HOUSE BILL No. 1592

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-10-11.5; IC 12-15.

Synopsis: Services for the aged and disabled. Allows the office of the secretary of family and social services (office) to reimburse a Medicaid provider for providing functional assessments if the provider completed training approved by the office. Prohibits the office from restricting access to certain assisted living services by establishing a Medicaid waiver wait list or any other method if there are available waiver slots. Requires the office to apply for additional waiver slots when the slots are all filled in a manner that is sufficient to complete the state fiscal year without implementing a wait list. Requires the office to reimburse for home and community based services from the date of the individual's application. Requires the office to apply to the federal government for: (1) an amendment to the aged and disabled Medicaid waiver concerning functional eligibility determinations and reimbursement within a specified time; and (2) a new Medicaid waiver to provide assisted living services. Repeals language concerning reporting of the development of a long term care risk based managed care program (program). Requires the office to include certain provisions in a contract for the program. Specifies requirements of an entity contracting with the office to participate in the program. Requires the office to develop and implement clinical and quality of life measures and allow provider owned entities to participate in the program. Allows the office to audit claims or data concerning the program and post the audit findings on the office's website. Allows the office to take administrative action against a contracted entity for violations. Sets forth claim submission and processing requirements for the program. Repeals the temporary emergency financial assistance program.

Effective: July 1, 2025.

Barrett, Karickhoff

January 21, 2025, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 124th General Assembly (2025)

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 2024 Regular Session of the General Assembly.

HOUSE BILL No. 1592

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

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

SECTION 1. IC 12-7-2-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 0.7. "Accountable care organization", for purposes of IC 12-15-5-17.7, has the meaning set forth in IC 12-15-5-17.7(b).**

SECTION 2. IC 12-7-2-48.7, AS ADDED BY P.L.131-2024, SECTION 1 AND P.L.136-2024, SECTION 37 AND P.L.17-2024, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 48.7. **(a) "Covered population", for purposes of IC 12-15-5, has the meaning set forth in IC 12-15-5-17.7(c).**

(b) "Covered population", for purposes of IC 12-15-13-1.8, has the meaning set forth in IC 12-15-13-1.8(a).

SECTION 3. IC 12-7-2-77.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 77.4. "Entity", for purposes of IC 12-15-5, has the meaning set forth in IC 12-15-5-17.7(d).**

SECTION 4. IC 12-7-2-90.5, AS ADDED BY P.L.149-2023, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2025]: Sec. 90.5. "Functional eligibility assessment", for purposes of IC 12-10-11.5-4.5 **and IC 12-15-1.3,** has the meaning set forth in IC 12-10-11.5-4.5(a).

SECTION 5. IC 12-7-2-103.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 103.4. "Health plan", for purposes of IC 12-15-5, has the meaning set forth in IC 12-15-5-17.7(e).**

SECTION 6. IC 12-7-2-144.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 144.8. "Primary care case management entity", for purposes of IC 12-15-5, has the meaning set forth in IC 12-15-5-17.7(f).**

SECTION 7. IC 12-7-2-196.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 196.7. "Utilization management", for purposes of IC 12-15-5, has the meaning set forth in IC 12-15-5-17.7(g).**

SECTION 8. IC 12-10-11.5-4.5, AS ADDED BY P.L.149-2023, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4.5. (a) As used in this section, "functional eligibility assessment" means a review of an individual's functional impairment level to determine whether an individual meets the eligibility requirements for the state's Medicaid aged and disabled waiver.

(b) As used in this section, "functional eligibility determination" means making a final decision concerning whether an individual meets the proper level of care requirements to receive services under the state's Medicaid aged and disabled waiver.

(c) Not later than June 30, 2025, the office shall provide at least one (1) statewide option other than the area agencies on aging for functional eligibility determinations for the state's Medicaid aged and disabled waiver.

