

HOUSE BILL No. 1439

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15; IC 16-38-6-2.

Synopsis: FSSA matters. Allows a Medicaid recipient who is incarcerated to have the recipient's Medicaid suspended for up to two years instead of one year before terminating the recipient's Medicaid eligibility. Defines "comprehensive risk contract" and "managed care organization" for purposes of Medicaid. Specifies that if a provision of Indiana insurance law is inconsistent with a law applying to a managed care organization with respect to the managed care organization's Medicaid responsibilities, the law applying to the managed care organization with respect to the Medicaid responsibilities is controlling. Changes language in the Medicaid law to reflect the existence of more than one risk based managed care program. Removes obsolete references to "primary care case management". Removes references to "insurer", "insurance", and "health maintenance organization" in the law concerning the healthy Indiana plan to reflect the sole use of managed care organizations to provide coverage under the plan. Makes conforming amendments. Makes a technical correction to a federal Code citation.

Effective: July 1, 2017.

Kirchhofer

January 17, 2017, read first time and referred to Committee on Public Health.



First Regular Session of the 120th General Assembly (2017)

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 2016 Regular Session of the General Assembly.

HOUSE BILL No. 1439

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:

1 SECTION 1. IC 12-7-2-40.4 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2017]: **Sec. 40.4. "Comprehensive risk contract" has the meaning**
4 **set forth in 42 CFR 438.2.**

5 SECTION 2. IC 12-7-2-126.9 IS ADDED TO THE INDIANA
6 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
7 [EFFECTIVE JULY 1, 2017]: **Sec. 126.9. "Managed care**
8 **organization" means a person that has a comprehensive risk**
9 **contract with the office of Medicaid policy and planning under**
10 **IC 12-15.**

11 SECTION 3. IC 12-15-1-20.4, AS AMENDED BY P.L.185-2015,
12 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
13 JULY 1, 2017]: Sec. 20.4. (a) If a Medicaid recipient is:

- 14 (1) adjudicated to be a delinquent child and placed in:
15 (A) a community based correctional facility for children;
16 (B) a juvenile detention facility; or
17 (C) a secure facility, not including a facility licensed as a child



1 caring institution under IC 31-27; or
 2 (2) incarcerated in a prison or jail; and
 3 ineligible to participate in the Medicaid program during the placement
 4 described in subdivision (1) or (2) because of federal Medicaid law, the
 5 division of family resources, upon notice that a child has been
 6 adjudicated to be a delinquent child and placed in a facility described
 7 in subdivision (1) or upon notice that a person is incarcerated in a
 8 prison or jail and placed in a facility described in subdivision (2), shall
 9 suspend the person's participation in the Medicaid program for up to
 10 ~~one (1) year~~ **two (2) years** before terminating the person's eligibility.

11 (b) If the division of family resources receives:

12 (1) a dispositional decree under IC 31-37-19-28; or

13 (2) a modified disposition order under IC 31-37-22-9;

14 and the department of correction gives the division at least forty (40)
 15 days notice that a person will be released from a facility described in
 16 subsection (a)(1)(C) or (a)(2), the division of family resources shall
 17 take action necessary to ensure that a person described in subsection
 18 (a) is eligible to participate in the Medicaid program upon the person's
 19 release, if the person is eligible to participate.

20 SECTION 4. IC 12-15-2-14, AS AMENDED BY THE
 21 TECHNICAL CORRECTIONS BILL OF THE 2017 GENERAL
 22 ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 23 JULY 1, 2017]: Sec. 14. (a) An individual:

24 (1) who is less than nineteen (19) years of age;

25 (2) who is not described in ~~42 U.S.C. 1396a(a)(10)(A)(i)~~; **42**
 26 **U.S.C. 1396a(a)(10)(A)(i)(I)**; and

27 (3) whose family income does not exceed the income level
 28 established in subsection (b);

29 is eligible to receive Medicaid.

30 (b) An individual described in this section is eligible to receive
 31 Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family
 32 income does not exceed one hundred fifty percent (150%) of the
 33 federal income poverty level for the same size family.

34 ~~(c) The office may apply a resource standard in determining the~~
 35 ~~eligibility of an individual described in this section. This subsection~~
 36 ~~expires December 31, 2013.~~

37 SECTION 5. IC 12-15-5-5, AS AMENDED BY P.L.101-2005,
 38 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 39 JULY 1, 2017]: Sec. 5. (a) The office may provide a prescription drug
 40 benefit to a Medicaid recipient ~~in the~~ **a** Medicaid risk based managed
 41 care program.

42 (b) If the office provides a prescription drug benefit to a Medicaid



1 recipient in ~~the~~ a Medicaid risk based managed care program:

- 2 (1) the office shall develop a procedure and provide the recipient's
3 risk based managed care provider with information concerning
4 the recipient's prescription drug utilization for the risk based
5 managed care provider's case management program; and
6 (2) the provisions of IC 12-15-35.5 apply.

7 (c) If the office does not provide a prescription drug benefit to a
8 Medicaid recipient in ~~the~~ a Medicaid risk based managed care
9 program, a ~~Medicaid~~ managed care organization shall provide coverage
10 and reimbursement for outpatient single source legend drugs subject to
11 IC 12-15-35-46, IC 12-15-35-47, and IC 12-15-35.5.

12 SECTION 6. IC 12-15-5-13, AS AMENDED BY P.L.8-2016,
13 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
14 JULY 1, 2017]: Sec. 13. (a) The office shall provide coverage for
15 treatment of opioid or alcohol dependence that includes the following:

- 16 (1) Counseling services that address the psychological and
17 behavioral aspects of addiction.
18 (2) When medically indicated, drug treatment involving agents
19 approved by the federal Food and Drug Administration for the:
20 (A) treatment of opioid or alcohol dependence; or
21 (B) prevention of relapse to opioids or alcohol after
22 detoxification.
23 (3) Inpatient detoxification:
24 (A) in accordance with:
25 (i) the most current edition of the American Society of
26 Addiction Medicine Patient Placement Criteria; or
27 (ii) other clinical criteria that are determined by the office
28 and are evidence based and peer reviewed; and
29 (B) when determined by the treatment plan to be medically
30 necessary.

31 (b) The office shall:

- 32 (1) develop quality measures to ensure; and
33 (2) require a ~~Medicaid~~ managed care organization to report;
34 compliance with the coverage required under subsection (a).
35 (c) The office may implement quality capitation withholding of
36 reimbursement to ensure that a ~~Medicaid~~ managed care organization
37 has provided the coverage required under subsection (a).

