April 9, 2019

ENGROSSED
SENATE BILL No. 436

DIGEST OF SB 436 (Updated April 9, 2019 1:59 pm - DI 134)

Citations Affected: IC 9-21; IC 12-15; IC 27-8; IC 27-13; IC 36-12; noncode.

Synopsis: State and local administration. Changes the terminology used in the statute governing the posting of signs to promote attractions and services for the traveling public. Allows the office of the secretary of family and social services (office) to apply for a state plan

(Continued next page)

Effective: Upon passage; July 1, 2019.

Zay, Charbonneau, Merritt, Mrvan, Melton, Niezgodski, Stoops, Randolph Lonnie M, Bohacek, Garten, Kruse

(HOUSE SPONSORS — CLERE, BACON, ZENT, FLEMING)

January 14, 2019, read first time and referred to Committee on Health and Provider Services.
January 17, 2019, amended, reported favorably — Do Pass.
January 22, 2019, read second time, ordered engrossed. Engrossed.
January 24, 2019, reassigned to Committee on Appropriations pursuant to Rule 68(b).
February 18, 2019, amended, reported favorably — Do Pass.
February 21, 2019, re-read second time, re-ordered engrossed. Re-engrossed.
February 25, 2019, read third time, passed. Yeas 48, nays 1.

HOUSE ACTION

March 5, 2019, read first time and referred to Statutory Committee on Interstate and International Cooperation.
April 4, 2019, amended, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 127.
April 9, 2019, amended, reported — Do Pass.

amendment that would require Medicaid reimbursement for eligible Medicaid rehabilitation option services provided in a school setting to a Medicaid recipient. Requires the office to review the Medicaid rehabilitation option services provided under Medicaid, determine whether additional services are appropriate, and submit the office's findings to the general assembly. Requires the office to study and report on the best means to provide: (1) Medicaid reimbursement for health care services and school based services to specified individuals provided by a school based health center; and (2) supplemental Medicaid reimbursement payments to qualified school based health centers under the fee for service Medicaid program. Requires a public library to adopt a criminal history check policy for employees and volunteers. Requires the board of veterinary medical examiners to study the regulation of veterinary technicians. Specifies contract requirements in hospital participation agreements between managed care organizations and multi-location hospitals. Voids certain waiver agreements between managed care organizations and multi-location hospitals. Establishes rates of payment for various emergency services and post-stabilization services furnished to individuals enrolled in a managed care organization. Specifies conditions concerning the assignment of benefits for emergency services and post-stabilization care services provided to insured persons. Provides for the resubmission of certain claims that were denied because the originally submitted claims identified the providers incorrectly.

April 9, 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.

ENGROSSED
SENATE BILL No. 436

A BILL FOR AN ACT to amend the Indiana Code concerning state and local administration.

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

SECTION 1. IC 9-21-4-5, AS AMENDED BY HEA 1115-2019, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) Except as provided in subsection (b), a person may not place or maintain upon a highway a traffic sign or signal bearing commercial advertising. A public authority may not permit the placement of a traffic sign or signal that bears a commercial message.

(b) Under **section 1 of this chapter and** criteria to be jointly established by the Indiana department of transportation and the office of tourism development (before July 1, 2020) or the Indiana destination development corporation (after June 30, 2020), the Indiana department of transportation may authorize the posting of any of the following:

(1) ~~Limited tourist attraction signage.~~ **Tourist oriented directional signs.**

(2) ~~Business signs on specific information panels~~ **Specific service or logo signs** on the interstate system of highways, ~~and other~~ freeways, **and expressway interchanges.**

All costs of manufacturing, installation, and maintenance to the Indiana department of transportation for a business sign posted under this subsection shall be paid by the business.

(c) Criteria established under subsection (b) for tourist ~~attraction signage~~ **oriented directional signs** must include a category for a tourist attraction that:

(1) is a trademarked destination brand; and

(2) encompasses buildings, structures, sites, or other facilities that are:

(A) listed on the National Register of Historic Places established under 16 U.S.C. 470 et seq.; or

(B) listed on the register of Indiana historic sites and historic structures established under IC 14-21-1;

regardless of the distance of the tourist attraction from the highway on which the tourist ~~attraction signage~~ **oriented directional sign** is placed.

(d) Criteria established under subsection (b) for tourist ~~attraction signage~~ **oriented directional signs** must include a category for a tourist attraction that is an establishment issued a brewer's permit under IC 7.1-3-2-2(b).

(e) A person may not place, maintain, or display a flashing, a rotating, or an alternating light, beacon, or other lighted device that:

(1) is visible from a highway; and

(2) may be mistaken for or confused with a traffic control device or for an authorized warning device on an emergency vehicle.

(f) This section does not prohibit the erection, upon private property adjacent to highways, of signs giving useful directional information and of a type that cannot be mistaken for official signs.

SECTION 2. IC 12-15-1.3-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 21. (a) As used in this section, "Medicaid rehabilitation option services" means clinical behavioral health services provided to recipients and families of recipients living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction as part of the Medicaid rehabilitation option program.**

(b) Before December 1, 2019, the office may apply to the United States Department of Health and Human Services for a state plan amendment that would require Medicaid reimbursement by:

(1) the office;

(2) a managed care organization that has contracted with the office; or

(3) a contractor of the office;

for eligible Medicaid rehabilitation option services in a school setting for any Medicaid recipient who qualifies for Medicaid rehabilitation option services by meeting specific diagnosis and level of need criteria under an assessment tool approved by the division of mental health and addiction or who submits prior authorization for Medicaid rehabilitation option services.

(c) If the office receives approval for the state plan amendment applied for under this section, the office shall comply with IC 12-15-5-19.

SECTION 3. IC 12-15-5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. (a) Not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall do the following:**

(1) Review the current services included in the Medicaid rehabilitation option services program in the school setting.

(2) Determine whether additional appropriate services, including:

(A) family engagement services; and

(B) additional comprehensive behavioral health services, including addiction services;

should be included as part of the program.

(3) Report the office's findings under this subsection to the general assembly in an electronic format under IC 5-14-6.

(b) Not later than three (3) months from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall notify each school corporation that the United States Department of Health and Human Services has approved the state plan amendment applied for under IC 12-15-1.3-21.

(c) Each school corporation shall, not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, contract with a community mental health center to provide Medicaid rehabilitation option services for:

(1) a student of the school corporation who is a Medicaid recipient; and

(2) the student's family.

SECTION 4. IC 12-15-12-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 18.5. (a) This section applies to hospital participation agreements between managed care organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an individual enrolled in a risk based managed care program.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a managed care organization and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in a risk based managed care program. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a person and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in a risk based managed care program for which the person serves as a managed care organization.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care

facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services" includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Risk based managed care program" means any Medicaid program to which this chapter applies.

(c) Subject to subsection (d), a hospital participation agreement between a managed care organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A managed care organization and a multi-location hospital

may agree in writing to waive one (1) or more of the requirements specified in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the managed care organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement; or

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the managed care organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a managed care organization and a multi-location hospital that:

(1) purports to waive or limit one (1) or more of the requirements of subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a managed care organization and a multi-location hospital before July 1, 2019, that would prevent the application of subsection (c) to a hospital participation agreement entered into or

renewed on or after July 1, 2019, is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) A managed care organization may not require a multi-location hospital to have a contract with an insurer under IC 27-8 or a contract with a health maintenance organization under IC 27-13 as a condition of entering into a hospital participation agreement with the hospital.

SECTION 5. IC 12-15-44.5-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 12. (a) This section applies to:**

(1) emergency services provided to an individual enrolled in the plan; and

(2) medically necessary screening services provided to an individual enrolled in the plan who presents to an emergency department with an emergency medical condition.

(b) This section does not apply to emergency services or screening services provided to an individual enrolled in the plan by a provider who has contracted with the individual's managed care organization to provide emergency services to the individual.

(c) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning set forth in IC 12-15-12-0.3.

(2) "Emergency services" has meaning set forth in IC 12-15-12-0.5.

(d) The payment rate for emergency services and medically necessary screening services in the emergency department of a hospital licensed under IC 16-21 must be comparable to the federal Medicare reimbursement rate for the service provided by the provider or equal to one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate. A managed care organization may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(e) This section does not limit the ability of the managed care organization to review, and make a determination of, the medical necessity of the services provided in a hospital's emergency department for purposes of determining coverage for such services.

SECTION 6. IC 12-15-44.5-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 13. (a) This section applies to**

post-stabilization care services provided to an individual enrolled in the plan.

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning set forth in IC 12-15-12-0.3.

(2) "Post-stabilization care services" refers to covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the enrollee's condition.

(c) The managed care organization through which an individual is enrolled in the plan is financially responsible for the following services provided to the enrollee:

(1) Post-stabilization care services that are preapproved by the managed care organization.

(2) Post-stabilization care services that are not preapproved by the managed care organization, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the managed care organization for preapproval of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by the managed care organization, but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the managed care organization is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the managed care organization shall give the enrollee's treating physician an opportunity to consult with a physician representing the managed care organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing the managed care organization is reached or until one (1) or more of the following criteria is met:

(1) A physician:

(A) representing the managed care organization; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the managed care organization assumes responsibility for the enrollee's care through transfer.

(3) A representative of the managed care organization and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) to an individual enrolled in the plan by a provider who has not contracted with the individual's managed care organization to provide post-stabilization care services to the enrollee. The payment rate for post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) must be must be comparable to the federal Medicare reimbursement rate for the service provided by the provider, or one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate. A managed care organization may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(f) This section does not limit the ability of the office or the managed care organization to review, and make a determination of the medical necessity of, the post-stabilization care services provided to an enrollee for purposes of determining coverage for the services.

SECTION 7. IC 12-15-44.5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 14. (a) This section applies to hospital participation agreements between managed care organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two

(2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two

(2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an

individual enrolled in the plan.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" refers to a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a managed care organization and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in the plan. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a managed care organization and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in the plan.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(c) Subject to subsection (d), a hospital participation agreement between a managed care organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A managed care organization and a multi-location hospital may agree in writing to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to so waive one (1) or more of the requirements of subsection (c)(1) through (c)(3) is entered into between the managed care organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement; or

(3) with regard to a hospital participation agreement that is

renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(3) is set forth in a separate written agreement between the multi-location hospital and the managed care organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a managed care organization and a multi-location hospital that:

(1) purports to waive or limit the requirements listed in subsection (c)(1) through (c)(3) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a managed care organization and a multi-location hospital prior to July 1, 2019, that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019, is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) A managed care organization may not require a multi-location hospital to have a contract with an insurer under IC 27-8, or a contract with a health maintenance organization under IC 27-13, as a condition for entering into a hospital participation agreement with the hospital.

