SENATE BILL No. 192

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-21.5; IC 12-15; IC 16-27; IC 16-51-1-1; IC 25-26-13-31.2; IC 27-1-37.7; IC 34-30-2.1-207.4.

Synopsis: Various health care matters. Makes changes to the law governing administrative adjudication and to provisions related to managed care organizations. Provides that if a physician has entered into a provider agreement with the office of Medicaid policy and planning (office) or a managed care organization and the physician, subject to the provider agreement, provides professional services to individuals participating in the state Medicaid program, the office or the managed care organization shall promptly compensate the physician for the professional services in accordance with the provider agreement. Prohibits any delay in or denial of compensation to the physician unless the cause of the delay or denial is specifically provided for in: (1) the Medicaid managed care law; (2) an administrative rule adopted under the Medicaid managed care law; (3) the federal administrative rules on Medicaid managed care; or (4) the provider agreement. Defines "antiretroviral" as a drug used to prevent a retrovirus, such as the human immunodeficiency virus (HIV), from replicating. Provides, for purposes of the Medicaid program and the children's health insurance program, that an FDA approved drug that is prescribed for the treatment or prevention of HIV or acquired immunodeficiency syndrome (AIDS), including antiretrovirals, shall not be subject to: (1) prior authorization; (2) a step therapy protocol; or (3) any other protocol that could restrict or delay the dispensing of the drug. Prohibits a health plan (including a policy of accident and sickness insurance, a health maintenance organization contract, the state employee self-insurance program and prepaid health care delivery plan, and a Medicaid risk based managed care program) from imposing

(Continued next page)

Effective: July 1, 2024.

Johnson T

January 9, 2024, read first time and referred to Committee on Health and Provider Services.

or enforcing: (1) a prior authorization requirement; (2) a step therapy protocol requirement; or (3) any other protocol requirement; if imposing or enforcing the requirement could restrict or delay the dispensing to a covered individual of an FDA approved drug, including an antiretroviral, that is prescribed for the treatment or prevention of HIV or AIDS. States that a home health agency is not required to conduct a tuberculosis test on a job applicant before the individual has contact with a patient. Repeals a statute that requires certain personal services agency employees or agents to complete a tuberculosis test. Authorizes the establishment of home health agency cooperative agreements. (A similar law enacted in 2022 expired on July 1, 2023.) Makes statements and findings of the general assembly concerning home health agency cooperative agreements. Specifies that a home health agency may contract directly or indirectly through a network of home health agencies. Exempts: (1) a remote location of a hospital; and (2) a free standing emergency department or other provider-based entity; from health care billing requirements. Allows a pharmacist to administer an immunization that is recommended by the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practices to a group of individuals under a drug order, under a prescription, or according to a protocol approved by a physician if certain conditions are met. (Current law allows a pharmacist to administer specified immunizations to a group of individuals under a drug order, under a prescription, or according to a protocol approved by a physician if certain conditions are met.) Removes a provision allowing a pharmacist to administer pneumonia immunizations to individuals who are at least 50 years of age.

Introduced

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

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

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

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

SENATE BILL No. 192

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

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

SECTION 1. IC 4-21.5-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 4. "Agency action" means any of the following:

(1) The whole or a part of an order.

(2) The failure to issue an order.

(3) An agency's performance of, or failure to perform, any other duty, function, or activity under this article.

(4) A final action taken by a managed care organization.

SECTION 2. IC 4-21.5-1-8.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.2. "Managed care organization" has the meaning set forth in IC 12-7-2-126.9.**

SECTION 3. IC 4-21.5-2-6, AS AMENDED BY P.L.53-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 6. This article does not apply to the formulation,

issuance, or administrative review (but does apply to the judicial review and civil enforcement) of any of the following:

(1) Except as provided in IC 12-17.2-3.5-17, IC 12-17.2-4-18.7, IC 12-17.2-5-18.7, and IC 12-17.2-6-20, determinations by the division of family resources and the department of child services.

(2) Determinations by the alcohol and tobacco commission.

(3) Determinations by the office of Medicaid policy and planning concerning recipients and applicants of Medicaid. However, this article does apply to ~~determinations~~ **agency actions** by the office of Medicaid policy and planning **or a managed care organization** concerning providers.

SECTION 4. IC 4-21.5-2-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 9. The amendments made to IC 4-21.5-1-4, IC 4-21.5-1-8.2, IC 4-21.5-2-6, IC 4-21.5-3-6, IC 4-21.5-3-7, IC 4-21.5-3-8, IC 4-21.5-3-17, IC 4-21.5-3-27, and IC 4-21.5-3-32 in the 2024 session of the general assembly apply only to agency actions commenced under IC 4-21.5-3 after June 30, 2024.**

SECTION 5. IC 4-21.5-3-6, AS AMENDED BY P.L.241-2023, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 6. (a) Notice shall be given under this section concerning the following:

(1) A safety order under IC 22-8-1.1.