38 (d) The office shall report the clinical use of the medications
39 covered under this section to the mental health Medicaid quality
40 advisory committee established by IC 12-15-35-51. The mental health
41 Medicaid quality advisory committee may make recommendations to
42 the office concerning this section.



1 SECTION 7. IC 12-15-11.5-0.5 IS AMENDED TO READ AS
 2 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 0.5. This chapter does
 3 not apply to a managed care ~~contractor~~ **organization** that, on or before
 4 July 1, 2000, did not directly contract with a hospital (as defined in
 5 section 1 of this chapter) for the provision of services under the office's
 6 managed care program.

7 SECTION 8. IC 12-15-11.5-2 IS AMENDED TO READ AS
 8 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2. The office's managed
 9 care ~~contractor~~ **organization** shall regard a hospital as a contracted
 10 provider in the office's managed care ~~services~~ program, which provides
 11 a capitated prepayment managed care system, for the provision of
 12 medical services to each individual who:

- 13 (1) is eligible to receive services under IC 12-15 and has enrolled
 14 in the office's managed care services program;
- 15 (2) resides in the same city in which the hospital is located; and
- 16 (3) has selected a primary care provider who:
 - 17 (A) is a contracted provider with the office's managed care
 18 ~~contractor;~~ **organization;** and
 - 19 (B) has medical staff privileges at the hospital.

20 SECTION 9. IC 12-15-11.5-6 IS AMENDED TO READ AS
 21 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 6. A claim for
 22 reimbursement for services shall be treated as a disputed claim under
 23 this chapter if:

- 24 (1) it is submitted within one hundred twenty (120) days after the
 25 date that services are rendered;
- 26 (2) it is denied by the managed care ~~contractor;~~ **organization;**
- 27 (3) the hospital submits a written notice of dispute for the claim
 28 to the managed care ~~contractor~~ **organization** not more than sixty
 29 (60) days after the receipt of the denial notice;
- 30 (4) it is appealed in accordance with the managed care
 31 ~~contractor's~~ **organization's** internal appeals process; and
- 32 (5) payment for the claim is denied by the managed care
 33 ~~contractor~~ **organization** following its internal appeals process.

34 SECTION 10. IC 12-15-11.5-7 IS AMENDED TO READ AS
 35 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 7. The office's managed
 36 care ~~contractor~~ **organization** must conclude an appeal under section
 37 6(4) of this chapter and notify the hospital of its decision not more than
 38 thirty-five (35) days after the managed care ~~contractor~~ **organization**
 39 receives a notice from the hospital disputing the managed care
 40 ~~contractor's~~ **organization's** denial of a claim.

41 SECTION 11. IC 12-15-11.5-8 IS AMENDED TO READ AS
 42 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 8. (a) A contract



1 entered into by a hospital with the office's managed care ~~contractor~~
 2 **organization** for the provision of services under the office's managed
 3 care ~~services~~ program must include a dispute resolution procedure for
 4 all disputed claims. Unless agreed to in writing by the hospital and the
 5 office's managed care ~~contractor~~, **organization**, the dispute resolution
 6 procedure must include the following requirements:

7 (1) That submission of disputed claims must be made to an
 8 independent arbitrator selected under subsection (b).

9 (2) Each claim must set forth with specificity the issues to be
 10 arbitrated, the amount involved, and the relief sought.

11 (3) That the hospital and the office's managed care ~~contractor~~
 12 **organization** shall attempt in good faith to resolve all disputed
 13 claims.

14 (4) The hospital shall submit to the arbitrator any claims that
 15 remain in dispute sixty (60) calendar days after the hospital
 16 receives written notice as provided under section 7 of this chapter.

17 (5) That resolution of disputes by the arbitrator must occur not
 18 later than ninety (90) calendar days after submission of disputed
 19 claims to the arbitrator, unless the parties mutually agree
 20 otherwise.

21 (6) That determinations of the arbitrator are final and binding and
 22 not subject to any appeal or review procedure.

23 (7) That the arbitrator does not have the authority to award any
 24 punitive or exemplary damages or to vary or ignore the terms of
 25 any contract between the parties and shall be bound by controlling
 26 law.

27 (8) That judgment upon the award rendered by the arbitrator may
 28 be entered and enforced in and is subject to the jurisdiction of a
 29 court with jurisdiction in Indiana.

30 (9) That the cost of the arbitrator must be shared equally by the
 31 parties, and each party must bear its own attorney and witness
 32 fees.

33 (b) The parties to a contract described in subsection (a) shall
 34 mutually agree on an independent arbitrator, or, if the parties are
 35 unable to reach agreement on an independent arbitrator, the following
 36 procedure must be followed:

37 (1) Each party shall select an independent representative, and the
 38 independent representatives shall select a panel of three (3)
 39 independent arbitrators who have experience in institutional and
 40 professional health care delivery practices and procedures and
 41 have had no prior dealing with either party other than as an
 42 arbitrator.



1 (2) The parties will each strike one (1) arbitrator from the panel
 2 selected under subdivision (1), and the remaining arbitrator serves
 3 as the arbitrator of the disputed claims under subsection (a).

4 (3) The procedures for selecting an arbitrator under this section
 5 must be completed not later than twenty (20) calendar days after
 6 the hospital provides written notice of at least one (1) disputed
 7 claim.

8 SECTION 12. IC 12-15-11.5-9 IS AMENDED TO READ AS
 9 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 9. The arbitration
 10 process described in section 8 of this chapter shall also be followed for
 11 resolution of disputed claims between a hospital and the office's
 12 managed care ~~contractor~~, **organization**, if the hospital is not a
 13 contracted provider in the office's managed health care ~~services~~
 14 program.

15 SECTION 13. IC 12-15-11.5-10, AS ADDED BY P.L.220-2011,
 16 SECTION 265, IS AMENDED TO READ AS FOLLOWS
 17 [EFFECTIVE JULY 1, 2017]: Sec. 10. A hospital and the managed
 18 care ~~contractor~~ **organization** of the office shall use the arbitration
 19 procedure in section 8 of this chapter for the resolution of all disputed
 20 claims that have accrued as of March 17, 2000.