SECTION 8. IC 27-8-11-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 13. (a) This section applies to hospital participation agreements between insurers and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the

same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an insured under the terms of a policy issued or administered by an insurer.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between an insurer and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items to an insured of the insurer. The term includes an agreement described in section 3(a)(1) of this chapter, and any amendment, addendum, or attachment to a direct or indirect agreement between an insurer and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items to an insured of the insurer.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Qualified inpatient care facility" means an inpatient care facility that, at the time a hospital participation agreement is entered into or, as applicable, at the time a hospital participation agreement is renewed, satisfies the following criteria, as certified by the multi-location hospital of which the inpatient care facility is a commonly licensed inpatient care facility (or, with regard to clause (A), as certified by an architect or engineer retained by the multi-location hospital):

(A) The building containing the inpatient care facility is at least sixty thousand (60,000) square feet in size, as measured using standards of the 2001 AIA Guidelines for Design and Construction for Healthcare Facilities.

(B) One hundred percent (100%) of the occupied floor area of the building is used, directly or indirectly, for:

(i) the delivery of inpatient hospital services or items;

(ii) the delivery of outpatient hospital services and items;

(iii) the staffing, supplying and equipping of inpatient and outpatient hospital services and items;

(iv) the delivery of other health care services; and

(v) the clinical, administrative, clerical, maintenance, engineering, and other activities that support items (i) through (iv).

(C) The inpatient care facility is staffed with physicians who are board certified inpatient hospitality who make rounds at the inpatient care facility at least once per day.

(D) The inpatient care facility includes an emergency department that is staffed twenty-four (24) hours per day, seven (7) days per week, with physicians who are board certified in emergency medicine or trauma medicine, or both.

(E) The inpatient care facility has an onsite a Category II hospital pharmacy for emergency department and

inpatient care.

(F) The inpatient care facility has an onsite pathology laboratory for emergency department and inpatient care.

(G) The inpatient care facility has onsite radiology services for emergency department and inpatient care, as well as onsite magnetic resonance imaging services.

(H) The emergency department of the inpatient care facility has one (1) or more:

(i) critical rooms; and

(ii) rooms that are equipped specifically for eye injuries, orthopedic injuries, and to afford seclusion for patients.

(I) One (1) or more negative pressure rooms for treatment of patients are located within the inpatient care facility.

(J) One (1) or more rooms dedicated for use in hazardous materials and decontamination cases are located within the inpatient care facility.

(K) A fixed, permanent, and marked helicopter landing site, approved by the Federal Aviation Administration, is located within two hundred (200) feet of the inpatient care facility's emergency department.

(L) The inpatient care facility staffs, equips, and maintains at least six (6) inpatient beds for use exclusively in the delivery of inpatient hospital services. Hospital beds located in an emergency department that are used to provide inpatient hospital services to inpatients of the inpatient care facility are not eligible to be counted as inpatient beds.

(M) Licensed social workers are available onsite at the inpatient care facility at least sixteen (16) hours per day, seven days per week.

(c) Subject to subsections (d) and (g), a hospital participation agreement between an insurer and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) An insurer and a multi-location hospital may agree in writing to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the insurer and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement;

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the insurer; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between an insurer and a multi-location hospital that:

(1) purports to waive or limit one (1) or more of the

requirements listed in subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between an insurer and a multi-location hospital prior to July 1, 2019 that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019 is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) Notwithstanding subsection (c), a hospital participation agreement with a multi-location hospital need not include the inpatient hospital services and items provided at an inpatient care facility that is commonly licensed with other inpatient care facilities of the multi-location hospital if that inpatient care facility does not satisfy the requirements of a qualified inpatient care facility (as defined in subsection (b)(12)) at the time the hospital participation agreement is entered into or, as applicable, at the time the hospital participation agreement is renewed.

SECTION 9. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 14. (a) This section applies to emergency services provided to an insured of an insurer.**

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(A) serious jeopardy to the health of:

(i) the individual; or

(ii) in the case of a pregnant woman, the woman or her unborn child;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(2) "Emergency services" means covered health care services that are:

(A) furnished by a provider qualified to furnish emergency services; and

(B) needed to evaluate or stabilize an emergency medical condition.

(c) An insurer is financially responsible for emergency services provided to its insured.

(d) This subsection applies to emergency services provided to an insured by a provider who has not contracted with the insured's insurer to provide emergency services. Payment for emergency services must be in an amount comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(e) Payment under subsection (d) for a provider's emergency services shall be made directly to the provider by the insurer in the event the insured has executed an assignment of benefits under IC 27-8-11.5.

(f) This section does not limit the ability of the insurer to review, and make a determination of, the medical necessity of the emergency services provided to an insured for purposes of determining coverage for such services.

SECTION 10. IC 27-8-11-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 15. (a) This section applies to post-stabilization care services provided to an insured.**

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning provided in section 3.5(b) of this chapter.

(2) "Post-stabilization care services" means covered health care services rendered by a provider that are related to an emergency medical condition and that are provided after an insured is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the insured's condition.

(c) The insurer is financially responsible for the following services provided to the insured:

(1) Post-stabilization care services that are preapproved by the insurer or the insurer's agent.

(2) Post-stabilization care services that are not preapproved by the insurer or the insurer's agent, but that are administered to maintain the insured's stabilized condition within one (1) hour of a request to the insurer for preapproval of post-stabilization care services.

(3) Post-stabilization care services provided after an insured is stabilized that are not preapproved by the insurer or the insurer's agent, but that are administered to maintain, improve, or resolve the insured's stabilized condition if the insurer:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the insured's treating physician concerning the insured's care, and a physician representing the insurer is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the insurer shall give the insured's treating physician an opportunity to consult with a physician representing the insurer. The insured's treating physician may continue with care of the insured until a physician representing the insurer is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the insurer; and

(B) who has privileges at the treating hospital;

assumes responsibility for the insured's care.

(2) A physician representing the insurer assumes responsibility for the insured's care through transfer.

(3) A representative of the insurer and the insured's treating physician reach an agreement concerning the insured's care.

(4) The insured is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), or (c)(3) to an insured by a provider who has not contracted with the insured's insurer to provide post-stabilization care services to the insured. Payment for post-stabilization care services provided under subsection (c)(1), (c)(2), or (c)(3) must be comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider; or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(f) Payment under subsection (e) for an out-of-network provider's post-stabilization care services shall be made directly to the provider by the insurer in the event the insured has executed an assignment of benefits under IC 27-8-11.5.

(g)This section does not limit the ability of the insurer to review, and make a determination of, the medical necessity of the

post-stabilization care services provided to an insured for purposes of determining coverage for such services.

SECTION 11. IC 27-8-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 11.5. Assignment of Benefits for Emergency Services and Post-Stabilization Care Services Provided to Insureds

Sec. 1. The following definitions apply throughout this chapter:

(1) "Assignment of benefits" means a written instrument that:

(A) is executed:

(i) by an insured; or

(ii) for an insured by the authorized representative of the insured; and

(B) assigns to a provider the insured's right to receive reimbursement for emergency services or post-stabilization care services, or both, that are provided by the provider to the insured.

(2) "Emergency services" has the meaning set forth in IC 27-8-11-14.

(3) "Health care services" has the meaning set forth in IC 27-8-11-1. The term includes ambulance services provided by a hospital.

(4) "Insured" has the meaning set forth in IC 27-8-11-1.

(5) "Insurer" includes the following:

(A) An insurer (as defined in IC 27-8-11-1 that issues a policy.

(B) An administrator licensed under IC 27-1-25 that pays or administers claims for benefits under a policy.

(6) "Noncontracted provider" means a provider that has not entered into a reimbursement agreement described in IC 27-8-11-3(a) with an insured's insurer.

(7) "Policy" refers to a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(8) "Post-stabilization care services" has the meaning set forth in IC 27-8-11-15(b).

(9) "Provider" has the meaning set forth in IC 27-8-11-1.

Sec. 2. (a) Except as provided in subsection (b), if:

(1) an insured's policy provides coverage for emergency services or post-stabilization care services, or both;

(2) emergency services or post stabilization care services, or both, are rendered by a noncontracted provider to the insured; and

(3) the noncontracted provider:

(A) has an assignment of benefits with regard to the insured to whom the emergency services or post stabilization care services, or both, were rendered, that assigns to the noncontracted provider the insured's right to reimbursement for the emergency services or post-stabilization care services, or both, as applicable; and

(B) provides written or electronic notification to the insurer that the noncontracted provider:

(i) has rendered the emergency services or post-stabilization care services, or both, to the insured; and

(ii) has the assignment of benefits;

the insurer shall pay the reimbursement owed to the noncontracted provider under this chapter directly to the noncontracted provider for the emergency services or post-stabilization care services, or both, as applicable, and send written notice of the payment to the insured or the authorized representative of the insured.

(b) An insurer is not required to make a benefit payment directly to a noncontracted provider described in subsection (a) if the noncontracted provider has been convicted of fraud.

(c) This section does not require:

(1) coverage for benefits not covered under the terms of a policy; or

(2) payment to a noncontracted provider that is not eligible for payment under the terms of a policy.

Sec. 3. If:

(1) a noncontracted provider is entitled to a direct payment under section 2(a) of this chapter;

(2) the insurer makes the payment owed under this chapter to the insured or the authorized representative of the insured rather than to the noncontracted provider; and

(3) the noncontracted provider notifies the insurer that the noncontracted provider has not received the payment owed to the noncontracted under this chapter;

the insurer, not more than thirty (30) days after receiving the notice from the noncontracted provider, shall pay directly to the noncontracted provider the reimbursement owed under this chapter to the noncontracted provider.

Sec. 4. (a) The rate of reimbursement paid by the insurer to a provider under section 2(a) for the prover's provision of emergency services shall be equal to the rate set forth in

IC 27-8-11-14(d).

(b) The rate of reimbursement paid by the insurer to a provider under section 2(a) for the provider's provision of post-stabilization care services shall be equal to the rate set forth in IC 27-8-11-15(e).

Sec. 5. If:

(1) a noncontracted provider is entitled to a direct payment under section 10(a) of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the insurer, not more than fourteen (14) business days after the insurer receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the noncontracted provider or the noncontracted provider's agent.

Sec. 6. (a) An insurer that does not comply with this chapter shall pay interest for each day of noncompliance at the same interest rate as provided in IC 12-15-21-3(7)(A).