(d) Not later than October 1, 2023, and every subsequent two (2) years, the office of the secretary, in consultation with home and community based health care providers that provide Medicaid services and the area agencies on aging, shall report the following information and analysis to the budget committee and the legislative council in an electronic format under IC 5-14-6:

(1) The average length of time taken by each area agency on aging to conduct functional eligibility assessments and make functional eligibility determinations for individuals seeking home

and community based Medicaid services.

(2) The average length of time taken by each entity approved by the office of the secretary to conduct functional eligibility assessments and make functional eligibility determinations for individuals seeking home and community based Medicaid services under the state's Medicaid aged and disabled waiver.

(3) A plan for determining functional eligibility of individuals seeking home and community based Medicaid services not later than seventy-two (72) hours from the completion of an eligibility assessment, including a time frame for implementation of the plan and specific metrics and compliance measures that will be used to improve the time frame for functional eligibility assessments and functional eligibility determinations.

(e) The office of the secretary shall:

(1) publish the report described in subsection (d) on the office of the secretary's website; and

(2) share the report with all home and community based providers that provide services for the Medicaid aged and disabled waiver.

(f) The office of the secretary may reimburse a Medicaid provider for providing functional eligibility assessments for individuals who have applied for the state's Medicaid aged and disabled waiver if the provider has completed training approved by the office of the secretary.

~~(f)~~ **(g)** This section expires December 1, 2029.

SECTION 9. IC 12-10-11.5-8, AS AMENDED BY P.L.149-2023, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 8. (a) As used in this chapter, "assisted living services" refers to services covered under a waiver and provided in any of the following entities:

(1) A residential care facility licensed under IC 16-28.

(2) Any other housing with services establishment.

(b) As used in this section, "level of services" means a determination of the type of services an individual may receive under a Medicaid waiver based on the individual's impairment and dependence and the corresponding reimbursement rate for the determined level of care.

(c) As used in this section, "office" includes the following:

(1) The office of the secretary of family and social services.

(2) A managed care organization that has contracted with the office of Medicaid policy and planning under IC 12-15.

(3) A person that has contracted with a managed care organization described in subdivision (2).

(d) Under ~~a~~ **any** Medicaid waiver that provides services to an individual who is aged or disabled, the office shall reimburse for the following services provided to the individual by a provider of assisted living services:

(1) Assisted living services.

(2) Integrated health care coordination.

(3) Transportation.

The office of the secretary may not restrict access to services described in this subsection under any waiver through the implementation of a Medicaid waiver wait list or any other method if the state has available slots under the waiver. If a Medicaid waiver that provides access to services described in this subsection has filled all available waiver slots, the office of the secretary shall apply to the United States Department of Health and Human Services for additional waiver slots that are sufficient enough to complete the state fiscal year without implementing a wait list.

(e) If the office approves an increase in the level of services for a recipient of assisted living services, the office shall reimburse the provider of assisted living services for the level of services for the increase as of the date that the provider has documentation of providing the increase in the level of services.

(f) The office ~~may~~ **shall** reimburse for any home and community based services provided to a Medicaid recipient beginning on the date of the individual's Medicaid application.

(g) The office may not do any of the following concerning assisted living services provided in ~~a~~ **any** home and community based services program:

(1) Require the installation of a sink in the kitchenette within any living unit of an entity that participated in the Medicaid home and community based service program before July 1, 2018.

(2) Require all living units within a setting that provides assisted living services to comply with physical plant requirements that are applicable to individual units occupied by a Medicaid recipient.

(3) Require a provider to offer only private rooms.

(4) Require a housing with services establishment provider to provide housing when:

(A) the provider is unable to meet the health needs of a resident without:

(i) undue financial or administrative burden; or

(ii) fundamentally altering the nature of the provider's operations; and

(B) the resident is unable to arrange for services to meet the resident's health needs.

(5) Require a housing with services establishment provider to separate an agreement for housing from an agreement for services.

(6) Prohibit a housing with services establishment provider from offering studio apartments with only a single sink in the unit.