21 SECTION 14. IC 12-15-12-0.9 IS ADDED TO THE INDIANA
 22 CODE AS A **NEW SECTION** READ AS FOLLOWS [EFFECTIVE
 23 JULY 1, 2017]: **Sec. 0.9. (a) This section applies only with respect**
 24 **to the responsibilities of a managed care organization under:**

25 **(1) this article;**

26 **(2) IC 12-17.6;**

27 **(3) 42 CFR 438; or**

28 **(4) a rule adopted under a law described in subdivision (1) or**
 29 **(2).**

30 **(b) If a provision of, or rule adopted under, IC 27 is inconsistent**
 31 **with a law described in subsection (a), the law described in**
 32 **subsection (a) is controlling.**

33 SECTION 15. IC 12-15-12-15 IS AMENDED TO READ AS
 34 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 15. ~~The office, for~~
 35 ~~purposes of the primary care case management program, and A~~
 36 ~~managed care contractor, for purposes of the risk-based managed care~~
 37 ~~program,~~ **organization** shall:

38 (1) cover and pay for all medically necessary screening services
 39 provided to an individual who presents to an emergency
 40 department with an emergency medical condition; and

41 (2) beginning July 1, 2001, ~~not neither deny or nor~~ fail to process
 42 a claim for reimbursement for emergency services on the basis



- 1 that the enrollee's primary care provider's authorization code for
 2 the services was not obtained before or after the services were
 3 rendered.
- 4 SECTION 16. IC 12-15-12-17 IS AMENDED TO READ AS
 5 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 17. (a) This section
 6 applies to post-stabilization care services provided to an individual
 7 enrolled in
 8 ~~(1) the a Medicaid risk-based~~ **risk based** managed care program.
 9 ~~or~~
 10 ~~(2) the Medicaid primary care case management program.~~
- 11 (b) ~~The office, if the individual is enrolled in the primary care case~~
 12 ~~management program, or the managed care organization if the~~ **through**
 13 **which an** individual is enrolled in ~~the a risk-based~~ **risk based** managed
 14 care program, is financially responsible for the following services
 15 provided to ~~an~~ **the** enrollee:
- 16 (1) Post-stabilization care services that are ~~pre-approved~~
 17 **preapproved** by a ~~representative of the office or~~ the managed
 18 care organization, ~~as applicable.~~
- 19 (2) Post-stabilization care services that are not ~~pre-approved~~
 20 **preapproved** by a ~~representative of the office or~~ the managed
 21 care organization, ~~as applicable,~~ but that are administered to
 22 maintain the enrollee's stabilized condition within one (1) hour of
 23 a request to the ~~office or~~ the managed care organization for
 24 ~~pre-approval~~ **preapproval** of further post-stabilization care
 25 services.
- 26 (3) Post-stabilization care services provided after an enrollee is
 27 stabilized that are not ~~pre-approved~~ **preapproved** by a
 28 ~~representative of the office or~~ the managed care organization, ~~as~~
 29 ~~applicable,~~ but that are administered to maintain, improve, or
 30 resolve the enrollee's stabilized condition if the ~~office or~~ the
 31 managed care organization:
- 32 (A) does not respond to a request for preapproval within one
 33 (1) hour;
 34 (B) cannot be contacted; or
 35 (C) cannot reach an agreement with the enrollee's treating
 36 physician concerning the enrollee's care, and a physician
 37 representing the ~~office or~~ the managed care organization ~~as~~
 38 ~~applicable,~~ is not available for consultation.
- 39 (c) If the conditions described in subsection (b)(3)(C) exist, ~~the~~
 40 ~~office or~~ the managed care organization ~~as applicable,~~ shall give the
 41 enrollee's treating physician an opportunity to consult with a physician
 42 representing the ~~office or~~ the managed care organization. The enrollee's



1 treating physician may continue with care of the enrollee until a
 2 physician representing the ~~office or the~~ managed care organization ~~as~~
 3 ~~applicable~~; is reached or until one (1) of the following criteria is met:

4 (1) A physician:

5 (A) representing the ~~office or the~~ managed care organization;
 6 ~~as applicable~~; and

7 (B) who has privileges at the treating hospital;
 8 assumes responsibility for the enrollee's care.

9 (2) A physician representing the ~~office or the~~ managed care
 10 organization ~~as applicable~~; assumes responsibility for the
 11 enrollee's care through transfer.

12 (3) A representative of the ~~office or the~~ managed care
 13 organization ~~as applicable~~; and the treating physician reach an
 14 agreement concerning the enrollee's care.

15 (4) The enrollee is discharged from the treating hospital.

16 (d) This subsection applies to post-stabilization care services
 17 provided under subsection (b)(1), (b)(2), and (b)(3) to an individual
 18 enrolled in ~~the a~~ Medicaid ~~risk-based~~ **risk based** managed care
 19 program by a provider who has not contracted with ~~a Medicaid~~
 20 ~~risk-based~~ **the individual's** managed care organization to provide
 21 post-stabilization care services under subsection (b)(1), (b)(2), and
 22 (b)(3) to the individual. Payment for post-stabilization care services
 23 provided under subsection (b)(1), (b)(2), and (b)(3) must be in an
 24 amount equal to one hundred percent (100%) of the current Medicaid
 25 fee for service reimbursement rates for such services.

26 (e) This section does not prohibit a managed care organization from
 27 entering into a subcontract with another ~~Medicaid risk-based~~ managed
 28 care organization providing for the latter **managed care** organization
 29 to assume financial responsibility for making the payments required
 30 under this section.

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

33 (1) review; and

34 (2) make a determination of;

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

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

40 (1) emergency services provided to an individual enrolled in ~~the~~
 41 ~~a~~ Medicaid ~~risk-based~~ **risk based** managed care program; and

42 (2) medically necessary screening services provided to an



1 individual enrolled in ~~the a~~ Medicaid ~~risk-based~~ **risk based**
 2 managed care program;
 3 who presents to an emergency department with an emergency medical
 4 condition.

5 (b) This section does not apply to emergency services or screening
 6 services provided to an individual enrolled in ~~the a~~ Medicaid
 7 ~~risk-based~~ **risk based** managed care program by a provider who has
 8 contracted with a Medicaid ~~risk-based~~ **the individual's** managed care
 9 organization to provide emergency services to the individual.

10 (c) Payment for emergency services and medically necessary
 11 screening services in the emergency department of a hospital licensed
 12 under IC 16-21 must be in an amount equal to one hundred percent
 13 (100%) of the current Medicaid fee for service reimbursement rates for
 14 such services.

15 (d) Payment under subsection (c) is the responsibility of the
 16 enrollee's ~~risk-based~~ managed care organization. This subsection does
 17 not prohibit the ~~risk-based~~ managed care organization from entering
 18 into a subcontract with another Medicaid ~~risk-based~~ managed care
 19 organization providing for the latter **managed care** organization to
 20 assume financial responsibility for making the payments required under
 21 this section.

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

- 24 (1) review; and
- 25 (2) make a determination of;

26 the medical necessity of the services provided in a hospital's emergency
 27 department for purposes of determining coverage for such services.

