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.

SENATE ENROLLED ACT No. 132

AN ACT to amend the Indiana Code concerning professions and occupations.

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

SECTION 1. IC 12-7-2-48.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 48.7. "Covered population", for purposes of IC 12-15-13-1.8, has the meaning set forth in IC 12-15-13-1.8(a).**

SECTION 2. IC 12-15-11-9, AS AMENDED BY P.L.190-2023, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9. (a) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the managed care organization or contractor of the office without returning the application to the provider for a revision or clarification.

(b) As used in this section, "credentialing" means a process by which a managed care organization or contractor of the office makes a determination that:

(1) is based on criteria established by the managed care organization or contractor of the office; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for Medicaid services; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and managed care organization or contractor of the office.

(c) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(d) This section applies to a managed care organization or contractor of the office.

(e) If the office or managed care organization issues a provisional credential to a provider under subsection (j), the office or managed care organization shall:

(1) issue a final credentialing determination not later than sixty (60) calendar days after the date in which the provider was provisionally credentialed; and

(2) except as provided in subsection (l), provide retroactive reimbursement under subsection (k).

(f) The office shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by a managed care organization or contractor of the office; and

(2) a managed care organization or contractor of the office that performs credentialing activities.

(g) A managed care organization or contractor of the office shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(h) A provider shall respond to the notification required under subsection (g) not later than five (5) business days after receipt of the notice.

(i) A managed care organization or contractor of the office shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the entity makes a final credentialing determination

concerning the provider.

(j) If the managed care organization or contractor of the office fails to issue a credentialing determination within fifteen (15) **business** days after receiving a completed clean credentialing application form from a provider, the managed care organization or contractor of the office shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(k) Once a managed care organization or contractor of the office fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The managed care organization or contractor of the office shall reimburse the provider at the rates determined by the contract between the provider and the:

(1) managed care organization; or

(2) contractor of the office.

(l) If a managed care organization or contractor of the office does not fully credential a provider that is provisionally credentialed under subsection (j), the provisional credentialing is terminated on the date the managed care organization or contractor of the office notifies the provider of the adverse credentialing determination. The managed care organization or contractor of the office is not required to reimburse for services rendered while the provider was provisionally credentialed.

(m) A managed care organization or contractor of the office may not require additional credentialing requirements in order to participate in a managed care organization's network. However, a contractor may collect additional information from the provider in order to complete a contract or provider agreement.

(n) A managed care organization or contractor of the office is not required to contract with a provider.

(o) A managed care organization or contractor of the office shall:

(1) send representatives to meetings and participate in the credentialing process as determined by the office; and

(2) not require additional credentialing information from a provider if a non-network credentialed provider is used.

(p) Except when a provider is no longer enrolled with the office, a credential acquired under this chapter is valid until recredentialing is required.

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

(r) The office may adopt rules under IC 4-22-2 to implement this section.

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) As used in this section, "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (b).**

(b) An individual is a member of the covered population if the individual:

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

(2) is:

(A) at least sixty (60) years of age;

(B) blind, aged, or disabled; and

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

(i) The aged and disabled Medicaid waiver.

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

(iii) The state Medicaid plan.

(c) The office of the secretary may implement a risk based managed care program for the covered population.

(d) The office of Medicaid policy and planning and the managed care organizations that intend to participate in the risk based managed care program established under subsection (c) shall conduct a claims submission testing period before the risk based managed care program is implemented under subsection (c).

(e) The office of Medicaid policy and planning shall convene a workgroup for purposes of this section. The members of the workgroup shall consist of the fiscal officer of the office of Medicaid policy and planning, representatives of managed care organizations that intend to participate in the risk based managed care program established under subsection (c) who are appointed by the director, and provider representatives appointed by the director. The workgroup shall do the following:

(1) Develop a uniform billing format to be used by the managed care organizations participating in the risk based managed care program established under subsection (c).

(2) Seek and receive feedback on the claims submission testing period conducted under subsection (d).

(3) Advise the office of Medicaid policy and planning on claim

submission education and training needs of providers participating in the risk based managed care program established under subsection (c).

(4) Develop a policy for defining "claims submitted appropriately" for the purposes of subsection (g)(1) and (g)(2).

(f) Subsections (g) through (k) apply during the first two hundred ten (210) days after the risk based managed care program for the covered population is implemented under subsection (c).

(g) The office of Medicaid policy and planning shall establish a temporary emergency financial assistance program for providers that experience financial emergencies due to claims payment issues while participating in the risk based managed care program established under subsection (c). For purposes of the program established under this subsection, a financial emergency exists:

(1) when the rate of denial of claims submitted in one (1) billing period by the provider to a managed care organization exceeds fifteen percent (15%) of claims submitted appropriately by the provider to the managed care organization under the risk based managed care program;

(2) when the provider, twenty-one (21) days after appropriately submitting claims to a managed care organization under the risk based managed care program, has not received payment for at least twenty-five thousand dollars ($25,000) in aggregate claims from the managed care organization;

(3) when, in the determination of the director, the claim submission system of a managed care organization with which the provider is contracted under the risk based managed care program experiences failure or overload; or

(4) upon the occurrence of other circumstances that, in the determination of the director, constitute a financial emergency for a provider.

(h) To be eligible for a payment of temporary emergency financial assistance under the program established under subsection (g), a provider:

(1) must have participated in the claims submission testing period conducted under subsection (d) for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c); and

(2) must submit to the office of Medicaid policy and planning

a written request that includes all of the following:

(A) Documentation providing evidence of the provider's financial need for emergency assistance.

(B) Evidence that the provider's billing staff participated in claims submission education and training offered through the risk based managed care program established under subsection (c).

(C) Evidence that the provider participated in the claims submission testing period conducted under subsection (d) for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c).

(D) Evidence of a consistent effort by the provider to submit claims in accordance with the uniform billing requirements developed under subsection (e)(1).