(2) Any order that:

(A) imposes a sanction on a person or terminates a legal right, duty, privilege, immunity, or other legal interest of a person;

(B) is not described in section 4 or 5 of this chapter or IC 4-21.5-4; and

(C) by statute becomes effective without a proceeding under this chapter if there is no request for a review of the order within a specified period after the order is issued or served.

(3) A notice of program reimbursement or equivalent determination or other notice regarding a hospital's reimbursement issued by the office of Medicaid policy and planning, ~~or by~~ a contractor of the office of Medicaid policy and planning, **or a managed care organization** regarding a hospital's year end cost settlement.

(4) A determination of audit findings or an equivalent determination by the office of Medicaid policy and planning, ~~or by~~ a contractor of the office of Medicaid policy and planning, **or a managed care organization** arising from a Medicaid postpayment or concurrent audit of a hospital's Medicaid claims.

(5) A license suspension or revocation under:
(A) IC 24-4.4-2;
(B) IC 24-4.5-3;
(C) IC 28-1-29;
(D) IC 28-7-5;
(E) IC 28-8-4.1; or
(F) IC 28-8-5.

(6) An order issued by the secretary or the secretary's designee against providers regulated by the division of aging or the bureau of disabilities services and not licensed by the Indiana department of health under IC 16-27 or IC 16-28.

(b) When an agency issues an order described by subsection (a), the agency shall give notice to the following persons:

(1) Each person to whom the order is specifically directed.

(2) Each person to whom a law requires notice to be given.

A person who is entitled to notice under this subsection is not a party to any proceeding resulting from the grant of a petition for review under section 7 of this chapter unless the person is designated as a party in the record of the proceeding.

(c) The notice must include the following:

(1) A brief description of the order.

(2) A brief explanation of the available procedures and the time limit for seeking administrative review of the order under section 7 of this chapter.

(3) Any other information required by law.

(d) An order described in subsection (a) is effective fifteen (15) days after the order is served, unless a statute other than this article specifies a different date or the agency specifies a later date in its order. This subsection does not preclude an agency from issuing, under IC 4-21.5-4, an emergency or other temporary order concerning the subject of an order described in subsection (a).

(e) If a petition for review of an order described in subsection (a) is filed within the period set by section 7 of this chapter and a petition for stay of effectiveness of the order is filed by a party or another person who has a pending petition for intervention in the proceeding, an administrative law judge shall, as soon as practicable, conduct a preliminary hearing to determine whether the order should be stayed in whole or in part. The burden of proof in the preliminary hearing is on the person seeking the stay. The administrative law judge may stay the order in whole or in part. The order concerning the stay may be issued after an order described in subsection (a) becomes effective. The resulting order concerning the stay shall be served on the parties and

any person who has a pending petition for intervention in the proceeding. It must include a statement of the facts and law on which it is based.

SECTION 6. IC 4-21.5-3-7, AS AMENDED BY P.L.205-2019, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 7. (a) To qualify for review of a personnel action to which IC 4-15-2.2 applies, a person must comply with IC 4-15-2.2-42. To qualify for review of any other order described in section 4, 5, or 6 of this chapter, a person must petition for review in a writing that does the following:

(1) States facts demonstrating that:

(A) the petitioner is a person to whom the order is specifically directed;

(B) the petitioner is aggrieved or adversely affected by the order; or

(C) the petitioner is entitled to review under any law.

(2) Includes, with respect to determinations of notice of program reimbursement and audit findings described in section 6(a)(3) and 6(a)(4) of this chapter, a statement of issues that includes:

(A) the specific findings, action, or determination of the office of Medicaid policy and planning, ~~or of~~ a contractor of the office of Medicaid policy and planning, **or a managed care organization** from which the provider is appealing;

(B) the reason the provider believes that the finding, action, or determination of the office of Medicaid policy and planning, ~~or of~~ a contractor of the office of Medicaid policy and planning, **or a managed care organization** was in error; and

(C) with respect to each finding, action, or determination of the office of Medicaid policy and planning or of a contractor of the office of Medicaid policy and planning, the statutes or rules that support the provider's contentions of error.

~~Not more than thirty (30) days after filing a petition for review under this section,~~ **At any point in the proceeding,** and upon a finding of good cause by the administrative law judge, a person may amend the statement of issues contained in a petition for review to add one (1) or more additional issues.