(b) IC 27-8-5.7 applies to payment of a claim submitted to an insurer by a noncontracted provider in compliance with this chapter.

Sec. 7. A noncontracted provider, by accepting an assignment of benefits from an insured, does not agree to accept an insurer's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 8. A policy or contract provision that violates this chapter is void.

SECTION 12. IC 27-13-15-1.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 1.3. (a) This section applies to hospital participation agreements between health maintenance organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under

the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an enrollee of a health maintenance organization, including coverage provided to an enrollee in a Medicare Advantage Plan that is offered by or through a health maintenance organization.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a health maintenance organization and a multi-location hospital for the multi-location hospital's provision of covered inpatient or outpatient hospital services or items to an enrollee of the health maintenance organization. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a health maintenance organization and a multi-location hospital that provides for the multi-location hospital's provision of covered inpatient or outpatient hospital services or items to an enrollee of the health maintenance organization.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Qualified inpatient care facility" means an inpatient care facility that, at the time a hospital participation agreement is entered into or, as applicable, at the time a hospital participation agreement is renewed, satisfies the following criteria, as certified by the multi-location hospital of which the inpatient care facility is a commonly licensed inpatient care facility (or, with regard to clause (A), as certified by an architect or engineer retained by the multi-location hospital):

(A) The building containing the inpatient care facility is at least sixty thousand (60,000) square feet in size, as measured using standards of the 2001 AIA Guidelines for Design and Construction for Healthcare Facilities.

(B) One hundred percent (100%) of the occupied floor area of the building is used, directly or indirectly, for:

(i) the delivery of inpatient hospital services or items;

(ii) the delivery of outpatient hospital services and items;

(iii) the staffing, supplying and equipping of inpatient and outpatient hospital services and items;

(iv) the delivery of other health care services; and

(v) the clinical, administrative, clerical, maintenance, engineering, and other activities that support the items listed in items (1) through (iv).

(C) The inpatient care facility is staffed with physicians who are board certified inpatient hospitality who make rounds at the inpatient care facility at least once per day.

(D) The inpatient care facility includes an emergency department that is staffed twenty-four (24) hours a day, seven (7) days a week, with physicians who are board certified in emergency medicine or trauma medicine, or both.

(E) The inpatient care facility has an onsite a Category II hospital pharmacy for emergency department and inpatient care.

(F) The inpatient care facility has an onsite pathology laboratory for emergency department and inpatient care.

(G) The inpatient care facility has onsite radiology services for emergency department and inpatient care, as well as onsite magnetic resonance imaging services.

(H) The emergency department of the inpatient care facility has one (1) or more:

(i) critical rooms; and

(ii) rooms that are equipped specifically for eye injuries, orthopedic injuries, and to afford seclusion for patients.

(I) One (1) or more negative pressure rooms for treatment of patients are located within the inpatient care facility.

(J) One (1) or more rooms dedicated for use in hazardous materials and decontamination cases are located within the inpatient care facility.

(K) A fixed, permanent, and marked helicopter landing site, approved by the Federal Aviation Administration, is located within two hundred (200) feet of the inpatient care facility's emergency department.

(L) The inpatient care facility staffs, equips, and maintains at least six (6) inpatient beds for use exclusively in the delivery of inpatient hospital services. Hospital beds located in an emergency department that are used to provide inpatient hospital services to inpatients of the inpatient care facility are not eligible to be counted as inpatient beds.

(M) Licensed social workers are available onsite at the inpatient care facility at least sixteen (16) hours per day, seven days per week).

(c) Subject to subsections (d) and (g), a hospital participation agreement between a health maintenance organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A health maintenance organization and a multi-location hospital may agree in writing to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the health maintenance organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsections (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement;

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the health maintenance organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a health maintenance organization and a multi-location hospital that:

(1) purports to waive or limit one (1) or more of the

requirements listed in subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a health maintenance organization and a multi-location hospital prior to July 1, 2019 that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019 is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) Notwithstanding subsection (c), a hospital participation agreement with a multi-location hospital is not required to include the inpatient hospital services and items provided at an inpatient care facility that is commonly licensed with other inpatient care facilities of the multi-location hospital if that inpatient care facility does not satisfy the requirements of a qualified inpatient care facility (as defined in subsection (b)) at the time the hospital participation agreement is entered into or, as applicable, at the time the hospital participation agreement is renewed.

SECTION 13. IC 27-13-36-9.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.2. (a) The following definitions apply throughout this section:**

(1) "Care obtained in an emergency" means, with respect to an enrollee, covered services that are:

(A) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and

(B) needed to evaluate or stabilize an individual in an emergency.

(2) "Stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(A) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.

(B) The transfer of the individual from an emergency

department or other care setting where emergency services are provided to the individual to another health care facility.

(C) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(b) As described in subsection (c), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

(1) prior authorization; or

(2) regard to the contractual relationship between:

(A) the provider who provided health care services to the enrollee in an emergency; and

(B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(c) Each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency from an out of network provider at a rate comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate. emergency services at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.

(2) An amount agreed to between the health maintenance organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.

(d) Payment under subsection (c) for a provider's care provided in an emergency shall be made directly to the provider by the health maintenance organization in the event the enrollee has executed an assignment of benefits under IC 27-13-36.5.

(e) This section does not limit the ability of the health maintenance organization to review, and make a determination of, the medical necessity of the emergency services provided to an enrollee for purposes of determining coverage for such services.

SECTION 14. IC 27-13-36-9.3. IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.3. (a) This section applies to post-stabilization care services provided to an enrollee of a health maintenance organization.**

(b) As used in this section, "post-stabilization care services" means covered health care services related to an emergency that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the enrollee's condition.

(c) The health maintenance organization is financially responsible for the following services provided to the enrollee:

(1) Post-stabilization care services that are preapproved by the health maintenance organization or the health maintenance organization's agent.

(2) Post-stabilization care services that are not preapproved by the health maintenance organization or the health maintenance organization's agent, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the health maintenance organization for preapproval of post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by the health maintenance organization or the health maintenance organization's agent, but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the health maintenance organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the health maintenance organization is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the health maintenance organization shall give the enrollee's treating physician an opportunity to consult with a physician representing the health maintenance organization. The enrollee's treating

physician may continue with care of the enrollee until a physician representing the health maintenance organization is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the health maintenance organization; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the health maintenance organization assumes responsibility for the enrollee's care through transfer.

(3) A representative of the health maintenance organization and the enrollee's treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) to an enrollee by an out of network provider. Payment for post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) must be in an amount comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(f) Payment under subsection (d) for a provider's care provided in an emergency shall be made directly to the provider by the health maintenance organization in the event the enrollee has executed an assignment of benefits under IC 27-13-36.5.

(g) This section does not limit the ability of the health maintenance organization to review, and make a determination of, the medical necessity of the emergency services provided to an enrollee for purposes of determining coverage for such services.

SECTION 15. IC 27-13-36.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 36.5. Assignment of Benefits for Emergency Services and Post-Stabilization Care Services Provided to Enrollees of Health Maintenance Organizations

Sec. 1. The following definition apply throughout this chapter:

(1) "Assignment of benefits" means a written instrument that:

(A) is executed:

(i) by an enrollee; or

(ii) for an enrollee by the authorized representative of

the enrollee; and

(B) assigns to a nonparticipating provider:

(i) the enrollee's right to receive reimbursement for the health care services provided for the enrollee by the nonparticipating provider under IC 27-13-36-9;

(ii) the enrollee's right to receive reimbursement for the post stabilization care services provided for the enrollee by the nonparticipating provider under IC 27-13-36-9.3; or

(iii) the rights described under both items (i) and (ii).

(2) "Nonparticipating provider" means a provider that is not a participating provider.

Sec. 2. (a) Except as provided in subsection (b), if:

(1) an enrollee is entitled to coverage for health care services obtained in an emergency under IC 27-13-36-9 or post-stabilization care services obtained under IC 27-13-36-9.3, or both;

(2) the nonparticipating provider furnished health care services for the enrollee in an emergency under IC 27-13-36-9 or furnished post stabilization care services under IC 27-13-36-9.3, or both; and

(3) the nonparticipating provider:

(A) has an assignment of benefits with regard to the enrollee to whom the services described in subdivision (2) were rendered, that assigns to the nonparticipating provider the enrollee's right to reimbursement for such services; and

(B) provides written or electronic notification to the health maintenance organization that the nonparticipating provider:

(i) has furnished health care services for the enrollee in an emergency under IC 27-13-36-9 or furnished post stabilization care services for the enrollee under IC 27-13-36-9.3, or both; and

(ii) has the assignment of benefits;

the health maintenance organization shall directly reimburse the nonparticipating provider for the health care services provided by the provider under IC 27-13-36-9 or the post stabilization care services provided by the provider under IC 27-13-36-9.3, or both.

(b) An health maintenance organization is not required to make a payment directly to a nonparticipating provider described in subsection (a)(2) if the nonparticipating provider has been

convicted of fraud.

(c) This section does not require:

(1) health care services for which coverage is not provided for an enrollee; or

(2) payment to a nonparticipating provider that is not eligible for reimbursement under an enrollee's coverage.

Sec. 3. If:

(1) a nonparticipating provider is entitled to direct reimbursement under section 3(a) of this chapter;

(2) the health maintenance organization tenders the reimbursement to the enrollee or a representative of the enrollee rather than to the nonparticipating provider; and

(3) the nonparticipating provider notifies the health maintenance organization that the nonparticipating provider has not received the reimbursement;

the health maintenance organization, not more than thirty (30) days after receiving the notice from the nonparticipating provider, shall tender the reimbursement owed to the nonparticipating provider under this chapter directly to the nonparticipating provider.

Sec. 4. (a) The rate of reimbursement paid by the health maintenance organization to the nonparticipating provider under section 3(a) of this chapter for the provider's provision of health care services obtained in an emergency under IC 27-13-36-9 shall be the rate set forth in IC 27-13-36-9(d).

(b) The rate of reimbursement paid by the health maintenance organization to the nonparticipating provider under section 3(a) for the provider's provision of post stabilization care services under IC 27-13-36-9.3 shall be the rate set forth in IC 27-13-36-9.3(e).

Sec. 5. If:

(1) a nonparticipating provider is entitled to be reimbursed directly by the health maintenance organization under section 3(a) of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the health maintenance organization, not more than fourteen (14) business days after the health maintenance organization receives

the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the nonparticipating provider or the nonparticipating provider's agent.

Sec. 6. (a) A health maintenance organization that does not comply with this chapter shall pay interest for each day of noncompliance at the same interest rate prescribed in IC 12-15-21-3(7)(A).

