Reprinted
April 15, 2015

ENGROSSED
HOUSE BILL No. 1269

DIGEST OF HB 1269 (Updated April 14, 2015 5:58 pm - DI 104)

Citations Affected: IC 5-10; IC 11-10; IC 11-12; IC 12-15; IC 12-21; IC 16-18; IC 16-31; IC 16-36; IC 20-20; IC 20-28; IC 20-34; IC 27-8; IC 27-13; IC 36-2; noncode.

Synopsis: Health matters. Makes the department of correction (DOC) an inmate's authorized representative for applying for Medicaid for inmates who are potentially eligible for Medicaid and who incur medical care expenses that are not otherwise reimbursable. Requires the DOC and the office of the secretary of family and social services to enter into an agreement in which the DOC pays the state share of the Medicaid costs incurred for the inmate. Makes the sheriff the individual's authorized representative for applying for Medicaid for individuals subject to lawful detention who are potentially eligible for Medicaid. Requires a sheriff to enter into an agreement with the office of the secretary of family and social services to pay the state share of the Medicaid costs incurred for the individuals. Specifies reimbursement for the services provided. Provides that the DOC or the county shall assist a committed offender in applying for Medicaid and securing certain treatment upon discharge from the DOC or a county
(Continued next page)

Effective: July 1, 2015; January 1, 2016.

Clere, Steuerwald, Brown C, Pierce

(SENATE SPONSORS — MILLER PATRICIA, CRIDER, YOUNG R MICHAEL, STOOPS, BECKER, ALTING)

January 13, 2015, read first time and referred to Committee on Public Health.
February 19, 2015, amended, reported — Do Pass.
February 23, 2015, read second time, ordered engrossed. Engrossed.
February 24, 2015, read third time, passed. Yeas 95, nays 0.

SENATE ACTION

March 2, 2015, read first time and referred to Committee on Health & Provider Services.
April 9, 2015, amended, reported favorably — Do Pass.
April 14, 2015, read second time, amended, ordered engrossed.

jail. Specifies providers that may be used to provide treatment for DOC inmates and county jail offenders. Requires the office of Medicaid policy and planning (office) to prepare an annual report concerning the use of qualified providers to provide presumptive eligibility services. Allows a community mental health center to use the center's provider identification number to file any Medicaid claim, including primary care health service, if certain conditions are met. Prohibits the office from limiting the filing by a community mental health center of primary care health services and mental health services for a recipient if the services are covered services and necessary to ensure coordinated care for the recipient. Requires the division of mental health and addiction to develop a mental health first aid training program. Includes a mental health first aid training program in the: (1) continuing education programs promoted by the emergency medical services commission; and (2) basic or inservice course of education and training for teaching professionals beginning in the 2016-2017 school year. Establishes the mental health counselor licenses for school counselors grant. Authorizes a school corporation to enter into a memorandum of understanding with a mental health care provider or a community mental health center to establish conditions or terms for referring students of the school corporation for services. Requires the school corporation to obtain written parental consent before referring a student to mental health services and limits mental health information that may be included in the student's record. Prohibits a school counselor or other school corporation employee from diagnosing a student as having a mental health condition. Specifies that, if a health care treatment or procedure has been routinely covered by the Medicare program or the Medicaid program during the three preceding years, an insurer or health maintenance organization may not deny coverage on the basis that the procedure or treatment is investigational or experimental. Provides for coverage of telemedicine services under a policy of accident and sickness insurance and a health maintenance contract. Prohibits a health care provider from being required to obtain a separate additional written health care consent for the provision of telemedicine services. Requires the department of insurance to review specified information concerning denied insurance claims and report certain information before October 1, 2015, to the legislative council and the public health, behavioral health, and human services interim study committee.

Reprinted
April 15, 2015

First Regular Session of the 119th General Assembly (2015)

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 2014 Regular Session and 2014 Second Regular Technical Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1269

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

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

SECTION 1. IC 5-10-8-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 17. If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, a self-insurance program established under section 7(b) of this chapter or a contract with a prepaid health coverage plan entered into under section 7(c) of this chapter shall not limit or deny coverage of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**

SECTION 2. IC 11-10-3-6, AS AMENDED BY P.L.205-2013, SECTION 169, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 6. (a) This section:

(1) does not apply in the case of a person who is subject to lawful

detention by a county sheriff and is:

(A) covered under private health coverage for health care services; or

(B) willing to pay for the person's own health care services; ~~and~~

(2) does not apply to an inmate receiving inpatient services under section 7 of this chapter; and

~~(2)~~ **(3)** does not affect copayments required under section 5 of this chapter.

(b) The following definitions apply throughout this section:

(1) "Charge description master" means a listing of the amount charged by a hospital for each service, item, and procedure:

(A) provided by the hospital; and

(B) for which a separate charge exists.

(2) "Health care service" means the following:

(A) Medical care.

(B) Dental care.

(C) Eye care.

(D) Any other health care related service.

The term includes health care items and procedures.

(c) Except as provided in subsection (d), when the department or a county is responsible for payment for health care services provided to a person who is committed to the department, the department shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) another health care provider;

for the cost of a health care service at the federal Medicare reimbursement rate for the health care service provided plus four percent (4%).

(d) If there is no federal Medicare reimbursement rate for a health care service described in subsection (c), the department shall do the following:

(1) If the health care service is provided by a hospital, the department shall reimburse the hospital an amount equal to sixty-five percent (65%) of the amount charged by the hospital according to the hospital's charge description master.

(2) If the health care service is provided by a physician or another health care provider, the department shall reimburse the physician or health care provider an amount equal to sixty-five percent (65%) of the amount charged by the physician or health care provider.

SECTION 3. IC 11-10-3-7, AS ADDED BY P.L.205-2013, SECTION 170, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 7. **(a)** If the department or a county incurs medical care expenses in providing medical care to an inmate who is committed to the department and the medical care expenses are not reimbursed, the department or the county shall attempt to determine the amount, if any, of the medical care expenses that may be paid:

(1) by a policy of insurance that is maintained by the inmate and that covers medical care, dental care, eye care, or any other health care related service; or

(2) by Medicaid.

(b) For an inmate who:

(1) is committed to the department and resides in a department facility or jail;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable;

(3) is unwilling or unable to pay for the inmate's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15);

the department is the inmate's Medicaid authorized representative and may apply for Medicaid on behalf of the inmate.

(c) The department and the office of the secretary of family and social services shall enter into a written memorandum of understanding providing that the department shall reimburse the office of the secretary for administrative costs and the state share of the Medicaid costs incurred for an inmate.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to an inmate as an inpatient in a hospital must be as follows:

(1) For inmates eligible and participating in the Indiana check-up plan (IC 12-15-44.2), the reimbursement rates described in IC 12-15-44.2-14.

(2) For inmates other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of

health care services provided to the inmate as an inpatient in the hospital.

SECTION 4. IC 11-10-12-5.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 5.3. (a) The department shall assist a committed offender in applying for Medicaid, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the committed offender might be eligible for assistance when the offender is subsequently:**

(1) released on parole;

(2) assigned to a community transition program; or

(3) discharged from the department.

(b) The department shall provide the assistance described in subsection (a) in sufficient time to ensure that the committed offender will be able to receive assistance at the time the committed offender is:

(1) released on parole;

(2) assigned to a community transition program; or

(3) discharged from the department.