(3) Is filed:

(A) with respect to an order described in section 4, 5, 6(a)(1), 6(a)(2), or 6(a)(5) of this chapter, with the ~~ultimate authority for the agency issuing the order~~ **office of administrative law proceedings** within fifteen (15) days after the person is given notice of the order or any longer period set by statute; or

(B) with respect to a determination described in section 6(a)(3) or 6(a)(4) of this chapter, with the office of ~~Medicaid policy and planning~~ **administrative law proceedings** not more than one hundred eighty (180) days after the hospital is provided notice of the determination.

The issuance of an amended notice of program reimbursement by the office of Medicaid policy and planning does not extend the time within which a hospital must file a petition for review from the original notice of program reimbursement under clause (B), except for matters that are the subject of the amended notice of program reimbursement.

If the petition for review is denied, the petition shall be treated as a petition for intervention in any review initiated under subsection (d).

(b) If ~~an agency denies~~ a petition for review under subsection (a) **is denied** and the petitioner is not allowed to intervene as a party in a proceeding resulting from the grant of the petition for review of another person, the ~~agency~~ **office of administrative proceedings** shall serve a written notice on the petitioner that includes the following:

(1) A statement that the petition for review is denied.

(2) A brief explanation of the available procedures and the time limit for seeking administrative review of the denial under subsection (c).

(c) ~~An agency shall assign an administrative law judge, or after June 30, 2020, if the proceeding is subject to the jurisdiction of the office of administrative law proceedings, an agency shall request assignment of an administrative law judge by the office of administrative law proceedings, to~~ **Upon a person's written request, the administrative law judge shall** conduct a preliminary hearing on the issue of whether a person is qualified under subsection (a) to obtain review of an order. ~~when a person requests reconsideration of the denial of review in a writing that:~~ **The written request is valid if the request:**

(1) states facts demonstrating that the person filed a petition for review of an order described in section 4, 5, or 6 of this chapter;

(2) states facts ~~demonstrating that the person was denied review without an evidentiary hearing;~~ **relevant to the denial and any supporting laws, rules, or regulations;** and

(3) is filed with the ~~ultimate authority for the agency denying the review~~ **administrative law judge** within fifteen (15) days after the notice required by subsection (b) was served on the petitioner.

Notice of the preliminary hearing shall be given to the parties, each person who has a pending petition for intervention in the proceeding, and any other person described by section 5(d) of this chapter. The

resulting order must be served on the persons to whom notice of the preliminary hearing must be given and include a statement of the facts and law on which it is based.

(d) If a petition for review is granted, the petitioner becomes a party to the proceeding. ~~and:~~

~~(1) the agency shall assign the matter to an administrative law judge or, after June 30, 2020, if the proceeding is subject to the jurisdiction of the office of administrative law proceedings, request assignment of an administrative law judge by the office of administrative law proceedings; or~~

~~(2)~~ **The administrative law judge may** certify the matter to another agency for the assignment of an administrative law judge (if a statute transfers responsibility for a hearing on the matter to another agency).

~~The agency granting the administrative review or the agency to which the matter is transferred may conduct informal proceedings to settle the matter to the extent allowed by law.~~

SECTION 7. IC 4-21.5-3-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 8. (a) An agency may issue a sanction or terminate a legal right, duty, privilege, immunity, or other legal interest not described by section 4, 5, or 6 of this chapter only after conducting a proceeding under this chapter. However, this subsection does not preclude an agency from issuing, under IC 4-21.5-4, an emergency or other temporary order concerning the subject of the proceeding. **Orders to which this subsection applies include any order that suspends Medicaid payments, as determined by the office of Medicaid policy and planning.**

(b) When an agency seeks to issue an order that is described by subsection (a), the agency shall serve a complaint upon:

(1) each person to whom any resulting order will be specifically directed; and

(2) any other person required by law to be notified.

A person notified under this subsection is not a party to the proceeding unless the person is a person against whom any resulting order will be specifically directed or the person is designated by the agency as a party in the record of the proceeding.

(c) The complaint required by subsection (b) must include the following:

(1) A short, plain statement showing that the pleader is entitled to an order.

(2) A demand for the order that the pleader seeks.

(d) The administrative law judge conducting a proceeding under

this section concerning a Medicaid payment suspension may consider the factors under 42 CFR 455.23(e) or 42 CFR 455.23(f). The administrative law judge's decision to halt a Medicaid payment suspension does not prohibit the office of Medicaid policy and planning from referring the provider to the Medicaid fraud control unit.