(b) IC 27-13-36.2-4 applies to payment of a claim submitted to a health maintenance organization by a nonparticipating provider in compliance with this chapter.

Sec. 7. A nonparticipating provider, by accepting an assignment of benefits from an enrollee, does not agree to accept a health maintenance organizations' fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 8. A provision of a group contract or an individual contract that violates this chapter is void.

SECTION 16. IC 36-12-3-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. A public library shall adopt a criminal history check policy for employees and volunteers.**

SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) The Indiana board of veterinary medical examiners shall study the regulation of veterinary technicians and submit a report to the legislative council in an electronic format under IC 5-14-6 before November 1, 2019.**

(b) This SECTION expires January 1, 2020.

SECTION 18. [EFFECTIVE UPON PASSAGE] **(a) This SECTION applies to a hospital licensed under IC 16-21-2 that, during the period January 8, 2018, through June 30, 2019, submitted claims to a managed care organization (as defined in IC 12-7-2-126.9) for covered health care services or items provided to individuals enrolled in a Medicaid risk based managed care program governed by IC 12-15-12, or for covered health care services or items provided to individuals enrolled in the Healthy Indiana Plan under IC 12-15-44.5, using an incorrect or otherwise inapplicable NPI code.**

(b) As used in this SECTION, "NPI" refers to a National Provider Identifier record assigned by the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES).

(c) Any managed care organization receiving claims described

in subsection (a) shall allow the hospital to resubmit the claims using a correct NPIs, or otherwise reconcile the claims described in subsection (a) with the hospital's correct NPI, and shall pay the amounts due the hospital for the claims as if the claims had been originally submitted using the correct NPI. The reimbursement for each claim shall be paid to the hospital within sixty (60) days after the hospital provides the correct NPI for the claims to the managed care organization.

(d) This SECTION expires January 1, 2021.

SECTION 19. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "school based health center" means a clinic operated on behalf of a public school, including a charter school, that provides health care services either:**

(1) by qualified health care providers employed by the school; or

(2) through a contract with a health care provider.

(b) The office of the secretary of family and social services shall study the feasibility and best means to provide:

(1) Medicaid reimbursement for health care services and school based services to specified individuals provided by a school based health center; and

(2) supplemental Medicaid reimbursement payments to qualified school based health centers under the fee for service Medicaid program.

(c) The office of the secretary of family and social services shall submit a report detailing the office's findings to the members of the interim study committee on public health, behavioral health, and human services (established by IC 2-5-1.3-4) and to the legislative council in an electronic format under IC 5-14-6 before November 1, 2019.

(d) This SECTION expires January 1, 2020.

SECTION 20. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 436, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 17, delete "Each party" and insert "**A**".

Page 6, line 20, delete "data" and insert "**based information**".

Page 10, line 6, delete "data" and insert "**based information**".

and when so amended that said bill do pass.

(Reference is to SB 436 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 11, Nays 0.

REPORT OF THE PRESIDENT
PRO TEMPORE

Madam President: Pursuant to Senate Rule 68(b), I hereby report that, Engrossed Senate Bill 436 which was ordered to engrossment on January 22, 2019 has been returned from engrossment and reassigned to the Committee on Appropriations.

BRAY

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 436, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 3, between lines 1 and 2, begin a new paragraph and insert:

"SECTION 2. IC 25-23-1-11, AS AMENDED BY P.L.134-2008, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: 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.

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

(c) 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.

(d) 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.

(e) 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. The lesser of the following amounts from fees collected under this subsection 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.

(f) Any person who holds a license to practice as a registered nurse in:

(1) Indiana; or

(2) a party state (as defined in IC 25-23.3-2-11);

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 3. IC 25-23-1-12, AS AMENDED BY P.L.134-2008, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: 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.

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

(c) 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.

(d) 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. The lesser of the following amounts from fees collected under this subsection 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.

(e) Any person who holds a license to practice as a licensed practical nurse in:

(1) Indiana; or

(2) a party state (as defined in IC 25-23.3-2-11);

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 4. IC 25-23-1-16.1, AS AMENDED BY P.L.177-2015, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 16.1. (a) Subject to IC 25-1-2-6(e), a license to practice as a registered nurse expires on October 31 in each odd-numbered year. Failure to renew the license on or before the expiration date will automatically render the license invalid without any action by the board.

(b) Subject to IC 25-1-2-6(e), a license to practice as a licensed practical nurse expires on October 31 in each even-numbered year. Failure to renew the license on or before the expiration date will automatically render the license invalid without any action by the board.

(c) The procedures and fee for renewal shall be set by the board. **If the license being renewed is 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) must be paid in addition to the fee for renewal set by the board.**

(d) At the time of license renewal, each registered nurse and each licensed practical nurse shall pay a renewal fee, a portion of which shall be for the rehabilitation of impaired registered nurses and impaired licensed practical nurses. The lesser of the following amounts from fees collected under this subsection 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 renewal fee per license renewed under this section.

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

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 436 as printed January 18, 2019.)

MISHLER, Chairperson

Committee Vote: Yeas 13, Nays 0.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Statutory Committee on Interstate and International Cooperation, to which was referred Senate Bill 436, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning state and local administration.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 9-21-4-5, AS AMENDED BY HEA 1115-2019, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) Except as provided in subsection (b), a person may not place or maintain upon a highway a traffic sign or signal bearing commercial advertising. A public authority may not permit the placement of a traffic sign or signal that bears a commercial message.

(b) Under **section 1 of this chapter and** criteria to be jointly established by the Indiana department of transportation and the office of tourism development (before July 1, 2020) or the Indiana destination development corporation (after June 30, 2020), the Indiana department of transportation may authorize the posting of any of the following:

(1) ~~Limited tourist attraction signage.~~ **Tourist oriented directional signs.**

(2) ~~Business signs on specific information panels~~ **Specific service or logo signs** on the interstate system of highways, ~~and other~~ freeways, **and expressway interchanges.**

All costs of manufacturing, installation, and maintenance to the Indiana department of transportation for a business sign posted under this subsection shall be paid by the business.

(c) Criteria established under subsection (b) for tourist ~~attraction signage~~ **oriented directional signs** must include a category for a tourist attraction that:

(1) is a trademarked destination brand; and

(2) encompasses buildings, structures, sites, or other facilities that are:

(A) listed on the National Register of Historic Places established under 16 U.S.C. 470 et seq.; or

(B) listed on the register of Indiana historic sites and historic structures established under IC 14-21-1;

regardless of the distance of the tourist attraction from the highway on which the tourist ~~attraction signage~~ **oriented directional sign** is placed.

(d) Criteria established under subsection (b) for tourist ~~attraction signage~~ **oriented directional signs** must include a category for a tourist attraction that is an establishment issued a brewer's permit under IC 7.1-3-2-2(b).

(e) A person may not place, maintain, or display a flashing, a rotating, or an alternating light, beacon, or other lighted device that:

(1) is visible from a highway; and

(2) may be mistaken for or confused with a traffic control device or for an authorized warning device on an emergency vehicle.

(f) This section does not prohibit the erection, upon private property adjacent to highways, of signs giving useful directional information and of a type that cannot be mistaken for official signs.

SECTION 2. IC 12-7-2-170.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 170.5. "School based health center", for purposes of IC 12-15, means a clinic operated on behalf of a public school (as defined in IC 20-18-2-15(1)), including a charter school, that provides health care services either:**

(1) by qualified health care providers employed by the school; or

(2) through a contract with a health care provider, including any of the following:

(A) A hospital licensed under IC 16-21.

(B) A physician group practice.

(C) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(D) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(E) A community mental health center.

SECTION 3. IC 12-7-2-170.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 170.7. "School based services", for purposes of IC 12-15, means any covered Medicaid service provided to any Medicaid recipient at a school based health center.**

SECTION 4. IC 12-15-1.3-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 20. (a) This section applies to a Medicaid recipient who:**

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

(2) is the parent of a recipient described in subdivision (1); or

(3) is a teacher or staff member of the public school for which the school based health center is operated.

(b) The office may apply to the United States Department of Health and Human Services for a state plan amendment to require Medicaid reimbursement by:

(1) the office;

(2) a managed care organization that has contracted with the office; or

(3) a contractor of the office;

for Medicaid covered school based services and other health care services provided to a Medicaid recipient described in subsection (a) by a school based health center.

(c) The office may apply to the United States Department of Health and Human Services for a state plan amendment to provide supplemental Medicaid reimbursement under the Medicaid fee for service program and an alternate fee schedule for the Medicaid risk based managed care program as set forth in subsections (d) and (e) to a school based health center that:

(1) is qualified to make; and

(2) has entered into an agreement with the office to make, or has made on the school based health center's behalf;

an intergovernmental transfer to cover the nonfederal share of supplemental Medicaid payments for Medicaid fee for service program claims and alternate fee schedule payments under the Medicaid risk based managed care program.

(d) For purposes of the fee for service program, a supplemental Medicaid payment to a qualified school based health center under this section by the office must be equal to either:

(1) the difference between the Medicaid fee for service rate and the rate that Medicare pays for the same service; or

(2) if there is not a Medicare rate for the service, an amount determined by the office.

(e) For purposes of the risk based managed care program, an alternate fee schedule to a qualified school based health center under this section by the office must be equal to either:

(1) the Medicare rate for the same service; or

(2) an amount determined by the office if there is not a Medicare rate for the service.

(f) A school based health center must obtain consent under IC 16-36-1 for each health care service provided at a school based health center to an individual who is less than eighteen (18) years of age, including reproductive health services or referral for any services.

(g) An employee or volunteer of a school based health center or school Medicaid provider may not dispense abortifacients or refer an individual to any entity that:

(1) performs abortions; or

(2) maintains or operates a facility where abortions are performed.

(h) Any individual employed at the school based health center must have had a national criminal history background check in accordance with IC 20-26-5-10 and IC 20-26-5-11.

(i) State expenditures and local school expenditures for funding for Medicaid covered school based services and other health care services provided to a Medicaid recipient by a school based health center under this section may be made only if:

(1) the state plan amendment authorized in subsection (c) is approved by the United States Department of Health and Human Services; and

(2) intergovernmental transfer funding for the nonfederal share of supplemental Medicaid payments for the Medicaid fee for services program and the nonfederal share of the difference between Medicaid fee for service payments and alternate fee schedule payments under the risk based managed care program is continuously made.

School based services shall not be provided under this article if intergovernmental transfer funding for the nonfederal share of supplemental Medicaid payments for the Medicaid fee for services program or intergovernmental transfer funding for the nonfederal share of the difference between Medicaid fee for service payments

and alternate fee schedule payments under the risk based managed care program ceases to be made.