(7) Preclude the use of a shared bathroom between adjoining or shared units if the participants consent to the use of a shared bathroom.

(8) Reduce the scope of services that may be provided by a provider of assisted living services under the aged and disabled Medicaid waiver in effect on July 1, 2021.

(h) The division may adopt rules under IC 4-22-2 that establish the right, and an appeals process, for a resident to appeal a provider's determination that the provider is unable to meet the health needs of the resident as described in subsection (g)(4). The process:

(1) must require an objective third party to review the provider's determination in a timely manner; and

(2) may not be required if the provider is licensed by the Indiana department of health and the licensure requirements include an appellate procedure for such a determination.

SECTION 10. IC 12-15-1.3-19.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 19.5. Before November 1, 2025, the office of the secretary shall apply to the United States Department of Health and Human Services for an amendment to the Medicaid aged and disabled waiver and a Medicaid waiver that specifically applies for services in the assisted living setting to require that an individual applying for either of the waivers:**

(1) receives a functional eligibility determination; and

(2) is authorized to receive reimbursable services under the waiver if the individual is determined eligible for the waiver; not later than seventy-two (72) hours after a functional eligibility assessment is performed for the individual.

SECTION 11. IC 12-15-1.3-19.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 19.7. (a) Before September 1, 2025, the office of the secretary shall apply to the United States Department of Health and Human Services for a Medicaid waiver to provide assisted living services effective July 1, 2025, in a waiver separate from the Medicaid aged and disabled waiver.**

(b) The office of the secretary shall establish a work group of interested stakeholders to assist in the development and implementation of the waiver described in subsection (a). The secretary shall appoint the members of the work group and include providers of assisted living services as members of the work group.

SECTION 12. IC 12-15-5-17.5 IS REPEALED [EFFECTIVE JULY 1, 2025]. ~~Sec. 17.5. (a) The office shall report on its progress on the development of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services to the interim study committee on public health, behavioral health, and human services before November 1, 2021.~~

~~(b) Not later than February 1, 2022, the office shall report the following information and analysis to the legislative council and budget committee (in an electronic format under IC 5-14-6) regarding the implementation of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services, as follows:~~

~~(1) The projected utilization of home and community based services and institutional services for the four (4) years following implementation, and including, but not limited to, information on:~~

~~(A) provider network adequacy;~~

~~(B) family caregiver programming; and~~

~~(C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.~~

~~(2) How administrative processes, including service approval and billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.~~

~~(3) Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.~~

~~(4) The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality assessment fee and~~

~~supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.~~

~~(c) A request for proposal for the procurement of a Medicaid program to enroll a Medicaid recipient who is eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services in a risk based managed care program or capitated managed care program may not be issued until the request for proposal has been reviewed by the budget committee.~~

~~(d) After the review of a request for proposal by the budget committee under subsection (c), the office may not enter into a final contract that would implement a program described in subsection (c) before January 31, 2023.~~

SECTION 13. IC 12-15-5-17.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 17.7. (a) This section applies to a risk based managed care program established by IC 12-15-13-1.8(c).**

(b) As used in this section, "accountable care organization" means a legal organization formed under Indiana law that is composed of any type or combination of health care providers enrolled in the Medicaid program, including:

(1) physicians licensed under IC 25-22.5;

(2) advanced practice registered nurses licensed under IC 25-23;

(3) hospitals licensed under IC 16-21;

(4) hospices licensed under IC 16-25;

(5) home health agencies licensed under IC 16-27;

(6) health facilities licensed under IC 16-28;

(7) intermediate care facilities for individuals with intellectual disabilities; or

(8) care managers certified by the office of the secretary to provide care management services to individuals;

and may include a health plan.

(c) As used in this section, "covered population" means a Medicaid recipient who:

(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) over 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) An assisted living specific Medicaid waiver.

(iv) State Medicaid plan services.

(d) As used in this section, "entity" means any of the following:

(1) A managed care organization that seeks to contract with or contracts with the office of the secretary to provide services under a risk based managed care program for the covered population.