28 SECTION 18. IC 12-15-12-19 IS REPEALED [EFFECTIVE JULY
 29 1, 2017]. Sec. 19: (a) This section applies to an individual who is a
 30 Medicaid recipient:

31 (b) Subject to subsection (c), the office shall develop the following
 32 programs regarding individuals described in subsection (a):

33 (1) A disease management program for recipients with any of the
 34 following chronic diseases:

- 35 (A) Asthma;
- 36 (B) Diabetes;
- 37 (C) Congestive heart failure or coronary heart disease;
- 38 (D) Hypertension;
- 39 (E) Kidney disease;

40 (2) A case management program for recipients described in
 41 subsection (a) who are at high risk of chronic disease; that is
 42 based on a combination of cost measures, clinical measures, and



1 health outcomes identified and developed by the office with input
 2 and guidance from the state department of health and other
 3 experts in health care case management or disease management
 4 programs:

5 (c) The office shall implement:

6 (1) a pilot program for at least two (2) of the diseases listed in
 7 subsection (b) not later than July 1, 2003; and

8 (2) a statewide chronic disease program as soon as practicable
 9 after the office has done the following:

10 (A) Evaluated a pilot program described in subdivision (1):

11 (B) Made any necessary changes in the program based on the
 12 evaluation performed under clause (A):

13 (d) The office shall develop and implement a program required
 14 under this section in cooperation with the state department of health
 15 and shall use the following persons to the extent possible:

16 (1) Community health centers:

17 (2) Federally qualified health centers (as defined in 42 U.S.C.
 18 1396d(1)(2)(B)):

19 (3) Rural health clinics (as defined in 42 U.S.C. 1396d(1)(1)):

20 (4) Local health departments:

21 (5) Hospitals:

22 (6) Public and private third party payers:

23 (e) The office may contract with an outside vendor or vendors to
 24 assist in the development and implementation of the programs required
 25 under this section:

26 (f) The office and the state department of health shall provide the
 27 interim study committee on public health, behavioral health, and
 28 human services established by IC 2-5-1.3-4 in an electronic format
 29 under IC 5-14-6 with an evaluation and recommendations on the costs,
 30 benefits, and health outcomes of the pilot programs required under this
 31 section. The evaluations required under this subsection must be
 32 provided not more than twelve (12) months after the implementation
 33 date of the pilot programs:

34 (g) The office and the state department of health shall report to the
 35 interim study committee on public health, behavioral health, and
 36 human services established by IC 2-5-1.3-4 in an electronic format
 37 under IC 5-14-6 not later than November 1 of each year regarding the
 38 programs developed under this section:

39 (h) The disease management program services for a recipient
 40 diagnosed with diabetes or hypertension must include education for the
 41 recipient on kidney disease and the benefits of having evaluations and
 42 treatment for chronic kidney disease according to accepted practice



1 guidelines:

2 SECTION 19. IC 12-15-12-20, AS ADDED BY P.L.135-2005,
3 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
4 JULY 1, 2017]: Sec. 20. The office shall develop the following:

5 (1) A measure to evaluate the performance of a ~~Medicaid~~
6 managed care organization in screening a child who is less than
7 six (6) years of age for lead poisoning.

8 (2) A system to maintain the results of an evaluation under
9 subdivision (1) in written form.

10 (3) A performance incentive program for ~~Medicaid~~ managed care
11 organizations evaluated under subdivision (1).

12 SECTION 20. IC 12-15-12-21, AS ADDED BY P.L.113-2008,
13 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
14 JULY 1, 2017]: Sec. 21. (a) Not later than January 1, 2011, the
15 following must be accredited by the National Committee for Quality
16 Assurance or its successor:

17 (1) A managed care organization that has contracted with the
18 office before July 1, 2008, to provide Medicaid services under ~~the~~
19 a risk based managed care program.

20 (2) A behavioral health managed care organization that has
21 contracted before July 1, 2008, with a managed care organization
22 described in subdivision (1).

23 (b) A:

24 (1) managed care organization that has contracted with the office
25 after June 30, 2008, to provide Medicaid services under ~~the~~ a risk
26 based managed care program; or

27 (2) behavioral health managed care organization that has
28 contracted after June 30, 2008, with a managed care organization
29 described in subdivision (1);

30 must begin the accreditation process and obtain accreditation by the
31 National Committee for Quality Assurance or its successor at the
32 earliest time that the National Committee for Quality Assurance allows
33 a managed care organization to be accredited.

34 SECTION 21. IC 12-15-12-22, AS ADDED BY P.L.113-2008,
35 SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
36 JULY 1, 2017]: Sec. 22. A:

37 (1) managed care organization that has a contract with the office
38 to provide Medicaid services under ~~the~~ a risk based managed care
39 program; or

40 (2) behavioral health managed care organization that has
41 contracted with a managed care organization described in
42 subdivision (1);



1 shall accept, receive, and process claims for payment that are filed
2 electronically by a Medicaid provider.

3 SECTION 22. IC 12-15-13-6, AS AMENDED BY P.L.153-2011,
4 SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
5 JULY 1, 2017]: Sec. 6. (a) Except as provided by IC 12-15-35-50, a
6 notice or bulletin that is issued by:

- 7 (1) the office;
8 (2) a contractor of the office; or
9 (3) a managed care ~~plan under the office;~~ **organization;**

10 concerning a change to the Medicaid program, including a change to
11 prior authorization, claims processing, payment rates, and medical
12 policies, that does not require use of the rulemaking process under
13 IC 4-22-2 may not become effective until thirty (30) days after the date
14 the notice or bulletin is communicated to the parties affected by the
15 notice or bulletin.

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

19 (c) If the office, a contractor of the office, or a managed care ~~plan~~
20 ~~under the office~~ **organization** does not comply with the requirements
21 in subsections (a) and (b):

- 22 (1) the notice or bulletin is void;
23 (2) a claim may not be denied because the claim does not comply
24 with the void notice or bulletin; and
25 (3) the office, a contractor of the office, or a managed care ~~plan~~
26 ~~under the office~~ **organization** may not reissue the bulletin or
27 notice for thirty (30) days unless the change is required by the
28 federal government to be implemented earlier.

29 SECTION 23. IC 12-15-15-2.5 IS AMENDED TO READ AS
30 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2.5. (a) Payment for
31 physician services provided in the emergency department of a hospital
32 licensed under IC 16-21 must be at a rate of one hundred percent
33 (100%) of rates payable under the Medicaid fee structure.