SECTION 5. IC 12-15-1.3-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 21. (a) As used in this section, "Medicaid rehabilitation option services" means clinical behavioral health services provided to recipients and families of recipients living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction as part of the Medicaid rehabilitation option program.**

(b) Before December 1, 2019, the office may apply to the United States Department of Health and Human Services for a state plan amendment that would require Medicaid reimbursement by:

(1) the office;

(2) a managed care organization that has contracted with the office; or

(3) a contractor of the office;

for eligible Medicaid rehabilitation option services in a school setting for any Medicaid recipient who qualifies for Medicaid rehabilitation option services by meeting specific diagnosis and level of need criteria under an assessment tool approved by the division of mental health and addiction or who submits prior authorization for Medicaid rehabilitation option services.

(c) If the office receives approval for the state plan amendment applied for under this section, the office shall comply with IC 12-15-5-19.

SECTION 6. IC 12-15-5-1, AS AMENDED BY P.L.210-2015, SECTION 47, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 1. Except as provided in IC 12-15-2-12, IC 12-15-6, and IC 12-15-21, the following services and supplies are provided under Medicaid:

(1) Inpatient hospital services.

(2) Nursing facility services.

(3) Physician's services, including services provided under IC 25-10-1 and IC 25-22.5-1.

(4) Outpatient hospital or clinic services.

(5) Home health care services.

(6) Private duty nursing services.

(7) Physical therapy and related services.

(8) Dental services.

(9) Prescribed laboratory and x-ray services.

(10) Prescribed drugs and pharmacist services.

(11) Eyeglasses and prosthetic devices.
(12) Optometric services.
(13) Diagnostic, screening, preventive, and rehabilitative services.
(14) Podiatric medicine services.
(15) Hospice services.
(16) Services or supplies recognized under Indiana law and specified under rules adopted by the office.
(17) Family planning services except the performance of abortions.
(18) Nonmedical nursing care given in accordance with the tenets and practices of a recognized church or religious denomination to an individual qualified for Medicaid who depends upon healing by prayer and spiritual means alone in accordance with the tenets and practices of the individual's church or religious denomination.
(19) Services provided to individuals described in IC 12-15-2-8.
(20) Services provided under IC 12-15-34 and IC 12-15-32.
(21) Case management services provided to individuals described in IC 12-15-2-11 and IC 12-15-2-13.
(22) Any other type of remedial care recognized under Indiana law and specified by the United States Secretary of Health and Human Services.
(23) Examinations required under IC 16-41-17-2(a)(10).
(24) Inpatient substance abuse detoxification services.
(25) Subject to approval of the state plan amendment applied for under IC 12-15-1.3-20, school based services.

SECTION 7. IC 12-15-5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. (a) Not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall do the following:**

(1) Review the current services included in the Medicaid rehabilitation option services program in the school setting.
(2) Determine whether additional appropriate services, including:
(A) family engagement services; and
(B) additional comprehensive behavioral health services, including addiction services;
should be included as part of the program.
(3) Report the office's findings under this subsection to the general assembly in an electronic format under IC 5-14-6.

(b) Not later than three (3) months from the date the office

receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, the office shall notify each school corporation that the United States Department of Health and Human Services has approved the state plan amendment applied for under IC 12-15-1.3-21.

(c) Each school corporation shall, not later than one (1) year from the date the office receives approval for the state plan amendment described in IC 12-15-1.3-21 concerning Medicaid rehabilitation option services, contract with a community mental health center to provide Medicaid rehabilitation option services for:

(1) a student of the school corporation who is a Medicaid recipient; and

(2) the student's family.".

Page 27, after line 3, begin a new paragraph and insert:

"SECTION 14. IC 36-7-39 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 39. Workforce Investment Training Area

Sec. 1. This chapter applies only to Muncie.

Sec. 2. As used in this chapter, "budget agency" means the budget agency established by IC 4-12-1.

Sec. 3. As used in this chapter, "budget committee" has the meaning set forth in IC 4-12-1-3.

Sec. 4. As used in this chapter, "covered taxes" means the part of the following taxes attributable to the operation of a facility designated as part of a tax area under section 8 of this chapter:

(1) The state gross retail tax imposed under IC 6-2.5-2-1 or use tax imposed under IC 6-2.5-3-2.

(2) An adjusted gross income tax imposed under IC 6-3-2-1 on an individual.

(3) The local income tax imposed under IC 6-3.6.

(4) A food and beverage tax imposed under IC 6-9.

(5) An innkeeper's tax imposed under IC 6-9.

Sec. 5. As used in this chapter, "department" refers to the department of state revenue.

Sec. 6. As used in this chapter, "tax area" means a geographic area established as a workforce investment training area under section 10 of this chapter.

Sec. 7. As used in this chapter, "taxpayer" means a person that is liable for a covered tax.

Sec. 8. (a) After June 30, 2021, the city fiscal body may designate as a workforce investment training area any facility that is:

(1) located within the city;

(2) owned by a nonprofit corporation; and

(3) used as a training institute and teaching hotel.

(b) Only one (1) tax area may be created in the city.

Sec. 9. (a) A tax area must be initially established:

(1) by resolution after June 30, 2021, and before July 1, 2023; and

(2) according to the procedures set forth for the establishment of an economic development area under IC 36-7-14.

(b) In establishing the tax area, the designating body must make the following findings instead of the findings required for the establishment of economic development areas:

(1) That the use of covered taxes under this chapter will benefit the public health and welfare and will be of public utility and benefit.

(2) That the use of covered taxes under this chapter will protect or increase state and local tax bases and tax revenues.

(c) The tax area established under this chapter is a special taxing district authorized by the general assembly to enable the designating body to provide special benefits to taxpayers in the tax area by promoting workforce investment and training that is of public use and benefit.

Sec. 10. (a) A tax area must be established by resolution. A resolution establishing a tax area must provide for the allocation of covered taxes earned or collected in the tax area to the workforce investment training area fund established for the city. The allocation provision must apply to the entire tax area.

(b) The resolution establishing the tax area must designate the facility and the facility site for which the tax area is established.

(c) The department may adopt rules under IC 4-22-2 and guidelines to govern the allocation of covered taxes to a tax area.

Sec. 11. (a) Upon adoption of a resolution establishing a tax area under section 10 of this chapter, the city fiscal officer shall submit the resolution to the budget committee for review and recommendation to the budget agency.

(b) The budget committee shall meet not later than sixty (60) days after receipt of a resolution and shall make a recommendation on the resolution to the budget agency.

Sec. 12. (a) The budget agency must approve the resolution before covered taxes may be allocated under section 10 of this

chapter.

(b) When considering a resolution, the budget committee and the budget agency must find that the use of covered taxes from the tax area designated under the resolution is economically sound and will benefit the people of Indiana by protecting or increasing state and local tax bases and tax revenues for at least the duration of the tax area established under this chapter.

Sec. 13. (a) When the city fiscal body adopts an allocation provision, the city fiscal officer shall notify the department by certified mail of the adoption of the provision and shall include with the notification a complete list of the following:

(1) Employers in the tax area.

(2) Street names and the range of street numbers of each street in the tax area.

The city fiscal officer shall update the list before July 1 of each year.

(b) Each taxpayer operating in the tax area shall report annually, in the manner and in the form prescribed by the department, information that the department determines necessary to calculate the salary, wages, bonuses, and other compensation that are earned in the tax area.

(c) A taxpayer operating in the tax area that files a consolidated tax return with the department also shall file annually an informational return with the department for each business location of the taxpayer within the tax area.

(d) If a taxpayer fails to report the information required by this section or file an informational return required by this section, the department shall use the best information available in calculating the amount of covered taxes attributable to a taxable event in a tax area or covered taxes from income earned in a tax area.

Sec. 14. If a tax area is established under section 10 of this chapter, a state fund known as the workforce investment training area fund is established for that tax area. The fund shall be administered by the department. Money in the fund does not revert to the state general fund at the end of a state fiscal year.

Sec. 15. The department shall deposit covered taxes attributable to a taxing area under section 10 of this chapter in the workforce investment training area fund.

Sec. 16. On or before the twentieth day of each month, all amounts held in the workforce investment training area fund shall be distributed to the city fiscal officer.

Sec. 17. The department shall notify the county auditor of the

amount of taxes to be distributed to the city fiscal officer. The notice must specify the distribution and uses of covered taxes to be allocated under this chapter.

Sec. 18. All distributions from the workforce investment training area fund for the city must be made by warrants issued by the auditor of state to the treasurer of state ordering those payments to the city fiscal officer.

Sec. 19. The resolution establishing the tax area must designate the use of the funds. The funds may be used only for the financing or refinancing of a facility described in section 8(a) of this chapter.

Sec. 20. The city fiscal body shall repay to the workforce investment training area fund any amount that is distributed to the designating body and used for:

(1) a purpose that is not described in this chapter; or

(2) a facility or facility site other than the facility and facility site to which covered taxes are designated under the resolution described in section 10 of this chapter.

The department shall distribute the covered taxes repaid to the workforce investment training area fund under this section proportionately to the funds and the political subdivisions that would have received the covered taxes if the covered taxes had not been allocated to the tax area under this chapter.

Sec. 21. This chapter expires June 30, 2033.

SECTION 15. IC 36-12-3-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 19. A public library shall adopt a criminal history check policy for employees and volunteers.**

SECTION 16. [EFFECTIVE UPON PASSAGE] **(a) The Indiana board of veterinary medical examiners shall study the regulation of veterinary technicians and submit a report to the legislative council in an electronic format under IC 5-14-6 before November 1, 2019.**

(b) This SECTION expires January 1, 2020.

SECTION 17. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 436 as printed February 19, 2019.)

BACON

Committee Vote: yeas 7, nays 2.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Engrossed Senate Bill 436, 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 2, delete lines 29 through 42.

Delete pages 3 through 4.

Page 5, delete lines 1 through 2.

Page 5, delete lines 27 through 42.

Page 6, delete lines 1 through 25.

Page 7, delete lines 16 through 42, begin a new paragraph and insert:

"SECTION 8. IC 12-15-12-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 18.5. (a) This section applies to hospital participation agreements between managed care organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an individual enrolled in a risk based managed care program.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a managed care organization and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in a risk based managed care program. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a person and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in a risk based managed care program for which the person serves as a managed care organization.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services" includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Risk based managed care program" means any Medicaid program to which this chapter applies.