(i) The office of Medicaid policy and planning:

(1) shall determine whether a provider is experiencing a financial emergency based upon the provider's submission of a written request that meets the requirements of subsection (h)(2); and

(2) shall make a determination whether a provider is experiencing a financial emergency not more than seven (7) calendar days after it receives a written request submitted by a provider under subsection (h)(2).

(j) If the office of Medicaid policy and planning determines that a provider is experiencing a financial emergency for purposes of the program established under subsection (g), it shall direct each managed care organization with which the provider is contracted under the risk based managed care program established under subsection (c) to provide a temporary emergency assistance payment to the provider. A managed care organization directed to provide a temporary emergency assistance payment to a provider under this subsection shall provide the payment in not more than seven (7) calendar days after the office directs the managed care organization to provide the payment. The amount of the temporary emergency assistance payment that a managed care organization shall make to a provider under this subsection is equal to seventy-five percent (75%) of the monthly average of the provider's long-term services and supports Medicaid claims for the six (6) month period immediately preceding the implementation of the risk based managed care program under subsection (c), adjusted in proportion to the ratio of the managed care

organization's covered population membership to the total covered population membership of the risk based managed care program established under subsection (c).

(k) Upon issuing any payment of a temporary emergency assistance to a provider under subsection (j), a managed care organization shall set up a receivable to reconcile the temporary emergency assistance funds with actual claims payment amounts. A managed care organization shall reconcile the temporary emergency assistance payment funds with actual claims payment amounts on the first day of the month that is more than thirty-one (31) days after the managed care organization issues the temporary emergency assistance funds to the provider. If a temporary emergency assistance payment is issued to a provider, managed care organizations are still required to meet contract obligations for reviewing and paying claims, specifically claims that total a payment in excess of the temporary emergency assistance payment reconciliation. However, if a managed care organization fails to comply with a directive of the office of Medicaid policy and planning under subsection (j) to provide a temporary emergency assistance payment to a provider, the failure of the managed care organization:

(1) is a violation of the claim processing requirements of the managed care organization's contract; and

(2) makes the managed care organization subject to the penalties set forth in the contract, including payment of interest on the amount of the unpaid temporary emergency assistance at the rate set forth in IC 12-15-21-3(7)(A).

SECTION 4. IC 16-21-6-3, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, ~~for 2022,~~ the state department shall grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.
(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health

insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from facility fees provided ~~from facility fees~~ to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health

insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(C) The total net patient revenue and total number of paid claims from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(10) A statement including:
(A) Medicare gross revenue;
(B) Medicaid gross revenue;
(C) other revenue from state programs;
(D) revenue from local government programs;
(E) local tax support;
(F) charitable contributions;
(G) other third party payments;
(H) gross inpatient revenue;
(I) gross outpatient revenue;
(J) contractual allowance;
(K) any other deductions from revenue;
(L) charity care provided;
(M) itemization of bad debt expense; and
(N) an estimation of the unreimbursed cost of subsidized health services.
(11) A statement itemizing donations.
(12) A statement describing the total cost of reimbursed and unreimbursed research.
(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:
(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.
(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.
(C) Education of patients concerning diseases and home care in response to community needs.
(D) Community health education through informational

programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

~~(d) If a hospital submitted the hospital's report for 2022 before July 1, 2023, the hospital must submit a revised report with the data set forth in subsection (a)(7) through (a)(9) before December 1, 2023. This subsection expires December 31, 2023.~~

SECTION 5. IC 25-1-9.5-9, AS AMENDED BY P.L.85-2021, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9. (a) A practitioner who is physically located outside Indiana is engaged in the provision of health care services in Indiana when the practitioner:

(1) establishes a provider-patient relationship under this chapter with; or

(2) determines whether to issue a prescription under this chapter for;

an individual who is located in Indiana.

(b) A practitioner described in subsection (a) ~~may not establish a provider-patient relationship under this chapter with or issue a prescription under this chapter for an individual who is located in Indiana unless the practitioner and the practitioner's employer or the practitioner's contractor, for purposes of providing health care services under this chapter, have certified in writing to the Indiana professional licensing agency, in a manner specified by the Indiana professional licensing agency, that the practitioner and the practitioner's employer or practitioner's contractor agree~~ **agrees** to be subject to:

(1) the jurisdiction of the courts of law of Indiana; and

(2) Indiana substantive and procedural laws;

concerning any claim asserted against the practitioner, the practitioner's employer, or the practitioner's contractor arising from the provision of health care services under this chapter to an individual who is located in Indiana at the time the health care services were provided. The ~~filing of the certification under this subsection shall constitute~~ **provision of**

health care services described in subsection (a)(1) and (a)(2) by a practitioner described in subsection (a) constitutes a voluntary waiver by the practitioner, the practitioner's employer, or the practitioner's contractor of any respective right to avail themselves of the jurisdiction or laws other than those specified in this subsection concerning the claim. ~~However, a practitioner that practices predominately in Indiana is not required to file the certification required by this subsection.~~

~~(c) A practitioner shall renew the certification required under subsection (b) at the time the practitioner renews the practitioner's license.~~

~~(d) A practitioner's employer or a practitioner's contractor is required to file the certification required by this section only at the time of initial certification.~~

SECTION 6. IC 25-1-9.5-10, AS AMENDED BY P.L.85-2021, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 10. (a) A practitioner who violates this chapter is subject to disciplinary action under IC 25-1-9.

(b) A practitioner's employer or a practitioner's contractor that violates this section commits a Class B infraction. ~~for each act in which a certification is not filed as required by section 9 of this chapter.~~

SECTION 7. IC 25-19-1-3, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) The board may issue licenses to qualified persons as health facility administrators.

