February 15, 2019

HOUSE BILL No. 1548

DIGEST OF HB 1548 (Updated February 13, 2019 7:21 pm - DI 77)

Citations Affected: IC 2-5; IC 4-21.5; 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. Adds an appointment by the Indiana Association of Health Plans to the Medicaid advisory committee (committee). Increases the membership of the committee by providing for the president pro tempore of the senate and the speaker of the house of representatives to each appoint six members (instead of one member). Provides that three of the members appointed by the president pro tempore and three of the members appointed by the speaker shall serve on a standing fiscal subcommittee of the committee. Requires that three of the members appointed by the speaker of the house of representatives and three of the members appointed by the president pro tempore be members of the minority party. Provides that subcommittees of the committee may convene as often as needed. Requires the committee to review, study, and make advisory recommendations concerning certain subjects before July 1, 2021. 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, Shackleford

January 17, 2019, read first time and referred to Committee on Public Health.
February 14, 2019, amended, reported — Do Pass.

February 15, 2019

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:

SECTION 1. IC 2-5-45 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 45. Joint Commission on Medicaid Oversight

Sec. 1. As used in this chapter, "commission" refers to the joint commission on Medicaid oversight established by section 3 of this chapter.

Sec. 2. As used in this chapter, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6.5-1.

Sec. 3. The joint commission on Medicaid oversight is established.

Sec. 4. The commission consists of twelve (12) voting members appointed as follows:

(1) Six (6) members appointed from the senate by the president pro tempore of the senate, not more than three (3) of whom may be from the same political party.

(2) Six (6) members appointed from the house of

representatives by the speaker of the house of representatives, not more than three (3) of whom may be from the same political party.

Sec. 5. A vacancy on the commission shall be filled by the appointing authority.

Sec. 6. The president pro tempore of the senate shall appoint a member of the commission to serve as chairperson of the commission from January 1 through December 31 of even-numbered years.

Sec. 7. The speaker of the house of representatives shall appoint a member of the commission to serve as chairperson of the commission from January 1 through December 31 of odd-numbered years.

Sec. 8. The commission shall do the following:

(1) Determine whether the contractor for the office under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.

(2) Determine whether a managed care organization that has contracted with the office to administer the Medicaid benefit has properly performed the terms of the managed care organization's contract with the state.

(3) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process Medicaid claims and eliminate reimbursement backlogs, delays, and errors.

(4) Oversee the implementation of a case mix reimbursement system developed by the office and designed for Indiana Medicaid certified nursing facilities.

(5) Study, investigate, and propose legislative and administrative procedures on any other matter related to Medicaid.

(6) Study and investigate all matters related to the implementation of the children's health insurance program established under IC 12-17.6.

Sec. 9. The commission shall meet at the call of the chairperson.

Sec. 10. (a) Except as provided in subsections (b) and (c), the commission shall operate under the policies governing study committees adopted by the legislative council, including the requirement of filing an annual report in an electronic format 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,

SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. The rules adopted under section 2 of this chapter must include the following:

(1) Providing for prior review and approval of medical services.

(2) Specifying the method of determining the amount of reimbursement for services.

(3) Establishing limitations that are consistent with medical necessity concerning the amount, scope, and duration of the services and supplies to be provided. The rules may contain limitations on services that are more restrictive than allowed under a provider's scope of practice (as defined in Indiana law).

(4) Denying payment or instructing the contractor under IC 12-15-30 to deny payment to a provider for services provided to an individual or claimed to be provided to an individual if the office after investigation finds any of the following:

(A) The services claimed cannot be documented by the provider.

(B) The claims were made for services or materials determined by licensed medical staff of the office as not medically reasonable and necessary.

(C) The amount claimed for the services has been or can be paid from other sources.

(D) The services claimed were provided to a person other than the person in whose name the claim is made.

(E) The services claimed were provided to a person who was not eligible for Medicaid.

(F) The claim rises out of an act or practice prohibited by law or by rules of the secretary.

(5) Recovering payment or instructing the contractor under IC 12-15-30-3 to recover payment from a provider for services rendered to an individual or claimed to be rendered to an individual if the office after investigation finds any of the following:

(A) The services paid for cannot be documented by the provider.

(B) The amount paid for such services has been or can be paid from other sources.

(C) The services were provided to a person other than the person in whose name the claim was made and paid.

(D) The services paid for were provided to a person who was not eligible for Medicaid.

(E) The paid claim rises out of an act or practice prohibited by

law or by rules of the secretary.

(6) Recovering interest due from a provider:

(A) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state general fund money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(B) accruing from the date of overpayment;

on amounts paid to the provider that are in excess of the amount subsequently determined to be due the provider as a result of an audit, a reimbursement cost settlement, or a judicial or an administrative proceeding.

(7) Paying interest to providers:

(A) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state general fund money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(B) accruing from the date that an overpayment is erroneously recovered by the office until the office restores the overpayment to the provider.

(8) Establishing a system with the following conditions:

(A) Audits may be conducted by the office after service has been provided and before reimbursement for the service has been made.

(B) Reimbursement for services may be denied if an audit conducted under clause (A) concludes that reimbursement should be denied.

(C) Audits may be conducted by the office after service has been provided and after reimbursement has been made.

(D) Reimbursement for services may be recovered if an audit conducted under clause (C) concludes that the money reimbursed should be recovered.

(9) Establishing a dispute resolution procedure described in IC 12-15-13-2.5 for disputes between a Medicaid provider and a contractor under IC 12-15-30, including a time period in which all disputes must be determined from the time the dispute is submitted to the contractor.

SECTION 6. IC 12-15-33-3, AS AMENDED BY P.L.114-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. **(a)** The committee shall be appointed as follows:

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

(A) Indiana Council of Community Mental Health Centers.

