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.

Introduced

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

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:

SECTION 1. IC 12-15-12-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 12. **(a)** For a managed care program or demonstration project established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, the office must provide for payment to providers in the managed care program that the office finds is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers in order to:

(1) provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards; and

(2) ensure that individuals eligible for medical assistance under the managed care program or demonstration project have reasonable access (taking into account geographic location and reasonable travel time) to the services provided by the managed care program.

(b) A managed care organization and a provider may mutually

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

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

(b) The managed care organization through which an individual is enrolled in a risk based managed care program, 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.

(c) If the conditions described in subsection (b)(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) 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.

(d) This subsection applies to post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) to an individual enrolled in a Medicaid risk based managed care program by a provider who has not contracted with the individual's managed care organization to provide post-stabilization care services under subsection (b)(1), (b)(2), and (b)(3) to the individual. Payment for post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services **unless the managed care organization and the provider both mutually agree in writing to a different rate or payment methodology.**

(e) This section does not prohibit a managed care organization from entering into a subcontract with another managed care organization providing for the latter managed care organization to assume financial responsibility for making the payments required under this section.

(f) This section does not limit the ability of the office or the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the post-stabilization care services provided to an enrollee for purposes of determining coverage for such services.

SECTION 3. IC 12-15-12-18, AS AMENDED BY P.L.152-2017, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 18. (a) Except as provided in subsection (b), this section applies to:

(1) emergency services provided to an individual enrolled in a Medicaid risk based managed care program; and

(2) medically necessary screening services provided to an individual enrolled in a Medicaid risk based managed care program;

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 a Medicaid risk based managed care program by a provider who has contracted with the individual's managed care organization to provide emergency services to the individual.

(c) Payment for emergency services and medically necessary

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

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

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

(1) review; and

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

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

(2) Is a Medicaid provider.

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

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

(1) advanced life support services;

(2) basic life support services; and

(3) nonemergency medical transportation services;

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

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

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

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

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

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

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