(c) The department shall implement the requirements under this section to establish an inmate's Medicaid coverage regardless of the inmate's medical need. Upon a determination that the inmate qualifies for Medicaid coverage, the office of the secretary of family and social services, division of family resources, shall authorize and then immediately suspend Medicaid coverage for those inmates not requiring immediate medical attention.

SECTION 5. IC 11-10-12-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 5.7. (a) The department shall assist a committed offender who has a mental illness or addictive disorder in securing treatment through an approved Medicaid program, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the committed offender might be eligible for treatment when the offender is:**

(1) released on parole;

(2) assigned to a community transition program;

(3) discharged from the department; or

(4) required to receive inpatient psychiatric services while incarcerated to the extent authorized under federal law.

(b) The department shall provide the assistance described in subsection (a) in sufficient time to ensure that the committed offender will be able to receive treatment at the time the committed offender is:

(1) released on parole;

(2) assigned to a community transition program; or

(3) discharged from the department.

(c) Subject to federal approval, an inmate placed in a work release program or other department program involving alternative sentencing programs is eligible for Medicaid covered services.

(d) The department may use a community mental health center (as defined in IC 12-7-2-38), hospital, mental health professional, or other provider certified or licensed by the division of mental health and addiction to provide treatment for a mental illness or addictive disorder through the Medicaid program.

SECTION 6. IC 11-12-3.8-1, AS ADDED BY P.L.184-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 1. As used in this chapter, "mental health and addiction forensic treatment services" means evidence based treatment and recovery wraparound support services provided to individuals who have entered the criminal justice system as a felon or with a prior felony conviction. The term includes:

(1) mental health and substance abuse treatment **assessments;**

(2) vocational services;

(3) housing assistance;

(4) community support services;

(5) care coordination; and

(6) transportation assistance.

SECTION 7. IC 11-12-5-5.5, AS AMENDED BY P.L.205-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 5.5. (a) As used in this section, "charge description master" means a listing of the amount charged by a hospital for each service, item, and procedure:

(1) provided by the hospital; and

(2) for which a separate charge exists.

(b) As used in this section, "health care services" includes health care items and procedures.

(c) As used in this section, "lawful detention" means the following:

(1) Arrest.

(2) Custody following surrender in lieu of arrest.

(3) Detention in a penal facility.

(4) Detention for extradition or deportation.

(5) Custody for purposes incident to any of the above, including transportation, medical diagnosis or treatment, court appearances, work, or recreation.

The term does not include supervision of a person on probation or parole or constraint incidental to release with or without bail.

(d) This section:

(1) does not apply in the case of a person who is subject to lawful detention by a county sheriff and is:

(A) covered under private health coverage for health care services; or

(B) willing to pay for the person's own health care services; ~~and~~

(2) does not apply to an inmate receiving inpatient services under IC 36-2-13-19; and

~~(2)~~ **(3)** does not affect copayments required under section 5 of this chapter.

(e) Except as provided in subsections (f) and (g), a county that is responsible for payment for health care services provided to a person who is subject to lawful detention by the county's sheriff shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) another health care provider;

for the cost of a health care service at the federal Medicare reimbursement rate for the health care service provided plus four percent (4%).

(f) Except as provided in subsection (g), if there is no federal Medicare reimbursement rate for a health care service described in subsection (e), the county shall do the following:

(1) If the health care service is provided by a hospital, the county shall reimburse the hospital an amount equal to sixty-five percent (65%) of the amount charged by the hospital according to the hospital's charge description master.

(2) If the health care service is provided by a physician or another health care provider, the county shall reimburse the physician or health care provider an amount equal to sixty-five percent (65%) of the amount charged by the physician or health care provider.

(g) A county described in subsection (e) or (f) may reimburse a health care provider described in subsection (e)(1), (e)(2), or (e)(3) at a lower reimbursement rate than the rate required by subsection (e) or (f) if the county enters into an agreement with a health care provider

described in subsection (e)(1), (e)(2), or (e)(3) to reimburse the health care provider for a health care service at the lower reimbursement rate.

SECTION 8. IC 11-12-5-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 9. (a) Before discharge or release of an offender from a county jail, the county in which the incarcerated person is located shall assist the offender in applying for Medicaid, if eligible, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the offender might be eligible for coverage when the offender is subsequently released from the county jail.**

(b) The county shall provide the assistance described in subsection (a) in sufficient time to ensure that the offender will be able to receive coverage at the time the offender is released from the county jail.

(c) A county may contract with any entity who complies with IC 27-19-2-12, including a hospital or outreach eligibility worker, to assist with Medicaid applications under this section. A county may develop intergovernmental agreements with other counties to provide both authorized representative and health navigator services required under this section. Upon a determination that an incarcerated individual qualifies for Medicaid coverage, the office of the secretary of family and social services, division of family resources, shall authorize and then immediately suspend Medicaid coverage for those inmates not requiring immediate medical attention.

SECTION 9. IC 11-12-5-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 10. (a) Upon discharge or release of an inmate from the county jail, the county shall assist an offender who has a mental illness or addictive disorder in securing treatment for the mental illness or for substance abuse addiction, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the offender might be eligible for treatment when the offender is subsequently released from the county jail.**

(b) The county shall provide the assistance described in subsection (a) in sufficient time to ensure that the offender will be able to receive treatment at the time the committed offender is released from the county jail.

(c) A county shall use a community mental health center (as defined in IC 12-7-2-38) or a provider certified or licensed by the

division of mental health and addiction, including a hospital or outreach eligibility worker, to assist with securing treatment for a mental illness or addictive disorder through the Medicaid program under this section.

SECTION 10. IC 12-15-1-20.4, AS AMENDED BY P.L.1-2010, SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 20.4. (a) If a Medicaid recipient is:

~~(1) less than eighteen (18) years of age;~~

~~(2)~~ **(1)** adjudicated to be a delinquent child and placed in:

(A) a community based correctional facility for children;

(B) a juvenile detention facility; or

(C) a secure facility, not including a facility licensed as a child caring institution under IC 31-27; **or**

(2) incarcerated in a prison or jail; and

~~(3)~~ ineligible to participate in the Medicaid program during the placement described in subdivision **(1) or** (2) because of federal Medicaid law, the division of family resources, upon notice that a child has been adjudicated to be a delinquent child and placed in a facility described in subdivision ~~(2)~~ **(1) or upon notice that a person is incarcerated in a prison or jail and placed in a facility described in subdivision (2),** shall suspend the ~~child's~~ **person's** participation in the Medicaid program for up to ~~six (6) months~~ **one (1) year** before terminating the ~~child's~~ **person's** eligibility.

(b) If the division of family resources receives:

(1) a dispositional decree under IC 31-37-19-28; or

(2) a modified disposition order under IC 31-37-22-9;

and the department of correction gives the division at least forty (40) days notice that a ~~child~~ **person** will be released from a facility described in subsection ~~(a)(2)(C),~~ **(a)(1)(C) or (a)(2),** the division of family resources shall take action necessary to ensure that a ~~child~~ **person** described in subsection (a) is eligible to participate in the Medicaid program upon the ~~child's~~ **person's** release, if the ~~child~~ **person** is eligible to participate.

SECTION 11. IC 12-15-1.3-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 13.5. (a) As used in this section, "qualified provider" refers to a health provider authorized by the office to provide Medicaid presumptive eligibility services.**

(b) The office shall present a report to the interim study committee on public health, behavioral health, and human services not later than September 30 of each year, regarding the use of

qualified providers to undertake presumptive eligibility services under the Medicaid program.

(c) The report must include the following:

(1) The number of presumptive eligibility qualified providers and their location and distribution in the state.