(b) A person who applies to the board to practice as a health facility administrator must:

(1) not have been convicted of a crime that has a direct bearing on the person's ability to practice competently in accordance with ~~IC 25-1-21;~~ **IC 25-1-1.1;**

(2) successfully complete an administrator in training **internship** program **described in section 18 of this chapter;**

(3) achieve a passing score, as determined by the board, on a state jurisprudence examination described in section 3.2 of this chapter; **and**

(4) successfully complete the national examination. ~~and~~

~~(5) meet one (1) of the following:~~

~~(A) Possess a bachelor's degree or higher degree from an accredited postsecondary educational institution.~~

~~(B) Possess an associate's associate degree from an accredited postsecondary educational institution and complete a~~

~~specialized course of study in long term health care administration, as prescribed by the board.~~

~~(C) Complete a specialized course of study in long term care administration prescribed by the board.~~

(c) Subject to section 3.3 of this chapter, the board may issue a provisional license for a single period not to exceed six (6) months for the purpose of enabling a qualified individual to fill a health facility administrator position that has been unexpectedly vacated.

SECTION 8. IC 25-19-1-3.3, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3.3. (a) The board may issue a provisional health facility administrator license ~~or provisional residential care administrator license~~ to an individual for a specific licensed health facility or residential care facility if the individual has:

(1) at least two (2) years of administrative experience in a licensed health facility; ~~or residential care facility;~~ and

(2) not been convicted of a crime that has a direct bearing on the individual's ability to practice competently in accordance with ~~IC 25-1-21.~~ **IC 25-1-1.1.**

(b) The board may issue a provisional residential care administrator license to an individual for a specific residential care facility if the individual has:

(1) at least two (2) years of administrative experience in a residential care facility; and

(2) not been convicted of a crime that has a direct bearing on the individual's ability to practice competently in accordance with ~~IC 25-1-21.~~ **IC 25-1-1.1.**

(c) Subject to subsection (d), the chair of the board may issue a provisional health facility administrator license or a provisional residential care administrator license to an individual who appears to be qualified.

(d) If the board determines that an individual described in subsection (c) fails to meet all applicable ~~qualification~~ **qualifications** for a provisional license described in subsection (a) or (b), the board may withdraw the provisional license.

(e) Experience that an individual gains while practicing health facility administration with a provisional license issued under this section may count toward the requirements for an administrator in training **program,** as approved by the board.

SECTION 9. IC 25-19-1-9.5, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL

ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 9.5. (a) Subject to IC 25-1-8-6, a health facility administrator or residential care administrator whose license is in inactive status may apply to the board to renew the administrator's license.

(b) A health facility administrator or residential care administrator while in an inactive status may not practice as a health facility administrator or residential care administrator.

(c) A licensed health facility administrator who has been inactive must show proof of having completed forty (40) hours of continuing education within the two (2) year period immediately before the date the reactivation application is filed.

(d) A licensed residential care administrator who has been inactive must show proof of having ~~competed~~ **completed** twenty (20) hours of continuing education within the two (2) year period immediately before the date the reactivation application is filed.

(e) The board may request that a licensed health facility administrator **or residential care administrator** who has been inactive for a period of more than three (3) years at the date the reactivation application is filed make a personal appearance before the board to answer any questions from the board about the application that are unresolved before making a determination on the application.

SECTION 10. IC 25-19-1-10, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 10. (a) The board shall issue a health facility administrator's license to any person who applies for a health facility administrator license, if the applicant:

(1) does not have a criminal history that disqualifies the applicant from obtaining a health facility administrator license in Indiana in accordance with ~~IC 25-1-21;~~ **IC 25-1-1.1;**

(2) has practiced in another state for at least one (1) year as a:

(A) licensed health facility administrator and currently holds an active license in good standing as a health facility administrator in another state;

(B) chief executive officer of a hospital; or

(C) chief operations officer of a hospital; and

(3) has successfully completed the:

(A) national examination; and

(B) Indiana jurisprudence examination, as approved by the board.

(b) The board shall issue a residential care administrator license to

any person who applies for a residential care administrator license, if the applicant:

(1) does not have a criminal history that disqualifies the applicant from obtaining a residential care administrator license in Indiana in accordance with ~~IC 25-1-21;~~ **IC 25-1-1.1;** and

(2) has practiced in another state for at least one (1) year as a:

(A) licensed health facility administrator and currently holds an active license in good standing as a health facility administrator in another state;

(B) licensed, certified, or registered residential care administrator and currently holds an active license, certification, or registration that is in good standing as a residential care administrator in another state;

(C) chief executive officer of a hospital; or

(D) chief operations officer of a hospital.

(c) The board shall issue a health facility administrator license or a residential care administrator license to an individual who:

(1) holds an approved National Association of Long Term Care ~~Administrators Board~~ **Administrator Boards** Health Services Executive license in good standing; and

(2) does not have a criminal history that disqualifies the applicant from obtaining a health facility administrator license or a residential care administrator license in Indiana in accordance with ~~IC 25-1-21.~~ **IC 25-1-1.1.**

SECTION 11. IC 25-19-1-15 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 15. An individual who is licensed as a health facility administrator or residential care administrator shall display the individual's license in a prominent location in the individual's principal office.~~

SECTION 12. IC 25-19-1-16 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 16. Upon receipt of satisfactory evidence from a licensed health facility administrator or licensed residential care administrator that the administrator's license has been:~~

~~(1) lost;~~

~~(2) stolen;~~

~~(3) mutilated; or~~

~~(4) destroyed;~~

~~the board shall issue a duplicate license to the administrator.~~

SECTION 13. IC 25-19-1-17, AS ADDED BY P.L.149-2023, SECTION 40, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 17. (a) This section applies to an administrator in training or a student intern seeking licensure as a health facility

administrator.

(b) An administrator in training or student intern ~~shall satisfactorily complete~~ **may take** a **specialized** course ~~prescribed~~ **that:**

(1) is approved by the board ~~that~~ **as described in section 18 of this chapter;**

(2) includes instruction and training on: ~~the following:~~

~~(1)~~ **(A)** standards of competent practice;

~~(2)~~ **(B)** facility administration and management;

~~(3)~~ **(C)** housekeeping and laundry;

~~(4)~~ **(D)** nursing;

~~(5)~~ **(E)** dietary needs of residents;

~~(6)~~ **(F)** facility related activities;

~~(7)~~ **(G)** business office management; **and**

~~(8)~~ **(H)** facility admission and marketing; **and**

(3) may include instruction and training on other subjects.