34 (b) The payment under subsection (a) must be calculated using the
35 same methodology used for all other physicians participating in the
36 Medicaid program.

37 (c) For services rendered and documented in an individual's medical
38 record, physicians must be reimbursed for federally required medical
39 screening exams that are necessary to determine the presence of an
40 emergency using the appropriate Current Procedural Terminology
41 (CPT) codes 99281, 99282, or 99283 described in the Current
42 Procedural Terminology Manual published annually by the American



1 Medical Association, without authorization by the enrollee's primary
2 medical provider.

3 (d) Payment for all other physician services provided in an
4 emergency department of a hospital to enrollees in the Medicaid
5 primary care case management program must be at a rate of one
6 hundred percent (100%) of the Medicaid fee structure rates; provided
7 the service is authorized; prospectively or retrospectively; by the
8 enrollee's primary medical provider.

9 (e) (d) This section does not apply to a person enrolled in the a
10 Medicaid ~~risk-based~~ **risk based** managed care program.

11 SECTION 24. IC 12-15-30-3 IS AMENDED TO READ AS
12 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 3. The office shall
13 select an approach to finance and administer Medicaid claims
14 consisting of one (1) of the following:

- 15 (1) A direct provider payment plan administered by the office.
- 16 (2) A direct provider payment plan administered by a fiscal agent.
- 17 (3) A ~~Medicaid insurance plan administered by a health insurer.~~
18 **managed care organization.**
- 19 (4) Any combination of the plans described in this section.

20 SECTION 25. IC 12-15-35-18.7 IS AMENDED TO READ AS
21 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 18.7. A formulary
22 established by a ~~Medicaid~~ managed care organization is subject to
23 sections 46 and 47 of this chapter.

24 SECTION 26. IC 12-15-35-20 IS AMENDED TO READ AS
25 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 20. The board is
26 composed of the following:

- 27 (1) Four (4) individuals licensed and actively engaged in the
28 practice of medicine or osteopathic medicine in Indiana under
29 IC 25-22.5.
- 30 (2) Four (4) individuals licensed under IC 25-26 and actively
31 engaged in the practice of pharmacy in Indiana.
- 32 (3) One (1) individual with expertise in therapeutic pharmacology
33 who is neither a physician or a pharmacist.
- 34 (4) A representative of the office who shall serve as an ex-officio
35 nonvoting member of the board.
- 36 (5) One (1) individual who:
 - 37 (A) is employed by a health maintenance organization that has
38 a pharmacy benefit; and
 - 39 (B) has expertise in formulary development and pharmacy
40 benefit administration.

41 The individual appointed under this subdivision may not be
42 employed by a health maintenance organization that is ~~under~~



1 contract or subcontract with the state to provide services to
 2 Medicaid recipients under this article: a managed care
 3 organization.

4 (6) One (1) individual who is a health economist.

5 SECTION 27. IC 12-15-35-28, AS AMENDED BY P.L.210-2015,
 6 SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 7 JULY 1, 2017]: Sec. 28. (a) The board has the following duties:

8 (1) The implementation of a Medicaid retrospective and
 9 prospective DUR program as outlined in this chapter, including
 10 the approval of software programs to be used by the pharmacist
 11 for prospective DUR and recommendations concerning the
 12 provisions of the contractual agreement between the state and any
 13 other entity that will be processing and reviewing Medicaid drug
 14 claims and profiles for the DUR program under this chapter.

15 (2) The development and application of the predetermined criteria
 16 and standards for appropriate prescribing to be used in
 17 retrospective and prospective DUR to ensure that such criteria
 18 and standards for appropriate prescribing are based on the
 19 compendia and developed with professional input with provisions
 20 for timely revisions and assessments as necessary.

21 (3) The development, selection, application, and assessment of
 22 interventions for physicians, pharmacists, and patients that are
 23 educational and not punitive in nature.

24 (4) The publication of an annual report that must be subject to
 25 public comment before issuance to the federal Department of
 26 Health and Human Services and to the Indiana legislative council
 27 by December 1 of each year. The report issued to the legislative
 28 council must be in an electronic format under IC 5-14-6.

29 (5) The development of a working agreement for the board to
 30 clarify the areas of responsibility with related boards or agencies,
 31 including the following:

32 (A) The Indiana board of pharmacy.

33 (B) The medical licensing board of Indiana.

34 (C) The SURS staff.

35 (6) The establishment of a grievance and appeals process for
 36 physicians or pharmacists under this chapter.

37 (7) The publication and dissemination of educational information
 38 to physicians and pharmacists regarding the board and the DUR
 39 program, including information on the following:

40 (A) Identifying and reducing the frequency of patterns of
 41 fraud, abuse, gross overuse, or inappropriate or medically
 42 unnecessary care among physicians, pharmacists, and



- 1 recipients.
- 2 (B) Potential or actual severe or adverse reactions to drugs.
- 3 (C) Therapeutic appropriateness.
- 4 (D) Overutilization or underutilization.
- 5 (E) Appropriate use of generic drugs.
- 6 (F) Therapeutic duplication.
- 7 (G) Drug-disease contraindications.
- 8 (H) Drug-drug interactions.
- 9 (I) Incorrect drug dosage and duration of drug treatment.
- 10 (J) Drug allergy interactions.
- 11 (K) Clinical abuse and misuse.
- 12 (8) The adoption and implementation of procedures designed to
- 13 ensure the confidentiality of any information collected, stored,
- 14 retrieved, assessed, or analyzed by the board, staff to the board, or
- 15 contractors to the DUR program that identifies individual
- 16 physicians, pharmacists, or recipients.
- 17 (9) The implementation of additional drug utilization review with
- 18 respect to drugs dispensed to residents of nursing facilities shall
- 19 not be required if the nursing facility is in compliance with the
- 20 drug regimen procedures under 410 IAC 16.2-3.1 and 42 CFR
- 21 483.60.
- 22 (10) The research, development, and approval of a preferred drug
- 23 list for:
- 24 (A) Medicaid's fee for service program;
- 25 ~~(B) Medicaid's primary care case management program;~~
- 26 ~~(C) Medicaid's (B) a risk based managed care program, if the~~
- 27 ~~office provides a prescription drug benefit and subject to~~
- 28 ~~IC 12-15-5; and~~
- 29 ~~(D) (C) the children's health insurance program under~~
- 30 ~~IC 12-17.6;~~
- 31 in consultation with the therapeutics committee.
- 32 (11) The approval of the review and maintenance of the preferred
- 33 drug list at least two (2) times per year.
- 34 (12) The preparation and submission of a report concerning the
- 35 preferred drug list at least one (1) time per year to the interim
- 36 study committee on public health, behavioral health, and human
- 37 services established by IC 2-5-1.3-4 in an electronic format under
- 38 IC 5-14-6.
- 39 (13) The collection of data reflecting prescribing patterns related
- 40 to treatment of children diagnosed with attention deficit disorder
- 41 or attention deficit hyperactivity disorder.
- 42 (14) Advising the Indiana comprehensive health insurance