(2) A primary care case management entity that seeks to contract with the office of the secretary to provide services to the covered population.

(3) An accountable care organization that seeks to contract with the office of the secretary to provide services to the covered population.

(e) As used in this section, "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), excluding coverage described 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).

(f) As used in this section, "primary care case management entity" has the meaning set forth in 42 CFR 438.2.

(g) As used in this section, "utilization management" means:

(1) completing initial requests and concurrent reviews for prior authorization of services;

(2) completing initial determinations of medical necessity;

(3) completing provider and recipient appeals and expedited appeals for prior authorization of service requests or medical necessity determinations;

(4) notifying providers and recipients in writing of decisions on initial prior authorization requests and medical necessity determinations; and

(5) notifying providers and recipients in writing of the

decisions on appeals and expedited appeals of prior authorization requests and medical necessity determinations.

(h) The office of the secretary shall include the following requirements in any contract with an entity for a program described in subsection (a):

(1) Has Indiana based staff and leadership with long term services and supports experience, including at least one (1) geriatrician licensed to practice in Indiana.

(2) Employs management with expertise and experience in long term services and supports, including either providing long term services and supports or being employed by a provider of long term services and supports, including the following provider types:

(A) Nursing facilities.

(B) Residential care facilities.

(C) Home health agencies.

(D) Hospices.

(E) Family caregivers.

(F) Social workers.

(G) Nurses.

(H) Behavioral health specialists.

(I) Care managers certified by the office of the secretary to provide case management services to recipients under a Medicaid waiver.

(3) Has provider credentialing requirements.

(4) Includes an independent appeals process for the resolution of claims disputes and denials of prior authorization for services for recipients.

(5) States that the tender of a provider agreement occurs at least ninety (90) days before the effective date of the agreement.

(6) Includes provider agreement termination provisions that include the following:

(A) Health care providers may be terminated by an entity for cause only, and limited to:

(i) termination of the provider from the Medicare program or the Medicaid program by the United States Department of Health and Human Services or the office of the secretary;

(ii) a provider's loss of licensure or certification by a state agency; or

(iii) a regulatory action that has the effect of

permanently rendering the provider unable or ineligible to deliver Medicare or Medicaid services.

If a health care provider is terminated by an entity, the entity must provide recipients who receive services from the terminated health care provider advance written notice of the termination of the provider, that the recipient is provided continuity of care with the terminating provider, and assist the recipients in seamlessly transitioning to another network provider.

(B) Termination must:

(i) occur by written notice to the provider that includes any reason for the termination;

(ii) include an explanation of the standards and information used to evaluate the provider;

(iii) include the criteria used in the decision to terminate the provider; and

(iv) include information concerning the provider's right to appeal the determination and an explanation of the appellate procedure.

(7) Includes prompt payment requirements that comply with IC 12-15-13 and include a liquidated damages provision that contains financial penalties as described in subdivision (8)(B) for failure to meet the prompt payment requirements.

(8) Specifies standardized processes for provider claims appeals, including:

(A) provider claims payment appeals with second level appeals administered by the office of the secretary to ensure unbiased adjudication of the claims payment appeal; and

(B) financial penalties of not less than ten percent (10%) of the total claim allowed charges based on the current:

(i) Medicare fee for service fee schedule; or

(ii) Indiana Medicaid fee schedule;

as applicable, for all claims denials or underpayments overturned at the first or second appeal level.

(9) Specifies a description of the medical necessity criteria that must include enhanced protections for the covered population concerning the coverage of services that are more limited or are not addressed in commercially available resources that address utilization management and medical necessity.

(10) Includes a requirement for the continuation of

reimbursement to a provider when a recipient is transferred or discharged from a nursing facility under 410 IAC 16.2-3.1-12 or a residential care facility under 410 IAC 16.2-5-1.2, or any other subsequent rule or statute, concerning transfer or discharge until:

(A) the transfer or discharge is complete, even if an extended stay has not been approved; and

(B) any appeal right has been exhausted or expired.

