

**ENGROSSED
HOUSE BILL No. 1349**

DIGEST OF HB 1349 (Updated February 19, 1998 11:06 am - DI 88)

Citations Affected: IC 12-14; IC 12-15; IC 12-16; IC 12-29.

Synopsis: Disproportionate share providers; Medicaid. Provides that a county office of family and children may not consider \$5,000 of equity value in a motor vehicle when determining the eligibility of a child for assistance under Indiana's Title IV-A program (Temporary Assistance to Needy Families). Provides that the office of Medicaid policy and planning may not consider \$5,000 of equity value in one motor vehicle belonging to an applicant or a recipient or a member of an applicant's or a recipient's family when the office of Medicaid policy and planning applies a resource standard to determine the eligibility of an applicant or to redetermine the eligibility of a recipient for Medicaid. Creates a Medicaid shortfall program for governmentally owned hospitals that do not receive reimbursement in an amount that compensates the hospitals for the costs associated with delivering Medicaid services. Finances the state's share of the program through
(Continued next page)

Effective: See text of bill.

Crawford, Buell

(SENATE SPONSORS — JOHNSON, ROGERS)

January 13, 1998, read first time and referred to Committee on Ways and Means.
January 27, 1998, amended, reported — Do Pass.
February 2, 1998, read second time, amended, ordered engrossed.
February 3, 1998, engrossed. Read third time, passed. Yeas 97, nays 1.

SENATE ACTION

February 12, 1998, read first time and referred to Committee on Finance.
February 19, 1998, amended, reported favorably — Do Pass.

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intergovernmental transfers. Creates a new disproportionate share program for municipal hospitals that provides reimbursement for a portion of each hospital's services to indigent patients that is not otherwise reimbursed. Provides that a municipal hospital that has Medicaid volume greater than one percent of the hospital's total volume is eligible to participate in the program. Requires a hospital that wishes to participate in the program to provide an intergovernmental transfer. Creates a similar program for community mental health centers. Provides that certain funds within the health care for the indigent program fund may be deposited into the Medicaid indigent care trust fund to pay the state's share of enhanced disproportionate share payments to qualifying providers. Repeals provisions that do the following: (1) Provide a formula for computing a hospital's per diem rate that is added to the hospital's base inpatient payment rate. (2) Require certain entities to make certain intergovernmental transfers during state fiscal year 1997. (3) Base a hospital's enhanced disproportionate share payment adjustments on data reported during calendar year 1991. (4) Require that Medicaid rates paid to hospitals must be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals that provide service in compliance with all applicable laws and quality and safety standards. Makes other changes to the basic and enhanced disproportionate share provider programs. Provides that Medicaid payments to nursing facilities must be determined in accordance with federal law. (Current law provides that these payments must be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities that provide care and services in compliance with all applicable laws and quality and safety standards.)

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February 20, 1998

Second Regular Session 110th General Assembly (1998)

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 1997 General Assembly.

ENGROSSED HOUSE BILL No. 1349

A BILL FOR AN ACT to amend the Indiana Code concerning human services and to make an appropriation.

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

1 SECTION 1. IC 12-14-2-1, AS AMENDED BY P.L.15-1997,
2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 1998]: Sec. 1. (a) After the investigation under IC 12-14-1-6,
4 the county office shall decide the following:
5 (1) Whether the child is eligible for assistance under this article.
6 (2) The amount of assistance.
7 (3) The date assistance begins.
8 (b) The county office may not consider:
9 (1) money in an individual development account under IC 4-4-28
10 that belongs to the child or a member of the child's family; **or**
11 (2) **five thousand dollars (\$5,000) of equity value (as defined**
12 **in 470 IAC 10.1-3-1) in one (1) motor vehicle that belongs to**
13 **a member of the child's family;**
14 when determining whether the child is eligible for assistance under this
15 article.

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1 SECTION 2. IC 12-15-2-22 IS ADDED TO THE INDIANA CODE
 2 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE JULY
 3 1, 1998]: **Sec. 22. When the office applies a resource standard to**
 4 **determine an applicant's or a recipient's eligibility for Medicaid**
 5 **under this chapter, the office may not consider five thousand**
 6 **dollars (\$5,000) of equity value (as defined in 470 IAC 10.1-3-1) in**
 7 **one (1) motor vehicle belonging to:**

8 (1) **the applicant or recipient; or**

9 (2) **a member of the applicant's or recipient's family.**

10 SECTION 3. IC 12-15-14-2, AS AMENDED BY P.L.257-1996,
 11 SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 UPON PASSAGE]: **Sec. 2. (a) Payment of nursing facility services**
 13 **under shall be determined in accordance with 42 U.S.C.**
 14 **1396a(a)(13)(A). shall be determined in accordance with a prospective**
 15 **payment rate that meets the following conditions:**