(2) The number of presumptive eligibility applications submitted and in a per provider format.

(3) The number and percent of presumptive eligibility applications submitted that were approved or denied and the information in a per provider and by county format.

(4) The number and percent of presumptive eligibility applications that resulted in a Medicaid application submission and the information in a per provider and by county format.

(5) The number and percent of presumptive eligibility applications that were subsequently approved or denied for full coverage and the information in a per provider and by county format.

(6) The method the office used to communicate presumptive eligibility opportunities to qualified providers and health consumers.

(7) The error rate of qualified providers in accepting presumptive eligibility applications that were subsequently determined to be ineligible.

(8) The education and technical assistance and availability provided by the office for ongoing training and retention of qualified providers.

(9) Any other information the office considers relevant on the use of qualified providers in carrying out presumptive eligibility services under the Medicaid program.

(d) This section expires January 1, 2018.

SECTION 12. IC 12-15-4-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 2.5. (a) The department of correction is, for an inmate described in IC 11-10-3-7(b), the inmate's Medicaid authorized representative.**

(b) A sheriff who:

(1) agrees to the requirements set forth in IC 36-2-13-19; and

(2) applies for Medicaid for a person who:

(A) is subject to lawful detention; and

(B) is described in IC 36-2-13-19;

is the inmate's Medicaid authorized representative.

SECTION 13. IC 12-15-11-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2016]: **Sec. 8. (a) A community mental health center may use the center's provider identification number to file any Medicaid claim, including primary care health services, if the community mental health center:**

(1) is otherwise treating the individual for a mental health condition or an addictive disorder; and

(2) meets the requirements to provide the services rendered.

(b) The office may not require a community mental health center to obtain a separate provider identification number to provide services that the community mental health center meets the requirements to provide.

(c) The office may not limit the filing of a Medicaid claim by a community mental health center for primary care services, mental health conditions, and addictive disorders on the same day as long as the claim is filed in accordance with the rules set forth by the office and the services are covered services and necessary to ensure coordinated care for the recipient.

SECTION 14. IC 12-21-5-2, AS AMENDED BY P.L.93-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 2. The division is responsible for the following:

(1) The planning, research, and development of programs and methods for the education and treatment of children with an emotional disturbance.

(2) The coordination of governmental services, activities, and programs in Indiana relating to such children.

(3) The administration of the state supported services concerned with such children.

(4) The preparation of the annual report required by IC 7.1-6-2-5.

(5) The provision of **a mental health first aid training program developed under section 4 of this chapter, including providing** information and guidance to local school corporations on the development of evidence based programs for basic or inservice courses for teachers and training for teachers on the following:

(A) Prevention of child suicide.

(B) Recognition of signs that a student may be considering suicide.

SECTION 15. IC 12-21-5-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 4. (a) To the extent that funds are made available, the division, in consultation with:**

(1) the department of education;

(2) the law enforcement training board;

(3) the Indiana Council of Community Mental Health Centers;

(4) Mental Health America-Indiana;

(5) the Indiana emergency medical services commission; and

(6) a private foundation dedicated to the prevention of youth suicide through education and awareness;

shall develop and administer a mental health first aid training program.

(b) The mental health first aid training program developed under subsection (a) must do the following:

(1) Train individuals attending the training program to recognize the risk factors and signs of mental health problems or crises in children and young adults, including signs that a child or young adult may be considering suicide.

(2) Train individuals attending the training program to guide children and young adults who exhibit signs of a mental health problem or crisis to appropriate behavioral health services.

(3) Train individuals attending the training program to not label children who are at risk or show signs of mental health problems in a manner that would stigmatize the child.

(c) The division shall provide training for individuals who will be instructors in the mental health first aid training program.

(d) The division shall make the mental health first aid training program available to licensed teachers, school counselors, emergency medical service providers, law enforcement officers, leaders of community faith organizations, and other persons interested in receiving training under the program.

(e) The division, the department of education, and the Indiana emergency medical services commission may seek federal and state funding and may accept private contributions to administer and provide mental health first aid training programs.

(f) Notwithstanding any other law, the division is not required to implement the mental health first aid training program until after June 30, 2016.

(g) Before October 1, 2015, the division shall report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4(14) concerning the status of the development of the mental health first aid training program.

SECTION 16. IC 16-18-2-348.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 348.5. "Telemedicine", for purposes of IC 16-36-1, means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include the use of the following:**

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

SECTION 17. IC 16-31-2-7, AS AMENDED BY P.L.77-2012, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 7. **(a)** The commission shall do the following:

(1) Develop and promote, in cooperation with state, regional, and local public and private organizations, agencies, and persons, a statewide program for the provision of emergency medical services that must include the following:

(A) Preparation of state, regional, and local emergency ambulance service plans.

(B) Provision of consultative services to state, regional, and local organizations and agencies in developing and implementing emergency ambulance service programs.

(C) Promotion of a statewide system of emergency medical service facilities by developing minimum standards, procedures, and guidelines in regard to personnel, equipment, supplies, communications, facilities, and location of such centers.

(D) Promotion of programs for the training of personnel providing emergency medical services and programs for the education of the general public in first aid techniques and procedures. The training shall be held in various local communities of the state and shall be conducted by agreement with publicly and privately supported educational institutions or hospitals licensed under IC 16-21, wherever appropriate.

(E) Promotion of coordination of emergency communications, resources, and procedures throughout Indiana and, in cooperation with interested state, regional, and local public and private agencies, organizations, and persons, the development of an effective state, regional, and local emergency communications system.

(F) Organizing and sponsoring a statewide emergency medical services conference to provide continuing education for persons providing emergency medical services.

(2) Regulate, inspect, and certify or license services, facilities, and personnel engaged in providing emergency medical services as provided in this article.

(3) Adopt rules required to implement an approved system of emergency medical services.

(4) Adopt rules concerning triage and transportation protocols for the transportation of trauma patients consistent with the field triage decision scheme of the American College of Surgeons Committee on Trauma.

(5) Apply for, receive, and accept gifts, bequests, grants-in-aid, state, federal, and local aid, and other forms of financial assistance for the support of emergency medical services.

(6) Employ necessary administrative staff.

(b) The commission shall include the provision of the mental health first aid training program developed under IC 12-21-5-4 in the promotion of continuing education programs under subsection (a)(1)(D).

SECTION 18. IC 16-36-1-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 15. A health care provider (as defined in IC 16-18-2-163(a)) may not be required to obtain a separate additional written health care consent for the provision of telemedicine services.**

SECTION 19. IC 20-20-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]:

Chapter 18.5. Grants for Mental Health Counselor Licenses for School Counselors

Sec. 1. The mental health counselor licenses for school counselors grant is established for the purpose of awarding grants to provide funding for training for school counselors in kindergarten through grade 12 schools to obtain a mental health counselor license under IC 25-23.6-8.5.

Sec. 2. (a) The mental health counselor licenses for school counselors fund is established for purposes of funding the grant set forth in section 1 of this chapter.

(b) The department shall administer the fund.

(c) The fund consists of the following:

(1) Appropriations from the general assembly.

(2) Gifts to the fund.

(3) Grants, including grants from private entities.

(d) In awarding a grant under this chapter, the department shall ensure that the following criteria are met:

(1) Not more than one hundred (100) school counselors may be awarded a grant annually.

(2) An individual receiving a grant under this chapter must have been employed as a school counselor before July 1, 2015, and must be currently employed as a school counselor.