SECTION 8. IC 4-21.5-3-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 17. (a) The administrative law judge, at appropriate stages of a proceeding, shall give all parties full opportunity to file pleadings, **amendments to pleadings or initial filings,** motions, and objections and submit offers of settlement.

(b) The administrative law judge, at appropriate stages of a proceeding, may give all parties full opportunity to file briefs, proposed findings of fact, and proposed orders.

(c) A party shall serve copies of any filed item on all parties.

(d) The administrative law judge shall serve copies of all notices, orders, and other papers generated by the administrative law judge on all parties. The administrative law judge shall give notice of preliminary hearings, prehearing conferences, hearings, stays, and orders disposing of the proceeding to persons described by section 5(d) of this chapter.

SECTION 9. IC 4-21.5-3-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 27. (a) If the administrative law judge is the ultimate authority for the agency, the ultimate authority's order disposing of a proceeding is a final order. If the administrative law judge is not the ultimate authority, the administrative law judge's order disposing of the proceeding becomes a final order when affirmed under section 29 of this chapter. Regardless of whether the order is final, it must comply with this section.

(b) This subsection applies only to an order not subject to subsection (c). The order must include, separately stated, findings of fact for all aspects of the order, including the remedy prescribed and, if applicable, the action taken on a petition for stay of effectiveness. Findings of ultimate fact must be accompanied by a concise statement of the underlying basic facts of record to support the findings. The order must also include a statement of the available procedures and time limit for seeking administrative review of the order (if administrative review is available). **The administrative law judge shall apply the standards of review described in IC 4-21.5-5-14 when evaluating an agency action or order.**

(c) This subsection applies only to an order of the ultimate authority

entered under IC 13, IC 14, or IC 25. The order must include separately stated findings of fact and, if a final order, conclusions of law for all aspects of the order, including the remedy prescribed and, if applicable, the action taken on a petition for stay of effectiveness. Findings of ultimate fact must be accompanied by a concise statement of the underlying basic facts of record to support the findings. Conclusions of law must consider prior final orders (other than negotiated orders) of the ultimate authority under the same or similar circumstances if those prior final orders are raised on the record in writing by a party and must state the reasons for deviations from those prior orders. The order must also include a statement of the available procedures and time limit for seeking administrative review of the order (if administrative review is available). **The ultimate authority shall apply the standards of review described under this section when evaluating an agency action or order.**

(d) Findings must be based exclusively upon the evidence of record in the proceeding and on matters officially noticed in that proceeding. Findings must be based upon the kind of evidence that is substantial and reliable. The administrative law judge's experience, technical competence, and specialized knowledge may be used in evaluating evidence.

(e) Conclusions of law must be based upon duly enacted laws, agency rules, or judicial opinions. An administrative law judge or ultimate authority shall invalidate any agency action or order that is based upon a policy or other publication that does not comply with IC 4-22-2 and may order the agency to pay attorney's fees under section 27.5 of this chapter.

~~(e)~~ **(f)** A substitute administrative law judge may issue the order under this section upon the record that was generated by a previous administrative law judge.

~~(f)~~ **(g)** The administrative law judge may allow the parties a designated amount of time after conclusion of the hearing for the submission of proposed findings.

~~(g)~~ **(h)** An order under this section shall be issued in writing within ninety (90) days after conclusion of the hearing or after submission of proposed findings in accordance with subsection ~~(f),~~ **(g),** unless this period is waived or extended with the written consent of all parties. ~~or for good cause shown.~~

~~(h)~~ **(i)** The administrative law judge shall have copies of the order under this section delivered to each party and to the ultimate authority for the agency (if it is not rendered by the ultimate authority).

SECTION 10. IC 4-21.5-3-32 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 32. (a) ~~Each agency shall make all written final orders available for public inspection and copying under IC 5-14-3. The agency shall index final orders that are issued after June 30, 1987, by name and subject. An agency shall index an order issued before July 1, 1987, if a person submits a written request to the agency that the order be indexed. An agency shall delete from these orders identifying details to the extent required by IC 5-14-3 or other law. In each case, the justification for the deletion must be explained in writing and attached to the order.~~ **The office of administrative law proceedings shall create a data base that contains all final orders in a searchable format and that is accessible to the public. The public shall not be charged a fee to access the data base. Not more than sixty (60) calendar days after the issuance of the final order, the agency shall prepare final orders for publication in the data base, including redacting private, protected information, or other confidential information in accordance with state or federal law.**

(b) An agency may not rely on a written final order as precedent to the detriment of any person until the order has been made available ~~for~~ **to the** public ~~inspection and indexed~~ in the manner described in subsection (a). However, this subsection does not apply to any person who has actual timely knowledge of the order. The burden of proving that knowledge is on the agency.