16 (1) **Is reasonable and adequate to meet the costs that must be**
 17 **incurred by efficiently and economically operated facilities to**
 18 **provide care and services in conformity with state and federal:**

19 (A) **laws, rules, and regulations; and**

20 (B) **quality and safety standards.**

21 (2) **Is determined in accordance with and as defined by generally**
 22 **accepted accounting principles.**

23 (b) **The office may not require a provider to submit non-Medicaid**
 24 **revenue information in the provider's annual historical financial report.**
 25 **Non-Medicaid revenue information obtained by Medicaid auditors in**
 26 **the course of their audits may not be used for public reporting**
 27 **purposes.**

28 (c) **The office may only request complete balance sheet data that**
 29 **applies directly to the provider's facility. Complete balance sheet data**
 30 **acquired by the office under this subsection:**

31 (1) **is confidential; and**

32 (2) **may only be disclosed:**

33 (A) **in the aggregate; or**

34 (B) **for an individual facility;**

35 **if the office removes all non-Medicaid data.**

36 (d) **The office of the secretary shall adopt rules under IC 4-22-2 to**
 37 **implement the reimbursement system required by this section.**

38 SECTION 4. IC 12-15-15-1.1 IS ADDED AS A **NEW SECTION**
 39 **TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:** **Sec. 1.1.**

40 (a) **This section applies to a hospital that is:**

41 (1) **licensed under IC 16-21; and**

42 (2) **established and operated under IC 16-22-2 or IC 16-23.**



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1 **(b) For a state fiscal year ending after June 30, 1997, in addition**
 2 **to reimbursement received under section 1 of this chapter, a**
 3 **hospital is entitled to reimbursement in an amount calculated from**
 4 **the hospital's cost report filed with the office for the hospital's**
 5 **fiscal period ending during the state fiscal year, equal to the**
 6 **difference between:**

7 **(1) the amount of payments to the hospital under this article,**
 8 **excluding payments under IC 12-15-16 and IC 12-15-19, for**
 9 **services provided by the hospital during the state fiscal year;**
 10 **and**

11 **(2) an amount equal to the lesser of the following:**

12 **(A) The hospital's customary charges for the services**
 13 **described in subdivision (1).**

14 **(B) A reasonable estimate by the office of the amount that**
 15 **must be paid for the services described in subdivision (1)**
 16 **under Medicare payment principles.**

17 **(c) Subject to subsection (e), reimbursement under this section**
 18 **consists of a single payment made after the close of each state fiscal**
 19 **year. A payment described in this subsection is not due to a**
 20 **hospital unless an intergovernmental transfer is made under**
 21 **subsection (d).**

22 **(d) Subject to subsection (e), a hospital may make an**
 23 **intergovernmental transfer, or an intergovernmental transfer may**
 24 **be made on behalf of the hospital, after the close of each state fiscal**
 25 **year. An intergovernmental transfer under this subsection shall be**
 26 **made to the Medicaid indigent care trust fund in an amount equal**
 27 **to eighty-five percent (85%) of the amount determined under**
 28 **subsection (b). The intergovernmental transfer must be used to pay**
 29 **the state's share of enhanced disproportionate share payments**
 30 **under IC 12-15-20-2(1).**

31 **(e) An entity making an intergovernmental transfer under**
 32 **subsection (d) may appeal under IC 4-21.5 the amount determined**
 33 **by the office to be paid under subsection (b). The periods described**
 34 **in subsections (c) and (d) are tolled pending the administrative**
 35 **appeal and any judicial review initiated by the hospital under**
 36 **IC 4-21.5.**

37 **(f) The office may not implement this section until the federal**
 38 **Health Care Financing Administration has issued its approval of**
 39 **the amended state plan for medical assistance. The office may**
 40 **determine not to continue to implement this section if federal**
 41 **financial participation is not available.**

42 SECTION 5. IC 12-15-15-9 IS ADDED TO THE INDIANA CODE

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1 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
2 1, 1997 (RETROACTIVE)]: **Sec. 9. (a) For each state fiscal year
3 beginning on or after July 1, 1997, a hospital is entitled to a
4 payment under this section.**

5 **(b) Total payments to hospitals under this section for a state
6 fiscal year shall be equal to all amounts transferred from the
7 hospital care for the indigent fund for Medicaid current obligations
8 during the state fiscal year, including amounts of the fund
9 appropriated for Medicaid current obligations.**