~~(c) The course described in subsection (b) must occur in a licensed comprehensive care facility.~~

SECTION 14. IC 25-19-1-18, AS ADDED BY P.L.149-2023, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 18. (a) An administrator in training seeking licensure as a health facility administrator shall do the following:

(1) File an administrator in training application with the board and be approved by the board before starting an internship program.

~~(2) Meet educational requirements described in section 3 of this chapter at the time the administrator in training files an application.~~

~~(3)~~ **(2)** Observe and become familiar with the responsibilities and duties of the preceptor or approved training center and administrator in training.

~~(4)~~ **(3)** Be assigned responsibilities in each health facility department, with experience on every shift, including weekends.

~~(5)~~ **(4)** Serve as an administrator in training for at least twenty (20) hours per week and not more than ten (10) hours per day.

~~(6)~~ **(5)** Complete the internship program in not less than three (3) months and not more than twelve (12) months for a minimum total of hours as follows:

(A) An administrator in training who:

(i) holds an associate degree, bachelor's degree, master's degree, or doctoral degree; and

(ii) has at least two (2) years of long term care experience;

shall complete a total of six hundred eighty (680) hours of

training, of which two hundred (200) hours may be fulfilled by successfully completing a two hundred (200) hour state approved, specialized course in long term care management.

(B) An administrator in training who:

(i) holds an associate degree, bachelor's degree, master's degree, or doctoral degree; and

(ii) does not have long term care experience;

shall complete a total of eight hundred eighty (880) hours of training, of which two hundred (200) hours may be fulfilled by successfully completing a two hundred (200) hour state approved, specialized course in long term care management.

(C) An administrator in training who holds a high school diploma or general educational development (GED) diploma shall complete a total of one thousand forty (1,040) hours of training, of which two hundred (200) hours may be fulfilled by successfully completing a two hundred (200) hour state approved, specialized course in long term care management.

~~(7)~~ **(6)** Seek and accept instruction and assistance from the preceptor or approved training center.

~~(8)~~ **(7)** Notify the board on a form prescribed by the board of any change of status or discontinuance of the administrator in training program.

~~(9)~~ **(8)** Upon completion of the program, provide to the board an affidavit stating the administrator in training has fulfilled the requirements of the program.

(b) An administrator in training may not:

(1) have been convicted of a crime that has a direct bearing on the administrator in training's ability to practice competently in accordance with ~~IC 25-1-21;~~ **IC 25-1-1.1;** and

(2) hold a position in the health facility during the hours of the administrator in training program.

(c) The board may waive up to thirty percent (30%) of the total required training hours for an administrator in training described in subsection ~~(a)(6)(C)~~ **(a)(5)(C)** if:

(1) the administrator in training has served in a long term care facility department manager position, based upon criteria approved by the board; and

(2) the administrator in training's experience described in subdivision (1) is verifiable to the board's satisfaction.

(d) Except as provided in subsection (e), an administrator in training may serve up to twenty percent (20%) of the internship in a setting other than the preceptor's facility.

(e) An administrator in training in an approved training center may, at the discretion of the approved training center, exceed the twenty percent (20%) limit described in subsection (d).

(f) The board may take appropriate action for failure of an administrator in training to comply with this section.

(g) The administrator in training internship program must adequately prepare administrators in training to meet the facility administration duties and policies described in IC 25-19-2.

SECTION 15. IC 25-19-1-20, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 20. (a) To qualify as a preceptor, an applicant must:

(1) be currently licensed as a health facility administrator under this article;

(2) be in good standing and not the subject of a disciplinary action by the board;

(3) file an application with the board and be approved before serving as the preceptor;

(4) complete a board approved educational program;

(5) provide to the board, with the administrator in training application, a certificate of completion for a program described in subdivision (4);

(6) have the training, knowledge, professional activity, and a facility or organizational setting at the individual's disposal to teach prospective health facility ~~administrator~~ **administrators** or residential care facility administrators; **and**

(7) meet one (1) of the following:

(A) Have active work experience as a health facility administrator for at least two (2) years prior to the date of serving as a preceptor.

(B) Be currently employed as a chief executive officer of a continuing care retirement community.

(C) Be currently employed as a regional manager for a health facility.

(D) Be employed by an administrator in training school.

(b) An individual who submits an application to be a preceptor shall file a new application for each administrator in training applicant for whom the preceptor applicant intends to serve as a preceptor.

(c) An individual who meets the requirements of this section and is approved as a preceptor by the board shall do the following:

(1) Act as a teacher rather than an employer and provide the

administrator in training with educational opportunities.

(2) Inform the board if an administrator in training presents a problem that may affect the facility's service and operation or the administrator in training program.

(3) Notify the board on a form prescribed by the board of a change of status or discontinuance of the administrator in training program.

(4) Upon completion of the program, submit to the board an affidavit, as prescribed by the board, stating that the requirements described in section 17 of this chapter have been met.

(5) Maintain the records of an administrator in training program for a period of five (5) years and, upon request by the board, allow the board to review the records.

(6) Except for a preceptor in an approved training center or as necessary to accommodate a special situation or emergency, spend a majority of the required work hours during normal daytime business hours in the facility where training occurs.

(d) Except as provided in subsection (e), a preceptor who serves as an administrator of a licensed comprehensive care facility ~~or residential care facility~~ may not supervise more than two (2) administrators in training at any given time.

(e) A preceptor may supervise more than two (2) administrators in training at a given time:

(1) if the administrator in training is enrolled in:

(A) an approved training center; or

(B) a postsecondary educational institution accredited program; or

(2) at the discretion of the board.

(f) A preceptor may precept more than two (2) administrators in training but not more than four (4) administrators in training if:

(1) the preceptor's sole duty is that of a preceptor; and

(2) the preceptor spends at least eight (8) hours per week with each administrator in training.

A preceptor shall affirm to the professional licensing agency compliance with this subsection.

(g) A preceptor's approval as a preceptor expires when the administrator in training applicant that the preceptor is supervising completes the course of instruction and training prescribed by the board or fails to complete the requirements described in section 18 of this chapter.