- 1 association established by IC 27-8-10-2.1 concerning
 2 implementation of chronic disease management and
 3 pharmaceutical management programs under IC 27-8-10-3.5.
- 4 (b) The board shall use the clinical expertise of the therapeutics
 5 committee in developing a preferred drug list. The board shall also
 6 consider expert testimony in the development of a preferred drug list.
- 7 (c) In researching and developing a preferred drug list under
 8 subsection (a)(10), the board shall do the following:
- 9 (1) Use literature abstracting technology.
 10 (2) Use commonly accepted guidance principles of disease
 11 management.
 12 (3) Develop therapeutic classifications for the preferred drug list.
 13 (4) Give primary consideration to the clinical efficacy or
 14 appropriateness of a particular drug in treating a specific medical
 15 condition.
 16 (5) Include in any cost effectiveness considerations the cost
 17 implications of other components of the state's Medicaid program
 18 and other state funded programs.
- 19 (d) Prior authorization is required for coverage under a program
 20 described in subsection (a)(10) of a drug that is not included on the
 21 preferred drug list.
- 22 (e) The board shall determine whether to include a single source
 23 covered outpatient drug that is newly approved by the federal Food and
 24 Drug Administration on the preferred drug list not later than sixty (60)
 25 days after the date on which the manufacturer notifies the board in
 26 writing of the drug's approval. However, if the board determines that
 27 there is inadequate information about the drug available to the board
 28 to make a determination, the board may have an additional sixty (60)
 29 days to make a determination from the date that the board receives
 30 adequate information to perform the board's review. Prior authorization
 31 may not be automatically required for a single source drug that is newly
 32 approved by the federal Food and Drug Administration, and that is:
- 33 (1) in a therapeutic classification:
 34 (A) that has not been reviewed by the board; and
 35 (B) for which prior authorization is not required; or
 36 (2) the sole drug in a new therapeutic classification that has not
 37 been reviewed by the board.
- 38 (f) The board may not exclude a drug from the preferred drug list
 39 based solely on price.
- 40 (g) The following requirements apply to a preferred drug list
 41 developed under subsection (a)(10):
 42 (1) Except as provided by IC 12-15-35.5-3(b) and



1 IC 12-15-35.5-3(c), the office or the board may require prior
 2 authorization for a drug that is included on the preferred drug list
 3 under the following circumstances:

4 (A) To override a prospective drug utilization review alert.

5 (B) To permit reimbursement for a medically necessary brand
 6 name drug that is subject to generic substitution under
 7 IC 16-42-22-10.

8 (C) To prevent fraud, abuse, waste, overutilization, or
 9 inappropriate utilization.

10 (D) To permit implementation of a disease management
 11 program.

12 (E) To implement other initiatives permitted by state or federal
 13 law.

14 (2) All drugs described in IC 12-15-35.5-3(b) must be included on
 15 the preferred drug list.

16 (3) The office may add a drug that has been approved by the
 17 federal Food and Drug Administration to the preferred drug list
 18 without prior approval from the board.

19 (4) The board may add a drug that has been approved by the
 20 federal Food and Drug Administration to the preferred drug list.

21 (h) At least one (1) time each year, the board shall provide a report
 22 to the interim study committee on public health, behavioral health, and
 23 human services established by IC 2-5-1.3-4 in an electronic format
 24 under IC 5-14-6. The report must contain the following information:

25 (1) The cost of administering the preferred drug list.

26 (2) Any increase in Medicaid physician, laboratory, or hospital
 27 costs or in other state funded programs as a result of the preferred
 28 drug list.

29 (3) The impact of the preferred drug list on the ability of a
 30 Medicaid recipient to obtain prescription drugs.

31 (4) The number of times prior authorization was requested, and
 32 the number of times prior authorization was:

33 (A) approved; and

34 (B) disapproved.

35 (i) The board shall provide the first report required under subsection
 36 (h) not later than six (6) months after the board submits an initial
 37 preferred drug list to the office.

38 SECTION 28. IC 12-15-35-45, AS AMENDED BY P.L.101-2005,
 39 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 40 JULY 1, 2017]: Sec. 45. (a) The chairman of the board, subject to the
 41 approval of the board members, may appoint an advisory committee to
 42 make recommendations to the board on the development of a Medicaid



1 outpatient drug formulary.

2 (b) If the office decides to establish a Medicaid outpatient drug
3 formulary, the formulary shall be developed by the board.

4 (c) A formulary, preferred drug list, or prescription drug benefit
5 used by a Medicaid managed care organization is subject to
6 IC 12-15-5-5, IC 12-15-35.5, and sections 46 and 47 of this chapter.

7 SECTION 29. IC 12-15-35-46 IS AMENDED TO READ AS
8 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 46. (a) This section
9 applies to a managed care organization that enters into an initial
10 contract with the office to be a Medicaid managed care organization
11 after May 13, 1999.

12 (b) Before a Medicaid managed care organization described in
13 subsection (a) implements a formulary, the managed care organization
14 shall submit the formulary to the office at least thirty-five (35) days
15 before the date that the managed care organization implements the
16 formulary for Medicaid recipients.

17 (c) The office shall forward the formulary to the board for the
18 board's review and recommendation.

19 (d) The office shall provide at least thirty (30) days notification to
20 the public that the board will review a Medicaid managed care
21 organization's proposed formulary at a particular board meeting. The
22 notification shall contain the following information:

- 23 (1) A statement of the date, time, and place at which the board
24 meeting will be convened.
- 25 (2) A general description of the subject matter of the board
26 meeting.
- 27 (3) An explanation of how a copy of the formulary to be discussed
28 may be obtained.

29 The board shall meet to review the formulary at least thirty (30) days
30 but not more than sixty (60) days after the notification.

