COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 132, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, line 4, delete "IC 12-15-5-17.6," and insert "**IC 12-15-13,**".

Page 1, line 4, delete "IC 12-15-5-17.6(c)." and insert "**IC 12-15-13-1.8(c).**".

Page 1, line 8, delete "IC 12-15-5-17.6," and insert "**IC 12-15-13,**".

Page 1, line 8, delete "IC 12-15-5-17.6(d)." and insert "**IC 12-15-13-1.8(d).**".

Page 1, line 13, delete "IC 12-15-5-17.6(h)(1)," and insert "**IC 12-15-13-1.8(h)(1),**".

Page 3, delete lines 30 through 42.

Delete pages 4 and 5.

Page 8, between lines 19 and 20, begin a new paragraph and insert:

"SECTION 6. IC 12-15-13-1.5, AS AMENDED BY P.L.42-2011, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1.5. (a) This section:

(1) applies only to claims submitted for payment by nursing facilities; **and**

(2) does not apply when section 1.8 of this chapter is in effect.

(b) If the office:

(1) fails to pay a clean claim in the time required under section

1(b) of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the office shall pay the provider interest on the Medicaid allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 1(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 1(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) The office shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

SECTION 7. IC 12-15-13-1.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 1.8. (a) This section does not apply to Medicaid recipients:**

(1) who participate in the Program of All-Inclusive Care for the Elderly (PACE) implemented under IC 12-15-43;

(2) who participate in any Medicaid waiver administered by the office of the secretary in conjunction with the division of disability and rehabilitative services;

(3) who participate in the residential care assistance program described in IC 12-10-6;

(4) who:

(A) participate in the traumatic brain injury Medicaid waiver; or

(B) receive traumatic brain injury services out of state;

(5) who are enrolled in the Medicare shared savings program established by 42 U.S.C. 1395jjj;

(6) who are eligible only for emergency services;

(7) who participate in the Indiana end stage renal disease Medicaid waiver;

(8) who qualify for Medicaid as participants in the breast and cervical cancer program;

(9) who participate in the intermediate care facility for individuals with intellectual disabilities program;

(10) who are family planning only members;

(11) who are members of the Healthy Indiana Plan (IC 12-15-44.5) with modified adjusted gross income eligibility;

(12) who are Hoosier Healthwise members with modified adjusted gross income eligibility; or

(13) who are registered members of a federally-recognized tribe and are eligible for the healthy Indiana plan (IC 12-15-44.5) but have opted out into fee-for-service coverage.

(b) For purposes of this section, there are the following six (6) claims types:

(1) Professional paper claims.

(2) Professional electronic claims.

(3) Facility paper claims.

(4) Facility electronic claims.

(5) Pharmacy paper claims.

(6) Pharmacy electronic claims.

This section applies to the payment of dental claims. This section does not require the claim to be a clean claim.

(c) As used in this section, "auto assignment" refers to the process in which an eligible Medicaid recipient is automatically assigned to a managed care organization if the member does not select a managed care organization within the time allotted for the selection.

(d) As used in this section, "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (e).

(e) An individual is member of the covered population if the individual:

(1) is eligible to participate in the federal Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services; or

(2) is:

(A) at least sixty (60) years of age;

(B) blind, aged, or disabled; and

(C) receiving services through one (1) of the following:

(i) The aged and disabled Medicaid waiver.

(ii) A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate

in the federal Medicare program.

(iii) The state Medicaid plan.

(f) The office of the secretary may implement a risk based managed care program for the covered population.

(g) This subsection applies during the first one hundred eighty (180) days after the risk based managed care program for the covered population is implemented under subsection (f). If a managed care organization that contracts with the office of the secretary to provide services under a risk based managed care program for the covered population receives a provider claim and does not, within twenty-one (21) days after receiving the claim:

(1) pay the claim at the Medicaid allowable rate; or

(2) appropriately deny the claim;

the managed care organization shall pay the claim on the twenty-first day after receiving the claim in an amount at least equal to eighty-seven and one-half percent (87.5%) of the applicable fee schedule amount for the provider, subject to a claim reconciliation conducted by the managed care organization at the end of the one hundred eighty (180) day period. If the provider claim is subsequently denied in good faith by the managed care organization after the managed care organization paid the percentage of the claim specified in this subsection, the managed care organization may recoup the payment from the provider.

(h) If a managed care organization fails to pay in accordance with subsection (g), for any provider claims that the managed care organization has not paid at the Medicaid allowable rate or appropriately denied:

(1) the managed care organization shall pay to the office of the secretary liquidated damages in the amount of five thousand seven hundred dollars ($5,700) for each claim not paid in accordance with subsection (g); and

(2) the office of the secretary shall suspend all auto assignment of recipients to the managed care organization until the managed care organization pays all claims in accordance with subsection (g).

