Reprinted
February 24, 2026

ENGROSSED
SENATE BILL No. 275

DIGEST OF SB 275 (Updated February 23, 2026 7:00 pm - DI 147)

Citations Affected: IC 12-8; IC 12-11; IC 12-15; IC 29-1.

Synopsis: FSSA fiscal matters. Amends the duties of the office of the secretary of family and social services (office) concerning home and community based services waivers (waiver). Requires: (1) a provider of waiver services to provide certain documentation to a waiver recipient; (2) a waiver recipient to review the documentation and report errors or inconsistencies; and (3) the recipient's case manager to provide assistance to the recipient in reviewing the documentation and reporting any errors or inconsistencies. Establishes a time frame in which the bureau of disabilities services must review and approve or deny requests for an increase in service units provided to certain individuals with a disability. Creates an exemption for presumptive
(Continued next page)

Effective: Upon passage; July 1, 2026.

Mishler, Garten, Randolph Lonnie M
(HOUSE SPONSORS — LOPEZ, JORDAN)

January 8, 2026, read first time and referred to Committee on Appropriations.
January 20, 2026, amended, reported favorably — Do Pass.
January 28, 2026, read second time, amended, ordered engrossed.
January 29, 2026, engrossed. Read third time, passed. Yeas 39, nays 9.

HOUSE ACTION
February 2, 2026, read first time and referred to Committee on Ways and Means.
February 18, 2026, amended, reported — Do Pass.
February 23, 2026, read second time, amended, ordered engrossed.

eligibility standards. Provides reimbursement exemptions under certain Medicaid programs when operating under a value based health care reimbursement agreement. Provides that a provision prohibiting the office from reducing reimbursement for home health services expires June 30, 2027. Requires the office to collaborate with certain entities to develop a new reimbursement methodology for home health services. Specifies that public notice of at least six months (rather than one year) must be provided before a health facility service reimbursement that results in a reduction in reimbursement may be changed. Provides that a claim by the estate recovery unit of the office of Medicaid policy and planning (estate recovery unit) is forever barred unless the estate recovery unit files a claim in the court in which the decedent's estate is being administered not later than nine months after the date of death of the decedent.

Reprinted
February 24, 2026

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.

ENGROSSED
SENATE BILL No. 275

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 12-8-1.6-4, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The office of the secretary has all powers necessary and convenient to administer a home and community based services waiver.

(b) The office of the secretary shall do the following:

(1) Administer money appropriated or allocated to the office of the secretary by the state, including money appropriated or allocated for a home and community based services waiver.

(2) Take any action necessary to implement a home and community based services waiver, including applying to the United States Department of Health and Human Services for approval to amend or renew the waiver, implement a new Medicaid waiver, or amend the Medicaid state plan.

(3) Ensure that a home and community based services waiver is subject to funding available to the office of the secretary.

(4) Ensure, in coordination with the budget agency, that the cost

of a home and community based services waiver does not exceed the total amount of funding available by the budget agency, including state and federal funds, for the Medicaid programs established to provide services under a home and community based services waiver.

(5) Establish and administer a program for a home and community based services waiver to provide an eligible individual with care that does not cost more than services provided to a similarly situated individual residing in an institution.

(6) Within the limits of available resources, provide service coordination services to individuals receiving services under a home and community based services waiver, including the development of an individual service plan that:

(A) addresses an individual's needs;

(B) identifies and considers family and community resources that are potentially available to meet the individual's needs; and

(C) is consistent with the person centered care approach for receiving services under a waiver.

(7) Monitor services provided by a provider that:

(A) provides services to an individual using funds provided by the office of the secretary or under the authority of the office of the secretary; or

(B) entered into one (1) or more provider agreements to provide services under a home and community based services waiver.

(8) Establish and administer a confidential complaint process for:

(A) an individual receiving; or

(B) a provider described in subdivision (7) providing;

services under a home and community based services waiver.

(9) Establish a procedure for documenting compliance with subdivision (6) in the individual service plan of an individual receiving services under a home and community based services waiver, which must include provider attestation that services delivered to a recipient align with the recipient's individual service plan.

(c) The office of the secretary may do the following:

(1) At the office's discretion, delegate any of its authority under this chapter to any division or office within the office of the secretary.