(11) Includes a requirement to provide a recipient and the recipient's family with:

(A) freedom of choice in selecting a provider of services, including choice of a nursing facility or home and community based services;

(B) individualized information concerning whether the provider network includes the providers with whom the recipient has an established patient relationship, including an attestation or similar documentation from the recipient or the recipient's responsible party concerning the providers and services that were included in the information provided and the provider and services selected;

(C) adequate time for the recipient and the recipient's family to make a decision concerning providers and services; and

(D) a new health care or services provider determined not later than three (3) days from request by the recipient or the recipient's responsible party.

(12) Prohibits on payment arrangements or other contract terms that:

(A) reimburse providers at enhanced rates; or

(B) offer other inducements;

in exchange for steering, exclusivity, or other activities that have the effect of limiting consumer choice.

(13) Sets forth the entity's role in:

(A) discharge planning;

(B) imposing prior authorization requirements; and

(C) the process for appealing adverse determinations, including the process for expedited appeals and second level appeals of adverse determination.

(14) Specifies that capacity for prior authorization determinations for services must be available twenty-four (24) hours a day, seven (7) days a week, and:

(A) be resolved not later than:

(i) twenty-four (24) hours from the submission of the request for urgent and expedited requests; and

(ii) forty-eight (48) hours for all other requests;

(B) be reviewed and completed by a physician licensed under IC 25-22.5 with:

(i) specialty experience in the primary diagnosis for which the prior authorization is requested;

(ii) demonstrated experience in treating aged or disabled individuals; and

(iii) knowledge of long term services and supports provider operations;

(C) include a requirement that failure to render a prior authorization determination in the time set forth in clause (A) deems the prior authorization approved without retroactive denial, additional documentation requests, or payment denial except as may be required to:

(i) conform with consumer retroactive loss of eligibility or disenrollment;

(ii) address criminal activity or fraud; or

(iii) address waste and abuse investigations promulgated by the federal government, state government, or a law enforcement agency; and

(D) may not be denied for a member of the covered population who is in need of:

(i) hospital services, as determined by the individual's primary care provider;

(ii) nursing facility services when the member chooses nursing facility services and meets the level of care criteria determined by the office of the secretary under 405 IAC 1-3, or a successor law or regulation; or

(iii) home and community based services when the covered population chooses home and community based services and meets the level of care criteria determined by the office of the secretary for home and community based services.

(15) Requires compliance with IC 12-15-12 concerning the coverage of emergency services.

(16) Specifies that utilization management staff and managers:

(A) meet minimum qualifications, including:

(i) being licensed as a registered nurse under IC 25-23;

and

(ii) having at least two (2) years experience in providing utilization management services or other comparable clinical management services for older adults;

(B) are based in Indiana and available twenty-four (24) hours a day through telephone or other means; and

(C) have access to case management and medical information systems necessary to facilitate continuity of care to work with the office of the secretary and other agencies on resolving urgent matters impacting recipients, including:

(i) public emergencies;

(ii) fires; or

(iii) severe care deficiencies.

(17) Prohibits requiring any health care provider to exclusively contract with an entity.

(18) Specifies reimbursement for an entity in an integrated care model to comply with:

(A) 42 CFR 438.206(b)(4) concerning out of network provider access;

(B) the applicable network adequacy requirements; and

(C) 42 CFR 438.206(b)(5) concerning cost sharing for out of network provider access;

at no additional cost to the recipient.

(19) Requires that all authorized and routine care provided by an out of network provider must be covered and reimbursed at a rate that is at least one hundred percent (100%) of the Medicaid fee for service rate unless a negotiated rate has been agreed upon by all parties. However, an out of network provider may be subject to prior authorization requirements for nonself-referral or nonemergency services.

(20) Specifies that network adequacy at least meet the requirements of the current guidance from the Centers for Medicare and Medicaid Services and that are applicable to organizations that participate in Medicare Advantage plans.