(e) The expenses of administering the fund shall be paid from the fund.

(f) Money in the fund that is not needed to pay the obligations of the fund may be invested in the manner that other public money may be invested. Interest from the investment of money in the fund becomes part of the fund.

(g) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Sec. 3. (a) A school counselor or a school corporation is eligible to apply for a grant under this chapter. A school counselor or a school corporation applying for a grant under this chapter must apply in the manner prescribed by the department.

(b) The department shall determine the amount and the terms of a grant awarded under this chapter.

Sec. 4. The department may adopt rules under IC 4-22-2 necessary to administer this chapter.

SECTION 20. IC 20-28-3-4, AS AMENDED BY P.L.93-2011, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 4. A governing body may adjourn the governing body's schools for not more than three (3) days in a school year to allow teachers, school administrators, and paraprofessionals to participate in:

(1) a session concerning agricultural instruction conducted in the county;

(2) a meeting of a teachers' association;

(3) a visitation of model schools under a governing body's direction;

(4) a basic or inservice course of education and training on autism that is certified by the state board in conjunction with the state health commissioner and any other appropriate entity determined by the state board; or

(5) a basic or inservice course of education and training on:

(A) beginning in the 2016-2017 school year, mental health first aid (IC 12-21-5-4); and

(B) the prevention of child suicide and the recognition of signs that a student may be considering suicide.

A governing body shall pay a teacher the teacher's per diem salary for the teacher's participation.

SECTION 21. IC 20-34-3-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 21. (a) Before July 1, 2016, each school corporation may enter into a memorandum of understanding with a community mental health center established under IC 12-29-2 or a provider certified or licensed by the division of mental health and addiction to establish conditions or terms for referring students of the school corporation to the mental health care provider or community mental health center for services.**

(b) A school corporation may not refer a student to a mental health care provider or a community mental health center for services unless the school corporation has received the written consent of the student's parent or guardian.

(c) If a school corporation refers a student to a mental health care provider, the school corporation may note the referral in the student's record but may not include any possible diagnosis or information concerning the student's mental health other than any medication that the student takes for the student's mental health.

(d) A school counselor or other employee of a school corporation may not diagnose a student as having a mental health condition.

SECTION 22. IC 27-8-5-30 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 30. If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, an insurer shall not limit or deny coverage under a policy of accident and sickness insurance of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**

SECTION 23. IC 27-8-34 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]:

Chapter 34. Coverage for Telemedicine Services

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

Sec. 2. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 3. As used in this chapter, "policy" means a policy of accident and sickness insurance (as defined in IC 27-8-5-1). The term does not include dental insurance or vision insurance.

Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 5. (a) As used in this chapter, "telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

(b) The term does not include the delivery of health care services by use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

Sec. 6. (a) A policy of accident and sickness insurance must provide coverage for telemedicine services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person.

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance requirement that applies to the same health care services delivered to a covered individual in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.

(d) A separate consent for telemedicine services may not be required.

Sec. 7. This chapter does not do any of the following:

(1) Require a policy to provide coverage for a telemedicine service that is not a covered health care service under the policy.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to a covered individual in person.

SECTION 24. IC 27-13-1-34 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 34. (a) "Telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:**

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

(b) The term does not include the delivery of health care services by use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

SECTION 25. IC 27-13-7-22 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 22. (a) An individual contract or a group contract must provide coverage for telemedicine services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.**

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee than the dollar limit, copayment, or coinsurance requirement that applies to the same health care services delivered to an enrollee in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the individual contract or the group contract.

(d) This section does not do any of the following:

(1) Require an individual contract or a group contract to provide coverage for a telemedicine service that is not a covered health care service under the individual contract or group contract.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to an enrollee in person.

(e) A separate consent for telemedicine services and health care services delivered in person may not be required.

SECTION 26. IC 27-13-39-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 2. **(a) If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, a health maintenance organization shall not limit or deny coverage of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**

~~(a)~~ **(b)** A health maintenance organization that limits coverage for experimental treatments, procedures, drugs, or devices must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

~~(b)~~ **(c)** The disclosure required under subsection ~~(a)~~ **(b)** must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection ~~(a).~~ **(b).**

(2) A description of the criteria the health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental, as provided in section 1 of this chapter.

SECTION 27. IC 36-2-13-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 19. (a) This section applies to a person who:**

(1) is subject to lawful detention;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable during the lawful detention;

(3) is unwilling or unable to pay for the person's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15).

(b) For a person described in subsection (a), the sheriff is the person's Medicaid authorized representative and may apply for Medicaid on behalf of the person.

(c) A sheriff and the office of the secretary of family and social services shall enter into a written memorandum of understanding providing that the sheriff shall reimburse the office of the secretary

for administrative costs and the state share of the Medicaid costs incurred for a person described in this section.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to a person as an inpatient in a hospital must be as follows:

(1) For individuals eligible under the Indiana check-up plan (IC 12-15-44.2), the reimbursement rates described in IC 12-15-44.2-14.

(2) For individuals other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of health care services provided to the person as an inpatient in the hospital.

(e) The state share of all claims reimbursed by Medicaid for a person described in subsection (a) shall be paid by the county.

SECTION 28. [EFFECTIVE JULY 1, 2015] **(a) Before October 1, 2016, the office of the secretary of family and social services shall report to the general assembly in an electronic format under IC 5-14-6 the following information:**

(1) The number of individuals who received health care services under:

(A) IC 11-10-3-7(b), as amended by this act; and

(B) IC 36-2-13-19, as added by this act.

(2) The total reimbursement cost for these individuals.

(b) This SECTION expires December 31, 2016.

SECTION 29. [EFFECTIVE JULY 1, 2015] **(a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.**

(b) As used in this SECTION, "denied claim" means a claim for which:

(1) a denial of coverage; or

(2) required submission of additional information;

was communicated by the insurer or administrator in response to the submission of the claim, regardless of whether the claim was eventually paid by the insurer or administrator.

(c) The department shall review a statistically relevant sample of all claims denied:

(1) by:

(A) the three (3) insurers that issued the largest number by premium of policies of accident and sickness insurance (as defined in IC 27-8-5-1) in Indiana during the 2014 calendar year; and

(B) an administrator of health coverage described in IC 27-1-25; and

(2) during the period beginning July 1, 2014, and ending December 31, 2014.

(d) The department's review under this SECTION shall include all of the following:

(1) A determination of whether the denial of each claim was appropriately based on the terms of the applicable policy of accident and sickness insurance or health coverage plan.

(2) The number of denied claims based on a requirement of the insurer or administrator that the covered individual receive a less expensive procedure before receiving the procedure that was the subject of the denied claim.

(e) An insurer or administrator described in subsection (c) shall provide, upon request, access to all records and information determined by the commissioner of insurance to be required for the department's review of the denied claims described in subsection (c).

(f) An insurer or administrator subject to review under this SECTION shall do all of the following:

(1) If a claim described in subsection (c) was denied for lack of medical necessity, disclose to the department whether, in order to determine medical necessity, the insurer or administrator had a physician:

(A) examine the covered individual; or

(B) review the medical record of the covered individual.

(2) Specify the policy or plan provision that resulted in the denied claim.

(3) Specify the health care procedure for which a claim is most frequently denied by the insurer or administrator.

(4) With respect to a denied claim described in subsection (b)(2), specify the additional information that was required for payment of the claim.

(g) The department may retain expert consultants to perform the review required by this SECTION.

(h) An insurer or administrator subject to a review under this SECTION shall pay all costs associated with the review.

