

HOUSE BILL No. 1414

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Managed care organization reimbursement. Allows a managed care organization and a Medicaid provider to both agree in writing to a reimbursement rate for a Medicaid service that is less than an established reimbursement rate for that service.

Effective: July 1, 2024.

Karickhoff

January 11, 2024, read first time and referred to Committee on Public Health.



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

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

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

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

HOUSE BILL No. 1414



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

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

1 SECTION 1. IC 12-15-12-12 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 12. **(a)** For a managed
3 care program or demonstration project established or authorized by the
4 office, or established or authorized by another entity or agency working
5 in conjunction with or under agreement with the office, the office must
6 provide for payment to providers in the managed care program that the
7 office finds is reasonable and adequate to meet the costs that must be
8 incurred by efficiently and economically operated providers in order to:
9 (1) provide care and services in conformity with applicable state
10 and federal laws, regulations, and quality and safety standards;
11 and
12 (2) ensure that individuals eligible for medical assistance under
13 the managed care program or demonstration project have
14 reasonable access (taking into account geographic location and
15 reasonable travel time) to the services provided by the managed
16 care program.
17 **(b) A managed care organization and a provider may mutually**



1 **agree in writing to a reimbursement rate for a Medicaid service**
 2 **that is less than a rate set by the office of the secretary for the**
 3 **service.**

4 SECTION 2. IC 12-15-12-17, AS AMENDED BY P.L.152-2017,
 5 SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 6 JULY 1, 2024]: Sec. 17. (a) This section applies to post-stabilization
 7 care services provided to an individual enrolled in a Medicaid risk
 8 based managed care program.

9 (b) The managed care organization through which an individual is
 10 enrolled in a risk based managed care program, is financially
 11 responsible for the following services provided to the enrollee:

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

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

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

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

26 (B) cannot be contacted; or

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

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

37 (1) A physician:

38 (A) representing the managed care organization; and

39 (B) who has privileges at the treating hospital;

40 assumes responsibility for the enrollee's care.

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



- 1 (3) A representative of the managed care organization and the
 2 treating physician reach an agreement concerning the enrollee's
 3 care.
- 4 (4) The enrollee is discharged from the treating hospital.
- 5 (d) This subsection applies to post-stabilization care services
 6 provided under subsection (b)(1), (b)(2), and (b)(3) to an individual
 7 enrolled in a Medicaid risk based managed care program by a provider
 8 who has not contracted with the individual's managed care organization
 9 to provide post-stabilization care services under subsection (b)(1),
 10 (b)(2), and (b)(3) to the individual. Payment for post-stabilization care
 11 services provided under subsection (b)(1), (b)(2), and (b)(3) must be
 12 in an amount equal to one hundred percent (100%) of the current
 13 Medicaid fee for service reimbursement rates for such services **unless**
 14 **the managed care organization and the provider both mutually**
 15 **agree in writing to a different rate or payment methodology.**
- 16 (e) This section does not prohibit a managed care organization from
 17 entering into a subcontract with another managed care organization
 18 providing for the latter managed care organization to assume financial
 19 responsibility for making the payments required under this section.
- 20 (f) This section does not limit the ability of the office or the
 21 managed care organization to:
- 22 (1) review; and
 23 (2) make a determination of;
- 24 the medical necessity of the post-stabilization care services provided
 25 to an enrollee for purposes of determining coverage for such services.
- 26 SECTION 3. IC 12-15-12-18, AS AMENDED BY P.L.152-2017,
 27 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 28 JULY 1, 2024]: Sec. 18. (a) Except as provided in subsection (b), this
 29 section applies to:
- 30 (1) emergency services provided to an individual enrolled in a
 31 Medicaid risk based managed care program; and
 32 (2) medically necessary screening services provided to an
 33 individual enrolled in a Medicaid risk based managed care
 34 program;
 35 who presents to an emergency department with an emergency medical
 36 condition.
- 37 (b) This section does not apply to emergency services or screening
 38 services provided to an individual enrolled in a Medicaid risk based
 39 managed care program by a provider who has contracted with the
 40 individual's managed care organization to provide emergency services
 41 to the individual.
- 42 (c) Payment for emergency services and medically necessary



1 screening services in the emergency department of a hospital licensed
 2 under IC 16-21 must be in an amount equal to one hundred percent
 3 (100%) of the current Medicaid fee for service reimbursement rates for
 4 such services **unless the managed care organization and the**
 5 **provider both mutually agree in writing to a different rate or**
 6 **payment methodology.**

7 (d) Payment under subsection (c) is the responsibility of the
 8 enrollee's managed care organization. This subsection does not prohibit
 9 the managed care organization from entering into a subcontract with
 10 another managed care organization providing for the latter managed
 11 care organization to assume financial responsibility for making the
 12 payments required under this section.

13 (e) This section does not limit the ability of the managed care
 14 organization to:

15 (1) review; and

16 (2) make a determination of;

17 the medical necessity of the services provided in a hospital's emergency
 18 department for purposes of determining coverage for such services.

19 SECTION 4. IC 12-15-12-18.5, AS ADDED BY P.L.142-2022,
 20 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 21 JULY 1, 2024]: Sec. 18.5. (a) Except as provided in subsection (b), this
 22 section applies to an emergency medical services provider organization
 23 that meets the following requirements:

24 (1) Is certified by the Indiana emergency medical services
 25 commission to provide emergency medical services.

26 (2) Is a Medicaid provider.

27 (b) This section does not apply to an emergency medical services
 28 provider organization that has contracted with the recipient's managed
 29 care organization to provide emergency medical services described in
 30 this section at a negotiated rate that is different than the Medicare rate
 31 described in this section.

32 (c) ~~Beginning July 1, 2023~~; A managed care organization shall
 33 reimburse an emergency medical services provider organization for
 34 Medicaid covered services provided to a Medicaid recipient, including:

35 (1) advanced life support services;

36 (2) basic life support services; and

37 (3) nonemergency medical transportation services;

38 that are within the emergency medical services provider organization's
 39 scope of practice at a rate that is comparable to the federal Medicare
 40 reimbursement rate for the service provided by the emergency medical
 41 services provider organization **unless the managed care organization**
 42 **and the provider both mutually agree in writing to a different rate**



1 **or payment methodology. However, the reimbursement rate specified**
2 **in this subsection may not be implemented by the office of the**
3 **secretary before July 1, 2023.**

4 SECTION 5. IC 12-15-44.5-5, AS AMENDED BY P.L.201-2023,
5 SECTION 136, IS AMENDED TO READ AS FOLLOWS
6 [EFFECTIVE JULY 1, 2024]: Sec. 5. (a) A managed care organization
7 that contracts with the office to provide health coverage, dental
8 coverage, or vision coverage to an individual who participates in the
9 plan:

10 (1) is responsible for the claim processing for the coverage;

11 (2) shall reimburse providers at a rate that is not less than the rate
12 established by the secretary **unless the managed care**
13 **organization and the provider both mutually agree in writing**
14 **to a different rate or payment methodology; and**

15 (3) may not deny coverage to an eligible individual who has been
16 approved by the office to participate in the plan.

17 (b) A managed care organization that contracts with the office to
18 provide health coverage under the plan must incorporate cultural
19 competency standards established by the office. The standards must
20 include standards for non-English speaking, minority, and disabled
21 populations.

