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SENATE BILL No. 275

Proposed Changes to January 29, 2026 printing by AM027514

DIGEST OF PROPOSED AMENDMENT

Value based health care reimbursement agreements. Exempts value based health care reimbursement agreements between a managed care organization that provides services or coverage and a provider from certain reimbursement requirements.

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 12-11-2.1-3, 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 2. IC 12-15-2-3.5, AS AMENDED BY P.L.210-2015, SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2027]: Sec. 3.5. An individual:

(1) who is:

(A) at least sixty-five (65) years of age; or

(B) disabled, as determined by the Supplemental Security Income program; and

(2) whose income and resources do not exceed those levels established by the Supplemental Security Income program;

is eligible to receive Medicaid assistance. ~~if the individual's family income does not exceed one hundred percent (100%) of the federal income poverty level for the same size family, using income counting standards and criteria established by the federal Social Security Administration.~~

SECTION 3. IC 12-15-2-26, AS ADDED BY P.L.278-2013, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2027]: Sec. 26. (a) This section applies beginning the later of the following:

(1) The date that the office is informed that the United States Department of Health and Human Services has approved Indiana's conversion to 1634 status within the Medicaid program.

(2) January 1, 2014.

(b) As used in this section, "qualified Medicare beneficiary" means an individual defined in 42 U.S.C. 1396d(p)(1).

(c) As used in this section, "qualifying individual" refers to an individual described in 42 U.S.C. 1396a(a)(10)(E)(iv).

(d) As used in this section, "specified low-income Medicare beneficiary" refers to an individual described in 42 U.S.C. 1396a(a)(10)(E)(iii).

(e) The following individuals are eligible for the specified coverage under this section:

(1) A qualified Medicare beneficiary whose:

(A) income does not exceed one hundred ~~fifty~~ percent ~~(150%)~~ **(100%)** of the federal income poverty level; and

(B) resources do not exceed the resource limits established by the office;

is eligible for Medicare Part A and Medicare Part B premiums, coinsurance, and deductibles.

(2) A specified low-income Medicare beneficiary whose:

(A) income does not exceed one hundred ~~seventy~~ **twenty**[ ]percent ~~(170%)~~ **(120%)** of the federal income poverty level; and

(B) resources do not exceed the resource limits set by the office;

is eligible for coverage of Medicare Part B premiums.

(3) A qualifying individual whose:

(A) income does not exceed one hundred ~~eighty-five~~ **thirty-five** percent ~~(185%)~~ **(135%)** of the federal income poverty level; and

(B) resources do not exceed the resource limits set by the office;

is eligible for coverage of Medicare Part B premiums.

(f) The office may adopt rules under IC 4-22-2 to implement this section.

[SECTION 4. 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 ~~<4>~~[5]. 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 ~~<5>~~[6]. IC 12-15-34-14.5 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~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.~~

[SECTION 7. 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 ~~6~~[8]. 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)~~ **three hundred sixty-five (365)** days after the date of death of the decedent.

SECTION ~~<7>~~[9]. **An emergency is declared for this act.**