31 (e) In reviewing the formulary, the board shall do the following:

- 32 (1) Make a determination, after considering evidence and credible
33 information provided to the board by the office and the public,
34 that the use of the formulary will not:
 - 35 (A) impede the quality of patient care in the Medicaid
36 program; or
 - 37 (B) increase costs in other parts of the Medicaid program,
38 including hospital costs and physician costs.
- 39 (2) Make a determination that:
 - 40 (A) there is access to at least two (2) alternative drugs within
41 each therapeutic classification, if available, on the formulary;
 - 42 (B) a process is in place through which a Medicaid member



- 1 has access to medically necessary drugs; and
 2 (C) the managed care organization otherwise meets the
 3 requirements of IC 27-13-38.
- 4 (f) The board shall consider:
 5 (1) health economic data;
 6 (2) cost data; and
 7 (3) the use of formularies in the non-Medicaid markets;
 8 in developing its recommendation to the office.
- 9 (g) Within thirty (30) days after the board meeting, the board shall
 10 make a recommendation to the office regarding whether the proposed
 11 formulary should be approved, disapproved, or modified.
- 12 (h) The office shall rely significantly on the clinical expertise of the
 13 board. If the office does not agree with the recommendations of the
 14 board, the office shall, at a public meeting, discuss the disagreement
 15 with the board and present any additional information to the board for
 16 the board's consideration. The board's consideration of additional
 17 information must be conducted at a public meeting.
- 18 (i) Based on the final recommendations of the board, the office shall
 19 approve, disapprove, or require modifications to the ~~Medicaid~~ managed
 20 care organization's proposed formulary. The office shall notify the
 21 managed care organization of the office's decision within fifteen (15)
 22 days of receiving the board's final recommendation.
- 23 (j) The managed care organization must comply with the office's
 24 decision within sixty (60) days after receiving notice of the office's
 25 decision.
- 26 (k) Notwithstanding the other provisions of this section, the office
 27 may temporarily approve a ~~Medicaid~~ managed care organization's
 28 proposed formulary pending a final recommendation from the board.
- 29 SECTION 30. IC 12-15-35-47 IS AMENDED TO READ AS
 30 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 47. (a) This section
 31 applies to the following changes to a formulary used by a ~~Medicaid~~
 32 managed care organization for Medicaid recipients:
 33 (1) Removing one (1) or more drugs from the formulary.
 34 (2) Placing new restrictions on one (1) or more drugs on the
 35 formulary.
- 36 (b) Before a ~~Medicaid~~ managed care organization makes a change
 37 described in subsection (a), the managed care organization shall submit
 38 the proposed change to the office.
- 39 (c) The office shall forward the proposed change to the board for the
 40 board's review and recommendation.
- 41 (d) The office shall provide at least thirty (30) days notification to
 42 the public that the board will:



- 1 (1) review the proposed change; and
 2 (2) consider evidence and credible information provided to the
 3 board;
 4 at the board's regular board meeting before making a recommendation
 5 to the office regarding whether the proposed change should be
 6 approved or disapproved.
 7 (e) Based on the final recommendation of the board, the office may
 8 approve or disapprove the proposed change. If a proposed change is not
 9 disapproved within ninety (90) days after the date the managed care
 10 organization submits the proposed change to the office, the managed
 11 care organization may implement the change to the formulary.
 12 (f) A ~~Medicaid~~ managed care organization:
 13 (1) may add a drug to the managed care organization's formulary
 14 without the approval of the office; and
 15 (2) shall notify the office of any addition to the managed care
 16 organization's formulary within thirty (30) days after making the
 17 addition.
 18 SECTION 31. IC 12-15-35-48, AS AMENDED BY P.L.53-2014,
 19 SECTION 106, IS AMENDED TO READ AS FOLLOWS
 20 [EFFECTIVE JULY 1, 2017]: Sec. 48. (a) The board shall review the
 21 prescription drug program of a managed care organization that
 22 participates in ~~the state's risk-based~~ **a risk based** managed care
 23 program at least one (1) time per year. The board's review of a
 24 prescription drug program must include the following:
 25 (1) An analysis of the single source drugs requiring prior
 26 authorization, including the number of drugs requiring prior
 27 authorization in comparison to other managed care organizations'
 28 prescription drug programs that participate in the state's Medicaid
 29 program.
 30 (2) A determination and analysis of the number and the type of
 31 drugs subject to a restriction.
 32 (3) A review of the rationale for:
 33 (A) the prior authorization of a drug described in subdivision
 34 (1); and
 35 (B) a restriction on a drug.
 36 (4) A review of the number of requests a managed care
 37 organization received for prior authorization, including the
 38 number of times prior authorization was approved and the number
 39 of times prior authorization was disapproved.
 40 (5) A review of:
 41 (A) patient and provider satisfaction survey reports; and
 42 (B) pharmacy-related grievance data for a twelve (12) month



1 period.

2 (b) A managed care organization described in subsection (a) shall
3 provide the board with the information necessary for the board to
4 conduct its review under subsection (a).

5 (c) The board shall report to the interim study committee on public
6 health, behavioral health, and human services established by
7 IC 2-5-1.3-4 in an electronic format under IC 5-14-6 at least one (1)
8 time per year on the board's review under subsection (a).

9 SECTION 32. IC 12-15-44.5-3, AS AMENDED BY P.L.30-2016,
10 SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
11 JULY 1, 2017]: Sec. 3. (a) The healthy Indiana plan is established.

12 (b) The office shall administer the plan.

13 (c) The following individuals are eligible for the plan:

- 14 (1) The adult group described in 42 CFR 435.119.
15 (2) Parents and caretaker relatives eligible under 42 CFR 435.110.
16 (3) Low income individuals who are:
17 (A) at least nineteen (19) years of age; and
18 (B) less than twenty-one (21) years of age;
19 and eligible under 42 CFR 435.222.
20 (4) Individuals, for purposes of receiving transitional medical
21 assistance.

22 An individual must meet the Medicaid residency requirements under
23 IC 12-15-4-4 and this article to be eligible for the plan.

24 (d) The following individuals are not eligible for the plan:

- 25 (1) An individual who participates in the federal Medicare
26 program (42 U.S.C. 1395 et seq.).
27 (2) An individual who is otherwise eligible and enrolled for
28 medical assistance.

29 (e) The department of insurance and the office of the secretary shall
30 provide oversight of the marketing practices of the plan.

31 (f) The office shall promote the plan and provide information to
32 potential eligible individuals who live in medically underserved rural
33 areas of Indiana.

34 (g) The office shall, to the extent possible, ensure that enrollment in
35 the plan is distributed throughout Indiana in proportion to the number
36 of individuals throughout Indiana who are eligible for participation in
37 the plan.