SECTION 11. IC 12-15-12-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) If:**

(1) a physician has entered into a provider agreement with:

(A) the office; or

(B) a managed care organization;

under IC 12-15-11-4(a) for the provision of physician services; and

(2) the physician, subject to the provider agreement referred to in subdivision (1), provides professional services to individuals participating in the state Medicaid program;

the office or the managed care organization shall promptly compensate the physician for the professional services in accordance with the provider agreement.

(b) A physician's compensation under subsection (a) shall not be delayed due to the retrospective review of the medical services provided or for any other reason unless the cause of the delay is specifically provided for in:

(1) this article;

(2) a rule adopted under this article;

(3) 42 CFR 438; or

(4) the provider agreement referred to in subsection (a)(1).

(c) A physician shall not be denied compensation for professional services to which subsection (a) applies unless the cause of the denial is specifically provided for in:

(1) this article;

(2) a rule adopted under this article;

(3) 42 CFR 438; or

(4) the provider agreement referred to in subsection (a)(1).

SECTION 12. IC 12-15-12-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 25. Any action, order, or decision by a managed care organization that adversely affects a provider under contract with that entity is subject to administrative review under IC 4-21.5. An agency's final order is binding on the managed care organization.**

SECTION 13. IC 12-15-12-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 26. (a) For purposes of this section, the term "prepayment review" means any action by a managed care organization or a contractor, assignee, agent, or entity acting on the behalf of a managed care organization requiring a provider to provide medical record documentation in conjunction with or after the submission of a claim for payment for medical services rendered, but before the claim has been adjudicated by the managed care organization.**

(b) A managed care organization or a contractor, assignee, agent, or entity acting on the behalf of a managed care organization shall be prohibited from requiring any enrolled provider to be subject to prepayment review unless the requirement is implemented directly by the office.

(c) Nothing in this section shall prohibit a managed care organization from notifying the office of providers suspected of committing fraud and abuse or prohibit the office from requiring managed care organizations to coordinate efforts to combat and prevent fraud and abuse pursuant to federal or state law or regulation.

(d) When authorized by the office under this section, a managed care organization's prepayment review is subject to all of the following conditions:

(1) During the prepayment review period, the managed care

organization shall give detailed reports to the provider on a weekly basis that includes, at a minimum, the claim or claims that were denied, the requirement or requirements that must be followed, the reason any claim or claims did not comply with such requirement or requirements, and the name and phone number of the reviewer.

(2) The managed care organization must designate a reviewer to be responsible for reviewing and discussing all prepayment review findings with the provider. The reviewer must have knowledge of the provider's claims and the resulting findings. The reviewer shall meet with a provider at least on a monthly basis during the term of the prepayment review.

(3) The managed care organization must allow the provider to challenge the managed care organization's findings during the term of prepayment review. The provider shall be allowed to appeal the managed care organization's findings to the office. Any decision by the office shall be binding on the managed care organization.

(4) The managed care organization shall deliver a final report to the provider within thirty (30) days of the end of the prepayment review term summarizing the findings and providing educational materials to the provider.

(5) The prepayment period cannot last more than six (6) months. The office may authorize an extension of payment review if the managed care organization demonstrates that the provider willfully or recklessly ignored the managed care organization directives during the prepayment review period.

(6) The provider shall be deemed to be released from prepayment review if the managed care organization fails to meet any obligations under this section.

(7) The managed care organization shall not use prepayment review to retaliate against a provider for exercising the provider's statutory or contractual rights.

SECTION 14. IC 12-15-13-6, AS AMENDED BY P.L.152-2017, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 6. (a) Except as provided by IC 12-15-35-50, a notice or bulletin that is issued by:

(1) the office;

(2) a contractor of the office; or

(3) a managed care organization;

concerning a change to the Medicaid program, including a change to prior authorization, claims processing, payment rates, and medical

policies, that does not require use of the rulemaking process under IC 4-22-2 may not become effective until thirty (30) days after the date the notice or bulletin is communicated to the parties affected by the notice or bulletin.

(b) The office must provide a written notice or bulletin described in subsection (a) within five (5) business days after the date on the notice or bulletin.

(c) If the office, a contractor of the office, or a managed care organization does not comply with the requirements in subsections (a) and (b):

(1) the notice or bulletin is void;

(2) a claim may not be denied because the claim does not comply with the void notice or bulletin; and

(3) the office, a contractor of the office, or a managed care organization may not reissue the bulletin or notice for thirty (30) days unless the change is required by the federal government to be implemented earlier.