(2) Issue administrative orders under IC 4-21.5-3-6 regarding the

provision of a home and community based services waiver.

SECTION 2. IC 12-8-1.6-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) An individual receiving services under a home and community based services waiver shall do the following:**

(1) Review any record or statement the individual receives under IC 12-15-11-11.

(2) Not later than forty-five (45) days after receiving a record or statement described in subdivision (1), report to the office of the secretary or other appropriate entity any:

(A) error in the record or statement; or

(B) inconsistency between the record or statement and services received.

(b) Upon request, the case manager of a recipient described in subsection (a) shall do the following:

(1) Assist the recipient in reviewing the recipient's record or statement described in subsection (a)(1).

(2) Assist in reporting and resolving any error or inconsistency under subsection (a).

SECTION 3. IC 12-11-2.1-3, AS AMENDED BY P.L.99-2007, SECTION 78, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. **(a)** All services provided to an individual must be provided under the individual service plan of the individual with a disability. To the extent that services described in IC 12-11-1.1-1(e) are available and meet the individual's needs, services provided to an individual shall be provided in the least restrictive environment possible.

(b) Pursuant to the applicable home and community based services waiver, a request to increase service units on an individual's approved service plan must be submitted to the bureau for review and approval or denial not later than forty-five (45) calendar days from the first day of the qualifying event, as prescribed by the bureau.

SECTION 4. IC 12-15-4-1.5, AS ADDED BY P.L.126-2025, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1.5. (a) **This section does not apply to a presumptive eligibility determination for an involuntary detainment or commitment under a statute specified in IC 12-26-1-1.**

(b) The office of the secretary shall establish the following:

(1) Performance standards for hospitals to use in making

presumptive eligibility determinations.

(2) An appeals process for a hospital that disputes a determination that a presumptive eligibility standard was violated.

The office of the secretary shall limit presumptive eligibility determination to qualified hospitals.

~~(b)~~ **(c)** A hospital shall do the following when making a presumptive eligibility determination:

(1) Notify the office of the secretary of each presumptive eligibility determination not later than five (5) business days after the date of the determination.

(2) Assist individuals whom the hospital determines are presumptively eligible with completing and submitting a full Medicaid application.

(3) Notify the applicant in writing and on all relevant forms with plain language and large print that if the applicant:

(A) does not file a full Medicaid application with the office of the secretary before the last day of the following month, presumptive eligibility will end on that last day; and

(B) files a full Medicaid application with the office of the secretary before the last day of the following month, presumptive eligibility will continue until an eligibility determination is made concerning the application.

~~(c)~~ **(d)** The office of the secretary shall use the following performance standards to establish and ensure accurate presumptive eligibility determinations by a qualified hospital:

(1) Determine whether each presumptive eligibility determination received from the hospital complied with the time requirement set forth in subsection ~~(b)(1).~~ **(c)(1).**

(2) Determine whether the office of the secretary received before the expiration of each presumptive eligibility period the full application from the individual determined by the hospital to be presumptively eligible.

(3) Determine whether each applicant who was determined by the hospital to be presumptively eligible was determined to be eligible for Medicaid after the full application was received.

~~(d)~~ **(e)** Each single violation by a hospital of any of the performance standards under subsection ~~(c)~~ **(d)** counts as one (1) violation for the presumptive eligibility determination. Each subsequent violation of a performance standard is an additional violation for purposes of this section.

~~(e)~~ **(f)** For the first violation of a presumptive eligibility standard under this section that a hospital receives in a calendar year, the office

of the secretary shall notify the hospital in writing not later than five (5) days after the determination of a violation is made. The notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) Notice that a second finding on noncompliance with a standard will result in a requirement that the hospital's applicable staff participate in mandatory training on hospital presumptive eligibility rules and standards that is performed by the office of the secretary.

(3) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

~~(f)~~ **(g)** If the office of the secretary determines that a hospital has failed to meet any of the presumptive eligibility standards under this section in any presumptive eligibility determination by the hospital for a second time within a twelve (12) month period of a first violation, the office of the secretary shall notify the hospital in writing not later than five (5) days after the determination that a second violation has occurred. The written notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) Notice that the hospital's applicable staff must participate in mandatory training on hospital presumptive eligibility rules and standards that is performed by the office of the secretary, and information concerning the date, time, and location of the training by the office.

