a). An entity that has contracted with the office of the secretary to operate a program described in subsection (a) may not pay less than the reimbursement rates established by the office of the secretary unless the lower amount is:

(1) agreed upon by the contracted entity and the provider; and

(2) approved by the office of the secretary.

(h) A managed care organization shall contract with any provider that is:

(1) licensed under state law;

(2) for a nursing facility, certified by the United States Department of Health and Human Services to provide services under the Medicaid or Medicare program; and

(3) willing to contract with the managed care organization to provide the services;

under the same terms and conditions that are offered by the managed care organization to any other participating provider that has contracted with the managed care organization to provide that service under any policy, contract, or plan for the risk based managed care program described in this section. The terms and conditions for the services must set forth the minimum reimbursement rates established by the office of the secretary under subsection (g).

(i) Except as set forth in subsections (j) and (k), a managed care organization or an entity operating an integrated care model described in subsection (a) may not delegate or subcontract to third parties any function concerning:

(1) provider contracting;

(2) credentialing;

(3) recipient appeals;

(4) claims processing;

(5) care management;

(6) pharmacy benefit management; and

(7) prior authorization.

(j) If a managed care organization or entity described in

subsection (a) determines to delegate or subcontract a function set forth in subsection (i), the managed care organization or entity must provide at least one hundred twenty (120) days written notice to the office of the secretary that includes the following:

(1) A written plan that specifies how each subcontractor will fulfill each of the delegated or contracted services.

(2) Information concerning continuity of services during the transition to the delegated or subcontracted entity.

The office of the secretary must approve or deny any delegation or subcontract requested under this subsection, and only a delegation or subcontract approved by the office of the secretary may go into effect.

(k) Any change or amendment to the delegation or subcontract previously granted by the office of the secretary under subsection (j) must be submitted in writing to the office of the secretary at least one hundred twenty (120) days before the requested implementation date with sufficient written detail concerning the amendment that specifies how the delegated or subcontracted services will be fulfilled. The office of the secretary must approve or deny the requested amendment and only an approved change or amendment may be implemented.

SECTION 8. **An emergency is declared for this act.**