(B) Indiana State Medical Association.

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

(D) Indiana Hospital Association.

(E) Indiana Dental Association.

(F) Indiana State Psychiatric Association.

(G) Indiana State Osteopathic Association.

(H) Indiana State Nurses Association.

(I) Indiana State Licensed Practical Nurses Association.

(J) Indiana State Podiatry Association.

(K) Indiana Health Care Association.

(L) Indiana Optometric Association.

(M) Indiana Pharmaceutical Association.

(N) Indiana Psychological Association.

(O) Indiana State Chiropractic Association.

(P) Indiana Ambulance Association.

(Q) Indiana Association for Home Care.

(R) Indiana Academy of Ophthalmology.

(S) Indiana Speech and Hearing Association.

(T) Indiana Academy of Physician Assistants.

(U) Indiana Association of Rehabilitation Facilities.

(V) Indiana Association of Health Plans.

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

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

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

(C) One (1) member who represents labor interests.

(D) One (1) member who represents insurance interests.

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

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

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

(3) ~~One (1) member~~ **Six (6) members** shall be appointed by the president pro tempore of the senate acting in the capacity as president pro tempore of the senate to represent the senate. **Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.**

(4) ~~One (1) member~~ **Six (6) members** shall be appointed by the speaker of the house of representatives to represent the house of representatives. **Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.**

(b) Notwithstanding subsection (a)(3), after consultation with the minority leader of the senate, the president pro tempore of the senate shall appoint three (3) of the members from the minority party of the senate.

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

SECTION 7. IC 12-15-33-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 8. **(a)** A subcommittee may be created as the committee considers necessary.

(b) The committee shall create a standing fiscal subcommittee.

(c) The chairman of each subcommittee must be a member of the committee.

(d) Subcommittees may convene as often as needed.

SECTION 8. IC 12-15-33-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.5 (a) The committee shall review, study, and make advisory recommendations concerning the following subjects:**

(1) Review emergency department coverage and reimbursement to providers.

(2) The reporting of Medicaid prior authorization denials by Medicaid managed care entities, excluding pharmacies.

(3) The reporting of Medicaid denials based on:

(A) administrative and medically necessary criteria; or

(B) errors or omissions made by the managed care entity.

(4) Prompt payment to providers for claims:

(A) within thirty (30) days;

(B) within ninety (90) days;

(C) within one hundred eighty (180) days; and

(D) over three hundred sixty-five (365) days.

(5) The provider appeals process for administrative and medically necessary Medicaid denials and the resolution of appeals, including rates of reversal.

(6) The central credentialing portal.

(7) Policy changes to the Medicaid program with an

implementation period for providers or managed care entities of more than thirty (30) days.

(8) The reporting of Medicaid denials due to retro-eligibility status.

(9) Other subjects, as the committee considers necessary.

(b) This section expires July 1, 2021.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1548, 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:

Page 6, after line 38, begin a new paragraph and insert:

"SECTION 6. IC 12-15-33-3, AS AMENDED BY P.L.114-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3. **(a)** The committee shall be appointed as follows:

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

(A) Indiana Council of Community Mental Health Centers.

(B) Indiana State Medical Association.

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

(D) Indiana Hospital Association.

(E) Indiana Dental Association.

(F) Indiana State Psychiatric Association.

(G) Indiana State Osteopathic Association.

(H) Indiana State Nurses Association.

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(J) Indiana State Podiatry Association.

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(S) Indiana Speech and Hearing Association.

(T) Indiana Academy of Physician Assistants.

(U) Indiana Association of Rehabilitation Facilities.

(V) Indiana Association of Health Plans.

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

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

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

(C) One (1) member who represents labor interests.

(D) One (1) member who represents insurance interests.

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

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

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

(3) ~~One (1) member~~ **Six (6) members** shall be appointed by the president pro tempore of the senate acting in the capacity as president pro tempore of the senate to represent the senate. **Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.**

(4) ~~One (1) member~~ **Six (6) members** shall be appointed by the speaker of the house of representatives to represent the house of representatives. **Three (3) of the members appointed under this subdivision shall serve on the standing fiscal subcommittee created under section 8(b) of this chapter.**

(b) Notwithstanding subsection (a)(3), after consultation with the minority leader of the senate, the president pro tempore of the senate shall appoint three (3) of the members from the minority party of the senate.

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

SECTION 7. IC 12-15-33-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 8. **(a)** A subcommittee may be created as the committee considers necessary.

(b) The committee shall create a standing fiscal subcommittee.

(c) The chairman of each subcommittee must be a member of the committee.

(d) Subcommittees may convene as often as needed.

SECTION 8. IC 12-15-33-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.5 (a) The committee shall review, study, and make advisory recommendations concerning the following subjects:**

(1) Review emergency department coverage and reimbursement to providers.

(2) The reporting of Medicaid prior authorization denials by Medicaid managed care entities, excluding pharmacies.

(3) The reporting of Medicaid denials based on:

(A) administrative and medically necessary criteria; or

(B) errors or omissions made by the managed care entity.

(4) Prompt payment to providers for claims:

(A) within thirty (30) days;

(B) within ninety (90) days;

(C) within one hundred eighty (180) days; and

(D) over three hundred sixty-five (365) days.

(5) The provider appeals process for administrative and medically necessary Medicaid denials and the resolution of appeals, including rates of reversal.

(6) The central credentialing portal.

(7) Policy changes to the Medicaid program with an implementation period for providers or managed care entities of more than thirty (30) days.

(8) The reporting of Medicaid denials due to retro-eligibility status.

(9) Other subjects, as the committee considers necessary.

(b) This section expires July 1, 2021.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1548 as introduced.)

KIRCHHOFER

Committee Vote: yeas 13, nays 0.