10 **(c) The payment due to a hospital under this section must be
11 based on a policy developed by the office. The policy:**

12 **(1) is not required to provide for equal payments to all
13 hospitals;**

14 **(2) must attempt, to the extent practicable as determined by
15 the office, to establish a payment rate that minimizes the
16 difference between the aggregate amount paid under this
17 section to all hospitals in a county for a state fiscal year and
18 the amount of the county's hospital care for the indigent
19 property tax levy for that state fiscal year; and**

20 **(3) must provide that no hospital will receive a payment under
21 this section less than the amount the hospital received under
22 IC 12-15-15-8 for the state fiscal year ending June 30, 1997.**

23 **(d) Following the transfer of funds under subsection (b), an
24 amount equal to the amount determined in the following STEPS
25 shall be deposited in the Medicaid indigent care trust fund under
26 IC 12-15-20-2(1) and used to pay the state's share of the enhanced
27 disproportionate share payments to providers for the state fiscal
28 year:**

29 **STEP ONE: Determine the difference between:**

30 **(A) the amount transferred from the state hospital care for
31 the indigent fund under subsection (b); and**

32 **(B) thirty-five million dollars (\$35,000,000).**

33 **STEP TWO: Multiply the amount determined under STEP
34 ONE by the federal medical assistance percentage for the
35 state fiscal year.**

36 **SECTION 6. IC 12-15-16-1 IS AMENDED TO READ AS
37 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1.**

38 **(a) A provider under IC 12-15-17 is a basic disproportionate share
39 provider if the provider's:**

40 **(1) Medicaid inpatient utilization rate is at least one (1) standard
41 deviation above the mean Medicaid inpatient utilization rate for
42 providers receiving Medicaid payments in Indiana; however, the**

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1 Medicaid inpatient utilization of providers whose low income
2 utilization rate exceeds twenty-five percent (25%) must be
3 excluded in calculating the statewide mean Medicaid inpatient
4 utilization rate; **or**

5 (2) low income utilization rate exceeds twenty-five percent
6 (25%). **or**

7 (3) Medicaid inpatient days are equal or greater than twenty
8 thousand (20,000) days per year.

9 (b) An acute care hospital licensed under IC 16-21 ~~that, based on~~
10 ~~utilization and revenue data for the cost reporting period appropriate to~~
11 ~~determine eligibility for enhanced disproportionate share adjustments~~
12 ~~as of July 1, 1992, had a minimum of six thousand (6,000) Medicaid~~
13 ~~inpatient days and a minimum of seven hundred fifty (750) Medicaid~~
14 ~~discharges is an enhanced disproportionate share provider under either~~
15 ~~of the following conditions:~~

16 (1) If the provider's Medicaid inpatient utilization rate is at least
17 one (1) standard deviation above the mean Medicaid inpatient
18 utilization rate for providers receiving Medicaid payments in
19 Indiana. However, the Medicaid inpatient utilization rate of
20 providers whose low income utilization rate exceeds twenty-five
21 percent (25%) must be excluded in calculating the statewide
22 mean Medicaid inpatient utilization rate.

23 (2) If the provider's low income utilization rate exceeds
24 twenty-five percent (25%).

25 (c) **An acute care hospital licensed under 16-21 is a municipal**
26 **disproportionate share provider if the hospital:**

27 (1) **has a Medicaid utilization rate greater than one percent**
28 **(1%); and**

29 (2) **is established and operated under IC 16-22-2 or IC 16-23.**

30 (d) **A community mental health center that:**

31 (1) **is identified in IC 12-29-2-1;**

32 (2) **receives funding under IC 12-29-1-7(b) or from other**
33 **county sources; and**

34 (3) **provides inpatient services to Medicaid patients;**

35 **is a community mental health center disproportionate share**
36 **provider if the community mental health center's Medicaid**
37 **inpatient utilization rate is greater than one percent (1%).**

38 (e) (e) A disproportionate share provider under IC 12-15-17 must
39 have at least two (2) obstetricians who have staff privileges and who
40 have agreed to provide obstetric services under the Medicaid program.
41 For a hospital located in a rural area (as defined in Section 1886 of the
42 Social Security Act), an obstetrician includes a physician with staff

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1 privileges at the hospital who has agreed to perform nonemergency
 2 obstetric procedures. However, this obstetric service requirement does
 3 not apply to a provider whose inpatients are predominantly individuals
 4 less than eighteen (18) years of age or that did not offer nonemergency
 5 obstetric services as of December 21, 1987.