(3) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

(4) Notice that a third violation by the hospital of a presumptive eligibility standard within a twelve (12) month period from the second violation will result in the hospital no longer being qualified to make presumptive eligibility determinations.

If a hospital appeals a finding of a violation of presumptive eligibility standards described in this subsection, the hospital must provide clear and convincing evidence during the appeals process that the standard was met by the hospital.

~~(g)~~ **(h)** If the office of the secretary determines that a hospital has failed to meet any of the presumptive eligibility standards under this section in any presumptive eligibility determination by the hospital for a third time within a twelve (12) month period of the second violation

by the hospital, the office of the secretary shall notify the hospital in writing not later than five (5) days from a determination that a presumptive eligibility standard was violated by the hospital for the third time. The written notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

(3) Notice that, effective immediately from receipt of the notice, the hospital is no longer qualified to make presumptive eligibility determinations for the Medicaid program.

~~(h)~~ **(i)** If a hospital appeals a finding of a violation of presumptive eligibility standards described in subsection ~~(g),~~ **(h),** the hospital must provide clear and convincing evidence during the appeals process that the standard was met by the hospital.

SECTION 5. IC 12-15-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 11. A provider of services under a home and community based services waiver (as defined in IC 12-8-1.6-2) shall do the following:**

(1) Upon request by an individual receiving services under the waiver or the individual's legal guardian, but not more than once per calendar quarter, provide to the individual or the individual's legal guardian the provider's accounting records of service delivery for the recipient.

(2) Upon request, but not more than twice per calendar year, provide to an individual receiving services under the waiver an itemized statement of the services billed by the provider for the recipient. The statement must be in plain language.

SECTION 6. IC 12-15-12.7-2, AS ADDED BY P.L.174-2025, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. (a) 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 rendered under the program.

(b) **This subsection does not apply to a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15) entered into between a managed care organization and a provider.** A managed care organization may not pay a provider less than the reimbursement rates established by the office of the secretary under this section.

SECTION 7. IC 12-15-14-8, AS AMENDED BY P.L.241-2023, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) The office may implement an end of therapy reclassification methodology in the RUG-IV, 48-Group model or its successor for payment of nursing facility services.

(b) Before the office changes a health facility service reimbursement that results in a reduction in reimbursement, the office shall provide public notice of at least ~~one (1) year.~~ **six (6) months.** The public notice under this subsection:

(1) is not a rulemaking action or part of the administrative rulemaking process under IC 4-22; and

(2) must include the fiscal impact of the proposed reimbursement change.

SECTION 8. IC 12-15-34-14.5, AS ADDED BY P.L.217-2017, SECTION 79, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14.5. (a) This section is effective beginning July 1, 2017.

(b) The office of the secretary may not reduce reimbursement for home health services.

(c) 405 IAC 1-4.2-4(l) and any successor rule concerning reducing home health services reimbursement are void and may not be renewed or otherwise implemented.

(d) This section expires June 30, 2027.

SECTION 9. IC 12-15-34-14.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 14.6. (a) The office of the secretary shall, in partnership and collaboration with a home health services association and providers of home health services, develop a new reimbursement methodology for home health services and, not later than November 30, 2026, submit the new reimbursement methodology for home health services to the legislative council in an electronic format under IC 5-14-6.**

(b) This section expires December 31, 2027.

SECTION 10. IC 12-15-44.5-5, AS AMENDED BY P.L.201-2023, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. (a) A managed care organization that contracts with the office to provide health coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall, **except in the case of a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15)**

entered into between the managed care organization and a provider, reimburse providers at a rate that is not less than the rate established by the secretary; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) A managed care organization that contracts with the office to provide health coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 11. IC 29-1-14-1, AS AMENDED BY P.L.99-2024, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) Except as provided in IC 29-1-7-7, all claims against a decedent's estate, other than expenses of administration and claims of the United States, the state, or a subdivision of the state, whether due or to become due, absolute or contingent, liquidated or unliquidated, founded on contract or otherwise, shall be forever barred against the estate, the personal representative, the heirs, devisees, and legatees of the decedent, unless filed with the court in which such estate is being administered within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(b) No claim shall be allowed which was barred by any statute of limitations at the time of decedent's death.