(h) The board reserves the right to take appropriate action for failure of a preceptor to comply with this section.

SECTION 16. IC 25-19-1-21, AS ADDED BY P.L.149-2023, SECTION 44, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 21. (a) Except as provided in subsection (b), to qualify as a postsecondary educational institution accredited program preceptor, an applicant must demonstrate that the program has faculty members who are currently licensed as health facility administrators under this article to instruct student interns in a health facility in accordance with ~~section 17 of~~ this chapter.

(b) A postsecondary educational institution accredited program faculty member who does not provide instruction in a health facility is not required to be a licensed health facility administrator.

(c) To serve as a preceptor, a currently licensed health facility administrator who is part of a postsecondary educational institution accredited program's faculty described in subsection (a):

(1) must have attended, within the five (5) years prior to becoming a faculty member, a board approved educational preceptor program and provide the university accredited program with a certificate of completion; and

(2) may not have any disciplinary action taken by the board against the health facility administrator in the last two (2) years.

(d) Each approved postsecondary educational institution accredited program preceptor shall do the following:

(1) Act as a teacher rather than an employer and provide a student intern with educational opportunities.

(2) Inform the board if the student intern presents any problems that may affect the facility's service and operation or the student internship program.

(3) Notify the board on a form prescribed by the board of any change in status or discontinuance of the student internship program.

(4) Upon a student's completion of the program, submit to the board an affidavit, as prescribed by the board, stating that the requirements described in section 17 of this chapter have been met.

(5) Maintain the records of student internship programs for a period of five (5) years, and, upon request by the board, allow the board to review the records.

(e) A preceptor's approval as a preceptor expires when the student intern that the preceptor is supervising completes the course of instruction and training prescribed by the board or fails to complete the requirements described in section 19 of this chapter.

(f) The applicant for approval as a preceptor shall file a new

application for each student intern applicant for whom the preceptor applicant desires to serve as a preceptor.

(g) The board reserves the right to take appropriate action for failure of a preceptor to comply with the duties enumerated above.

SECTION 17. IC 25-23-1-11, AS AMENDED BY P.L.148-2023, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 11. (a) Any person who applies to the board for a license to practice as a registered nurse must:

(1) not have:

(A) been convicted of a crime that has a direct bearing on the person's ability to practice competently; or

(B) committed an act that would constitute a ground for a disciplinary sanction under IC 25-1-9;

(2) have completed:

(A) the prescribed curriculum and met the graduation requirements of a state accredited program of registered nursing that only accepts students who have a high school diploma or its equivalent as determined by the board; or

(B) the prescribed curriculum and graduation requirements of a nursing education program in a foreign country that is substantially equivalent to a board approved program as determined by the board. The board may by rule adopted under IC 4-22-2 require an applicant under this subsection to successfully complete an examination approved by the board to measure the applicant's qualifications and background in the practice of nursing and proficiency in the English language; and

(3) be physically and mentally capable of and professionally competent to safely engage in the practice of nursing as determined by the board.

The board may not require a person to have a baccalaureate degree in nursing as a prerequisite for licensure. **An applicant meets the English proficiency requirement under subdivision (2) if the applicant passes an English course as certified in the transcript from the board's approved nursing education program or submits proof of passing the National Council Licensure Examination (NCLEX) that was taken in only the English language.**

(b) The applicant must pass an examination in such subjects as the board may determine.

(c) The board may issue a temporary registered nurse permit to practice as a registered nurse applicant to a person who has initially applied for license by examination, after the board receives the

necessary materials to determine compliance with subsection (a). The temporary registered nurse permit is valid until the earlier of six (6) months after issuance or the registered nurse applicant's examination results under subsection (b) are received. If the registered nurse applicant does not receive a passing score on the first examination under subsection (b), the temporary registered nurse permit is no longer valid.

(d) A registered nurse applicant must:

(1) practice under the supervision of a registered nurse; and

(2) use the abbreviation "RNG" after the registered nurse graduate's name.

(e) The board may issue by endorsement a license to practice as a registered nurse to an applicant who has been licensed as a registered nurse, by examination, under the laws of another state if the applicant presents proof satisfactory to the board that, at the time that the applicant applies for an Indiana license by endorsement, the applicant holds a current license in another state and possesses credentials and qualifications that are substantially equivalent to requirements in Indiana for licensure by examination. The board may specify by rule what constitutes substantial equivalence under this subsection.

(f) The board may issue by endorsement a license to practice as a registered nurse to an applicant who:

(1) has completed the English version of the:

(A) Canadian Nurse Association Testing Service Examination (CNAT); or

(B) Canadian Registered Nurse Examination (CRNE);

(2) achieved the passing score required on the examination at the time the examination was taken;

(3) is currently licensed in a Canadian province or in another state; and

(4) meets the other requirements under this section.

(g) The board shall issue by endorsement **or examination** a license to practice as a registered nurse to an applicant who:

(1) is a graduate of a foreign nursing school;

(2) **has successfully passed the National Council Licensure Examination (NCLEX);**

(3) provides:

(A) documentation that the applicant has:

(i) taken an examination prepared by the Commission on Graduates of Foreign Nursing Schools International, Inc. (CGFNS); and

(ii) achieved the passing score required on the examination

at the time the examination was taken;

(B) a satisfactory Credentials Evaluation Service Professional Report issued by CGFNS; ~~or~~

(C) a satisfactory VisaScreen Certificate verification letter issued by CGFNS; ~~and~~ **or**

(D) a satisfactory credential verification assessment from an organization that is a member of the National Association of Credential Evaluation Services or any other organization approved by the board; and

~~(3)~~ **(4)** meets the other requirements of this section.

(h) Each applicant for examination and registration to practice as a registered nurse shall pay:

(1) a fee set by the board; and

(2) if the applicant is applying for a multistate license (as defined in IC 25-42-1-11) under IC 25-42 (Nurse Licensure Compact), a fee of twenty-five dollars ($25) in addition to the fee under subdivision (1);

a part of which must be used for the rehabilitation of impaired registered nurses and impaired licensed practical nurses. Payment of the fee or fees shall be made by the applicant prior to the date of examination.