(21) Specify that the covered population and their designated representatives be provided the following:

(A) Options counseling concerning the full continuum of services, including caregiver assessment, training, and supports, available to the recipient either before or after eligibility is determined.

(B) A beneficiary support system to assist recipients in

accessing services and in understanding and exercising their rights under state and federal law, regulations, and policies including those emanating from the contract between the risk based managed care plan and the office and the 1915(b) and 1915(c) waiver applications to the Centers for Medicare and Medicaid Services.

(C) A choice of at least three (3) entities and individualized choice counseling that includes information concerning whether the entity's network includes the providers with whom the recipient has an established patient relationship.

(22) Prohibit the covered population from having to travel more than twenty (20) minutes in an urban area and sixty (60) minutes in a rural area to a service from the member's residence to access services, as measured by public transportation where public transportation is available.

(23) Include continuity of care protections that provide at least ninety (90) days after the start of the program during which the covered population must be provided the same services and same amount, duration, and scope of those services as the recipient was receiving before managed care enrollment. After the start of the program, continuity of care protections for new recipients in the covered population to a managed care program must be in place for at least sixty (60) days to prevent against disruption in service delivery.

(24) Include any additional provisions established by the office of the secretary in collaboration with consumer and provider stakeholders.

(i) The office of the secretary shall determine all eligibility requirements and level of care criteria for a program described in this section and may not contract out or otherwise delegate these requirements. In determining the eligibility requirements and the level of care criteria under this subsection, the office of the secretary shall consider input from stakeholders and providers engaged in providing nursing facility care and long term services and supports.

(j) The office of the secretary shall determine the base reimbursement rate structure, methodology, and reimbursement rates that may be paid to a provider for the services performed in a program described in this section. The reimbursement rates must be sufficient to provide an adequate number of providers to provide home and community based services under this section. An entity that has contracted with the office of the secretary to operate

a program described in this section may not pay less than the reimbursement rates established by the office of the secretary.

(k) An entity shall contract with any provider that is:

(1) licensed under state law;

(2) for a nursing facility, certified by the United States Department of Health and Human Services to provide services under the Medicaid or Medicare program; and

(3) willing to contract with the entity to provide the services;

under the same terms and conditions that are offered by the entity to any other participating provider that has contracted with the entity to provide that service under any policy, contract, or plan for the risk based managed care program described in this section. The terms and conditions for the services must set forth the minimum reimbursement rates established by the office of the secretary under subsection (j).

(l) Except as set forth in subsections (m) and (n), an entity described in this section may not delegate or subcontract to third parties any function concerning:

(1) provider contracting;

(2) credentialing;

(3) recipient appeals;

(4) claims processing;

(5) utilization management;

(6) pharmacy benefit management; and

(7) prior authorization.

(m) If an entity determines to delegate or subcontract a function set forth in subsection (l), the entity must provide at least sixty (60) days written notice to the office of the secretary that includes the following:

(1) A written plan that specifies how each subcontractor will fulfill each of the delegated or contracted services.

(2) Information concerning continuity of services during the transition to the delegated or subcontracted entity.

The office of the secretary must approve or deny any delegation or subcontract requested under this subsection, and only a delegation or subcontract approved by the office of the secretary may go into effect.

(n) Any change or amendment to the delegation or subcontract previously granted by the office of the secretary under subsection (m) must be submitted in writing to the office of the secretary at least sixty (60) days before the requested implementation date with sufficient written detail concerning the amendment that specifies

how the delegated or subcontracted services will be fulfilled. The office of the secretary must approve or deny the requested amendment and only an approved change or amendment may be implemented.

(o) The office of the secretary shall develop and implement clinical and quality of life measures that apply to all health care providers serving the covered population.

(p) Not later than July 1, 2028, the office of the secretary shall allow a provider owned and operated entity that has at least a fifty-one percent (51%) ownership interest that is held by a health care provider that:

(1) is a licensed provider in Indiana; and

(2) certified as an Indiana Medicaid provider;

to apply to be part of the risk based managed care program established by IC 12-15-13-1.8(c).

