HOUSE BILL No. 1548

DIGEST OF INTRODUCED BILL

Citations Affected: IC 2-5-45; IC 4-21.5-2-6; IC 12-15.

Synopsis: Medicaid managed care matters. Establishes the joint commission on Medicaid oversight with the authority to meet throughout the year. Sets forth responsibilities of the commission. Repeals a statute specifying that Medicaid laws, with respect to managed care organizations, are controlling over insurance laws. Prohibits the office of Medicaid policy and planning or a contractor of the office from denying, delaying, or decreasing the amount of payment for a medically necessary covered service based on a lack of eligibility or coverage if the Medicaid provider meets certain requirements. Requires the secretary of the office of family and social services to adopt rules establishing a dispute resolution procedure for disputes between Medicaid providers and Medicaid contractors.

Effective: July 1, 2019.

Kirchhofer

January 17, 2019, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 121st General Assembly (2019)

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 2018 Regular and Special Session of the General Assembly.

HOUSE BILL No. 1548

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

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

1 SECTION 1. IC 2-5-45 IS ADDED TO THE INDIANA CODE AS
2 A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2019]:
4 **Chapter 45. Joint Commission on Medicaid Oversight**
5 **Sec. 1. As used in this chapter, "commission" refers to the joint**
6 **commission on Medicaid oversight established by section 3 of this**
7 **chapter.**
8 **Sec. 2. As used in this chapter, "office" refers to the office of**
9 **Medicaid policy and planning established by IC 12-8-6.5-1.**
10 **Sec. 3. The joint commission on Medicaid oversight is**
11 **established.**
12 **Sec. 4. The commission consists of twelve (12) voting members**
13 **appointed as follows:**
14 **(1) Six (6) members appointed from the senate by the**
15 **president pro tempore of the senate, not more than three (3)**
16 **of whom may be from the same political party.**
17 **(2) Six (6) members appointed from the house of**

1 **representatives by the speaker of the house of representatives,**
2 **not more than three (3) of whom may be from the same**
3 **political party.**
4 **Sec. 5. A vacancy on the commission shall be filled by the**
5 **appointing authority.**
6 **Sec. 6. The president pro tempore of the senate shall appoint a**
7 **member of the commission to serve as chairperson of the**
8 **commission from January 1 through December 31 of**
9 **even-numbered years.**
10 **Sec. 7. The speaker of the house of representatives shall appoint**
11 **a member of the commission to serve as chairperson of the**
12 **commission from January 1 through December 31 of**
13 **odd-numbered years.**
14 **Sec. 8. The commission shall do the following:**
15 **(1) Determine whether the contractor for the office under**
16 **IC 12-15-30 that has responsibility for processing provider**
17 **claims for payment under the Medicaid program has properly**
18 **performed the terms of the contractor's contract with the**
19 **state.**
20 **(2) Determine whether a managed care organization that has**
21 **contracted with the office to administer the Medicaid benefit**
22 **has properly performed the terms of the managed care**
23 **organization's contract with the state.**
24 **(3) Study and propose legislative and administrative**
25 **procedures that could help reduce the amount of time needed**
26 **to process Medicaid claims and eliminate reimbursement**
27 **backlogs, delays, and errors.**
28 **(4) Oversee the implementation of a case mix reimbursement**
29 **system developed by the office and designed for Indiana**
30 **Medicaid certified nursing facilities.**
31 **(5) Study, investigate, and propose legislative and**
32 **administrative procedures on any other matter related to**
33 **Medicaid.**
34 **(6) Study and investigate all matters related to the**
35 **implementation of the children's health insurance program**
36 **established under IC 12-17.6.**
37 **Sec. 9. The commission shall meet at the call of the chairperson.**
38 **Sec. 10. (a) Except as provided in subsections (b) and (c), the**
39 **commission shall operate under the policies governing study**
40 **committees adopted by the legislative council, including the**
41 **requirement of filing an annual report in an electronic format**
42 **under IC 5-14-6.**

(b) The commission may meet at any time during the calendar year.

(c) The commission may consider any topic concerning Medicaid, regardless of whether it was assigned to the commission to be studied by the legislative council.

Sec. 11. The affirmative votes of a majority of the voting members appointed to the commission are required for the commission to take action on any measure.

Sec. 12. The legislative services agency shall provide staff support for the commission.

Sec. 13. Each member of the commission appointed under this chapter is entitled to receive the per diem, mileage, and travel allowances paid to members of the general assembly serving on legislative study committees established by the legislative council.

Sec. 14. The contractor for the office under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program shall:

(1) review actual expenditures of the Medicaid program based on claims that are processed by the contractor; and

(2) provide oral and written reports on the expenditures to the commission:

(A) in a manner and format proposed by the commission; and

(B) whenever requested by the commission.

SECTION 2. IC 4-21.5-2-6, AS AMENDED BY P.L.53-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 6. This article does not apply to the formulation, issuance, or administrative review (but does apply to the judicial review and civil enforcement) of any of the following:

(1) Except as provided in IC 12-17.2-3.5-17, IC 12-17.2-4-18.7, IC 12-17.2-5-18.7, and IC 12-17.2-6-20, determinations by the division of family resources and the department of child services.

(2) Determinations by the alcohol and tobacco commission.

(3) Determinations by the office of Medicaid policy and planning concerning recipients and applicants of Medicaid. However, this article does apply to determinations by:

(A) the office of Medicaid policy and planning; **and**

(B) a managed care organization for purposes of IC 12-15-13-2.5;

concerning providers.