(c) No claim shall be barred by the statute of limitations which was not barred at the time of the decedent's death, if the claim shall be filed within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(d) All claims barrable under subsection (a) shall be barred if not filed within nine (9) months after the death of the decedent.

(e) Nothing in this section shall affect or prevent any action or proceeding to enforce any mortgage, pledge, or other lien upon property of the estate.

(f) Nothing in this section shall affect or prevent the enforcement of a claim for injury to person or damage to property arising out of negligence against the estate of a deceased tort feasor within the period of the statute of limitations provided for the tort action. A tort claim against the estate of the tort feasor may be opened or reopened and suit filed against the special representative of the estate within the period of the statute of limitations of the tort. Any recovery against the tort feasor's estate shall not affect any interest in the assets of the estate unless the suit was filed within the time allowed for filing claims against the estate. The rules of pleading and procedure in such cases shall be the same as apply in ordinary civil actions.

(g) A claim by the unit against a decedent's estate is forever barred unless:

(1) the unit files a claim in the court in which the decedent's estate is being administered; or

(2) the unit opens an estate for the decedent and files a claim against the decedent in the estate;

not later than ~~one hundred twenty (120) days~~ **nine (9) months** after the date of death of the decedent.

SECTION 12. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 275, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 4, delete lines 32 through 39, begin a new paragraph and insert:

"(g) A claim by the unit against a decedent's estate is forever barred unless

~~(1)~~ the unit files a claim in the court in which the decedent's estate is being administered ~~or~~

~~(2) the unit opens an estate for the decedent and files a claim against the decedent in the estate;~~

not later than ~~one hundred twenty (120) days~~ **one hundred eighty (180) days** after the ~~date of death of the decedent.~~ **estate has been opened.**".

and when so amended that said bill do pass.

(Reference is to SB 275 as introduced.)

MISHLER, Chairperson

Committee Vote: Yeas 9, Nays 2.

SENATE MOTION

Mr. President: I move that Senate Bill 275 be amended to read as follows:

Page 4, delete lines 32 through 40, begin a new paragraph and insert:

"(g) A claim by the unit against a decedent's estate is forever barred unless:

(1) the unit files a claim in the court in which the decedent's estate is being administered; or

(2) the unit opens an estate for the decedent and files a claim against the decedent in the estate;

not later than ~~one hundred twenty (120)~~ **three hundred sixty-five (365)** days after the date of death of the decedent.".

(Reference is to SB 275 as printed January 21, 2026.)

MISHLER

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Senate Bill 275, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 15 through 17.

Delete page 2.

Page 3, delete lines 1 through 9, begin a new paragraph and insert:

"SECTION 2. IC 12-15-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 11. A provider of services under a home and community based services waiver (as defined in IC 12-8-1.6-2) shall do the following:**

(1) Upon request by an individual receiving services under the waiver or the individual's legal guardian, but not more than once per calendar quarter, provide to the individual or the individual's legal guardian the provider's accounting records of service delivery for the recipient.

(2) Upon request, but not more than twice per calendar year, provide to an individual receiving services under the waiver an itemized statement of the services billed by the provider for the recipient. The statement must be in plain language.".

Page 3, delete lines 23 through 30, begin a new paragraph and insert:

"SECTION 4. IC 12-15-34-14.5, AS ADDED BY P.L.217-2017, SECTION 79, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14.5. (a) This section is effective beginning July 1, 2017.

(b) The office of the secretary may not reduce reimbursement for home health services.

(c) 405 IAC 1-4.2-4(l) and any successor rule concerning reducing home health services reimbursement are void and may not be renewed or otherwise implemented.

(d) This section expires June 30, 2027.

SECTION 5. IC 12-15-34-14.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 14.6. (a) The office of the secretary shall, in partnership and collaboration with a home health services association and providers of home health services, develop a new reimbursement methodology for home health services and, not later than November 30, 2026, submit the new reimbursement methodology for home health services to the legislative council in an electronic format under IC 5-14-6.**

(b) This section expires December 31, 2027.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 275 as reprinted January 29, 2026.)

