Reprinted
February 2, 2024

HOUSE BILL No. 1414

DIGEST OF HB 1414 (Updated February 1, 2024 12:15 pm - DI 147)

Citations Affected: IC 12-7; IC 12-15.

Synopsis: Managed care organization reimbursement. Requires the budget committee to review certain contracts with managed care organizations for the Medicaid program. Allows a managed care organization and a Medicaid provider to enter into a value based health care reimbursement agreement in writing providing for a reimbursement rate that is different than an established reimbursement rate for that service. Defines "value based health care reimbursement agreement". Prohibits a managed care organization from imposing a different rate or payment methodology through a notice of contract change to a provider. Requires a managed care organization to notify the office of the secretary of family and social services if the managed care organization and a provider enter into a value based health care reimbursement agreement. Provides that a managed care organization may not deny any provider willing and qualified to meet the terms and conditions of an agreement to provide services under the risk based managed care program for Medicaid recipients who are eligible to participate in the Medicare program and receive nursing facility services or home and community based services the right to enter into an agreement.

Effective: July 1, 2024.

Karickhoff, Manning, Fleming

January 11, 2024, read first time and referred to Committee on Public Health.
January 30, 2024, amended, reported — Do Pass.
February 1, 2024, read second time, amended, ordered engrossed.

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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:

SECTION 1. IC 12-7-2-196.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 196.7. (a) "Value based health care reimbursement agreement", for purposes of IC 12-15, may include the following:**

(1) An accountable care organization that has a contract with a managed care organization in which the managed care organization:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) Case rate.

(4) A capitated rate reimbursement arrangement.

(5) A pay for performance arrangement.

(6) Any other health care reimbursement arrangement in

which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.

SECTION 2. IC 12-15-1-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) If the office enters into a comprehensive risk contract with a managed care organization that:**

(1) establishes a capitated rate for a new contract; or

(2) changes a capitated rate for an existing or a renewal of a contract;

with a managed care organization, the office shall provide the capitated rates to the budget committee for review.

(b) As part of the review required under subsection (a), the office shall present the following information to the budget committee:

(1) The capitation rate and the percentage of any change.

(2) The rationale for the capitation rate.

(3) The fiscal impact of the capitation rate on the Medicaid program.

SECTION 3. 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 enter into a value based health care reimbursement agreement in writing providing for a reimbursement rate for a Medicaid service that is

different than a rate set by the office of the secretary for the service. However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.

(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (b), the managed care organization shall notify the office of the secretary.

SECTION 4. IC 12-15-12-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.5. (a) This section applies to a risk based managed care program that provides services to Medicaid recipients who are eligible to:**

(1) participate in the Medicare program (42 U.S.C. 1395 et seq.); and

(2) receive:

(A) nursing facility services; or

(B) home and community based services.

(b) This subsection applies to a contract entered into, amended, or renewed after June 30, 2024. A managed care organization may not deny any provider willing and qualified to meet the terms and conditions of an agreement to provide services under the risk based managed care program the right to enter into an agreement.

SECTION 5. 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 enter into a value based health care reimbursement agreement in writing providing for a different rate or payment methodology. However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**

(e) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (d), the managed care organization shall notify the office of the secretary.

~~(e)~~ **(f)** 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)~~ **(g)** 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 6. 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 enter into a value based health care reimbursement agreement in writing providing for a different rate or payment methodology. However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**

(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.

~~(d)~~ **(e)** 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.

~~(c)~~ **(f)** 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 7. 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 enter into a value based health care reimbursement agreement in writing providing for a different rate or payment methodology. However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.** ~~However, the reimbursement rate specified in this subsection may not be implemented by the office of the secretary before July 1, 2023.~~

(d) If a managed care organization and a provider enter into a

value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.

SECTION 8. 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 enter into a value based health care reimbursement agreement in writing providing for 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.

A managed care organization may not impose a different rate or payment methodology through under subdivision (2) a notice of contract change to a provider.

(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.

(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (a)(2), the managed care organization shall notify the office of the secretary.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1414, 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 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-196.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 196.7. (a) "Value based health care reimbursement agreement", for purposes of IC 12-15, may include the following:**

(1) An accountable care organization that has a contract with a managed care organization in which the managed care organization:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) Case rate.

(4) A capitated rate reimbursement arrangement.

(5) A pay for performance arrangement.

(6) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.".

Page 1, line 17, delete "mutually" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 2, line 1, delete "agree in writing to".

Page 2, line 2, delete "less" and insert "**different**".

Page 2, line 3, after "service." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 2, between lines 3 and 4, begin a new paragraph and insert:

"**(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under**

subsection (b), the managed care organization shall notify the office of the secretary.

SECTION 3. IC 12-15-12-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.5. (a) This section applies to a risk based managed care program that provides services to Medicaid recipients who are eligible to:**

(1) participate in the Medicare program (42 U.S.C. 1395 et seq.); and

(2) receive:

(A) nursing facility services; or

(B) home and community based services.

(b) This subsection applies to a contract entered into, amended, or renewed after June 30, 2024. A managed care organization may not deny any provider willing and qualified to meet the terms and conditions of an agreement to provide services under the risk based managed care program the right to enter into an agreement.".

Page 3, line 14, delete "both mutually" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 3, line 15, delete "agree in writing to".

Page 3, line 15, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 3, between lines 15 and 16, begin a new paragraph and insert:

"**(e) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (d), the managed care organization shall notify the office of the secretary.**"

Page 3, line 16, strike "(e)" and insert "**(f)**".

Page 3, line 20, strike "(f)" and insert "**(g)**".

Page 4, line 5, delete "both mutually agree in writing to" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 4, line 6, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 4, between lines 6 and 7, begin a new paragraph and insert:

"**(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.**".

Page 4, line 7, strike "(d)" and insert "**(e)**".

Page 4, line 13, strike "(e)" and insert "**(f)**".

Page 4, line 42, delete "both mutually agree in writing to" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 5, line 1, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 5, between lines 3 and 4, begin a new paragraph and insert:

"**(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.**".

Page 5, line 13, delete "both mutually agree in writing" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 5, line 14, delete "to".

Page 5, between lines 16 and 17, begin a new line blocked left and insert:

"**A managed care organization may not impose a different rate or payment methodology through under subdivision (2) a notice of contract change to a provider.**".

Page 5, after line 21, begin a new paragraph and insert:

"**(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (a)(2), the managed care organization shall notify the office of the secretary.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1414 as introduced.)

BARRETT

Committee Vote: yeas 10, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1414 be amended to read as follows:

Page 2, between lines 7 and 8, begin a new paragraph and insert:

"SECTION 2. IC 12-15-1-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) If the office enters into a comprehensive risk contract with a managed care organization that:**

(1) establishes a capitated rate for a new contract; or

(2) changes a capitated rate for an existing or a renewal of a contract;

with a managed care organization, the office shall provide the capitated rates to the budget committee for review.

(b) As part of the review required under subsection (a), the office shall present the following information to the budget committee:

(1) The capitation rate and the percentage of any change.

(2) The rationale for the capitation rate.

(3) The fiscal impact of the capitation rate on the Medicaid program.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1414 as printed January 30, 2024.)

KARICKHOFF