SECTION 14. IC 12-15-5-17.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 17.8. (a) This section applies to a risk based managed care program established by IC 12-15-1.3-1.8(c).**

(b) On a monthly basis, an entity shall provide a report to the office of the secretary documenting specific claim types that were denied the previous month at a rate of at least five percent (5%). The office of the secretary shall post the reports on the office of the secretary's website.

(c) The office of the secretary may audit claims or any other data collected by an entity for the covered population. If an entity denies at least ten percent (10%) of claims submitted by a provider in a billing period, the office of the secretary shall audit the entity and the denied claims to ensure the appropriateness of the denials.

(d) The office of the secretary shall make the findings of an audit under this section available to the public on the office of the secretary's website not later than one (1) week after completing the audit. The office of the secretary shall notify providers participating in the program described in subsection (a) of the availability of the audits when posted on the website.

(e) At least on an annual basis, the office of the secretary shall conduct external medical reviews of prior authorization denials and claim denials by an entity.

SECTION 15. IC 12-15-5-17.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 17.9. (a) If an entity:**

(1) fails to comply with any requirements in this chapter; or

(2) violates the contract entered into between the entity and the office of the secretary concerning a risk based managed care program established by IC 12-15-1.3-1.8(c);

the office of the secretary may impose an administrative action described in subsection (b).

(b) The office of the secretary may impose any of the following on an entity for a violation described in subsection (a):

(1) A notice of concern.

(2) A notice of cure.

(3) A corrective action plan.

(4) Sanctions.

(5) Any other action the office of the secretary deems appropriate.

An action under this subsection is subject to administrative review in accordance with IC 4-21.5.

SECTION 16. IC 12-15-13-1.8, AS ADDED BY P.L.131-2024, SECTION 10 AND P.L.136-2024, SECTION 38 AND P.L.17-2024, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1.8. (a) As used in this section, "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (b).

(b) An individual is a 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) An assisted living specific Medicaid waiver.

~~(iii)~~ **(iv)** The state Medicaid plan.

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

~~(d) The office of Medicaid policy and planning and the managed care organizations that intend to participate in the risk based managed care program established under subsection (c) shall conduct a claims submission testing period before the risk based managed care program~~

~~is implemented under subsection (c).~~

~~(c)~~ **(d)** The office of Medicaid policy and planning shall convene a workgroup for purposes of this section. The members of the workgroup shall consist of the fiscal officer of the office of Medicaid policy and planning, representatives of managed care organizations that intend to participate in the risk based managed care program established under subsection (c) who are appointed by the director, and provider representatives appointed by the director. The workgroup shall do the following:

(1) Develop a uniform billing format to be used by the managed care organizations participating in the risk based managed care program established under subsection (c).

~~(2) Seek and receive feedback on the claims submission testing period conducted under subsection (d).~~

~~(3)~~ **(2)** Advise the office of Medicaid policy and planning on claim submission education and training needs of providers participating in the risk based managed care program established under subsection (c).

~~(4) Develop a policy for defining "claims submitted appropriately" for the purposes of subsection (g)(1) and (g)(2).~~

(3) Develop policies to improve claims submission and claims processing.

(4) Advise the office of Medicaid policy and planning on claims submission issues.

(5) Advise the office of Medicaid policy and planning on improving the risk based managed care program established under subsection (c).

(e) Beginning July 1, 2025, the office of the secretary shall require that all claims submitted for services provided to a recipient under the risk based managed care program established by subsection (c) be submitted to the single entity that has contracted with the office of the secretary as of January 1, 2025, for receiving and processing claims under this section. The single entity shall process claims submitted under this section in accordance with this chapter.