THOMPSON

Committee Vote: yeas 24, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 275 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-8-1.6-4, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The office of the secretary has all powers necessary and convenient to administer a home and community based services waiver.

(b) The office of the secretary shall do the following:

(1) Administer money appropriated or allocated to the office of the secretary by the state, including money appropriated or allocated for a home and community based services waiver.

(2) Take any action necessary to implement a home and community based services waiver, including applying to the United States Department of Health and Human Services for approval to amend or renew the waiver, implement a new Medicaid waiver, or amend the Medicaid state plan.

(3) Ensure that a home and community based services waiver is

subject to funding available to the office of the secretary.

(4) Ensure, in coordination with the budget agency, that the cost of a home and community based services waiver does not exceed the total amount of funding available by the budget agency, including state and federal funds, for the Medicaid programs established to provide services under a home and community based services waiver.

(5) Establish and administer a program for a home and community based services waiver to provide an eligible individual with care that does not cost more than services provided to a similarly situated individual residing in an institution.

(6) Within the limits of available resources, provide service coordination services to individuals receiving services under a home and community based services waiver, including the development of an individual service plan that:

(A) addresses an individual's needs;

(B) identifies and considers family and community resources that are potentially available to meet the individual's needs; and

(C) is consistent with the person centered care approach for receiving services under a waiver.

(7) Monitor services provided by a provider that:

(A) provides services to an individual using funds provided by the office of the secretary or under the authority of the office of the secretary; or

(B) entered into one (1) or more provider agreements to provide services under a home and community based services waiver.

(8) Establish and administer a confidential complaint process for:

(A) an individual receiving; or

(B) a provider described in subdivision (7) providing;

services under a home and community based services waiver.

(9) Establish a procedure for documenting compliance with subdivision (6) in the individual service plan of an individual receiving services under a home and community based services waiver, which must include provider attestation that services delivered to a recipient align with the recipient's individual service plan.

(c) The office of the secretary may do the following:

(1) At the office's discretion, delegate any of its authority under this chapter to any division or office within the office of the

secretary.

(2) Issue administrative orders under IC 4-21.5-3-6 regarding the provision of a home and community based services waiver.

SECTION 2. IC 12-8-1.6-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) An individual receiving services under a home and community based services waiver shall do the following:**

(1) Review any record or statement the individual receives under IC 12-15-11-11.

(2) Not later than forty-five (45) days after receiving a record or statement described in subdivision (1), report to the office of the secretary or other appropriate entity any:

(A) error in the record or statement; or

(B) inconsistency between the record or statement and services received.

(b) Upon request, the case manager of a recipient described in subsection (a) shall do the following:

(1) Assist the recipient in reviewing the recipient's record or statement described in subsection (a)(1).

(2) Assist in reporting and resolving any error or inconsistency under subsection (a).".

Page 2, between lines 11 and 12, begin a new paragraph and insert:

"SECTION 5. IC 12-15-12.7-2, AS ADDED BY P.L.174-2025, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. (a) 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 rendered under the program.

(b) **This subsection does not apply to a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15) entered into between a managed care organization and a provider.** A managed care organization may not pay a provider less than the reimbursement rates established by the office of the secretary under this section.".

Page 3, between lines 2 and 3, begin a new paragraph and insert:

"SECTION 9. IC 12-15-44.5-5, AS AMENDED BY P.L.201-2023, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. (a) A managed care organization that contracts with the office to provide health coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall, **except in the case of a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15) entered into between the managed care organization and a provider,** reimburse providers at a rate that is not less than the rate established by the secretary; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) A managed care organization that contracts with the office to provide health coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 275 as printed February 18, 2026.)

LOPEZ

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 275 be amended to read as follows:

Page 4, line 10, delete "three hundred sixty-five".

Page 4, line 11, delete "(365)".

Page 4, line 11, strike "days" and insert "**nine (9) months**".

(Reference is to ESB 275 as printed February 18, 2026.)

MELTZER

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 275 be amended to read as follows:

Page 1, between lines 14 and 15, begin a new paragraph and insert:

"SECTION 2. IC 12-15-4-1.5, AS ADDED BY P.L.126-2025, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1.5. (a) **This section does not apply to a presumptive eligibility determination for an involuntary detainment or commitment under a statute specified in**

IC 12-26-1-1.