6 **(f) The determination of a provider's status as a**
 7 **disproportionate share provider under this section shall be based**
 8 **on utilization and revenue data from the most recent year for**
 9 **which an audited cost report from the provider is on file with the**
 10 **office.**

11 SECTION 7. IC 12-15-16-2, AS AMENDED BY P.L.156-1995,
 12 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 13 JULY 1, 1997 (RETROACTIVE)]: Sec. 2. (a) For purposes of basic,
 14 ~~and~~ enhanced, **municipal, and community mental health center**
 15 disproportionate share, a provider's Medicaid inpatient utilization rate
 16 is a fraction (expressed as a percentage) where:

17 (1) the numerator is the provider's total number of Medicaid and
 18 hospital care for the indigent program (IC 12-16-2) inpatient days
 19 ~~for a fixed cost reporting period specified in state rules; in the~~
 20 **most recent year for which an audited cost report is on file**
 21 **with the office;** and

22 (2) the denominator is the total number of the provider's inpatient
 23 days in the ~~same reporting period determined under section 1(b)~~
 24 ~~of this chapter.~~ **most recent year for which an audited cost**
 25 **report is on file with the office.**

26 (b) For purposes of this section, "inpatient days" includes days
 27 provided by an acute care excluded distinct part subprovider unit of the
 28 provider and inpatient days attributable to Medicaid beneficiaries from
 29 other states. The term also includes inpatient days attributable to
 30 Medicaid managed care recipients.

31 SECTION 8. IC 12-15-16-5, AS AMENDED BY P.L.156-1995,
 32 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 33 JULY 1, 1997 (RETROACTIVE)]: Sec. 5. (a) The office may not
 34 implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, or
 35 IC 12-15-20 until the federal Health Care Financing Administration has
 36 issued its approval of the amended state plan for medical assistance.

37 (b) The office may determine not to continue to implement this
 38 chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, and IC 12-15-20 if
 39 federal financial participation is not available.

40 (c) If federal financial participation is approved for less than all of
 41 the amounts paid into the Medicaid indigent care trust fund with
 42 respect to a fiscal year, the office may reduce payments attributable to



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1 that fiscal year under IC 12-15-19-1 and ~~IC 12-15-19-2~~ by a percentage
 2 sufficient to compensate for the aggregate reduction in federal financial
 3 participation. If additional federal financial participation is
 4 subsequently approved with respect to payments into the Medicaid
 5 indigent care trust fund for the same fiscal year, the office shall
 6 distribute such amounts using the percentage that was used to
 7 compensate for the prior reduction in federal financial participation.

8 SECTION 9. IC 12-15-16-6, AS AMENDED BY P.L.24-1997,
 9 SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 10 JULY 1, 1997 (RETROACTIVE)]: Sec. 6. (a) As used in this section,
 11 "low income utilization rate" refers to the low income utilization rate
 12 described in section 3 of this chapter.

13 (b) As used in this section, "Medicaid inpatient utilization rate"
 14 refers to the Medicaid inpatient utilization rate described in section
 15 2(a) of this chapter.

16 (c) Hospitals that qualify for basic disproportionate share under
 17 section 1(a) of this chapter shall receive disproportionate share
 18 payments as follows:

19 (1) For each of the state fiscal years ending after June 30, 1996,
 20 a pool not exceeding eight million dollars (\$8,000,000) shall be
 21 distributed to all hospitals licensed under IC 16-21 that qualify
 22 under section 1(a)(1) of this chapter. The funds in the pool must
 23 be distributed to qualifying hospitals in proportion to each
 24 hospital's Medicaid day utilization and Medicaid discharge rate,
 25 as determined based on data from the most recent audited cost
 26 report on file with the office.

27 (2) For each of the state fiscal years ending June 30, 1994 and
 28 1995, a pool of zero dollars (\$0) shall be distributed to all
 29 hospitals licensed under IC 16-21 that qualify under section
 30 1(a)(2) of this chapter. The funds in the pool must be distributed
 31 to qualifying hospitals in proportion to each hospital's low income
 32 utilization rate.

33 (3) Hospitals licensed under IC 16-21 that qualify under both
 34 section 1(a)(1) and 1(a)(2) of this chapter shall receive a
 35 disproportionate share payment in accordance with subdivision
 36 (1).

37 (4) For each of the state fiscal years ending after June 30, 1995,
 38 a pool not exceeding two million dollars (\$2,000,000) shall be
 39 distributed to all private psychiatric institutions licensed under
 40 IC 12-25 that qualify under either section 1(a)(1) or 1(a)(2) of this
 41 chapter. The funds in the pool must be distributed to the
 42 qualifying institutions in proportion to each institution's Medicaid



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1 day utilization rate, as determined based on data from the most
2 recent audited cost report on file with the office.

