# Indiana

## Indiana - HB 1158

**Sponsor:** Edward Treacy

**Actions:**
03/09/2022 Failed upon adjournment
02/23/2022 Hearing Canceled
02/16/2022 Removed from Agenda
02/07/2022 Referred to Senate Committee on Health and Provider Services
01/31/2022 Passed House
01/27/2022 Amended
01/19/2022 Hearing held; amended; passed committee
01/06/2022 Introduced; Referred to House Committee on Public Health

**Summary:** Summary of 1/27/2022 Version

This measure addresses various issues in health and human services such as a formation of a subcommittee on individuals with intellectual and developmental disabilities; allowing nurses and physician assistants to sign family service plans; pharmacist reimbursement and liability; removes provision on enforcing health professional standards for active and in-active license holders; narrowing the definition of wholesale drug distribution; regulations on operating a remote pharmaceutical dispensary; and revising health insurance coverage regulations.

This measure allows advanced practice registered nurses and physician assistants to sign certain individualized family service plans.

This measure establishes a subcommittee to make recommendations to the task force regarding ways to minimize health and safety risks of individuals with intellectual and developmental disabilities, examine current trends related to health and safety requests for the community integration habilitation Medicaid waiver or any other service, and the feasibility of the division establishing a pilot program to create special service review teams to assist families or individuals in a crisis situation to identify available resources and sources of assistance.

This measure allows a pharmacist to be reimbursed for health care services that are eligible for Medicaid claims and for Medicaid-covered services at a federally qualified health center or rural health clinic. Specifies responsibilities of pharmacists and pharmacy managers concerning duties previously responsible by a qualifying pharmacist. Allows a qualified pharmacy technician to administer any immunizations under the supervision of a pharmacist. This measure requires the board of pharmacy to adopt emergency rules concerning the preparation, dispensing, and administration of clinician-administered drugs. This measure adds pharmacists to the law concerning immunity for providing voluntary health care. This measure creates regulations on remote pharmaceutical dispensing that prevents pharmacists from operating more than one remote dispensing facility at a time.

This measure removes the provision that a practitioner, for the purpose of enforcing health professional standards, includes individuals who currently hold or have previously held a license.

This measure revises the definition of wholesale distribution to exclude drugs for the sale of a drug for research or clinical trial purposes, provided the seller is authorized by the FDA to sell the drug for research or clinical trial
purposes.

This measure requires policies of accident and sickness insurance, health maintenance organization contracts, and pharmacy benefit managers to permit a covered individual to obtain a clinician-administered drug from the provider or pharmacy of the covered individual's choice. This measure requires the department of state revenue to add to its forms and schedules a box for a tax filer to check to request further information regarding health care coverage under a public health insurance program or qualified health plan.

This measure will go into effect upon passage.

**Bill Links** 1/27/2022 Version
1/19/2022 Version
1/6/2022 Version

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# Indiana - HB 1271

**Sponsor:** Representative Donna Schaibley (R)

**Actions:** 03/09/2022 Failed upon adjournment
02/01/2022 Failed to Meet Crossover Deadline
01/10/2022 Introduced: Referred to House Committee on Financial Institutions and Insurance

**Summary:** Summary of 1/10/2022 Version

This measure establishes a process to exempt certain providers from prior authorization processes under certain circumstances.

This measure provides that when a health plan makes an adverse determination in response to a health care provider's request for prior authorization of a health care service, the health plan must provide the health care provider with the opportunity to request a peer-to-peer conversation with a clinical peer regarding the adverse determination. A peer-to-peer conversation must take effect within seven business days after the request is received by the health plan. Peer-to-peer conversations must take place between a health care provider and a clinical peer. Requests for a peer-to-peer conversation may be filed in writing or electronically.

This measure establishes evaluation periods during which a health plan is required to determine whether providers are entitled to an exemption from requesting prior authorization, this period begins on January 1, 2024. Each succeeding evaluation period begins immediately upon the expiration of the previous evaluation period. If a health plan approves at least 90% of a provider's requests for prior authorization of a specific health care service under the health plan's medical necessity criteria, the health plan may not require the provider to request prior authorization for that type of health care service during the six month exemption period as well as the six months immediately following the evaluation period. After an exemption period during which the provider is exempt from requesting prior authorization, a health plan may elect to continue the provider's exemption period or rescind it, providers are not required to request or apply for a continuing exemption. Health plans may rescind a providers exemption from prior authorization without meting the conditions of this section if the health plan determines that the provider has committed health care fraud in connection with one or more health care services for which the health plan provided coverage, or the provider's license or legal authorization to provide health care services is suspended or revoked.

Within 10 business days, after the provider qualifies for an exemption period, the health plan must provide the provider with a notice that includes: a statement that the health care provider is entitled to the exemption, a list of each type of health care service, and each health plan to which the exemption applies, and a statement detailing the duration of the initial exemption period and the continuance of the exemption for consecutive exemption periods.

A health plan may not require a health care provider to satisfy any prerequisite involving a process internal to the health plan before initiating a review of the rescission by an independent review panel. An independent review panel must determine whether at least 90% of the random sample of health care services reviewed met the medical necessity criteria used by the health plan in determining eligibility for the exemption. The provider may request that the independent review panel consider a new random sample of at least five and no more than 20 cases.

This measure defines “adverse determination" as (1) a denial of a preauthorization for a covered benefit; (2) a denial of a request for benefits for an individual on the ground that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; or (3) a denial of a request for benefits on the ground that the treatment or service is experimental or investigational.

This measure defines "exemption period" as the period of six months during which a health care provider is exempt from the requirement to request prior authorization from a particular health plan for a particular type of health care service.

**Bill Links** 1/10/2022 Version