(d) Any notice or bulletin issued under this section does not have the force and effect of law under IC 4-22-2.

SECTION 15. IC 12-15-23-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1. ~~Except as provided in section 2 of this chapter, if the administrator of the office determines that there are reasonable grounds to suspect that a provider has received payments that the provider is not entitled to under Medicaid, the administrator shall certify the evidence of the suspected activity to the state Medicaid fraud control unit established under IC 4-6-10.~~ **(a) Subject to the procedures in this section, the office may suspend Medicaid payments to a provider on the basis of a credible allegation of fraud and refer its findings to the Medicaid fraud control unit for investigation pursuant to 42 CFR 455.23.**

(b) The office's process for determination of a credible allegation of fraud shall include the administrative hearing conducted under IC 4-21.5-3-8. This subsection does not apply when the office bases its decision to suspend Medicaid payments on verified proof of fraud.

(c) The office shall not suspend a provider's payments if an administrative law judge determines that there is no credible allegation of fraud. Nothing in this subsection precludes the agency from referring the matter to the Medicaid fraud control unit for an investigation.

(d) The office shall suspend a provider's Medicaid payments if an administrative law judge agrees that there is a credible

allegation of fraud. In such cases, the office may proceed pursuant to 42 CFR 455.23.

(e) To ensure that a Medicaid payment suspension is temporary, the office shall reexamine the facts, circumstances, laws, and any new evidence every ninety (90) days to determine whether the credible allegation of fraud continues. The office shall solicit information from the provider that is the subject of the sanction as part of its reevaluation. If the Medicaid fraud control unit, or any prosecuting authorities, have not certified to the office that there is evidence of fraud within six (6) months after receiving the referral, the office shall deem the legal proceedings completed and lift the Medicaid payment suspension.

SECTION 16. IC 12-15-35.5-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 10. (a) As used in this section, "antiretroviral" means a drug used to prevent a retrovirus, such as the human immunodeficiency virus (HIV), from replicating.**

(b) As used in this section, "prior authorization" has the meaning set forth in 405 IAC 5-2-20.

(c) As used in this section, "step therapy protocol" means a protocol that specifies, as a condition of coverage, the order in which certain prescription drugs must be used to treat a covered individual's condition.

(d) A drug that is covered under a program described in section 1 of this chapter, that has been approved by the federal Food and Drug Administration, and that is prescribed for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), including antiretrovirals, shall not be subject to:

(1) prior authorization;

(2) a step therapy protocol; or

(3) any other protocol that could restrict or delay the dispensing of the drug.

SECTION 17. IC 16-27-1-19, AS ADDED BY P.L.117-2023, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 19. A home health agency is not required to conduct a preemployment physical **or a tuberculosis test** on a job applicant before the individual has contact with a home health agency patient.

SECTION 18. IC 16-27-4-15 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 15. An employee or agent of a personal services agency who will have direct client contact must complete a tuberculosis test in~~

~~the same manner as required by the state department for licensed home health agency employees and agents.~~

SECTION 19. IC 16-27-6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 6. Home Health Agency Cooperative Agreements

Sec. 0.5. (a) The general assembly recognizes the importance and necessity of home health services and home health agencies to promote and protect the public's general health, safety, and welfare.

(b) The general assembly finds it necessary and appropriate to encourage home health agencies to cooperate, take certain actions, and enter into agreements that will facilitate improved quality of care and increase access to home health services even if the cooperation or actions may:

(1) be characterized as anticompetitive;

(2) result in the acquisition, maintenance, or use of market power within the meaning of federal and state antitrust laws; or

(3) otherwise have the effect of displacing competition.

(c) The general assembly believes that it is in the state's best interest to supplant state and federal antitrust laws with:

(1) the process provided in this chapter; and

(2) active supervision from the secretary as set forth in this chapter.

(d) It is the intent of the general assembly that this chapter immunize, to the fullest extent possible, a person from all federal and state antitrust laws for any cooperation or action approved and supervised under this chapter. This intent is within the public policy of the state to facilitate the provision of quality and cost efficient health care services to patients.

Sec. 1. The definitions in IC 16-27-1 apply throughout this chapter.

Sec. 2. As used in this chapter, "office" refers to the office of the secretary of family and social services established by IC 12-8-1.5-1.

Sec. 3. As used in this chapter, "secretary" refers to the secretary of family and social services appointed under IC 12-8-1.5-2.

Sec. 4. Home health agencies may enter into cooperative agreements to carry out the following activities:

(1) To form and operate, either directly or indirectly, one (1) or more networks of home health agencies to arrange for the

provision of health care services through such networks, including to contract either directly or indirectly through a network.