3 (5) A pool not exceeding one hundred ninety-one million dollars
4 (\$191,000,000) for the state fiscal year ending June 30, 1995,
5 shall be distributed to all state mental health institutions under
6 IC 12-24-1-3 that qualify under either section 1(a)(1) or 1(a)(2)
7 of this chapter. The funds in a pool must be distributed to each
8 qualifying institution in proportion to each institution's low
9 income utilization rate, as determined based on the most recent
10 data on file with the office.

11 (6) For each of the state fiscal years ending after June 30, 1994,
12 a pool not exceeding eighteen million dollars (\$18,000,000) shall
13 be distributed to all hospitals licensed under IC 16-21 that:

14 (A) qualify under section ~~1(a)(3)~~ **1(a)(1) or 1(a)(2)** of this
15 chapter; and

16 (B) **have at least twenty thousand (20,000) Medicaid**
17 **inpatient days per year.**

18 The funds in the pool must be distributed to qualifying hospitals in
19 proportion to each hospital's Medicaid day utilization rate and total
20 patient days, as determined based on data from the most recent audited
21 cost report on file with the office. Payments under this subdivision are
22 in place of the payments made under subdivisions (1) and (2).

23 (d) Disproportionate share payments described in this section shall
24 be made on an interim basis throughout the year, as provided by the
25 office.

26 (e) For years ending after June 30, 1995, the individual pools shall
27 be adjusted by a ratio, the numerator of which is the Medicaid
28 payments for hospital inpatient services for the state's most recent fiscal
29 year, and the denominator of which is the Medicaid payments for
30 hospital inpatient services for the state's fiscal year preceding the state's
31 most recent fiscal year.

32 (f) For years ending after June 30, 1994, eligibility for basic
33 disproportionate share payments under this section shall be based on
34 data from the most recent year for which audited cost reports are on file
35 with the office for all potentially eligible hospitals on June 30 of the
36 immediately preceding state fiscal year.

37 SECTION 10. IC 12-15-18-5.1 IS ADDED TO THE INDIANA
38 CODE AS A NEW SECTION TO READ AS FOLLOWS
39 [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 5.1. (a) For**
40 **state fiscal years ending on or after June 30, 1998, the trustees and**
41 **each municipal health and hospital corporation established under**
42 **IC 16-22-8-6 are authorized to make intergovernmental transfers**

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1 to the Medicaid indigent care trust fund in amounts to be
 2 determined jointly by the office and the trustees, and the office and
 3 each municipal health and hospital corporation.

4 (b) The treasurer of state shall annually transfer from
 5 appropriations made for the division of mental health sufficient
 6 money to provide the state's share of payments under
 7 IC 12-15-16-6(c)(5).

8 (c) The office shall coordinate the transfers from the trustees
 9 and each municipal health and hospital corporation established
 10 under IC 16-22-8-6 so that the aggregate intergovernmental
 11 transfers, when combined with federal matching funds:

12 (1) produce payments to each hospital licensed under IC 16-21
 13 that qualifies as an enhanced disproportionate share provider
 14 under IC 12-15-16-1(b); and

15 (2) both individually and in the aggregate do not exceed limits
 16 prescribed by the United States Health Care Financing
 17 Administration.

18 The trustees and a municipal health and hospital corporation are
 19 not required to make intergovernmental transfers under this
 20 section. The trustees and a municipal health and hospital
 21 corporation may make additional transfers to the Medicaid
 22 indigent care trust fund to the extent necessary to make additional
 23 payments from the Medicaid indigent care trust fund apply to a
 24 prior federal fiscal year as provided in IC 12-15-19-1(c).

25 (d) A municipal disproportionate share provider (as defined in
 26 IC 12-15-16-1(c)) shall transfer to the Medicaid indigent care trust
 27 fund an amount determined jointly by the office and the municipal
 28 disproportionate share provider. A municipal disproportionate
 29 share provider is not required to make intergovernmental
 30 transfers under this section. A municipal disproportionate share
 31 provider may make additional transfers to the Medicaid indigent
 32 care trust fund to the extent necessary to make additional
 33 payments from the Medicaid indigent care trust fund apply to a
 34 prior federal fiscal year as provided in IC 12-15-19-1(c).

35 (e) A county treasurer making a payment under IC 12-29-1-7(b)
 36 or from other county sources to a community mental health center
 37 qualifying as a community mental health center disproportionate
 38 share provider shall certify that the payment represents
 39 expenditures that are eligible for federal financial participation
 40 under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office
 41 shall assist a county treasurer in making this certification.