(i) The lesser of the following amounts from fees collected under subsection (h) shall be deposited in the impaired nurses account of the state general fund established by section 34 of this chapter:

(1) Twenty-five percent (25%) of the license application fee per license applied for under this section.

(2) The cost per license to operate the impaired nurses program, as determined by the Indiana professional licensing agency.

(j) Any person who holds a license to practice as a registered nurse in Indiana or under IC 25-42 may use the title "Registered Nurse" and the abbreviation "R.N.". No other person shall practice or advertise as or assume the title of registered nurse or use the abbreviation of "R.N." or any other words, letters, signs, or figures to indicate that the person using same is a registered nurse.

SECTION 18. IC 25-23-1-12, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 12. (a) A person who applies to the board for a license to practice as a licensed practical nurse must:

(1) not have been convicted of:

(A) an act which would constitute a ground for disciplinary sanction under IC 25-1-9; or

(B) a crime that has a direct bearing on the person's ability to practice competently;

(2) have completed:

(A) the prescribed curriculum and met the graduation requirements of a state accredited program of practical nursing that only accepts students who have a high school diploma or its equivalent, as determined by the board; or

(B) the prescribed curriculum and graduation requirements of a nursing education program in a foreign country that is substantially equivalent to a board approved program as determined by the board. The board may by rule adopted under IC 4-22-2 require an applicant under this subsection to successfully complete an examination approved by the board to measure the applicant's qualifications and background in the practice of nursing and proficiency in the English language; and

(3) be physically and mentally capable of, and professionally competent to, safely engage in the practice of practical nursing as determined by the board.

An applicant meets the English proficiency requirement under subdivision (2) if the applicant passes an English course as certified in the transcript from the board's approved nursing education program or submits proof of passing the National Council Licensure Examination (NCLEX) that was taken in only the English language.

(b) The applicant must pass an examination in such subjects as the board may determine.

(c) The board may issue a temporary licensed practical nurse permit to practice as a licensed practical nurse applicant to a person who has initially applied for license by examination, after the board receives the necessary materials to determine compliance with subsection (a). The temporary licensed practical nurse permit is valid until the earlier of six (6) months after issuance or the licensed practical nurse applicant's examination results under subsection (b) are received. If the licensed practical nurse applicant does not receive a passing score on the first examination under subsection (b), the temporary licensed practical **nurse** permit is no longer valid.

(d) A licensed practical nurse applicant must:

(1) practice under the supervision of a licensed practical nurse or registered nurse; and

(2) use the abbreviation "LPNG" after the licensed practical nurse graduate's name.

(e) The board may issue by endorsement a license to practice as a licensed practical nurse to an applicant who has been licensed as a licensed practical nurse, by examination, under the laws of another state if the applicant presents proof satisfactory to the board that, at the time of application for an Indiana license by endorsement, the applicant possesses credentials and qualifications that are substantially equivalent to requirements in Indiana for licensure by examination. The board may specify by rule what shall constitute substantial equivalence under this subsection.

(f) The board shall issue by endorsement **or examination** a license to practice as a licensed practical nurse to an applicant who:

(1) is a graduate of a foreign nursing school;

(2) **has successfully passed the National Council Licensure Examination (NCLEX);**

(3) provides:

(A) documentation that the applicant has:

(i) taken an examination prepared by the Commission on Graduates of Foreign Nursing Schools International, Inc. (CGFNS); and

(ii) achieved the passing score required on the examination at the time the examination was taken;

(B) a satisfactory Credentials Evaluation Service Professional Report issued by CGFNS; ~~or~~

(C) a VisaScreen Certificate verification letter issued by CGFNS; ~~and~~ **or**

(D) a satisfactory credential verification assessment from an organization that is a member of the National Association of Credential Evaluation Services or any other organization approved by the board; and

~~(3)~~ **(4)** meets the other requirements of this section.

(g) Each applicant for examination and registration to practice as a practical nurse shall pay:

(1) a fee set by the board; and

(2) if the applicant is applying for a multistate license (as defined in IC 25-42-1-11) under IC 25-42 (Nurse Licensure Compact), a fee of twenty-five dollars ($25) in addition to the fee under subdivision (1);

a part of which must be used for the rehabilitation of impaired registered nurses and impaired licensed practical nurses. Payment of the fees shall be made by the applicant before the date of examination.

(h) The lesser of the following amounts from fees collected under subsection (g) shall be deposited in the impaired nurses account of the

state general fund established by section 34 of this chapter:

(1) Twenty-five percent (25%) of the license application fee per license applied for under this section.

(2) The cost per license to operate the impaired nurses program, as determined by the Indiana professional licensing agency.

(i) Any person who holds a license to practice as a licensed practical nurse in Indiana or under IC 25-42 may use the title "Licensed Practical Nurse" and the abbreviation "L.P.N.". No other person shall practice or advertise as or assume the title of licensed practical nurse or use the abbreviation of "L.P.N." or any other words, letters, signs, or figures to indicate that the person using them is a licensed practical nurse.

SECTION 19. IC 27-7-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 18. Third Party Access to Dental Provider Networks

Sec. 1. As used in this chapter, "contracting entity" means a dental carrier, a third party administrator, or another person that enters into a provider network contract with providers for the delivery of dental services in the ordinary course of business.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to:

(1) dental services; or

(2) coverage of dental services;

through a provider network contract.

Sec. 3. As used in this chapter, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) An entity that:

(A) provides dental services; or

(B) arranges for dental services to be provided;

but is not itself a provider.

Sec. 4. (a) As used in this chapter, "dental plan" means any of the following:

(1) A policy issued by an insurer (as defined in IC 27-1-2-3(x)) that provides coverage for dental services.

(2) A contract under which a health maintenance organization (as defined in IC 27-13-1-19) provides or covers dental services.

(3) A preferred provider plan (as defined in IC 27-8-11-1(g))

that provides or covers dental services.