(2) To contract, either directly or through such networks, with the office, or the office's contractors, to provide:

(A) services to Medicaid beneficiaries; and

(B) health care services in an efficient and cost effective manner on a prepaid, capitation, or other reimbursement basis.

(3) To undertake other managed health care activities.

Sec. 5. (a) Any health care provider licensed under this title or IC 25 may apply to become a participating provider in the networks described in this chapter provided the services the provider contracts for are within the lawful scope of the provider's practice.

(b) This section does not require a plan or network to provide coverage for any specific health care service.

Sec. 6. A home health agency may authorize any of the following, or any combination of the following, to undertake or effectuate any of the activities identified in this chapter:

(1) The Indiana Association for Home and Hospice Care, Inc.

(2) Any subsidiary of the corporation named in subdivision (1).

Sec. 7. The secretary or the secretary's designee shall supervise and oversee the activities described in this chapter and may take the following actions:

(1) Gather relevant facts, collect data, conduct public hearings, invite and receive public comments, investigate market conditions, conduct studies, and review documentary evidence or require the home health agencies or their third party designee to do the same.

(2) Evaluate the substantive merits of any action to be taken by the home health agencies and assess whether the action comports with the standards established by the general assembly.

(3) Issue written decisions approving, modifying, or disapproving the recommended action, and explaining the reasons and rationale for the decision.

(4) Require home health agencies or their third party designees to report annually on the extent of the benefits realized by the actions taken under this chapter.

Sec. 8. The secretary may adopt rules under IC 4-22-2 to

implement this chapter.

SECTION 20. IC 16-51-1-1, AS ADDED BY P.L.203-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1. (a) This chapter applies to an Indiana nonprofit hospital system.

(b) This chapter does not apply to the following:

(1) A hospital licensed under IC 16-21-2 that is operated by:

(A) a county;

(B) a city pursuant to IC 16-23; or

(C) the health and hospital corporation established under IC 16-22-8.

(2) A critical access hospital that meets the criteria under 42 CFR 485.601 through 42 CFR 485.647.

(3) Any of the following hospitals licensed under IC 16-21-2:

(A) A remote location of a hospital (as defined in 42 CFR 413.65(a)(2)).

(B) A free standing emergency department or other provider-based entity (as defined in 42 CFR 413.65(a)(2)) that:

(i) complies with requirements of 42 CFR 413.65; and

(ii) has the provider-based entity's location listed on the hospital's license.

~~(3)~~ **(4)** A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

~~(4)~~ **(5)** A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

~~(5)~~ **(6)** An oncology treatment facility, even if owned or operated by a hospital.

~~(6)~~ **(7)** A health facility licensed under IC 16-28.

~~(7)~~ **(8)** A community mental health center certified under IC 12-21-2-3(5)(C).

~~(8)~~ **(9)** A private mental health institution licensed under IC 12-25, including a service facility location for a private mental health institution and reimbursed as a hospital-based outpatient service site.

~~(9)~~ **(10)** Services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders in:

(A) any part of a hospital, whether or not a distinct part; or

(B) an outpatient off campus site that is within thirty-five (35) miles of a hospital.

~~(10)~~ **(11)** Billing under the Medicare program or a Medicare advantage plan.

~~(11)~~ **(12)** Billing under the Medicaid program.

SECTION 21. IC 25-26-13-31.2, AS AMENDED BY P.L.56-2023, SECTION 239, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 31.2. (a) A pharmacist may administer an immunization to an individual under a drug order or prescription.

(b) Subject to subsection (c), a pharmacist may administer ~~immunizations for the following~~ **an immunization that is recommended by the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practices** to a group of individuals under a drug order, under a prescription, or according to a protocol approved by a physician.

~~(1) Influenza.~~
~~(2) Shingles (herpes zoster).~~
~~(3) Pneumonia.~~
~~(4) Tetanus, diphtheria, and acellular pertussis (whooping cough).~~
~~(5) Human papillomavirus (HPV) infection.~~
~~(6) Meningitis.~~
~~(7) Measles, mumps, and rubella.~~
~~(8) Varicella.~~
~~(9) Hepatitis A.~~
~~(10) Hepatitis B.~~
~~(11) Haemophilus influenzae type b (Hib).~~
~~(12) Coronavirus disease.~~

(c) A pharmacist may administer an immunization under subsection (b) if the following requirements are met:

(1) The physician specifies in the drug order, prescription, or protocol the group of individuals to whom the immunization may be administered.

(2) The physician who writes the drug order, prescription, or protocol is licensed and actively practicing with a medical office in Indiana and not employed by a pharmacy.