42 SECTION 11. IC 12-15-19-1, AS AMENDED BY P.L.24-1997,

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1 SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 2 JULY 1, 1997 (RETROACTIVE)]: Sec. 1. (a) For the state fiscal year
 3 ending June 30, 1997, each hospital licensed under IC 16-21 that
 4 qualifies as an enhanced disproportionate share provider under
 5 IC 12-15-16-1(b) shall receive additional enhanced disproportionate
 6 share adjustments, based on utilization data for the hospital's cost
 7 reporting period ending during calendar year 1991, subject to the
 8 hospital specific limit specified in subsection (d), as follows:

9 (1) For hospitals with a Medicaid inpatient utilization rate of
 10 fifteen percent (15%) or less and less than twenty-five thousand
 11 (25,000) total adult and pediatric days of Medicaid care:

12 (A) one hundred sixty-three dollars (\$163) for each Medicaid
 13 inpatient day; and

14 (B) one thousand one hundred eleven dollars (\$1,111) for each
 15 Medicaid discharge.

16 (2) For hospitals with a Medicaid inpatient utilization rate of
 17 greater than fifteen percent (15%) and less than twenty thousand
 18 (20,000) total adult and pediatric Medicaid days:

19 (A) two hundred fifteen dollars (\$215) for each Medicaid
 20 inpatient day; and

21 (B) one thousand one hundred thirty-two dollars (\$1,132) for
 22 each Medicaid discharge.

23 (3) For hospitals with a Medicaid inpatient utilization rate of
 24 greater than twenty percent (20%) and less than twenty-five
 25 thousand (25,000) total adult and pediatric Medicaid days:

26 (A) two hundred forty-one dollars (\$241) for each Medicaid
 27 inpatient day; and

28 (B) one thousand one hundred thirty-three dollars (\$1,133) for
 29 each Medicaid discharge.

30 (4) For hospitals with less than four thousand (4,000) Medicaid
 31 discharges and at least twenty-five thousand (25,000) total adult
 32 and pediatric Medicaid days:

33 (A) two hundred forty-six dollars (\$246) for each Medicaid
 34 inpatient day; and

35 (B) two thousand four hundred sixty-five dollars (\$2,465) for
 36 each Medicaid discharge.

37 (5) For hospitals with at least four thousand (4,000) Medicaid
 38 discharges and at least twenty-five thousand (25,000) total adult
 39 and pediatric Medicaid days:

40 (A) five hundred twenty-five dollars (\$525) for each Medicaid
 41 inpatient day; and

42 (B) three thousand seven hundred sixty-five dollars (\$3,765)

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1 for each Medicaid discharge.
 2 However, the office may adjust the rates specified in this subsection
 3 only to the extent necessary to obtain approval from the federal
 4 government of the amendments to the Indiana Medicaid plan that are
 5 required to implement the rates specified in this subsection and may
 6 make additional payments as provided in subsection (c).

7 (b) For each state fiscal year ending on or after June 30, 1998, the
 8 office shall develop an enhanced disproportionate share payment
 9 methodology that ensures that each enhanced disproportionate share
 10 provider receives total disproportionate share payments that do not
 11 exceed its hospital specific limit specified in subsection (d). The
 12 methodology developed by the office shall ensure that hospitals
 13 operated by the governmental entities described in ~~IC 12-15-18-5(a)~~
 14 **IC 12-15-18-5.1(a)** receive, to the extent practicable, basic and
 15 enhanced disproportionate share payments equal to their hospital
 16 specific limits. **The funds shall be distributed to qualifying hospitals**
 17 **in proportion to each qualifying hospital's percentage of the total**
 18 **net hospital specific limits of all qualifying hospitals. A hospital's**
 19 **net hospital specific limit is determined under STEP THREE of the**
 20 **following formula:**

21 **STEP ONE: Determine the hospital's hospital specific limit**
 22 **under subsection (d).**

23 **STEP TWO: Subtract basic disproportionate share payments**
 24 **received by the hospital under IC 12-15-16-6 from the amount**
 25 **determined under STEP ONE.**

26 **STEP THREE: Subtract intergovernmental transfers paid by**
 27 **or on behalf of the hospital from the amount determined**
 28 **under STEP TWO.**