(b) The term does not include the following:

(1) A policy providing comprehensive coverage described in Class 1(b) and Class 2(a) of IC 27-1-5-1.

(2) Accident only, Medicare supplement, long term care, or disability income insurance.

(3) Coverage issued as a supplement to liability insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) Worker's compensation or similar insurance.

(7) A student health plan.

(8) A supplemental plan that always pays in addition to other coverage.

Sec. 5. (a) As used in this chapter, "dental service" means any service provided by a dentist within the scope of the dentist's licensure under IC 25-14.

(b) The term does not include a service delivered by a provider that is billed as a medical expense.

Sec. 6. As used in this chapter, "health insurer" means:

(1) an insurer that issues policies of accident and sickness insurance (as defined in IC 27-8-5-1); or

(2) a health maintenance organization (as defined in IC 27-13-1-19).

Sec. 7. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or any other legal entity.

Sec. 8. (a) As used in this chapter, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(b) The term does not include a physician organization or physician hospital organization that leases or rents the network of the physician organization or physician hospital organization network to a third party.

Sec. 9. As used in this chapter, "provider network contract" means a contract between a contracting entity and one (1) or more providers:

(1) that establishes a network through which the providers:

(A) provide dental services to covered individuals; and

(B) are compensated for providing the dental services; and

(2) that specifies the rights and responsibilities of the contracting entity and the providers concerning the network.

Sec. 10. (a) As used in this chapter, "third party" means a person that enters into a contract with a contracting entity or another third party to gain access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) The term does not include an employer or another group or entity for which the contracting entity provides administrative services.

Sec. 11. (a) This section applies if a contracting entity seeks to grant a third party access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) Except as provided in subsection (c) and section 17 of this chapter, in order for a contracting entity to grant a third party access as described in subsection (a), the following conditions must be satisfied:

(1) When a provider network contract is entered into or renewed, or when there are material modifications to a provider network contract relevant to granting access to a third party as described in subsection (a):

(A) any provider that is a party to the provider network contract must be allowed to choose not to participate in the third party access as described in subsection (a); or

(B) if third party access is to be provided through the acquisition of the provider network by a health insurer, any provider that is a party to the provider network contract must be allowed to enter into a contract directly with the health insurer that acquired the provider network.

(2) The provider network contract must specifically authorize the contracting entity to enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

(3) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, a

provider that is a party to the provider network contract must have chosen to participate in third party access at the time the provider network contract was entered into or renewed.

(4) If the contracting entity seeking to grant a third party access as described in subsection (a) is a health insurer, the provider network contract must contain a third party access provision specifically granting third party access to the provider network.

(5) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, the provider network contract must state that the provider has a right to choose not to participate in the third party access.

(6) The third party being granted access as described in subsection (a) must agree to comply with all of the terms of the provider network contract.

(7) The contracting entity seeking to grant third party access as described in subsection (a) must identify to each provider that is a party to the provider network contract, in writing or electronic form, all third parties in existence as of the date on which the provider network contract is entered into or renewed.

(8) The contracting entity granting third party access as described in subsection (a) must identify, in a list on its website that is updated at least once every ninety (90) days, all third parties to which third party access has been granted.

(9) If third party access as described in subsection (a) is to be granted through the sale or leasing of the network established by the provider network contract, the contracting entity must notify all providers that are parties to the provider network contract of the leasing or sale of the network at least thirty (30) days before the sale or lease of the network takes effect.

(10) The contracting entity seeking to grant third party access to contractual discounts as described in subsection (a)(3) must require each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. However, this subdivision does not apply to electronic transactions mandated by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(c) A contracting entity may grant a third party access as described in subsection (a) even if the conditions set forth in subsection (b)(1) are not satisfied if the contracting entity is not a

health insurer or a dental carrier.

(d) Except as provided in subsection (c) and section 17 of this chapter, a provider that is a party to a provider network contract is not required to provide dental services pursuant to third party access granted as described in subsection (a) unless all of the applicable conditions set forth in subsection (b) are satisfied.

Sec. 12. A contracting entity that is a party to a provider network contract with a provider that chooses under section 11(b)(1)(A) of this chapter not to participate in third party access shall not alter the provider's rights or status under the provider network contract because of the provider's choice not to participate in third party access.

Sec. 13. A contracting entity that is a party to a provider network contract shall notify a third party granted third party access as described in section 11(a) of this chapter of the termination of the provider network contract not more than thirty (30) days after the date of the termination.

Sec. 14. The right of a third party to contractual discounts described in section 11(a)(3) of this chapter ceases as of the termination date of the provider network contract.

Sec. 15. A contracting entity that is a party to a provider network contract shall make a copy of the provider network contract relied on in the adjudication of a claim available to a participating provider not more than thirty (30) days after the date of the participating provider's request.

Sec. 16. When entering into a provider network contract with providers, a contracting entity shall not reject a provider as a party to the provider network contract because the provider chooses or has chosen under section 11(b)(1)(A) of this chapter not to participate in third party access.

Sec. 17. (a) Section 11 of this chapter does not apply to access as described in section 11(a) of this chapter if granted by a contracting entity to:

(1) a dental carrier or other entity operating in accordance with the same brand licensee program as the contracting entity;

(2) an entity that is an affiliate of the contracting entity; or

(3) a third party if the contracting entity is a dental carrier that retains responsibility for administering the dental plan in accordance with its applicable provider network contracts, including all fee schedules and processing policies.

(b) For the purposes of this section, a contracting entity shall

make a list of the contracting entity's affiliates available to providers on the contracting entity's website.

(c) Section 11 of this chapter does not apply to a provider network contract for dental services provided to beneficiaries of health programs established or maintained by local, state, or federal government, such as:

(1) Medicaid established under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.);

(2) the children's health insurance program established under Title XXI of the federal Social Security Act (42 U.S.C. 1397aa-1397mm); or

(3) Medicare Advantage.

Sec. 18. The provisions of this chapter cannot be waived by contract. A contract provision that:

(1) conflicts with this chapter; or

(2) purports to waive any requirements of this chapter;

is null and void.