(i) All records and information provided to the department under this SECTION are confidential.

(j) The department shall, not later than October 1, 2015:

(1) perform a review required by this SECTION;

(2) compile a report of the:

(A) information; and

(B) results of the review;

required by this SECTION; and

(3) provide the report to:

(A) the public health, behavioral health, and human services interim study committee established by IC 2-5-1.3-4(14); and

(B) the legislative council;

in an electronic format under IC 5-14-6.

(k) Information contained in a report provided under subsection (j) may not include any information from which the identity of an individual covered under the policy of accident and sickness or health coverage plan may be ascertained.

(l) The department may establish the procedures under which the review under this SECTION is conducted.

(m) This SECTION expires January 1, 2016.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1269, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

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

Page 2, line 5, delete "The department of homeland security shall authorize the".

Page 2, delete lines 6 through 8.

Page 2, line 9, delete "matching grants under IC 12-29-5-1. A" and insert "**Subject to the availability of funding, a**".

Page 2, line 9, delete "funded" and insert "**program**".

Page 2, line 41, after "department;" insert "**and**".

Page 2, delete line 42.

Page 3, delete line 1.

Page 3, line 2, delete "(3)" and insert "**(2)**".

Page 3, line 3, delete "is" and insert "**shall act as**".

Page 3, line 3, after "representative" insert "**or health navigator under the requirements of IC 27-19-2-12**".

Page 3, line 4, delete "." and insert "**or assist the inmate in securing Medicaid eligibility as a health navigator.**".

Page 3, line 6, after "jail;" insert "**and**".

Page 3, delete lines 7 through 8.

Page 3, line 9, delete "(3)" and insert "**(2)**".

Page 3, delete lines 10 through 13 and insert "**the county where the offender has been incarcerated shall act as the offender's Medicaid authorized representative or a health navigator under the requirements of IC 27-19-2-12 and shall apply for Medicaid on behalf of the offender or assist the offender in securing Medicaid eligibility as a health navigator.**".

Page 3, line 16, after "jail;" insert "**and**".

Page 3, delete lines 17 through 18.

Page 3, line 19, delete "(4)" and insert "**(3)**".

Page 3, line 21, after "inmate." insert "**If the inmate does not require immediate medical attention, the department shall establish Medicaid eligibility using a health navigator established under IC 27-19-2-12.**".

Page 3, line 26, delete "," and insert "**or as a health navigator under the requirements of IC 27-19-2-12,**".

Page 3, line 39, delete "may use a community mental health center" and insert "**shall implement the requirements under this section to establish an inmate's Medicaid coverage regardless of the inmate's medical need. Upon a determination that the inmate qualifies for Medicaid coverage, the office of the secretary of family and social services, division of family resources, shall authorize and then immediately suspend Medicaid coverage for those inmates not requiring immediate medical attention.**".

Page 3, delete lines 40 through 41.

Page 4, line 6, delete "," and insert "**or as a health navigator under the requirements of IC 27-19-2-12,**".

Page 4, line 7, delete "subsequently:" and insert "**:**".

Page 4, line 9, delete "or".

Page 4, line 10, after "department" delete "." and insert "**; or**".

Page 4, between lines 10 and 11, begin a new line block indented and insert:

"**(4) required to receive inpatient psychiatric services while incarcerated to the extent authorized under federal law.**".

Page 4, between lines 17 and 18, begin a new paragraph and insert:

"**(c) Subject to federal approval, an inmate placed in a work release program or other department program involving alternative sentencing programs is eligible for Medicaid covered services.**".

Page 4, line 18, delete "(c)" and insert "**(d)**".

Page 4, line 19, after "IC 12-7-2-38)" insert "**, hospital, mental health professional, or other provider certified or licensed by the division of mental health and addiction**".

Page 4, line 19, delete "assist with securing" and insert "**provide Medicaid based**".

Page 4, line 20, after "program" insert "**.**".

Page 4, delete lines 21 through 42.

Page 5, delete lines 1 through 10, begin a new paragraph and insert:

"SECTION 5. IC 11-12-3.8-1, AS ADDED BY P.L.184-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 1. As used in this chapter, "mental health and addiction forensic treatment services" means evidence based treatment and recovery wraparound support services provided to individuals who have entered the criminal justice system as a felon or with a prior felony conviction. The term includes:

(1) mental health and substance abuse treatment;

(2) vocational services;

(3) housing assistance;

(4) community support services;

(5) care coordination; ~~and~~

(6) transportation assistance; **and**

(7) mental health and substance use assessments for incarcerated individuals.".

Page 5, line 13, delete "Upon" and insert "**Before**".

Page 5, line 14, delete "sheriff" and insert "**county in which the incarcerated person is located**".

Page 5, line 16, delete "," and insert "**or as a health navigator under the requirements of IC 27-19-2-12,**".

Page 5, line 18, delete "sheriff" and insert "**county**".

Page 5, line 22, delete "sheriff may use a community mental health center (as".

Page 5, line 23, delete "defined in IC 12-7-2-38)" and insert "**county may contract with any entity who complies with IC 27-19-2-12, including a hospital or outreach eligibility worker,**".

Page 5, line 24, after "section." insert "**A county may develop intergovernmental agreements with other counties to provide both authorized representative and health navigator services required under this section. Upon a determination that an incarcerated individual qualifies for Medicaid coverage, the office of the secretary of family and social services, division of family resources, shall authorize and then immediately suspend Medicaid coverage for those inmates not requiring immediate medical attention.**".

Page 5, line 28, delete "sheriff" and insert "**county**".

Page 5, line 31, delete "," and insert "**or as a health navigator under the requirements of IC 27-19-2-12,**".

Page 5, line 34, delete "sheriff" and insert "**county**".

Page 5, line 38, delete "sheriff may" and insert "**county shall**".

Page 5, line 39, after "IC 12-7-2-38)" insert "**or a provider certified or licensed by the division of mental health and addiction, including a hospital or outreach eligibility worker,**".

Page 6, line 17, delete "twelve (12)".

Page 6, line 17, strike "months" and insert "**three (3) years**".

Page 6, line 31, delete "Before January 1, 2016," and insert "**As used in this section, "qualified provider" refers to a health provider authorized by the office to provide Medicaid presumptive eligibility services.**

(b) The office shall present a report to the interim study committee on public health, behavioral health, and human services not later than September 30 of each year, regarding the use of

qualified providers to undertake presumptive eligibility services under the Medicaid program.

(c) The study must include the following:

(1) The number of presumptive eligibility qualified providers and their location and distribution in the state.

(2) The number of presumptive eligibility applications submitted and in a per provider format.

(3) The number and percent of presumptive eligibility applications submitted that were approved or denied and the information in a per provider and by county format.

(4) The number and percent of presumptive eligibility applications that resulted in a Medicaid application submission and the information in a per provider and by county format.

(5) The number and percent of presumptive eligibility applications that were subsequently approved or denied for full coverage and the information in a per provider and by county format.

(6) The method the office used to communicate presumptive eligibility opportunities to qualified providers and health consumers.

(7) The error rate of qualified providers in accepting presumptive eligibility applications that were subsequently determined to be ineligible.

(8) The education and technical assistance and availability provided by the office for ongoing training and retention of qualified providers.

(9) Any other information the office considers relevant on the use of qualified providers in carrying out presumptive eligibility services under the Medicaid program.

(d) This section expires January 1, 2018.".

Page 6, delete lines 32 through 42.

