HOUSE BILL No. 1374

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Medicaid providers and managed care organizations. Allows a provider that has entered into a contract with a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, to request an administrative appeal within the office of Medicaid policy and planning of the managed care organization's action in denying or reducing reimbursement for claims for covered services provided to an applicant, pending applicant, conditionally eligible individual, or member. Establishes a procedure for an administrative appeal, including a hearing before an administrative law judge that could be followed by agency review and then by judicial review. Prohibits a provision in a contract between a provider and a managed care organization that would negate or restrict the right of a provider to an administrative appeal and provides that such a contract provision is void and unenforceable. Repeals a provision under which Medicaid law is controlling when Medicaid law conflicts with insurance law. Provides that if the office of the secretary of family and social services or a contractor of the office fails to pay or denies a clean claim for any eligible Medicaid service within certain time limits due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or managed care organization, the office or contractor may not assert that the provider failed to meet the time filing requirements for the claim.

Effective: July 1, 2021.

Clere, Vermilion, Thompson, Fleming

January 14, 2021, read first time and referred to Committee on Public Health.

First Regular Session of the 122nd General Assembly (2021)

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 2020 Regular Session of the General Assembly.

HOUSE BILL No. 1374

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 12-15-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 10. (a) As used in this section, "action" means:**

(1) a denial of reimbursement for claims submitted for covered services to an applicant, pending applicant, conditionally eligible individual, or member; or

(2) a reduction in reimbursement for claims submitted for covered services to an applicant, pending applicant, conditionally eligible individual, or member.

(b) As used in this section, "contracted provider" means a provider that has entered into a contract with a managed care organization or a contractor of the office.

(c) Except as provided in this section, the right of a provider contracting with a managed care organization to dispute an action by the managed care organization is governed by the provider's contract with the managed care organization.

(d) A contracted provider that is directly affected by an action of a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, may file an administrative appeal of the managed care organization's action with the office.

(e) The following apply to an administrative appeal under this section:

(1) The appeal must be initiated by the filing of a request for an administrative hearing.

(2) The administrative hearing shall be conducted by an administrative law judge, who shall issue a written decision concerning the action of the managed care organization.

(3) The contracted provider or managed care organization, if dissatisfied with the decision of the administrative law judge, may request agency review of the decision. If agency review is requested under this subdivision, the secretary or the secretary's designee shall review the decision of the administrative law judge to determine whether it is supported by the evidence in the record and is in accordance with the statutes, regulations, rules, and policies applicable to the action. The parties shall be issued a written notice of the outcome of the agency review.

(4) If dissatisfied with the outcome of the agency review, the contracted provider or managed care organization may file a petition for judicial review in accordance with IC 4-21.5-5.

(f) The procedure, time limits, and other provisions set forth in 405 IAC 1.1-1 for appeals concerning applicants and recipients of Medicaid apply to appeals under this section.

SECTION 2. IC 12-15-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 11. (a) A contract between a provider and a managed care organization shall not negate nor restrict the right of a provider to an administrative appeal under section 10 this chapter.**

(b) A contract provision that violates subsection (a) is void and unenforceable.

SECTION 3. IC 12-15-12-0.9 IS REPEALED [EFFECTIVE JULY 1, 2021]. ~~Sec. 0.9. (a) This section applies only with respect to the responsibilities of a managed care organization under:~~

~~(1) this article;~~

~~(2) IC 12-17.6;~~

~~(3) 42 CFR 438; or~~

~~(4) a rule adopted under a law described in subdivision (1) or (2).~~

~~(b) Except as provided in IC 27-1-37.5 after December 31, 2020, if a provision of, or rule adopted under, IC 27 conflicts with the administration of the programs under a law described in subsection (a), the law described in subsection (a) is controlling.~~

SECTION 4. IC 12-15-13-1.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1.7. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(c) If:

(1) the office fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the office or a contractor of the office under IC 12-15-30 subsequently pays the claim;

the office shall pay the provider that submitted the claim interest on the Medicaid allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c) shall:

(1) begin accruing:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stop accruing on the date the claim is paid.

(e) In paying interest under subsection (c), the office shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

(f) If the office or a contractor of the office denies or fails to pay a clean claim for any eligible Medicaid service within the time allowed by subsection (b) due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or managed care organization, the office or contractor may not assert that the provider failed to meet the time filing requirements for the claim.