(b) The office of the secretary shall establish the following:

(1) Performance standards for hospitals to use in making presumptive eligibility determinations.

(2) An appeals process for a hospital that disputes a determination that a presumptive eligibility standard was violated.

The office of the secretary shall limit presumptive eligibility determination to qualified hospitals.

~~(b)~~ **(c)** A hospital shall do the following when making a presumptive eligibility determination:

(1) Notify the office of the secretary of each presumptive eligibility determination not later than five (5) business days after the date of the determination.

(2) Assist individuals whom the hospital determines are presumptively eligible with completing and submitting a full Medicaid application.

(3) Notify the applicant in writing and on all relevant forms with plain language and large print that if the applicant:

(A) does not file a full Medicaid application with the office of the secretary before the last day of the following month, presumptive eligibility will end on that last day; and

(B) files a full Medicaid application with the office of the secretary before the last day of the following month, presumptive eligibility will continue until an eligibility determination is made concerning the application.

~~(c)~~ **(d)** The office of the secretary shall use the following performance standards to establish and ensure accurate presumptive eligibility determinations by a qualified hospital:

(1) Determine whether each presumptive eligibility determination received from the hospital complied with the time requirement set forth in subsection ~~(b)(1).~~ **(c)(1).**

(2) Determine whether the office of the secretary received before the expiration of each presumptive eligibility period the full application from the individual determined by the hospital to be presumptively eligible.

(3) Determine whether each applicant who was determined by the hospital to be presumptively eligible was determined to be eligible for Medicaid after the full application was received.

~~(d)~~ **(e)** Each single violation by a hospital of any of the performance standards under subsection ~~(c)~~ **(d)** counts as one (1) violation for the presumptive eligibility determination. Each subsequent violation of a performance standard is an additional violation for purposes of this

section.

~~(e)~~ **(f)** For the first violation of a presumptive eligibility standard under this section that a hospital receives in a calendar year, the office of the secretary shall notify the hospital in writing not later than five (5) days after the determination of a violation is made. The notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) Notice that a second finding on noncompliance with a standard will result in a requirement that the hospital's applicable staff participate in mandatory training on hospital presumptive eligibility rules and standards that is performed by the office of the secretary.

(3) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

~~(f)~~ **(g)** If the office of the secretary determines that a hospital has failed to meet any of the presumptive eligibility standards under this section in any presumptive eligibility determination by the hospital for a second time within a twelve (12) month period of a first violation, the office of the secretary shall notify the hospital in writing not later than five (5) days after the determination that a second violation has occurred. The written notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) Notice that the hospital's applicable staff must participate in mandatory training on hospital presumptive eligibility rules and standards that is performed by the office of the secretary, and information concerning the date, time, and location of the training by the office.

(3) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

(4) Notice that a third violation by the hospital of a presumptive eligibility standard within a twelve (12) month period from the second violation will result in the hospital no longer being qualified to make presumptive eligibility determinations.

If a hospital appeals a finding of a violation of presumptive eligibility standards described in this subsection, the hospital must provide clear and convincing evidence during the appeals process that the standard was met by the hospital.

~~(g)~~ **(h)** If the office of the secretary determines that a hospital has

failed to meet any of the presumptive eligibility standards under this section in any presumptive eligibility determination by the hospital for a third time within a twelve (12) month period of the second violation by the hospital, the office of the secretary shall notify the hospital in writing not later than five (5) days from a determination that a presumptive eligibility standard was violated by the hospital for the third time. The written notice must include the following:

(1) A description of the standard that was not met and an explanation of why the hospital did not meet the standard.

(2) A description of the available appeal procedures that the hospital may use to dispute the finding of a violation of presumptive eligibility standards.

(3) Notice that, effective immediately from receipt of the notice, the hospital is no longer qualified to make presumptive eligibility determinations for the Medicaid program.

~~(h)~~ **(i)** If a hospital appeals a finding of a violation of presumptive eligibility standards described in subsection ~~(g),~~ **(h),** the hospital must provide clear and convincing evidence during the appeals process that the standard was met by the hospital.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 275 as printed February 18, 2026.)

STEUERWALD