HOUSE BILL No. 1374

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Medicaid claim payments for nursing facilities. Beginning July 1, 2024, and ending December 31, 2024, requires the office of the secretary of family and social services (office) and a managed care organization to pay 87.5% of a claim to a nursing facility if the claim is not paid within a specified time. Requires the office to assess a managed care organization a fine of $4,800 per claim for failure to pay a nursing facility claim within the required time. Repeals a provision concerning reporting that has expired.

Effective: July 1, 2024.

Karickhoff

January 10, 2024, read first time and referred to Committee on Public Health.

Introduced

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

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

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

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

HOUSE BILL No. 1374

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

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

SECTION 1. IC 12-15-5-17.5 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 17.5. (a) The office shall report on its progress on the development of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services to the interim study committee on public health, behavioral health, and human services before November 1, 2021.~~

~~(b) Not later than February 1, 2022, the office shall report the following information and analysis to the legislative council and budget committee (in an electronic format under IC 5-14-6) regarding the implementation of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services, as follows:~~

~~(1) The projected utilization of home and community based services and institutional services for the four (4) years following~~

~~implementation, and including, but not limited to, information on:~~

~~(A) provider network adequacy;~~

~~(B) family caregiver programming; and~~

~~(C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.~~

~~(2) How administrative processes, including service approval and billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.~~

~~(3) Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.~~

~~(4) The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality assessment fee and supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.~~

~~(c) A request for proposal for the procurement of a Medicaid program to enroll a Medicaid recipient who is eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services in a risk based managed care program or capitated managed care program may not be issued until the request for proposal has been reviewed by the budget committee.~~

~~(d) After the review of a request for proposal by the budget committee under subsection (c), the office may not enter into a final contract that would implement a program described in subsection (c) before January 31, 2023.~~

SECTION 2. IC 12-15-13-1.5, AS AMENDED BY P.L.42-2011, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1.5. (a) This section:

(1) applies only to claims submitted for payment by nursing facilities; **and**

(2) does not apply when section 1.8 of this chapter is in effect.

(b) If the office:

(1) fails to pay a clean claim in the time required under section 1(b) of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the office shall pay the provider interest on the Medicaid allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 1(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 1(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) The office shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

SECTION 3. IC 12-15-13-1.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 1.8. (a) This section applies:**

(1) beginning July 1, 2024, and ending December 31, 2024; and

(2) to claims submitted for payment by nursing facilities.

A claim under this section is not required to meet the requirements of a clean claim.

(b) If the office fails to pay a claim in the time required under section 1(b) of this chapter, the office shall reimburse the nursing facility at least eighty-seven and one-half percent (87.5%) of the claim:

(1) twenty-two (22) days after the date the claim is filed under section 1(b)(1) of this chapter; or

(2) thirty-one (31) days after the date the claim is filed under section 1(b)(2) of this chapter.

(c) The office of the secretary shall fine a managed care organization that fails to pay a claim in the time required under section 1(b) of this chapter four thousand eight hundred dollars ($4,800) per claim. If the managed care organization continuously fails to pay claims to a nursing facility in accordance with this chapter, the office of the secretary may stop assigning Medicaid recipients to the managed care organization for the provision of services.

(d) If a claim for which a payment was made under subsection

(b) is ultimately denied for a reason other than an administrative issue with the submission of the claim, the office and the nursing facility shall agree to the manner in which the payment under subsection (b) is to be recouped from the nursing facility.

(e) This section expires January 1, 2025.