HB 1352

Telehealth services. Provides (beginning January 1, 2024) that the office of Medicaid policy and planning may not require: (1) a provider that is licensed, certified, registered, or authorized with the appropriate state agency or board and exclusively offers telehealth services to maintain a physical address or site in Indiana to be eligible for enrollment as a Medicaid provider; or (2) a telehealth provider group with providers that are licensed, certified, registered, or authorized with the appropriate state agency or board to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

HB 1513

Repeals Medicaid copayment provisions that: (1) require the office of the secretary of family and social services (office) to apply a copayment for certain Medicaid services; (2) require a recipient to make a copayment upon the receipt of services and for a provider not to voluntarily waive a copayment; (3) set forth exemptions from copayment requirements; and (4) require the provider to charge the maximum allowable copayment. Allows for an enrollment fee, a premium, a copayment, or a similar charge to be imposed as a condition of an individual’s eligibility for the healthy Indiana plan and the children’s health insurance program. Removes a prohibition on the office from: (1) requiring certain providers to submit non-Medicaid revenue information in the provider’s annual historical financial report; and (2) only requesting balance sheets from

certain providers that apply directly to the provider’s facility.

HB 1583

Health plans and ambulance service providers. Amends the law requiring a health plan operator to fairly negotiate rates and terms with any ambulance service provider willing to become a participating provider with respect to the operator’s health plan. Provides that, if negotiations between an ambulance service provider and a health plan operator that occur after June 30, 2022, do not result in the ambulance service provider becoming a participating provider with respect to the health plan, each party, beginning May 1, 2023, is required to provide to the department of insurance (department) a written notice: (1) reporting the unsuccessful conclusion of the negotiations; and (2) stating the points that were discussed in the negotiations but on which agreement was not reached. Requires the department, not later than May 1, 2024, to submit to the legislative council and the interim study committee on public health, behavioral health, and human services a report summarizing the written notices that the department has received from ambulance service providers and health plan operators

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HB 1602

Medicaid reimbursement rates. Specifies Medicaid reimbursement rates for specified services (physician services, nonemergency medical transportation, and dental services) in the Medicaid risk based managed care program and the Medicaid fee for service program. The office shall set a reimbursement rate that is comparable to the federal Medicare reimbursement rate for the services or one hundred thirty percent (130%) of the Medicaid reimbursement rate in place on January 1, 2023, for a service that does not have a Medicare rate. The office shall adjust the rates described in subsection (b) on a biennial basis to reflect average growth in federal Medicare reimbursement rates.

SB 357

Health care. Authorizes the Indiana department of health (state department) to assess a public health assessment fee (fee) upon nonprofit hospitals (excluding county hospitals). Provides that the fee shall be imposed on total hospital net patient revenues at a rate determined by the state department after review by the budget committee. Requires the rate to be formulated to result in total fee revenue generation of: (1) $120,000,000 in state fiscal year 2024; and (2) $230,000,000 in state fiscal year 2025, and each state fiscal year thereafter. Establishes the local public health department fund (fund). Requires the revenue from the fee to be deposited in the fund. Provides that the fund is administered by the state department. Specifies the purposes for which money in the fund may be used

SB 400

Health care matters. Requires the state employee health plan, policies of accident and sickness insurance, and health maintenance organization contracts to provide coverage for wearable cardioverter defibrillators. Specifies requirements for credentialing a provider for the Medicaid program, an accident and sickness insurance policy, and a health maintenance organization contract. Establishes a provisional credential until a decision is made on a provider's credentialing application and allows for retroactive reimbursement. Provides that a hospital's quality assessment and improvement program must include a process for determining and reporting the occurrence of serious reportable events. Provides that the medical staff of a hospital may make recommendations on the granting of clinical privileges and the appointment or reappointment of an applicant to the governing board for a period not to exceed 36 months. Requires a hospital with an emergency department to have at least one physician on site and on duty who is responsible for the emergency department. Requires the legislative services agency to conduct an analysis of licensing fees and provide a report to the budget committee. Allows the commissioner of the department of insurance (commissioner) to issue an order to discontinue a violation of a law (current law specifies orders or rules). Requires the commissioner to consider specified information before approving or disapproving a premium rate increase. Requires a domestic stock insurer to file specified information with the department of insurance. Prohibits the state employee health plan from requiring prior authorization for certain specified services. Changes prior authorization time requirements for urgent care