(c) Subject to subsection (d), a hospital participation agreement between a managed care organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items

that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A managed care organization and a multi-location hospital may agree in writing to waive one (1) or more of the requirements specified in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the managed care organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement; or

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the managed care organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a managed care organization and a

multi-location hospital that:

(1) purports to waive or limit one (1) or more of the requirements of subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a managed care organization and a multi-location hospital before July 1, 2019, that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019, is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) A managed care organization may not require a multi-location hospital to have a contract with an insurer under IC 27-8 or a contract with a health maintenance organization under IC 27-13 as a condition of entering into a hospital participation agreement with the hospital.

SECTION 9. IC 12-15-44.5-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 12. (a) This section applies to:**

(1) emergency services provided to an individual enrolled in the plan; and

(2) medically necessary screening services provided to an individual enrolled in the plan who presents to an emergency department with an emergency medical condition.

(b) This section does not apply to emergency services or screening services provided to an individual enrolled in the plan by a provider who has contracted with the individual's managed care organization to provide emergency services to the individual.

(c) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning set forth in IC 12-15-12-0.3.

(2) "Emergency services" has meaning set forth in IC 12-15-12-0.5.

(d) The payment rate for emergency services and medically necessary screening services in the emergency department of a hospital licensed under IC 16-21 must be comparable to the federal Medicare reimbursement rate for the service provided by the provider or equal to one hundred thirty percent (130%) of the

Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate. A managed care organization may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(e) This section does not limit the ability of the managed care organization to review, and make a determination of, the medical necessity of the services provided in a hospital's emergency department for purposes of determining coverage for such services.

SECTION 10. IC 12-15-44.5-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 13. (a) This section applies to post-stabilization care services provided to an individual enrolled in the plan.**

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning set forth in IC 12-15-12-0.3.

(2) "Post-stabilization care services" refers to covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the enrollee's condition.

(c) The managed care organization through which an individual is enrolled in the plan is financially responsible for the following services provided to the enrollee:

(1) Post-stabilization care services that are preapproved by the managed care organization.

(2) Post-stabilization care services that are not preapproved by the managed care organization, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the managed care organization for preapproval of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by the managed care organization, but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating

physician concerning the enrollee's care, and a physician representing the managed care organization is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the managed care organization shall give the enrollee's treating physician an opportunity to consult with a physician representing the managed care organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing the managed care organization is reached or until one (1) or more of the following criteria is met:

(1) A physician:

(A) representing the managed care organization; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the managed care organization assumes responsibility for the enrollee's care through transfer.

(3) A representative of the managed care organization and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) to an individual enrolled in the plan by a provider who has not contracted with the individual's managed care organization to provide post-stabilization care services to the enrollee. The payment rate for post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) must be must be comparable to the federal Medicare reimbursement rate for the service provided by the provider, or one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate. A managed care organization may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(f) This section does not limit the ability of the office or the managed care organization to review, and make a determination of the medical necessity of, the post-stabilization care services provided to an enrollee for purposes of determining coverage for the services.

SECTION 11. IC 12-15-44.5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 14. (a) This section applies to**

hospital participation agreements between managed care organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an individual enrolled in the plan.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" refers to a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a managed care organization and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in the plan. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a managed care organization and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items for individuals enrolled in the plan.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are

provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(c) Subject to subsection (d), a hospital participation agreement between a managed care organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A managed care organization and a multi-location hospital may agree in writing to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to so waive one (1) or more of the

requirements of subsection (c)(1) through (c)(3) is entered into between the managed care organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement; or

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(3):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(3) is set forth in a separate written agreement between the multi-location hospital and the managed care organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a managed care organization and a multi-location hospital that:

(1) purports to waive or limit the requirements listed in subsection (c)(1) through (c)(3) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a managed care organization and a multi-location hospital prior to July 1, 2019, that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019, is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) A managed care organization may not require a

multi-location hospital to have a contract with an insurer under IC 27-8, or a contract with a health maintenance organization under IC 27-13, as a condition for entering into a hospital participation agreement with the hospital.

SECTION 17. IC 27-8-11-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 13. (a) This section applies to hospital participation agreements between insurers and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an insured under the terms of a policy issued or administered by an insurer.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between an insurer and a multi-location hospital for the hospital's provision of covered inpatient or outpatient hospital services or items to an insured of the insurer. The term includes an agreement described in section 3(a)(1) of this chapter, and any amendment, addendum, or attachment to a direct or indirect agreement between an insurer and a multi-location hospital that provides for the hospital's provision of covered inpatient or outpatient hospital services or items to an insured of the insurer.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Qualified inpatient care facility" means an inpatient care facility that, at the time a hospital participation agreement is entered into or, as applicable, at the time a hospital participation agreement is renewed, satisfies the following criteria, as certified by the multi-location hospital of which the inpatient care facility is a commonly licensed inpatient care facility (or, with regard to clause (A), as certified by an architect or engineer retained by the multi-location hospital):

(A) The building containing the inpatient care facility is at least sixty thousand (60,000) square feet in size, as measured using standards of the 2001 AIA Guidelines for Design and Construction for Healthcare Facilities.

(B) One hundred percent (100%) of the occupied floor area of the building is used, directly or indirectly, for:

(i) the delivery of inpatient hospital services or items;

(ii) the delivery of outpatient hospital services and items;

(iii) the staffing, supplying and equipping of inpatient and outpatient hospital services and items;

(iv) the delivery of other health care services; and

(v) the clinical, administrative, clerical, maintenance, engineering, and other activities that support items (i) through (iv).

(C) The inpatient care facility is staffed with physicians who are board certified inpatient hospitality who make rounds at the inpatient care facility at least once per day.

(D) The inpatient care facility includes an emergency department that is staffed twenty-four (24) hours per day, seven (7) days per week, with physicians who are board certified in emergency medicine or trauma medicine, or both.

(E) The inpatient care facility has an onsite a Category II hospital pharmacy for emergency department and inpatient care.

(F) The inpatient care facility has an onsite pathology laboratory for emergency department and inpatient care.

(G) The inpatient care facility has onsite radiology services for emergency department and inpatient care, as well as onsite magnetic resonance imaging services.

(H) The emergency department of the inpatient care facility has one (1) or more:

(i) critical rooms; and

(ii) rooms that are equipped specifically for eye injuries, orthopedic injuries, and to afford seclusion for patients.

(I) One (1) or more negative pressure rooms for treatment of patients are located within the inpatient care facility.

(J) One (1) or more rooms dedicated for use in hazardous materials and decontamination cases are located within the inpatient care facility.

(K) A fixed, permanent, and marked helicopter landing site, approved by the Federal Aviation Administration, is located within two hundred (200) feet of the inpatient care facility's emergency department.

(L) The inpatient care facility staffs, equips, and maintains at least six (6) inpatient beds for use exclusively in the delivery of inpatient hospital services. Hospital beds located in an emergency department that are used to provide inpatient hospital services to inpatients of the inpatient care facility are not eligible to be counted as inpatient beds.

(M) Licensed social workers are available onsite at the inpatient care facility at least sixteen (16) hours per day,

seven days per week.

(c) Subject to subsections (d) and (g), a hospital participation agreement between an insurer and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) An insurer and a multi-location hospital may agree in writing to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the insurer and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement;

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection

(c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the insurer; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between an insurer and a multi-location hospital that:

(1) purports to waive or limit one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between an insurer and a multi-location hospital prior to July 1, 2019 that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019 is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) Notwithstanding subsection (c), a hospital participation agreement with a multi-location hospital need not include the inpatient hospital services and items provided at an inpatient care facility that is commonly licensed with other inpatient care facilities of the multi-location hospital if that inpatient care facility does not satisfy the requirements of a qualified inpatient care facility (as defined in subsection (b)(12)) at the time the hospital participation agreement is entered into or, as applicable, at the time the hospital participation agreement is renewed.

SECTION 18. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 14. (a) This section applies to emergency services provided to an insured of an insurer.**

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent lay person

with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(A) serious jeopardy to the health of:

(i) the individual; or

(ii) in the case of a pregnant woman, the woman or her unborn child;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(2) "Emergency services" means covered health care services that are:

(A) furnished by a provider qualified to furnish emergency services; and

(B) needed to evaluate or stabilize an emergency medical condition.

(c) An insurer is financially responsible for emergency services provided to its insured.

(d) This subsection applies to emergency services provided to an insured by a provider who has not contracted with the insured's insurer to provide emergency services. Payment for emergency services must be in an amount comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(e) Payment under subsection (d) for a provider's emergency services shall be made directly to the provider by the insurer in the event the insured has executed an assignment of benefits under IC 27-8-11.5.

(f) This section does not limit the ability of the insurer to review, and make a determination of, the medical necessity of the emergency services provided to an insured for purposes of determining coverage for such services.

SECTION 19. IC 27-8-11-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 15. (a) This section applies to post-stabilization care services provided to an insured.**

(b) The following definitions apply throughout this section:

(1) "Emergency medical condition" has the meaning provided in section 3.5(b) of this chapter.

(2) "Post-stabilization care services" means covered health care services rendered by a provider that are related to an

emergency medical condition and that are provided after an insured is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the insured's condition.

(c) The insurer is financially responsible for the following services provided to the insured:

(1) Post-stabilization care services that are preapproved by the insurer or the insurer's agent.

(2) Post-stabilization care services that are not preapproved by the insurer or the insurer's agent, but that are administered to maintain the insured's stabilized condition within one (1) hour of a request to the insurer for preapproval of post-stabilization care services.

(3) Post-stabilization care services provided after an insured is stabilized that are not preapproved by the insurer or the insurer's agent, but that are administered to maintain, improve, or resolve the insured's stabilized condition if the insurer:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the insured's treating physician concerning the insured's care, and a physician representing the insurer is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the insurer shall give the insured's treating physician an opportunity to consult with a physician representing the insurer. The insured's treating physician may continue with care of the insured until a physician representing the insurer is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the insurer; and

(B) who has privileges at the treating hospital;

assumes responsibility for the insured's care.

(2) A physician representing the insurer assumes responsibility for the insured's care through transfer.

(3) A representative of the insurer and the insured's treating physician reach an agreement concerning the insured's care.

(4) The insured is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), or (c)(3) to an insured by a provider who has not contracted with the insured's insurer to

provide post-stabilization care services to the insured. Payment for post-stabilization care services provided under subsection (c)(1), (c)(2), or (c)(3) must be comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider; or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(f) Payment under subsection (e) for an out-of-network provider's post-stabilization care services shall be made directly to the provider by the insurer in the event the insured has executed an assignment of benefits under IC 27-8-11.5.

(g)This section does not limit the ability of the insurer to review, and make a determination of, the medical necessity of the post-stabilization care services provided to an insured for purposes of determining coverage for such services.