Sec. 19. (a) If a person violates this chapter, the insurance commissioner may enter an order requiring the person to cease and desist from violating this chapter.

(b) If a person violates a cease and desist order issued under subsection (a), the insurance commissioner, after notice and hearing under IC 4-21.5, may:

(1) impose a civil penalty upon the person of not more than ten thousand dollars ($10,000) for each day of violation;

(2) suspend or revoke the person's certificate of authority, if the person holds a certificate of authority under this title; or

(3) both impose a civil penalty upon the person under subdivision (1) and suspend or revoke the person's certificate of authority under subdivision (2).

SECTION 20. IC 27-8-11-7, AS AMENDED BY P.L.190-2023, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the insurer without returning the application to the provider for a revision or clarification.

(c) As used in this section, "credentialing" means a process by

which an insurer makes a determination that:

(1) is based on criteria established by the insurer; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the insurer.

(d) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(e) The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

(f) An insurer shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(g) A provider shall respond to the notification required under subsection (f) not later than five (5) business days after receipt of the notice.

(h) An insurer shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the insurer makes a final credentialing determination concerning the provider.

(i) If the insurer fails to issue a credentialing determination within fifteen (15) **business** days after receiving a completed clean credentialing application form from a provider, the insurer shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

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(j) Once an insurer fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(k) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (i), the provisional credentialing is terminated on the date the insurer notifies the provider of the adverse credentialing determination. The insurer is not required to reimburse for services rendered while the provider was provisionally credentialed.

SECTION 21. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 14. (a) As used in this section, "covered individual" means an individual who is entitled to the coverage of dental services by a dental carrier.**

(b) As used in this section, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) A preferred provider plan subject to this chapter under which dental services are provided.

(c) As used in this section, "dental services" means health care services provided by:

(1) a dentist licensed under IC 25-14;

(2) an individual using a dental residency permit issued under IC 25-14-1-5;

(3) an individual who holds:

(A) a dental faculty license under IC 25-14-1-5.5; or

(B) an instructor's license under IC 25-14-1-27.5;

(4) a dental hygienist licensed under IC 25-13; or

(5) a dental assistant (as defined in IC 25-14-1-1.5(4));

within the scope of the individual's license or work description in IC 25-13 or IC 25-14, as appropriate. However, the term does not include a service delivered by a provider if the service is billed as a medical expense.

(d) As used in this section, "network" means all providers that have entered into a contract with a dental carrier under which the providers agree to charge no more than a certain amount for

certain dental services provided to covered individuals who are entitled to the coverage of dental services by the dental carrier.

(e) As used in this section, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(f) If a covered individual assigns the rights of the covered individual to benefits for dental services to the provider of the dental services, the covered individual's dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.

(g) A dental carrier shall make a payment under this section:

(1) directly to the provider of the dental services; and

(2) according to the same criteria and payment schedule under which the dental carrier would have been required to make the payment to the covered individual if the insured had not assigned the insured's rights to the benefits.

(h) An assignment of benefits under this section does not affect or limit the dental carrier's obligation to pay the benefits.

(i) A dental carrier's payment of benefits in compliance with this section discharges the dental carrier's obligation to pay the benefits to the insured.

(j) If:

(1) a covered individual is entitled to coverage from a dental carrier;

(2) the covered individual is provided dental services by a provider;

(3) the covered individual assigns the covered individual's rights to benefits from the dental carrier to the provider of the dental services; and

(4) the provider of the dental services is a member of the network of the dental carrier;

the provider shall accept compensation from the dental carrier in the amount specified in the network contract as payment in full for the dental services provided to the covered individual and shall not bill the covered individual for the dental services, except for copayments, coinsurance and any deductible amount that remains after the dental carrier's payment for the dental services.

SECTION 22. IC 27-13-43-2, AS AMENDED BY P.L.190-2023, SECTION 36, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 2. (a) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the health maintenance organization without returning the application to the provider for a revision or clarification.

(b) As used in this section, "credentialing" means a process by which a health maintenance organization makes a determination that:

(1) is based on criteria established by the health maintenance organization; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the health maintenance organization.

(c) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(d) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing activities.

(e) A health maintenance organization shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(f) A provider shall respond to the notification required under subsection (e) not later than five (5) business days after receipt of the notice.

(g) A health maintenance organization shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the health maintenance organization makes a final credentialing determination concerning the provider.

(h) If the health maintenance organization fails to issue a credentialing determination within fifteen (15) **business** days after receiving a completed clean credentialing application form from a provider, the health maintenance organization shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(i) Once a health maintenance organization fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.

(j) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (h), the provisional credentialing is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.

SECTION 23. [EFFECTIVE JULY 1, 2024] **(a) As used in this SECTION, "board" refers to the Indiana state board of nursing.**

(b) The board shall amend 848 IAC 1-1-6(f) to conform with this act.

(c) In amending the administrative rule under subsection (b), the board may adopt a provisional rule as set forth in IC 4-22-2-37.1.

(d) A provisional administrative rule adopted under this SECTION expires on the date on which a rule that supersedes the provisional administrative rule is adopted by the board under IC 4-22-2-19.7 through IC 4-22-2-36.

(e) This SECTION expires June 30, 2025.

SECTION 24. [EFFECTIVE JULY 1, 2024] **(a) As used in this SECTION, "board" refers to the medical licensing board of Indiana.**

(b) The board shall study any rule adopted under

IC 25-22.5-2-7(a)(10) that requires an office based setting to be accredited by an accreditation agency approved by the board. The study must include the following:

(1) What accreditation agencies are or have been approved by the board.

(2) The cost of any accreditation by an accreditation agency for an office based setting.

(3) Options for reducing the cost of accreditation for office based settings.

(c) Before November 1, 2024, the board shall submit a report of the study under subsection (b), including any recommendations determined by the board concerning subsection (b)(3), to the general assembly in an electronic format under IC 5-14-6.

(d) This SECTION expires December 31, 2024.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____