29 (c) The office shall include a provision in each amendment to the
 30 state plan regarding enhanced disproportionate share payments,
 31 **municipal disproportionate share payments, and community**
 32 **mental health center disproportionate share payments** that the
 33 office submits to the federal Health Care Financing Administration
 34 that, as provided in 42 CFR 447.297(d)(3), allows the state to make
 35 additional enhanced disproportionate share expenditures, **municipal**
 36 **disproportionate share expenditures, and community mental**
 37 **health center disproportionate share expenditures** after the end of
 38 each federal fiscal year that relate back to the prior federal fiscal year.
 39 Each eligible hospital **or community mental health center** may
 40 receive an additional enhanced, **municipal, or community mental**
 41 **health center** disproportionate share adjustment ~~based on utilization~~
 42 ~~data for the hospital's cost reporting period that ended during calendar~~

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1 year 1991, if:

- 2 (1) additional intergovernmental transfers or certifications are
 3 made as authorized under ~~IC 12-15-18-5(c)~~; **IC 12-15-18-5.1**; and
 4 (2) the total disproportionate share payments to:
 5 (A) each individual hospital; and
 6 (B) all qualifying hospitals in the aggregate;
 7 do not exceed the limits provided by federal law and regulation.

8 (d) Total basic and enhanced disproportionate share payments to a
 9 hospital under this chapter and IC 12-15-16 shall not exceed the
 10 hospital specific limit provided under 42 U.S.C. 1396r-4(g). The
 11 hospital specific limit for a state fiscal year shall be determined by the
 12 office taking into account any data provided by each hospital for each
 13 hospital's most recent fiscal year (or in cases where a change in fiscal
 14 year causes the most recent fiscal period to be less than twelve (12)
 15 months, twelve (12) months of data ending at the end of the most
 16 recent fiscal year) as certified to the office by:

- 17 (1) an independent certified public accounting firm if the hospital
 18 is a hospital licensed under IC 16-21 that qualifies under
 19 ~~IC 12-15-16-1(a)(3)~~; **IC 12-15-16-1(a)**; or
 20 (2) the budget agency if the hospital is a state mental health
 21 institution listed under IC 12-24-1-3 that qualifies under either
 22 IC 12-15-16-1(a)(1) or IC 12-15-16-1(a)(2);

23 in accordance with this subsection and federal laws, regulations, and
 24 guidelines.

25 SECTION 12. IC 12-15-19-8 IS ADDED TO THE INDIANA
 26 CODE AS A NEW SECTION TO READ AS FOLLOWS
 27 [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 8. (a) A**
 28 **provider that qualifies as a municipal disproportionate share**
 29 **provider under IC 12-15-16-1(c) shall receive a disproportionate**
 30 **share adjustment, subject to the provider's hospital specific limits**
 31 **described in subsection (b), as follows:**

32 (1) **For each state fiscal year ending on or after June 30, 1998,**
 33 **an amount shall be distributed to each provider qualifying as**
 34 **a municipal disproportionate share provider under**
 35 **IC 12-15-16-1(c). The total amount distributed shall not**
 36 **exceed the sum of all hospital specific limits for all qualifying**
 37 **providers.**

38 (2) **For each municipal disproportionate share provider**
 39 **qualifying under IC 12-15-16-1(c) to receive basic**
 40 **disproportionate share payments under IC 12-15-16-1(a) or**
 41 **enhanced disproportionate share payments under**
 42 **IC 12-15-16-1(b), the amount in subdivision (1) shall be**

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1 reduced by the amount of basic disproportionate share
 2 payments and enhanced disproportionate share payments
 3 received by the provider. The office shall develop a municipal
 4 disproportionate share provider payment methodology that
 5 ensures that each municipal disproportionate share provider
 6 receives municipal disproportionate share payments that do
 7 not exceed the provider's hospital specific limit specified in
 8 subsection (b). The methodology developed by the office shall
 9 ensure that a municipal disproportionate share provider
 10 receives, to the extent possible, municipal disproportionate
 11 share payments that, when combined with any basic
 12 disproportionate share payments or enhanced
 13 disproportionate share payments owed to the provider, equals
 14 the provider's hospital specific limits.

15 (b) Total basic, enhanced, and municipal disproportionate share
 16 payments to a provider under this chapter and IC 12-15-16 shall
 17 not exceed the hospital specific limit provided under 42 U.S.C.
 18 1396r-4(g). The hospital specific limit for a state fiscal year shall be
 19 determined by the office taking into account data provided by each
 20 hospital for the hospital's most recent fiscal year or, if a change in
 21 fiscal year causes the most recent fiscal period to be less than
 22 twelve (12) months, twelve (12) months of data ending at the end
 23 of the most recent state fiscal year, as certified to the office by an
 24 independent certified public accounting firm.