SECTION 20. IC 27-8-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 11.5. Assignment of Benefits for Emergency Services and Post-Stabilization Care Services Provided to Insureds

Sec. 1. The following definitions apply throughout this chapter:

(1) "Assignment of benefits" means a written instrument that:

(A) is executed:

(i) by an insured; or

(ii) for an insured by the authorized representative of the insured; and

(B) assigns to a provider the insured's right to receive reimbursement for emergency services or post-stabilization care services, or both, that are provided by the provider to the insured.

(2) "Emergency services" has the meaning set forth in IC 27-8-11-14.

(3) "Health care services" has the meaning set forth in IC 27-8-11-1. The term includes ambulance services provided by a hospital.

(4) "Insured" has the meaning set forth in IC 27-8-11-1.

(5) "Insurer" includes the following:

(A) An insurer (as defined in IC 27-8-11-1 that issues a policy.

(B) An administrator licensed under IC 27-1-25 that pays or administers claims for benefits under a policy.

(6) "Noncontracted provider" means a provider that has not

entered into a reimbursement agreement described in IC 27-8-11-3(a) with an insured's insurer.

(7) "Policy" refers to a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(8) "Post-stabilization care services" has the meaning set forth in IC 27-8-11-15(b).

(9) "Provider" has the meaning set forth in IC 27-8-11-1.

Sec. 2. (a) Except as provided in subsection (b), if:

(1) an insured's policy provides coverage for emergency services or post-stabilization care services, or both;

(2) emergency services or post stabilization care services, or both, are rendered by a noncontracted provider to the insured; and

(3) the noncontracted provider:

(A) has an assignment of benefits with regard to the insured to whom the emergency services or post stabilization care services, or both, were rendered, that assigns to the noncontracted provider the insured's right to reimbursement for the emergency services or post-stabilization care services, or both, as applicable; and

(B) provides written or electronic notification to the insurer that the noncontracted provider:

(i) has rendered the emergency services or post-stabilization care services, or both, to the insured; and

(ii) has the assignment of benefits;

the insurer shall pay the reimbursement owed to the noncontracted provider under this chapter directly to the noncontracted provider for the emergency services or post-stabilization care services, or both, as applicable, and send written notice of the payment to the insured or the authorized representative of the insured.

(b) An insurer is not required to make a benefit payment directly to a noncontracted provider described in subsection (a) if the noncontracted provider has been convicted of fraud.

(c) This section does not require:

(1) coverage for benefits not covered under the terms of a policy; or

(2) payment to a noncontracted provider that is not eligible for payment under the terms of a policy.

Sec. 3. If:

(1) a noncontracted provider is entitled to a direct payment under section 2(a) of this chapter;

(2) the insurer makes the payment owed under this chapter to the insured or the authorized representative of the insured rather than to the noncontracted provider; and

(3) the noncontracted provider notifies the insurer that the noncontracted provider has not received the payment owed to the noncontracted under this chapter;

the insurer, not more than thirty (30) days after receiving the notice from the noncontracted provider, shall pay directly to the noncontracted provider the reimbursement owed under this chapter to the noncontracted provider.

Sec. 4. (a) The rate of reimbursement paid by the insurer to a provider under section 2(a) for the prover's provision of emergency services shall be equal to the rate set forth in IC 27-8-11-14(d).

(b) The rate of reimbursement paid by the insurer to a provider under section 2(a) for the provider's provision of post-stabilization care services shall be equal to the rate set forth in IC 27-8-11-15(e).

Sec. 5. If:

(1) a noncontracted provider is entitled to a direct payment under section 10(a) of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the insurer, not more than fourteen (14) business days after the insurer receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the noncontracted provider or the noncontracted provider's agent.

Sec. 6. (a) An insurer that does not comply with this chapter shall pay interest for each day of noncompliance at the same interest rate as provided in IC 12-15-21-3(7)(A).

(b) IC 27-8-5.7 applies to payment of a claim submitted to an insurer by a noncontracted provider in compliance with this chapter.

Sec. 7. A noncontracted provider, by accepting an assignment of benefits from an insured, does not agree to accept an insurer's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 8. A policy or contract provision that violates this chapter

is void.

SECTION 21. IC 27-13-15-1.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 1.3. (a) This section applies to hospital participation agreements between health maintenance organizations and multi-location hospitals that are entered into or renewed on or after July 1, 2019.**

(b) The following definitions apply throughout this section:

(1) "Commonly licensed inpatient care facilities" means two (2) or more inpatient care facilities that are licensed under the same hospital license.

(2) "Commonly licensed outpatient care facilities" means two (2) or more outpatient care facilities that are licensed under the same hospital license.

(3) "Covered" means an inpatient or outpatient hospital service or item for which coverage is provided to an enrollee of a health maintenance organization, including coverage provided to an enrollee in a Medicare Advantage Plan that is offered by or through a health maintenance organization.

(4) "Hospital" means a hospital licensed under IC 16-21-2.

(5) "Hospital license" means a hospital license issued under IC 16-21-2.

(6) "Hospital participation agreement" means an agreement between a health maintenance organization and a multi-location hospital for the multi-location hospital's provision of covered inpatient or outpatient hospital services or items to an enrollee of the health maintenance organization. The term includes any amendment, addendum, or attachment to a direct or indirect agreement between a health maintenance organization and a multi-location hospital that provides for the multi-location hospital's provision of covered inpatient or outpatient hospital services or items to an enrollee of the health maintenance organization.

(7) "Inpatient care facility" means a building:

(A) where inpatient hospital services and items and outpatient hospital services and items are provided;

(B) that is located on a parcel of property; and

(C) that is licensed under IC 16-21-2.

The term does not include a building or inpatient care facility located on a separate parcel of property.

(8) "Multi-location hospital" means a hospital:

(A) that consists of commonly licensed inpatient care

facilities and commonly licensed outpatient care facilities; and

(B) in which the commonly licensed outpatient care facilities are licensed under the same hospital license as the commonly licensed inpatient care facilities.

(9) "Outpatient care facility" means a building:

(A) where outpatient hospital services and items are provided;

(B) where inpatient hospital services and items are not provided, and the building does not contain inpatient equipment and inpatient beds for use in the delivery of inpatient hospital services at the building;

(C) that is located on a parcel of property; and

(D) that is licensed under IC 16-21-2.

The term does not include a building or outpatient care facility located on a separate parcel of property.

(10) "Outpatient hospital services", for purposes of subsection (c)(2) and (c)(5), includes emergency services (as defined in IC 12-15-12-0.5).

(11) "Parcel of property" means a unit of land all parts of which are contiguous.

(12) "Qualified inpatient care facility" means an inpatient care facility that, at the time a hospital participation agreement is entered into or, as applicable, at the time a hospital participation agreement is renewed, satisfies the following criteria, as certified by the multi-location hospital of which the inpatient care facility is a commonly licensed inpatient care facility (or, with regard to clause (A), as certified by an architect or engineer retained by the multi-location hospital):

(A) The building containing the inpatient care facility is at least sixty thousand (60,000) square feet in size, as measured using standards of the 2001 AIA Guidelines for Design and Construction for Healthcare Facilities.

(B) One hundred percent (100%) of the occupied floor area of the building is used, directly or indirectly, for:

(i) the delivery of inpatient hospital services or items;

(ii) the delivery of outpatient hospital services and items;

(iii) the staffing, supplying and equipping of inpatient and outpatient hospital services and items;

(iv) the delivery of other health care services; and

(v) the clinical, administrative, clerical, maintenance,

engineering, and other activities that support the items listed in items (1) through (iv).

(C) The inpatient care facility is staffed with physicians who are board certified inpatient hospitality who make rounds at the inpatient care facility at least once per day.

(D) The inpatient care facility includes an emergency department that is staffed twenty-four (24) hours a day, seven (7) days a week, with physicians who are board certified in emergency medicine or trauma medicine, or both.

(E) The inpatient care facility has an onsite a Category II hospital pharmacy for emergency department and inpatient care.

(F) The inpatient care facility has an onsite pathology laboratory for emergency department and inpatient care.

(G) The inpatient care facility has onsite radiology services for emergency department and inpatient care, as well as onsite magnetic resonance imaging services.

(H) The emergency department of the inpatient care facility has one (1) or more:

(i) critical rooms; and

(ii) rooms that are equipped specifically for eye injuries, orthopedic injuries, and to afford seclusion for patients.

(I) One (1) or more negative pressure rooms for treatment of patients are located within the inpatient care facility.

(J) One (1) or more rooms dedicated for use in hazardous materials and decontamination cases are located within the inpatient care facility.

(K) A fixed, permanent, and marked helicopter landing site, approved by the Federal Aviation Administration, is located within two hundred (200) feet of the inpatient care facility's emergency department.

(L) The inpatient care facility staffs, equips, and maintains at least six (6) inpatient beds for use exclusively in the delivery of inpatient hospital services. Hospital beds located in an emergency department that are used to provide inpatient hospital services to inpatients of the inpatient care facility are not eligible to be counted as inpatient beds.

(M) Licensed social workers are available onsite at the inpatient care facility at least sixteen (16) hours per day, seven days per week).

(c) Subject to subsections (d) and (g), a hospital participation agreement between a health maintenance organization and a multi-location hospital must:

(1) include all commonly licensed inpatient care facilities and all commonly licensed outpatient care facilities of the multi-location hospital;

(2) include all covered inpatient hospital services and items and all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed inpatient care facilities;

(3) include all covered outpatient hospital services and items that are provided at the multi-location hospital's commonly licensed outpatient care facilities;

(4) reimburse the multi-location hospital for a covered inpatient hospital service or item at the same rate regardless of which of the commonly licensed inpatient care facilities provided the service or item; and

(5) reimburse the multi-location hospital for a covered outpatient hospital service or item at the same rate regardless of which of the commonly licensed outpatient care facilities or commonly licensed inpatient care facilities provided the service or item.

(d) A health maintenance organization and a multi-location hospital may agree in writing to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5), as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019, if:

(1) the written agreement to waive one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) is entered into between the health maintenance organization and the multi-location hospital on or after July 1, 2019;

(2) with regard to a hospital participation agreement entered into on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsections (c)(1) through (c)(5):

(A) is expressly stated in the hospital participation agreement; and

(B) applies only to the initial term of the hospital participation agreement;

(3) with regard to a hospital participation agreement that is renewed on or after July 1, 2019, the written agreement to waive one (1) or more of the requirements listed in subsection

(c)(1) through (c)(5):

(A) is stated in the agreement to renew the hospital participation agreement or, if there is no separate agreement for the renewal of the hospital participation agreement, the agreement to waive one (1) or more of the requirements of subsection (c)(1) through (c)(5) is set forth in a separate written agreement between the multi-location hospital and the health maintenance organization; and

(B) applies only to the term of the hospital participation agreement that is being renewed.

