SENATE BILL No. 116

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Medicaid matters. Requires the office of the secretary of family and social services (office) to post information concerning the criteria for being determined to be medically frail and examples of notices on the office's website. Specifies requirements for a notice of Medicaid termination. Requires the office and managed care organizations to review all timely submitted information in a Medicaid redetermination before terminating coverage of a recipient. Requires a managed care organization to report information concerning: (1) claim denials under the Medicaid program on a quarterly basis; and (2) certain information on a monthly basis. Requires the office to post the reports on the office's website. Provides that the healthy Indiana plan includes at least 30 days of retroactive coverage.

Effective: July 1, 2026.

Yoder

December 9, 2025, read first time and referred to Committee on Health and Provider Services.

Introduced

Second Regular Session of the 124th General Assembly (2026)

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 2025 Regular Session of the General Assembly.

SENATE BILL No. 116

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

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

SECTION 1. IC 12-15-1-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 26. The office of the secretary shall post the following information on the office of the secretary's website:**

(1) The criteria used in determining whether an individual may be considered medically frail under this article.

(2) Examples of the notices sent to Medicaid applicants and recipients and an explanation of the meaning and reasoning of the notice.

SECTION 2. IC 12-15-1-27 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 27. (a) 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 this article.

(3) A person that has contracted with:

(A) the office of the secretary of family and social services; or

(B) a managed care organization described in subdivision (2).

(b) The office shall meet the following requirements concerning a notice of termination of Medicaid services for a recipient:

(1) The notice must be provided to the recipient:

(A) at least twenty-one (21) days before the termination of services is to occur; or

(B) if the time frame set forth in clause (A) would result in the loss of federal financial participation, in the maximum time that would allow for federal financial participation for the services.

(2) The notice may not include information or references to conditions or requirements of the program that are not being implemented or enforced by the office.

SECTION 3. IC 12-15-1-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 28. (a) 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 this article.

(3) A person that has contracted with:

(A) the office of the secretary of family and social services; or

(B) a managed care organization described in subdivision (2).

(b) In conducting an eligibility redetermination of a recipient, the office may not terminate coverage for a recipient until the office has reviewed all relevant information timely submitted by the recipient for the redetermination.

SECTION 4. IC 12-15-12-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 25. (a) On a quarterly basis, a managed care organization shall provide a report to the office of the secretary concerning the denial of claims. The report must specify denials by program and by claim type for the previous quarter.**

(b) The office of the secretary shall post the reports submitted under subsection (a) to the office of the secretary's website.

SECTION 5. IC 12-15-12-26 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 26. (a) A managed care organization shall report on a monthly basis the following information for the previous month to the office of the secretary by Medicaid program:**

(1) The number of Medicaid recipients covered by the managed care organization.

(2) The number of Medicaid recipients removed and each reason for the removal.

(3) The number of Medicaid recipients reinstated.

(4) The number of calls to the managed care organization's help line.

(5) The average wait time per call to the managed care organization's help line.

(b) The office of the secretary shall post the reports submitted under subsection (a) to the office of the secretary's website.

SECTION 6. IC 12-15-12.7-4, AS ADDED BY P.L.174-2025, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) **In addition to the reporting requirements under IC 12-15-12-25 and** on a monthly basis, a managed care organization shall provide a report to the office of the secretary concerning the denial of claims. The report must specify denials by claim type for the previous month if the denials for the claim type total at least five percent (5%).

(b) The office of the secretary shall post the reports submitted under subsection (a) to the office of the secretary's website.

SECTION 7. IC 12-15-44.5-3.5, AS AMENDED BY P.L.180-2022(ss), SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(15) Donated breast milk that meets requirements developed by the office of Medicaid policy and planning.

(16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(17) Retroactive coverage of at least thirty (30) days.

(b) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(c) The plan may provide vision services and dental services only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.

(d) The benefit package offered in the plan:

(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and

(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars ($500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment

requirements of the plan.

(h) The office shall apply to the United States Department of Health and Human Services for any amendment to the waiver necessary to implement the providing of the services or supplies described in subsection (a)(15). This subsection expires July 1, 2024.