Page 7, delete lines 1 through 9.

Page 7, line 12, delete "January" and insert "**July**".

Page 7, line 39, delete "sheriff responsible for the operation of a county jail that" and insert "**county in which**".

Page 8, line 2, delete "JULY 1, 2015]" and insert "JANUARY 1, 2016]".

Page 9, line 3, delete "and".

Page 9, line 4, after "commission;" insert "**and**".

Page 9, between lines 4 and 5, begin a new line block indented and insert:

"**(6) a private foundation dedicated to the prevention of youth suicide through education and awareness;**".

Page 10, line 2, delete "The department of homeland security".

Page 10, delete lines 3 through 5.

Page 13, line 41, delete "a mental health care provider or".

Page 13, line 42, after "IC 12-29-2" insert "**or a provider certified or licensed by the division of mental health and addiction**".

Page 14, between lines 3 and 4, begin a new paragraph and insert:

"SECTION 20. IC 27-8-34 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]:

Chapter 34. Coverage for Telemedicine Services

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

Sec. 2. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 3. As used in this chapter, "policy" means a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 5. (a) As used in this chapter, "telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

(b) The term does not include the delivery of health care services by use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

Sec. 6. (a) A policy of accident and sickness insurance must provide coverage for telemedicine services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person.

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance requirement that applies to the same health care services delivered to a covered individual in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.

(d) A separate consent for telemedicine services and health care services delivered in person may not be required.

Sec. 7. This chapter does not do any of the following:

(1) Require a policy to provide coverage for a telemedicine service that is not a covered health care service under the policy.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to a covered individual in person.

SECTION 21. IC 27-13-1-34 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 34. (a) "Telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:**

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

(b) The term does not include the delivery of health care services by use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

SECTION 22. IC 27-13-7-22 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 22. (a) An individual contract or a group contract must provide coverage for telemedicine services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.**

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee than the dollar limit, copayment, or coinsurance requirement that applies to the same health care services delivered to an enrollee in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the individual contract or the group contract.

(d) This section does not do any of the following:

(1) Require an individual contract or a group contract to provide coverage for a telemedicine service that is not a covered health care service under the individual contract or group contract.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to an enrollee in person.

(e) A separate consent for telemedicine services and health care services delivered in person may not be required.".

Page 14, line 6, delete "A" and insert "**Subject to the availability of funding and an agreement with the sheriff, a**".

Page 14, line 8, delete "who is associated with a community mental".

Page 14, line 9, delete "health center certified under IC 12-21-2-3(5)(C)" and insert "**or a provider certified or licensed by the division of mental health and addiction**".

Page 14, line 12, after "jail." insert "**However, an individual may not be assessed more than once every six (6) months, unless the mental health status of the individual indicates that a mental health assessment is needed.**".

Page 14, line 18, delete "and".

Page 14, line 19, delete "." and insert "**;**".

Page 14, after line 19, begin a new line block indented and insert:

"**(3) the prosecuting attorney; and**

(4) the court system having jurisdiction over the matter.

(c) A community mental health provider or other provider certified or licensed by the division of mental health and addiction is not required to provide any services under this section for which

funding is not made available to fully support the cost of a mental health or substance abuse assessment.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1269 as introduced.)

CLERE

Committee Vote: yeas 12, nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1269, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 14, begin a new paragraph and insert:

"SECTION 1. IC 5-10-8-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 17. A self-insurance plan established under section 7(b) of this chapter or a contract with a prepaid health coverage plan entered into under section 7(c) of this chapter shall not limit or deny coverage for investigational or experimental treatment if payment for the treatment has been made by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years.**

SECTION 2. IC 11-10-3-6, AS AMENDED BY P.L.205-2013, SECTION 169, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 6. (a) This section:

(1) does not apply in the case of a person who is subject to lawful detention by a county sheriff and is:

(A) covered under private health coverage for health care services; or

(B) willing to pay for the person's own health care services; ~~and~~

(2) does not apply to an inmate receiving inpatient services under section 7 of this chapter; and

~~(2)~~ **(3)** does not affect copayments required under section 5 of this chapter.

(b) The following definitions apply throughout this section:

(1) "Charge description master" means a listing of the amount charged by a hospital for each service, item, and procedure:

(A) provided by the hospital; and

(B) for which a separate charge exists.

(2) "Health care service" means the following:

(A) Medical care.

(B) Dental care.

(C) Eye care.

(D) Any other health care related service.

The term includes health care items and procedures.

(c) Except as provided in subsection (d), when the department or a county is responsible for payment for health care services provided to a person who is committed to the department, the department shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) another health care provider;

for the cost of a health care service at the federal Medicare reimbursement rate for the health care service provided plus four percent (4%).

(d) If there is no federal Medicare reimbursement rate for a health care service described in subsection (c), the department shall do the following:

(1) If the health care service is provided by a hospital, the department shall reimburse the hospital an amount equal to sixty-five percent (65%) of the amount charged by the hospital according to the hospital's charge description master.

(2) If the health care service is provided by a physician or another health care provider, the department shall reimburse the physician or health care provider an amount equal to sixty-five percent (65%) of the amount charged by the physician or health care provider.

SECTION 3. IC 11-10-3-7, AS ADDED BY P.L.205-2013, SECTION 170, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 7. **(a)** If the department or a county incurs medical care expenses in providing medical care to an inmate who is committed to the department and the medical care expenses are not reimbursed, the department or the county shall attempt to determine the amount, if any, of the medical care expenses that may be paid:

(1) by a policy of insurance that is maintained by the inmate and that covers medical care, dental care, eye care, or any other health care related service; or

(2) by Medicaid.

(b) For an inmate who:

(1) is committed to the department and resides in a department facility or jail;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable;

(3) is unwilling or unable to pay for the inmate's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15);

the department is the inmate's Medicaid authorized representative and may apply for Medicaid on behalf of the inmate.

(c) The department and the office of the secretary of family and social services shall enter into a written memorandum of understanding providing that the department shall reimburse the office of the secretary for administrative costs and the state share of the Medicaid costs incurred for an inmate.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to an inmate as an inpatient in a hospital must be as follows:

(1) For inmates eligible and participating in the Indiana check-up plan (IC 12-15-44.2), the reimbursement rates described in IC 12-15-44.2-14.

(2) For inmates other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of health care services provided to the inmate as an inpatient in the hospital.".

Delete page 2.

Page 3, delete lines 1 through 18.

Page 4, line 30, delete "Medicaid based".

Page 4, line 40, delete ";" and insert "**assessments;**".

Page 5, line 2, reset in roman "and".

Page 5, line 3, delete "; and" and insert ".".

Page 5, delete lines 4 through 5, begin a new paragraph and insert:

"SECTION 8. IC 11-12-5-5.5, AS AMENDED BY P.L.205-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 5.5. (a) As used in this section, "charge description master" means a listing of the amount charged by a hospital for each service, item, and procedure:

(1) provided by the hospital; and

(2) for which a separate charge exists.

(b) As used in this section, "health care services" includes health care items and procedures.

(c) As used in this section, "lawful detention" means the following:

(1) Arrest.

(2) Custody following surrender in lieu of arrest.

(3) Detention in a penal facility.

(4) Detention for extradition or deportation.

(5) Custody for purposes incident to any of the above, including transportation, medical diagnosis or treatment, court appearances, work, or recreation.

The term does not include supervision of a person on probation or parole or constraint incidental to release with or without bail.