(e) An agreement between a health maintenance organization and a multi-location hospital that:

(1) purports to waive or limit one (1) or more of the requirements listed in subsection (c)(1) through (c)(5) for a hospital participation agreement entered into or renewed on or after July 1, 2019; and

(2) does not satisfy the applicable requirements of subsection (d);

is void.

(f) A direct or indirect agreement entered into or renewed between a health maintenance organization and a multi-location hospital prior to July 1, 2019 that would prevent the application of subsection (c) to a hospital participation agreement entered into or renewed on or after July 1, 2019 is void as applied to a hospital participation agreement entered into or renewed on or after July 1, 2019.

(g) Notwithstanding subsection (c), a hospital participation agreement with a multi-location hospital is not required to include the inpatient hospital services and items provided at an inpatient care facility that is commonly licensed with other inpatient care facilities of the multi-location hospital if that inpatient care facility does not satisfy the requirements of a qualified inpatient care facility (as defined in subsection (b)) at the time the hospital participation agreement is entered into or, as applicable, at the time the hospital participation agreement is renewed.

SECTION 22. IC 27-13-36-9.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.2. (a) The following definitions apply throughout this section:**

(1) "Care obtained in an emergency" means, with respect to an enrollee, covered services that are:

(A) furnished by a provider within the scope of the

provider's license and as otherwise authorized under law; and

(B) needed to evaluate or stabilize an individual in an emergency.

(2) "Stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(A) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.

(B) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.

(C) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(b) As described in subsection (c), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

(1) prior authorization; or

(2) regard to the contractual relationship between:

(A) the provider who provided health care services to the enrollee in an emergency; and

(B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(c) Each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency from an out of network provider at a rate comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate. emergency services at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the health

maintenance organization's service area for health care services provided during the emergency.

(2) An amount agreed to between the health maintenance organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.

(d) Payment under subsection (c) for a provider's care provided in an emergency shall be made directly to the provider by the health maintenance organization in the event the enrollee has executed an assignment of benefits under IC 27-13-36.5.

(e) This section does not limit the ability of the health maintenance organization to review, and make a determination of, the medical necessity of the emergency services provided to an enrollee for purposes of determining coverage for such services.

SECTION 23. IC 27-13-36-9.3. IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 9.3. (a) This section applies to post-stabilization care services provided to an enrollee of a health maintenance organization.**

(b) As used in this section, "post-stabilization care services" means covered health care services related to an emergency that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in subsection (c)(3), to improve or resolve the enrollee's condition.

(c) The health maintenance organization is financially responsible for the following services provided to the enrollee:

(1) Post-stabilization care services that are preapproved by the health maintenance organization or the health maintenance organization's agent.

(2) Post-stabilization care services that are not preapproved by the health maintenance organization or the health maintenance organization's agent, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the health maintenance organization for preapproval of post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by the health maintenance organization or the health maintenance organization's agent, but that are administered to maintain,

improve, or resolve the enrollee's stabilized condition if the health maintenance organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the health maintenance organization is not available for consultation.

(d) If the conditions described in subsection (c)(3)(C) exist, the health maintenance organization shall give the enrollee's treating physician an opportunity to consult with a physician representing the health maintenance organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing the health maintenance organization is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the health maintenance organization; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the health maintenance organization assumes responsibility for the enrollee's care through transfer.

(3) A representative of the health maintenance organization and the enrollee's treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(e) This subsection applies to post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) to an enrollee by an out of network provider. Payment for post-stabilization care services provided under subsection (c)(1), (c)(2), and (c)(3) must be in an amount comparable to two hundred percent (200%) of the federal Medicare reimbursement rate for the service provided by the provider, or two hundred sixty percent (260%) of the Medicaid fee-for-service reimbursement rate for a service that does not have a Medicare reimbursement rate.

(f) Payment under subsection (d) for a provider's care provided in an emergency shall be made directly to the provider by the health maintenance organization in the event the enrollee has executed an assignment of benefits under IC 27-13-36.5.

(g) This section does not limit the ability of the health maintenance organization to review, and make a determination of,

the medical necessity of the emergency services provided to an enrollee for purposes of determining coverage for such services.

SECTION 24. IC 27-13-36.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]:

Chapter 36.5. Assignment of Benefits for Emergency Services and Post-Stabilization Care Services Provided to Enrollees of Health Maintenance Organizations

Sec. 1. The following definition apply throughout this chapter:

(1) "Assignment of benefits" means a written instrument that:

(A) is executed:

(i) by an enrollee; or

(ii) for an enrollee by the authorized representative of the enrollee; and

(B) assigns to a nonparticipating provider:

(i) the enrollee's right to receive reimbursement for the health care services provided for the enrollee by the nonparticipating provider under IC 27-13-36-9;

(ii) the enrollee's right to receive reimbursement for the post stabilization care services provided for the enrollee by the nonparticipating provider under IC 27-13-36-9.3; or

(iii) the rights described under both items (i) and (ii).

(2) "Nonparticipating provider" means a provider that is not a participating provider.

Sec. 2. (a) Except as provided in subsection (b), if:

(1) an enrollee is entitled to coverage for health care services obtained in an emergency under IC 27-13-36-9 or post-stabilization care services obtained under IC 27-13-36-9.3, or both;

(2) the nonparticipating provider furnished health care services for the enrollee in an emergency under IC 27-13-36-9 or furnished post stabilization care services under IC 27-13-36-9.3, or both; and

(3) the nonparticipating provider:

(A) has an assignment of benefits with regard to the enrollee to whom the services described in subdivision (2) were rendered, that assigns to the nonparticipating provider the enrollee's right to reimbursement for such services; and

(B) provides written or electronic notification to the health maintenance organization that the nonparticipating

provider:

(i) has furnished health care services for the enrollee in an emergency under IC 27-13-36-9 or furnished post stabilization care services for the enrollee under IC 27-13-36-9.3, or both; and

(ii) has the assignment of benefits;

the health maintenance organization shall directly reimburse the nonparticipating provider for the health care services provided by the provider under IC 27-13-36-9 or the post stabilization care services provided by the provider under IC 27-13-36-9.3, or both.

(b) An health maintenance organization is not required to make a payment directly to a nonparticipating provider described in subsection (a)(2) if the nonparticipating provider has been convicted of fraud.

(c) This section does not require:

(1) health care services for which coverage is not provided for an enrollee; or

(2) payment to a nonparticipating provider that is not eligible for reimbursement under an enrollee's coverage.

Sec. 3. If:

(1) a nonparticipating provider is entitled to direct reimbursement under section 3(a) of this chapter;

(2) the health maintenance organization tenders the reimbursement to the enrollee or a representative of the enrollee rather than to the nonparticipating provider; and

(3) the nonparticipating provider notifies the health maintenance organization that the nonparticipating provider has not received the reimbursement;

the health maintenance organization, not more than thirty (30) days after receiving the notice from the nonparticipating provider, shall tender the reimbursement owed to the nonparticipating provider under this chapter directly to the nonparticipating provider.

Sec. 4. (a) The rate of reimbursement paid by the health maintenance organization to the nonparticipating provider under section 3(a) of this chapter for the provider's provision of health care services obtained in an emergency under IC 27-13-36-9 shall be the rate set forth in IC 27-13-36-9(d).

(b) The rate of reimbursement paid by the health maintenance organization to the nonparticipating provider under section 3(a) for the provider's provision of post stabilization care services under IC 27-13-36-9.3 shall be the rate set forth in

IC 27-13-36-9.3(e).

Sec. 5. If:

(1) a nonparticipating provider is entitled to be reimbursed directly by the health maintenance organization under section 3(a) of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the health maintenance organization, not more than fourteen (14) business days after the health maintenance organization receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the nonparticipating provider or the nonparticipating provider's agent.

Sec. 6. (a) A health maintenance organization that does not comply with this chapter shall pay interest for each day of noncompliance at the same interest rate prescribed in IC 12-15-21-3(7)(A).

(b) IC 27-13-36.2-4 applies to payment of a claim submitted to a health maintenance organization by a nonparticipating provider in compliance with this chapter.

Sec. 7. A nonparticipating provider, by accepting an assignment of benefits from an enrollee, does not agree to accept a health maintenance organizations' fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 8. A provision of a group contract or an individual contract that violates this chapter is void.".

Delete pages 8 through 35.

Page 36, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 27. [EFFECTIVE UPON PASSAGE] **(a) This SECTION applies to a hospital licensed under IC 16-21-2 that, during the period January 8, 2018, through June 30, 2019, submitted claims to a managed care organization (as defined in IC 12-7-2-126.9) for covered health care services or items provided to individuals enrolled in a Medicaid risk based managed care program governed by IC 12-15-12, or for covered health care services or items provided to individuals enrolled in the Healthy Indiana Plan under IC 12-15-44.5, using an incorrect or otherwise inapplicable NPI code.**

(b) As used in this SECTION, "NPI" refers to a National Provider Identifier record assigned by the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES).

(c) Any managed care organization receiving claims described in subsection (a) shall allow the hospital to resubmit the claims using a correct NPIs, or otherwise reconcile the claims described in subsection (a) with the hospital's correct NPI, and shall pay the amounts due the hospital for the claims as if the claims had been originally submitted using the correct NPI. The reimbursement for each claim shall be paid to the hospital within sixty (60) days after the hospital provides the correct NPI for the claims to the managed care organization.

(d) This SECTION expires January 1, 2021.

SECTION 28. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "school based health center" means a clinic operated on behalf of a public school, including a charter school, that provides health care services either:**

(1) by qualified health care providers employed by the school; or

(2) through a contract with a health care provider.

(b) The office of the secretary of family and social services shall study the feasibility and best means to provide:

(1) Medicaid reimbursement for health care services and school based services to specified individuals provided by a school based health center; and

(2) supplemental Medicaid reimbursement payments to qualified school based health centers under the fee for service Medicaid program.

(c) The office of the secretary of family and social services shall submit a report detailing the office's findings to the members of the interim study committee on public health, behavioral health, and human services (established by IC 2-5-1.3-4) and to the legislative

council in an electronic format under IC 5-14-6 before November 1, 2019.

(d) This SECTION expires January 1, 2020.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to ESB 436 as printed April 5, 2019.)

HUSTON

Committee Vote: yeas 18, nays 3.