(3) The pharmacist who administers the immunization is responsible for notifying, not later than fourteen (14) days after the pharmacist administers the immunization, the physician who authorized the immunization and the individual's primary care physician that the individual received the immunization.

(4) If the physician uses a protocol, the protocol may apply only to an individual or group of individuals who

~~(A) except as provided in clause (B),~~ are at least eleven (11) years of age. ~~or~~

~~(B) for the pneumonia immunization under subsection (b)(3), are at least fifty (50) years of age.~~

(5) Before administering an immunization to an individual according to a protocol approved by a physician, the pharmacist must receive the consent of one (1) of the following:

(A) If the individual to whom the immunization is to be administered is at least eleven (11) years of age but less than eighteen (18) years of age, the parent or legal guardian of the individual.

(B) If the individual to whom the immunization is to be administered is at least eighteen (18) years of age but has a legal guardian, the legal guardian of the individual.

(C) If the individual to whom the immunization is to be administered is at least eighteen (18) years of age but has no legal guardian, the individual.

A parent or legal guardian who is required to give consent under this subdivision must be present at the time of immunization.

(d) If the Indiana department of health or the department of homeland security determines that an emergency exists, subject to IC 16-41-9-1.7(a)(2), a pharmacist may administer any immunization in accordance with:

(1) the requirements of subsection (c)(1) through (c)(3); and

(2) any instructions in the emergency determination.

(e) A pharmacist or pharmacist's designee shall provide immunization data to the immunization data registry (IC 16-38-5) in a manner prescribed by the Indiana department of health unless:

(1) the individual receiving the immunization;

(2) the parent of the individual receiving the immunization, if the individual receiving the immunization is less than eighteen (18) years of age; or

(3) the legal guardian of the individual receiving the immunization, if a legal guardian has been appointed;

has completed and filed with the pharmacist or pharmacist's designee a written immunization data exemption form, as provided in IC 16-38-5-2.

(f) If an immunization is administered under a protocol, then the name, license number, and contact information of the physician who wrote the protocol must be posted in the location where the immunization is administered. A copy of the protocol must be available for inspection by the individual receiving the immunization.

(g) A pharmacist may administer an immunization that is provided according to a standing order, prescription, or protocol issued under this section or IC 16-19-4-11 by the state health commissioner or the commissioner's designated public health authority who is a licensed

prescriber. If a pharmacist has received a protocol to administer an immunization from a physician and that specific immunization is covered by a standing order, prescription, or protocol issued by the state health commissioner or the commissioner's designated public health authority, the pharmacist must administer the immunization according to the standing order, prescription, or protocol issued by the state health commissioner or the commissioner's designated public health authority.

SECTION 22. IC 27-1-37.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 37.7. Coverage for Prescription Drugs to Treat or Prevent HIV or AIDS

Sec. 1. As used in this chapter, "antiretroviral" means a drug used to prevent a retrovirus, such as the human immunodeficiency virus (HIV), from replicating.

Sec. 2. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance, as defined in IC 27-8-5-1(a), excluding the types of insurance and plans set forth in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) A self-insurance program established under IC 5-10-8-7(b).

(4) A prepaid health care delivery plan entered into under IC 5-10-8-7(c).

(5) A Medicaid risk based managed care program operated under IC 12-15.

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) A self-insurance program described in subsection (a)(3).

(4) A prepaid health care delivery plan described in subsection (a)(4).

(5) A Medicaid risk based managed care program described in subsection (a)(5).

Sec. 3. As used in this chapter, "prior authorization" means a practice implemented by a health plan under which a covered individual or the covered individual's health care provider must

obtain approval from the health plan for a prescription for the covered individual as a prerequisite to the health plan covering the prescription.

Sec. 4. As used in this chapter, "step therapy protocol" means a protocol under which a health plan specifies that certain prescription drugs must be used to treat a covered individual's condition before the health plan will cover other prescription drugs for the treatment of the covered individual's condition.

Sec. 5. (a) This section applies to a health plan's coverage of a drug that:

(1) has been approved by the federal Food and Drug Administration; and

(2) is prescribed for the treatment or prevention of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

The term includes antiretrovirals.

(b) A health plan shall not impose or enforce:

(1) a prior authorization requirement;

(2) a step therapy protocol requirement; or

(3) any other protocol requirement;

if imposing or enforcing the requirement could restrict or delay the dispensing to a covered individual of a prescription drug to which this section applies.

SECTION 23. IC 34-30-2.1-207.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 207.4. IC 16-27-6-0.5 (Concerning federal and state antitrust laws for certain activities under the home health agency cooperative agreement law).**