(d) This section:

(1) does not apply in the case of a person who is subject to lawful detention by a county sheriff and is:

(A) covered under private health coverage for health care services; or

(B) willing to pay for the person's own health care services; ~~and~~

(2) does not apply to an inmate receiving inpatient services under IC 36-2-13-19; and

~~(2)~~ **(3)** does not affect copayments required under section 5 of this chapter.

(e) Except as provided in subsections (f) and (g), a county that is responsible for payment for health care services provided to a person who is subject to lawful detention by the county's sheriff shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) another health care provider;

for the cost of a health care service at the federal Medicare reimbursement rate for the health care service provided plus four percent (4%).

(f) Except as provided in subsection (g), if there is no federal Medicare reimbursement rate for a health care service described in subsection (e), the county shall do the following:

(1) If the health care service is provided by a hospital, the county shall reimburse the hospital an amount equal to sixty-five percent (65%) of the amount charged by the hospital according to the hospital's charge description master.

(2) If the health care service is provided by a physician or another health care provider, the county shall reimburse the physician or health care provider an amount equal to sixty-five percent (65%) of the amount charged by the physician or health care provider.

(g) A county described in subsection (e) or (f) may reimburse a health care provider described in subsection (e)(1), (e)(2), or (e)(3) at a lower reimbursement rate than the rate required by subsection (e) or (f) if the county enters into an agreement with a health care provider described in subsection (e)(1), (e)(2), or (e)(3) to reimburse the health care provider for a health care service at the lower reimbursement rate.".

Page 5, line 13, delete "assistance" and insert "**coverage**".

Page 5, line 17, delete "assistance" and insert "**coverage**".

Page 5, line 34, delete "through an" and insert "**for the mental illness or**".

Page 5, line 35, delete "approved Medicaid program".

Page 6, line 25, delete "three (3) years" and insert "**one (1) year**".

Page 7, delete lines 34 through 42.

Page 8, delete lines 1 through 22, begin a new paragraph and insert:

"SECTION 10. IC 12-15-4-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 2.5. (a) The department of correction is, for an inmate described in IC 11-10-3-7(b), the inmate's Medicaid authorized representative.**

(b) A sheriff who:

(1) agrees to the requirements set forth in IC 36-2-13-19; and

(2) applies for Medicaid for a person who:

(A) is subject to lawful detention; and

(B) is described in IC 36-2-13-19;

is the inmate's Medicaid authorized representative.".

Page 8, line 32, after "community" insert "**mental**".

Page 8, line 34, after "community" insert "**mental**".

Page 8, line 39, after "as" insert "**the claim is filed in accordance with the rules set forth by the office and**".

Page 9, line 33, delete "section" and insert "**subsection**".

Page 9, between lines 41 and 42, begin a new line block indented and insert:

"**(3) Train individuals attending the training program to not label children who are at risk or show signs of mental health problems in a manner that would stigmatize the child.**".

Page 10, delete lines 14 through 32, begin a new paragraph and insert:

"SECTION 16. IC 16-18-2-348.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 348.5. "Telemedicine", for purposes of IC 16-36-1, means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include the use of the following:**

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.".

Page 11, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 19. IC 16-36-1-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 15. A health care provider (as defined in IC 16-18-2-163(a)) may not require a separate additional written health care consent for the provision of telemedicine services.**

SECTION 20. IC 20-20-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]:

Chapter 18.5. Grants for Mental Health Counselor Licenses for School Counselors

Sec. 1. The mental health counselor licenses for school counselors grant is established for the purpose of awarding grants to provide funding for training for school counselors in elementary schools or high schools to obtain a mental health counselor license under IC 25-23.6-8.5.

Sec. 2. (a) The mental health counselor licensure for school counselors fund is established for purposes of funding the grant set forth in section 1 of this chapter.

(b) The department shall administer the fund.

(c) The fund consists of the following:

(1) Appropriations from the general assembly.

(2) Gifts to the fund.

(3) Grants, including grants from private entities.

(d) In awarding a grant under this chapter, the department shall ensure that the following criteria are met:

(1) Not more than one hundred (100) school counselors may be awarded a grant annually.

(2) An individual receiving a grant under this chapter must have been employed as a school counselor before July 1, 2015, and must be currently employed as a school counselor.

(e) The expenses of administering the fund shall be paid from the fund.

(f) Money in the fund that is not needed to pay the obligations of the fund may be invested in the manner that other public money may be invested. Interest from the investment of money in the fund becomes part of the fund.

(g) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Sec. 3. (a) A school counselor or a school corporation is eligible to apply for a grant under this chapter. A school counselor or a school corporation applying for a grant under this chapter must apply in the manner prescribed by the department.

(b) The department shall determine the amount and the terms of a grant awarded under this chapter.

Sec. 4. The department may adopt rules under IC 4-22-2 necessary to administer this chapter.".

Page 14, line 19, after "21." insert "**(a)**".

Page 14, between lines 25 and 26, begin a new paragraph and insert:

"**(b) A school corporation may not refer a student to a mental health care provider or a community mental health center for services unless the school corporation has received the consent of the student's parent or guardian.**

(c) If a school corporation refers a student to a mental health care provider, the school corporation may note the referral in the student's record but may not include any possible diagnosis or information concerning the student's mental health other than any medication that the student takes for the student's mental health.

SECTION 21. IC 27-8-5-30 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 30. An insurer shall not limit or deny coverage under a policy of accident and sickness insurance for investigational or experimental treatment if payment for the treatment has been made by the Medicaid program (IC 12-15) or the Medicare**

program (42 U.S.C. 1395 et seq.) during the three (3) preceding years.".

Page 14, line 36, after "." insert "**The term does not include dental insurance or vision insurance.**".

Page 15, line 22, delete "and health care".

Page 15, line 23, delete "services delivered in person".

Page 16, delete lines 36 through 42, begin a new paragraph and insert:

"SECTION 25. IC 27-13-39-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 2. **(a) A health maintenance organization shall not limit or deny coverage for investigational or experimental treatment if payment for the treatment has been made by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years.**

~~(a)~~ **(b)** A health maintenance organization that limits coverage for experimental treatments, procedures, drugs, or devices must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

~~(b)~~ **(c)** The disclosure required under subsection ~~(a)~~ **(b)** must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection ~~(a).~~ **(b).**

(2) A description of the criteria the health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental, as provided in section 1 of this chapter.

SECTION 26. IC 36-2-13-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 19. (a) This section applies to a person who:**

(1) is subject to lawful detention;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable during the lawful detention;

(3) is unwilling or unable to pay for the person's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15).

(b) For a person described in subsection (a), the sheriff is the person's Medicaid authorized representative and may apply for Medicaid on behalf of the person.

(c) A sheriff and the office of the secretary of family and social services shall enter into a written memorandum of understanding

providing that the sheriff shall reimburse the office of the secretary for administrative costs and the state share of the Medicaid costs incurred for a person described in this section.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to a person as an inpatient in a hospital must be as follows:

(1) For individuals eligible under the Indiana check-up plan (IC 12-15-44.2), the reimbursement rates described in IC 12-15-44.2-14.

(2) For individuals other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of health care services provided to the person as an inpatient in the hospital.

(e) The state share of all claims reimbursed by Medicaid for a person described in subsection (a) shall be paid by the county.

SECTION 27. [EFFECTIVE JULY 1, 2015] **(a) Before October 1, 2016, the office of the secretary of family and social services shall report to the general assembly in an electronic format under IC 5-14-6 the following information:**

(1) The number of individuals who received health care services under:

(A) IC 11-10-3-7(b), as amended by this act; and

(B) IC 36-2-13-19, as added by this act.