The office of the secretary shall deposit all liquidated damages paid under subdivision (1) in the payer affordability penalty fund established by IC 12-15-1-18.5.".

Page 9, delete lines 25 through 42.

Page 10, delete lines 1 through 13.

Page 10, line 23, strike "IC 25-1-21;" and insert "**IC 25-1-1.1;**".

Page 11, line 12, strike "IC 25-1-21." and insert "**IC 25-1-1.1.**".

Page 11, line 20, strike "IC 25-1-21." and insert "**IC 25-1-1.1.**".

Page 13, between lines 21 and 22, begin a new paragraph and insert:

"SECTION 16. IC 25-19-1-16 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 16. Upon receipt of satisfactory evidence from a licensed health facility administrator or licensed residential care administrator that the administrator's license has been:~~

~~(1) lost;~~

~~(2) stolen;~~

~~(3) mutilated; or~~

~~(4) destroyed;~~

~~the board shall issue a duplicate license to the administrator.~~".

Page 15, line 12, strike "IC 25-1-21;" and insert "**IC 25-1-1.1;**".

Page 18, line 11, after "licensure." insert "**An applicant meets the English proficiency requirement under subdivision (2) if the applicant passes an English course as certified in the transcript from the board's approved nursing education program or submits proof of passing the National Council Licensure Examination (NCLEX) that was taken in only the English language.**".

Page 18, line 28, delete "examination or".

Page 18, line 32, after "license" delete ",".

Page 18, line 32, reset in roman "by endorsement,".

Page 19, line 7, after "endorsement" insert "**or examination**".

Page 19, line 10, after "(2)" insert "**has successfully passed the National Council Licensure Examination (NCLEX);**

(3)".

Page 19, line 18, strike "or".

Page 19, line 20, strike "and" and insert "**or**

(D) a satisfactory credential verification assessment from an organization that is a member of the National Association of Credential Evaluation Services or any other organization approved by the board; and".

Page 19, line 21, strike "(3)" and insert "**(4)**".

Page 20, between lines 30 and 31, begin a new line blocked left and insert:

"**An applicant meets the English proficiency requirement under subdivision (2) if the applicant passes an English course as certified in the transcript from the board's approved nursing education program or submits proof of passing the National Council Licensure Examination (NCLEX) that was taken in only the English language.**".

Page 21, line 6, delete "examination or".

Page 21, line 10, after "license" delete ",".

Page 21, line 10, reset in roman "by endorsement,".

Page 21, line 15, after "endorsement" insert "**or examination**".

Page 21, line 18, after "(2)" insert "**has successfully passed the National Council Licensure Examination (NCLEX);**

(3)".

Page 21, line 26, strike "or".

Page 21, line 28, strike "and" and insert "**or**

(D) a satisfactory credential verification assessment from an organization that is a member of the National Association of Credential Evaluation Services or any other organization approved by the board; and".

Page 21, line 29, strike "(3)" and insert "**(4)**".

Page 31, after line 37, begin a new paragraph and insert:

"SECTION 26. [EFFECTIVE JULY 1, 2024] **(a) As used in this SECTION, "board" refers to the Indiana state board of nursing.**

(b) The board shall amend 848 IAC 1-1-6(f) to conform with this act.

(c) In amending the administrative rule under subsection (b), the board may adopt a provisional rule as set forth in IC 4-22-2-37.1.

(d) A provisional administrative rule adopted under this SECTION expires on the date on which a rule that supersedes the provisional administrative rule is adopted by the board under IC 4-22-2-19.7 through IC 4-22-2-36.

(e) This SECTION expires June 30, 2025.

SECTION 27. [EFFECTIVE JULY 1, 2024] **(a) As used in this SECTION, "board" refers to the medical licensing board of Indiana.**

(b) The board shall study any rule adopted under IC 25-22.5-2-7(a)(10) that requires an office based setting to be

accredited by an accreditation agency approved by the board. The study must include the following:

(1) What accreditation agencies are or have been approved by the board.

(2) The cost of any accreditation by an accreditation agency for an office based setting.

(3) Options for reducing the cost of accreditation for office based settings.

(c) Before November 1, 2024, the board shall submit a report of the study under subsection (b), including any recommendations determined by the board concerning subsection (b)(3), to the general assembly in an electronic format under IC 5-14-6.

(d) This SECTION expires December 31, 2024.".

Renumber all SECTIONS consecutively.

(Reference is to SB 132 as introduced.)

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

Committee Vote: Yeas 9, Nays 1.

Charbonneau Chairperson