situations. Adds an employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 and a state employee health plan to the definition of “health payer” for the purposes of the all payer claims data base (data base). Allows the department of insurance to adopt rules on certain matters concerning the data base. Requires a health plan to post certain information on the health plan’s website. Prohibits an insurer and a health maintenance organization from altering a CPT code for a claim or paying for a CPT code of lesser monetary value unless: (1) the CPT code submitted is not in accordance with certain guidelines and rules, or the terms and conditions of a participating provider’s agreement or contract with the insurer or health maintenance organization; or (2) the medical record of the claim has been reviewed by an employee or contractor of the insurer or health maintenance organization. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule at specified times. Urges the study by an interim committee of: (1) prior authorization exemptions for certain health care providers; and (2) whether Indiana should adopt an interstate mobility of occupational licensing. Requires a collaborating physician or physician designee to review certain patient encounters performed by a physician assistant within 14 business days. Requires a health plan to offer a health care provider the option to request a peer to peer review by a clinical peer concerning an adverse determination on a prior authorization request.

SB 457

Medicaid waiver reimbursement for direct care. Requires the office of the secretary of family and social services to apply for an amendment to specified Medicaid waivers to increase reimbursement rates for services provided by direct care staff. Sets forth the manner in which the increased reimbursement may be expended and sets requirements on authorized service providers as a condition to retaining the additional reimbursement.

SB 8

Prescription drug rebates and pricing. Requires a pharmacy benefit manager to provide a report to the department of insurance at least every six months. Provides that the report must include the: (1) overall aggregate amount charged to a health plan for all pharmaceutical claims processed by the pharmacy benefit manager; and (2) overall aggregate amount paid to pharmacies for claims processed by the pharmacy benefit manager. Requires that, for individual health insurance coverage, the defined cost sharing for a prescription drug be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 85% of all rebates in connection with the dispensing or administration of the prescription drug. Requires that, for group health insurance coverage, an insurer: (1) pass through to a plan sponsor 100% of all rebates concerning the dispensing or administration of prescription drugs to the covered individuals of the plan sponsor; (2) provide a plan sponsor, at the time of contracting,

the option of calculating defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by some or all of the rebates received concerning the dispensing or administration of the prescription drug; and (3) disclose specified information to the plan sponsor. Allows the department of insurance to enforce the provisions and impose a civil penalty

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HB 1610

Exemption from prior authorization requirements. Amends the law concerning the prior authorization of health care services by a health plan (which includes a policy of accident and sickness insurance, a health maintenance organization contract, and the Medicaid risk based managed care program). Provides that: (1) if a health plan, during a six month evaluation period, approves at least 90% of a health care provider’s requests for prior authorization for a particular type of health care service, the health plan may not require the health care provider to obtain prior authorization for that type of health care service for the entire duration of an exemption period of six calendar months immediately following the evaluation period; and (2) at the conclusion of the initial exemption period, the health plan shall continue granting consecutive exemption periods of six months to the health care provider unless the health plan rescinds the exemption. Provides that a health plan may rescind a health care provider’s exemption only on the basis of a determination by a physician that, in at least five and not more than 20 cases randomly selected for review, less than 90% of the health care services provided by the health care provider met

the health plan’s medical necessity criteria. Authorizes a health care provider that is notified of the rescission of its exemption to initiate a review of the rescission by an independent review panel. Requires the independent review panel to determine whether at least 90% of the health care services provided by the health care provider met the health plan’s medical necessity criteria. Requires a health plan to restore the health care provider’s exemption if the independent review panel’s determination is in favor of the health care provider. Requires the insurance commissioner to adopt rules.

SB 196

Healthy Indiana plan health care accounts. Repeals the health care account and cost sharing requirements of an individual for the healthy Indiana plan.