(2) The total reimbursement cost for these individuals.

(b) This SECTION expires December 31, 2016.

SECTION 28. [EFFECTIVE JULY 1, 2015] **(a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.**

(b) As used in this SECTION, "denied claim" means a claim for which:

(1) a denial of coverage; or

(2) required submission of additional information;

was communicated by the insurer or administrator in response to the submission of the claim.

(c) The department shall review a statistically relevant sample of all claims denied:

(1) by an:

(A) insurer that issued a policy of accident and sickness insurance (as defined in IC 27-8-5-1); and

(B) administrator of health coverage described in IC 27-1-25; and

(2) during the period beginning July 1, 2014, and ending December 31, 2014;

to determine whether the denial of each claim was appropriately based on the terms of the applicable policy of accident and sickness insurance or health coverage plan.

(d) An insurer or administrator described in subsection (c) shall provide, upon request, access to all records and information determined by the commissioner of insurance to be required for the department's review of the denied claims described in subsection (c).

(e) If a claim described in subsection (c) was denied for lack of medical necessity, the insurer or administrator shall disclose to the department the following:

(1) Whether the insurer or administrator had a physician examine the covered individual to determine medical necessity.

(2) If a physician described in subdivision (1) examined the covered individual, the identity and contact information of the physician.

(f) The department may retain expert consultants to perform the review required by subsection (c).

(g) An insurer or administrator subject to a review under this section shall pay all costs associated with the review.

(h) All records and information provided to the department under this section are confidential.

(i) The department shall, not later than October 1, 2015:

(1) perform a review required by this section;

(2) compile a report of the results of the review performed under subdivision (1); and

(3) provide the report to:

(A) the public health, behavioral health, and human services interim study committee established by IC 2-5-1.3-4(14); and

(B) the legislative council;

in an electronic format under IC 5-14-6.

(j) Information contained in a report provided under subsection (i) may not include any information from which the identity of an individual covered under the policy of accident and sickness or health coverage plan may be ascertained.

(k) This SECTION expires January 1, 2016.".

Delete page 17.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1269 as printed February 20, 2015.)

MILLER PATRICIA, Chairperson

Committee Vote: Yeas 8, Nays 0.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1269 be amended to read as follows:

Page 1, delete lines 1 through 9, begin a new paragraph and insert:

"SECTION 1. IC 5-10-8-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 17. If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, a self-insurance program established under section 7(b) of this chapter or a contract with a prepaid health coverage plan entered into under section 7(c) of this chapter shall not limit or deny coverage of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**".

Page 9, line 3, delete "study" and insert "**report**".

Page 11, between lines 37 and 38, begin a new paragraph and insert:

"**(g) Before October 1, 2015, the division shall report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4(14) concerning the status of the development of the mental health first aid training program.**".

Page 13, line 21, delete "require" and insert "**be required to obtain**".

Page 13, line 31, delete "elementary" and insert "**kindergarten through grade 12 schools**".

Page 13, line 32, delete "schools or high schools".

Page 13, line 34, delete "licensure" and insert "**licenses**".

Page 14, line 39, after "(A)" insert "**beginning in the 2016-2017 school year,**".

Page 15, delete lines 3 through 42.

Delete page 16.

Page 17, line 4, delete "shall" and insert "**may**".

Page 17, line 12, after "received the" insert "**written**".

Page 17, delete lines 19 through 26, begin a new paragraph and insert:

"**(d) A school counselor or other employee of a school corporation may not diagnose a student as having a mental health condition.**

SECTION 23. IC 27-8-5-30 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 30. If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, an insurer shall not limit or deny coverage under a policy of accident and sickness insurance of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**".

Page 19, delete lines 41 through 42, begin a new paragraph and insert:

"SECTION 27. IC 27-13-39-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 2. **(a) If a procedure or treatment has been routinely covered by the Medicaid program (IC 12-15) or the Medicare program (42 U.S.C. 1395 et seq.) during the three (3) preceding years, a health maintenance organization shall not limit or deny coverage of a procedure or treatment on the basis that the procedure or treatment is investigatory or experimental.**

~~(a)~~ **(b)** A health maintenance organization that limits coverage for experimental treatments, procedures, drugs, or devices must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

~~(b)~~ **(c)** The disclosure required under subsection ~~(a)~~ **(b)** must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection ~~(a).~~ **(b).**

(2) A description of the criteria the health maintenance organization uses to determine whether a treatment, procedure,

drug, or device is experimental, as provided in section 1 of this chapter.".

Page 20, delete lines 1 through 17.

Page 21, delete lines 24 through 41, begin a new paragraph and insert:

"SECTION 30. [EFFECTIVE JULY 1, 2015] **(a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.**

(b) As used in this SECTION, "denied claim" means a claim for which:

(1) a denial of coverage; or

(2) required submission of additional information;

was communicated by the insurer or administrator in response to the submission of the claim, regardless of whether the claim was eventually paid by the insurer or administrator.

(c) The department shall review a statistically relevant sample of all claims denied:

(1) by:

(A) the three (3) insurers that issued the largest number by premium of policies of accident and sickness insurance (as defined in IC 27-8-5-1) in Indiana during the 2014 calendar year; and

(B) an administrator of health coverage described in IC 27-1-25; and

(2) during the period beginning July 1, 2014, and ending December 31, 2014.

(d) The department's review under this SECTION shall include all of the following:

(1) A determination of whether the denial of each claim was appropriately based on the terms of the applicable policy of accident and sickness insurance or health coverage plan.

(2) The number of denied claims based on a requirement of the insurer or administrator that the covered individual receive a less expensive procedure before receiving the procedure that was the subject of the denied claim.

(e) An insurer or administrator described in subsection (c) shall provide, upon request, access to all records and information determined by the commissioner of insurance to be required for the department's review of the denied claims described in subsection (c).

(f) An insurer or administrator subject to review under this SECTION shall do all of the following:

(1) If a claim described in subsection (c) was denied for lack of medical necessity, disclose to the department whether, in order to determine medical necessity, the insurer or administrator had a physician:

(A) examine the covered individual; or

(B) review the medical record of the covered individual.

(2) Specify the policy or plan provision that resulted in the denied claim.

(3) Specify the health care procedure for which a claim is most frequently denied by the insurer or administrator.

(4) With respect to a denied claim described in subsection (b)(2), specify the additional information that was required for payment of the claim.

(g) The department may retain expert consultants to perform the review required by this SECTION.

(h) An insurer or administrator subject to a review under this SECTION shall pay all costs associated with the review.

(i) All records and information provided to the department under this SECTION are confidential.

(j) The department shall, not later than October 1, 2015:

(1) perform a review required by this SECTION;

(2) compile a report of the:

(A) information; and

(B) results of the review;

required by this SECTION; and

(3) provide the report to:

(A) the public health, behavioral health, and human services interim study committee established by IC 2-5-1.3-4(14); and

(B) the legislative council;

in an electronic format under IC 5-14-6.

(k) Information contained in a report provided under subsection (j) may not include any information from which the identity of an individual covered under the policy of accident and sickness or health coverage plan may be ascertained.

(l) The department may establish the procedures under which the review under this SECTION is conducted.

(m) This SECTION expires January 1, 2016.".

Delete page 22.

Renumber all SECTIONS consecutively.

(Reference is to EHB 1269 as printed April 10, 2015.)

MILLER PATRICIA