~~(f) Subsections (g) through (k) apply during the first two hundred ten (210) days after the risk based managed care program for the covered population is implemented under subsection (c).~~

~~(g) The office of Medicaid policy and planning shall establish a temporary emergency financial assistance program for providers that experience financial emergencies due to claims payment issues while participating in the risk based managed care program established under~~

~~subsection (c). For purposes of the program established under this subsection, a financial emergency exists:~~

~~(1) when the rate of denial of claims submitted in one (1) billing period by the provider to a managed care organization exceeds fifteen percent (15%) of claims submitted appropriately by the provider to the managed care organization under the risk based managed care program;~~

~~(2) when the provider, twenty-one (21) days after appropriately submitting claims to a managed care organization under the risk based managed care program, has not received payment for at least twenty-five thousand dollars ($25,000) in aggregate claims from the managed care organization;~~

~~(3) when, in the determination of the director, the claim submission system of a managed care organization with which the provider is contracted under the risk based managed care program experiences failure or overload; or~~

~~(4) upon the occurrence of other circumstances that, in the determination of the director, constitute a financial emergency for a provider.~~

~~(h) To be eligible for a payment of temporary emergency financial assistance under the program established under subsection (g), a provider:~~

~~(1) must have participated in the claims submission testing period conducted under subsection (d) for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c); and~~

~~(2) must submit to the office of Medicaid policy and planning a written request that includes all of the following:~~

~~(A) Documentation providing evidence of the provider's financial need for emergency assistance.~~

~~(B) Evidence that the provider's billing staff participated in claims submission education and training offered through the risk based managed care program established under subsection (c).~~

~~(C) Evidence that the provider participated in the claims submission testing period conducted under subsection (d) for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c).~~

~~(D) Evidence of a consistent effort by the provider to submit claims in accordance with the uniform billing requirements~~

developed under subsection (e)(1).

(i) The office of Medicaid policy and planning:

(1) shall determine whether a provider is experiencing a financial emergency based upon the provider's submission of a written request that meets the requirements of subsection (h)(2); and

(2) shall make a determination whether a provider is experiencing a financial emergency not more than seven (7) calendar days after it receives a written request submitted by a provider under subsection (h)(2).

(j) If the office of Medicaid policy and planning determines that a provider is experiencing a financial emergency for purposes of the program established under subsection (g), it shall direct each managed care organization with which the provider is contracted under the risk based managed care program established under subsection (c) to provide a temporary emergency assistance payment to the provider. A managed care organization directed to provide a temporary emergency assistance payment to a provider under this subsection shall provide the payment in not more than seven (7) calendar days after the office directs the managed care organization to provide the payment. The amount of the temporary emergency assistance payment that a managed care organization shall make to a provider under this subsection is equal to seventy-five percent (75%) of the monthly average of the provider's long-term services and supports Medicaid claims for the six (6) month period immediately preceding the implementation of the risk based managed care program under subsection (c), adjusted in proportion to the ratio of the managed care organization's covered population membership to the total covered population membership of the risk based managed care program established under subsection (c).

(k) Upon issuing any payment of a temporary emergency assistance to a provider under subsection (j), a managed care organization shall set up a receivable to reconcile the temporary emergency assistance funds with actual claims payment amounts. A managed care organization shall reconcile the temporary emergency assistance payment funds with actual claims payment amounts on the first day of the month that is more than thirty-one (31) days after the managed care organization issues the temporary emergency assistance funds to the provider. If a temporary emergency assistance payment is issued to a provider, managed care organizations are still required to meet contract obligations for reviewing and paying claims, specifically claims that total a payment in excess of the temporary emergency assistance payment reconciliation. However, if a managed care organization fails to comply with a directive of the office of Medicaid policy and

~~planning under subsection (j) to provide a temporary emergency assistance payment to a provider; the failure of the managed care organization:~~

~~(1) is a violation of the claim processing requirements of the managed care organization's contract; and~~

~~(2) makes the managed care organization subject to the penalties set forth in the contract, including payment of interest on the amount of the unpaid temporary emergency assistance at the rate set forth in IC 12-15-21-3(7)(A).~~