38 (h) The office shall establish standards for consumer protection,
39 including the following:

- 40 (1) Quality of care standards.
41 (2) A uniform process for participant grievances and appeals.
42 (3) Standardized reporting concerning provider performance,



- 1 consumer experience, and cost.
- 2 (i) A health care provider that provides care to an individual who
3 receives health insurance coverage under the plan shall also participate
4 in the Medicaid program under this article.
- 5 (j) The following do not apply to the plan:
- 6 (1) IC 12-15-6.
 - 7 (2) IC 12-15-12.
 - 8 (3) IC 12-15-13.
 - 9 (4) IC 12-15-14.
 - 10 (5) IC 12-15-15.
 - 11 (6) IC 12-15-21.
 - 12 (7) IC 12-15-26.
 - 13 (8) IC 12-15-31.1.
 - 14 (9) IC 12-15-34.
 - 15 (10) IC 12-15-35.
 - 16 (11) IC 16-42-22-10.
- 17 SECTION 33. IC 12-15-44.5-4.7, AS ADDED BY P.L.30-2016,
18 SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
19 JULY 1, 2017]: Sec. 4.7. (a) To participate in the plan, an individual
20 must apply for the plan on a form prescribed by the office. The office
21 may develop and allow a joint application for a household.
- 22 (b) A pregnant woman is not subject to the cost sharing provisions
23 of the plan. Subsections (c) through (g) do not apply to a pregnant
24 woman participating in the plan.
- 25 (c) An applicant who is approved to participate in the plan does not
26 begin benefits under the plan until a payment of at least:
- 27 (1) one-twelfth (1/12) of the two percent (2%) of annual income
28 contribution amount; or
 - 29 (2) ten dollars (\$10);
- 30 is made to the individual's health care account established under
31 section 4.5 of this chapter for the individual's participation in the plan.
32 To continue to participate in the plan, an individual must contribute to
33 the individual's health care account at least two percent (2%) of the
34 individual's annual household income per year but not less than one
35 dollar (\$1) per month.
- 36 (d) If an applicant who is approved to participate in the plan fails to
37 make the initial payment into the individual's health care account, at
38 least the following must occur:
- 39 (1) If the individual has an annual income that is at or below one
40 hundred percent (100%) of the federal poverty income level, the
41 individual's benefits are reduced as specified in subsection (e)(1).
 - 42 (2) If the individual has an annual income of more than one



- 1 hundred percent (100%) of the federal poverty income level, the
2 individual is not enrolled in the plan.
- 3 (e) If an enrolled individual's required monthly payment to the plan
4 is not made within sixty (60) days after the required payment date, the
5 following, at a minimum, occur:
- 6 (1) For an individual who has an annual income that is at or below
7 one hundred percent (100%) of the federal income poverty level,
8 the individual is:
- 9 (A) transferred to a plan that has a material reduction in
10 benefits, including the elimination of benefits for vision and
11 dental services; and
- 12 (B) required to make copayments for the provision of services
13 that may not be paid from the individual's health care account.
- 14 (2) For an individual who has an annual income of more than one
15 hundred percent (100%) of the federal poverty income level, the
16 individual shall be terminated from the plan and may not reenroll
17 in the plan for at least six (6) months.
- 18 (f) The state shall contribute to the individual's health care account
19 the difference between the individual's payment required under this
20 section and the plan deductible set forth in section 4.5(c) of this
21 chapter.
- 22 (g) A member shall remain enrolled with the same **health plan**
23 **managed care organization** during the member's benefit period. A
24 member may change **health plans managed care organizations** as
25 follows:
- 26 (1) Without cause:
- 27 (A) before making a contribution or before finalizing
28 enrollment in accordance with subsection (d)(1); or
- 29 (B) during the annual plan renewal process.
- 30 (2) For cause, as determined by the office.
- 31 SECTION 34. IC 12-15-44.5-5, AS ADDED BY P.L.213-2015,
32 SECTION 136, IS AMENDED TO READ AS FOLLOWS
33 [EFFECTIVE JULY 1, 2017]: Sec. 5. (a) ~~An insurer or health~~
34 ~~maintenance~~ **A managed care** organization that contracts with the
35 office to provide health ~~insurance~~ coverage, dental coverage, or vision
36 coverage to an individual who participates in the plan:
- 37 (1) is responsible for the claim processing for the coverage;
- 38 (2) shall reimburse providers at a rate that is not less than the rate
39 established by the secretary. The rate set by the secretary must be
40 based on a reimbursement formula that is:
- 41 (A) comparable to the federal Medicare reimbursement rate
42 for the service provided by the provider; or



- 1 (B) one hundred thirty percent (130%) of the Medicaid
 2 reimbursement rate for a service that does not have a Medicare
 3 reimbursement rate; and
 4 (3) may not deny coverage to an eligible individual who has been
 5 approved by the office to participate in the plan.
- 6 (b) ~~An insurer or health maintenance~~ **A managed care** organization
 7 that contracts with the office to provide health ~~insurance~~
 8 under the plan must incorporate cultural competency standards
 9 established by the office. The standards must include standards for
 10 non-English speaking, minority, and disabled populations.
- 11 SECTION 35. IC 12-15-44.5-8, AS ADDED BY P.L.213-2015,
 12 SECTION 136, IS AMENDED TO READ AS FOLLOWS
 13 [EFFECTIVE JULY 1, 2017]: Sec. 8. The following requirements
 14 apply to funds appropriated by the general assembly to the plan and the
 15 incremental fee used for purposes of IC 16-21-10-13.3:
- 16 (1) At least eighty-seven percent (87%) of the funds must be used
 17 to fund payment for health care services.
 18 (2) An amount determined by the office of the secretary to fund:
 19 (A) administrative costs of; and
 20 (B) any profit made by;
 21 ~~an insurer or a health maintenance~~ **managed care** organization
 22 under a contract with the office to provide health ~~insurance~~
 23 coverage under the plan. The amount determined under this
 24 subdivision may not exceed thirteen percent (13%) of the funds.
- 25 SECTION 36. IC 16-38-6-2 IS AMENDED TO READ AS
 26 FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 2. The state
 27 department, with the cooperation of the office of Medicaid policy and
 28 planning, shall establish a chronic disease registry for the purpose of:
 29 (1) recording chronic disease cases that are diagnosed or treated
 30 in Indiana; and
 31 (2) compiling necessary and appropriate information determined
 32 by the state department concerning cases described in subdivision
 33 (1) in order to do the following:
 34 (A) Conduct epidemiologic and environmental surveys of
 35 chronic disease and use appropriate preventive and control
 36 measures.
 37 (B) Inform citizens regarding programs designed to manage
 38 chronic disease.
 39 ~~(C) Provide guidance to the office of Medicaid policy and~~
 40 ~~planning to identify and develop cost and clinical measures for~~
 41 ~~use in a program required by IC 12-15-12-19.~~