SECTION 3. IC 12-15-12-0.9 IS REPEALED [EFFECTIVE JULY 1, 2019]. ~~Sec. 0.9. (a) This section applies only with respect to the~~

~~responsibilities of a managed care organization under:~~

~~(1) this article;~~

~~(2) IC 12-17.6;~~

~~(3) 42 CFR 438; or~~

~~(4) a rule adopted under a law described in subdivision (1) or (2).~~

~~(b) If a provision of, or rule adopted under, IC 27 conflicts with the administration of the programs under a law described in subsection (a), the law described in subsection (a) is controlling.~~

SECTION 4. IC 12-15-13-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 2.5. (a) If:**

(1) a Medicaid provider, before rendering a medically necessary covered service, makes a good faith effort to verify and document the patient's eligibility for Medicaid coverage through the office's enrollment verification system;

(2) the Medicaid provider renders the medically necessary covered service in reliance on the verification described in subdivision (1); and

(3) the verification described in subdivision (1) is later determined to have been inaccurate;

the office of Medicaid policy and planning or a contractor of the office may not deny, delay, or decrease the amount of payment for the medically necessary covered service based on a lack of eligibility or coverage.

(b) The office of Medicaid policy and planning shall, in consultation with provider representatives and managed care organization representatives, adopt rules under IC 4-22-2 to establish a procedure through which a provider may dispute a payment determination made in a situation described in subsection (a). Rules adopted under this subsection must do the following:

(1) Apply to the fee for service program and the risk based managed care program.

(2) Provide for an extension of any claim filing limitation.

(3) Provide for retroactive prior authorization.

(4) Guarantee minimum payment rates of not less than the rate for the medically necessary covered service on the date of service, including any applicable add on reimbursement.

(5) Place the burden on the office or the managed care organization in proving that the payment determination was justified.

(c) An adverse action under this section is subject to IC 4-21.5.

SECTION 5. IC 12-15-21-3, AS AMENDED BY P.L.113-2014,

1 SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
2 JULY 1, 2019]: Sec. 3. The rules adopted under section 2 of this
3 chapter must include the following:
4 (1) Providing for prior review and approval of medical services.
5 (2) Specifying the method of determining the amount of
6 reimbursement for services.
7 (3) Establishing limitations that are consistent with medical
8 necessity concerning the amount, scope, and duration of the
9 services and supplies to be provided. The rules may contain
10 limitations on services that are more restrictive than allowed
11 under a provider's scope of practice (as defined in Indiana law).
12 (4) Denying payment or instructing the contractor under
13 IC 12-15-30 to deny payment to a provider for services provided
14 to an individual or claimed to be provided to an individual if the
15 office after investigation finds any of the following:
16 (A) The services claimed cannot be documented by the
17 provider.
18 (B) The claims were made for services or materials determined
19 by licensed medical staff of the office as not medically
20 reasonable and necessary.
21 (C) The amount claimed for the services has been or can be
22 paid from other sources.
23 (D) The services claimed were provided to a person other than
24 the person in whose name the claim is made.
25 (E) The services claimed were provided to a person who was
26 not eligible for Medicaid.
27 (F) The claim rises out of an act or practice prohibited by law
28 or by rules of the secretary.
29 (5) Recovering payment or instructing the contractor under
30 IC 12-15-30-3 to recover payment from a provider for services
31 rendered to an individual or claimed to be rendered to an
32 individual if the office after investigation finds any of the
33 following:
34 (A) The services paid for cannot be documented by the
35 provider.
36 (B) The amount paid for such services has been or can be paid
37 from other sources.
38 (C) The services were provided to a person other than the
39 person in whose name the claim was made and paid.
40 (D) The services paid for were provided to a person who was
41 not eligible for Medicaid.
42 (E) The paid claim rises out of an act or practice prohibited by

1 law or by rules of the secretary.
2 (6) Recovering interest due from a provider:
3 (A) at a rate that is the percentage rounded to the nearest
4 whole number that equals the average investment yield on
5 state general fund money for the state's previous fiscal year,
6 excluding pension fund investments, as published in the
7 auditor of state's comprehensive annual financial report; and
8 (B) accruing from the date of overpayment;
9 on amounts paid to the provider that are in excess of the amount
10 subsequently determined to be due the provider as a result of an
11 audit, a reimbursement cost settlement, or a judicial or an
12 administrative proceeding.
13 (7) Paying interest to providers:
14 (A) at a rate that is the percentage rounded to the nearest
15 whole number that equals the average investment yield on
16 state general fund money for the state's previous fiscal year,
17 excluding pension fund investments, as published in the
18 auditor of state's comprehensive annual financial report; and
19 (B) accruing from the date that an overpayment is erroneously
20 recovered by the office until the office restores the
21 overpayment to the provider.
22 (8) Establishing a system with the following conditions:
23 (A) Audits may be conducted by the office after service has
24 been provided and before reimbursement for the service has
25 been made.
26 (B) Reimbursement for services may be denied if an audit
27 conducted under clause (A) concludes that reimbursement
28 should be denied.
29 (C) Audits may be conducted by the office after service has
30 been provided and after reimbursement has been made.
31 (D) Reimbursement for services may be recovered if an audit
32 conducted under clause (C) concludes that the money
33 reimbursed should be recovered.
34 **(9) Establishing a dispute resolution procedure described in**
35 **IC 12-15-13-2.5 for disputes between a Medicaid provider and**
36 **a contractor under IC 12-15-30, including a time period in**
37 **which all disputes must be determined from the time the**
38 **dispute is submitted to the contractor.**