25 SECTION 13. IC 12-15-19-9 IS ADDED TO THE INDIANA
 26 CODE AS A NEW SECTION TO READ AS FOLLOWS
 27 [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 9.** (a) For each
 28 state fiscal year ending after June 30, 1997, a community mental
 29 health center that qualifies as a community health center
 30 disproportionate share provider under IC 12-15-16-1(d) shall
 31 receive disproportionate share payments in an amount determined
 32 under STEP 3 of the following formula:

33 **STEP 1:** Determine the amount paid to the community mental
 34 health center during the state fiscal year under
 35 IC 12-29-1-7(b) or from other county sources.

36 **STEP 2:** Divide the amount determined under STEP 1 by a
 37 percentage equal to the state's medical assistance percentage
 38 for the state fiscal year.

39 **STEP 3:** Subtract the amount determined under STEP 1 from
 40 the sum determined under STEP 2.

41 (b) A community mental health center disproportionate share
 42 payment under this chapter and IC 12-15-16 to a community

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1 mental health center qualifying under IC 12-15-16-1(d) may not
 2 exceed the institution specific limit provided under 42 U.S.C.
 3 1396r-4(g). The institution specific limit for a state fiscal year shall
 4 be determined by the office taking into account data provided by
 5 the community mental health center for the community mental
 6 health center's most recent fiscal year or, if a change in fiscal year
 7 causes the most recent fiscal period to be less than twelve (12)
 8 months, twelve (12) months of data compiled to the end of the most
 9 recent state fiscal year, as certified to the office by an independent
 10 certified public accounting firm.

11 (c) Subject to IC 12-15-19-10, disproportionate share payments
 12 to community mental health centers may not result in total
 13 disproportionate share payments in excess of the state limit on such
 14 expenditures for institutions for mental diseases under 42 U.S.C.
 15 1396r-4(h). The office may reduce, on a pro rata basis, payments
 16 due under this section for a fiscal year if necessary to avoid
 17 exceeding the state limit on disproportionate share expenditures
 18 for institutions for mental diseases.

19 (d) A payment under this section may be recovered by the office
 20 from the community mental health center if federal financial
 21 participation is disallowed for the funds certified under
 22 IC 12-29-1-7(b) upon which such payment was based.

23 (e) This section expires July 1, 2001.

24 SECTION 14. IC 12-15-19-10 IS ADDED TO THE INDIANA
 25 CODE AS A NEW SECTION TO READ AS FOLLOWS
 26 [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 10.** If the state
 27 exceeds the state disproportionate share allocation (as defined in
 28 42 U.S.C. 1396r-4(f)(2) or the state limit on disproportionate share
 29 expenditures for institutions for mental diseases (as defined in 42
 30 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

31 (1) The state shall make basic disproportionate share provider
 32 payments under IC 12-15-16-1(a) until the state exceeds the
 33 state disproportionate share allocation.

34 (2) After the state makes all payments under subdivision (1),
 35 if the state fails to exceed the state disproportionate share
 36 allocation, the state shall make enhanced disproportionate
 37 share provider payments under IC 12-15-16-1(b).

38 (3) After the state makes all payments under subdivision (2),
 39 if the state fails to exceed the state disproportionate share
 40 allocation, the state shall make municipal disproportionate
 41 share provider payments under IC 12-15-16-1(c).

42 (4) After the state makes all payments under subdivision (3),



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1 **if the state fails to exceed the state disproportionate share**
2 **allocation, the state shall make community mental health**
3 **center disproportionate share provider payments under**
4 **IC 12-15-16-1(d).**

5 SECTION 15. IC 12-15-20-2, AS AMENDED BY P.L.24-1997,
6 SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
7 JULY 1, 1997 (RETROACTIVE)]: Sec. 2. The Medicaid indigent care
8 trust fund is established to pay the state's share of the following:

9 (1) Enhanced disproportionate share payments to providers under
10 IC 12-15-19.

11 (2) Disproportionate share payments and significant
12 disproportionate share payments for certain outpatient services
13 under IC 12-15-17-3.

14 (3) Medicaid payments for pregnant women described in
15 IC 12-15-2-13 and infants and children described in
16 IC 12-15-2-14, IC 12-15-2-15, and IC 12-15-2-15.5.

17 **(4) Municipal disproportionate share payments to providers**
18 **under IC 12-15-19-8.**

19 SECTION 16. IC 12-16-3-3 IS AMENDED TO READ AS
20 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The division
21 shall adopt rules under IC 4-22-2 to establish income and resource
22 eligibility standards for patients whose care is to be paid under the
23 hospital care for the indigent program.

24 (b) To the extent possible, rules adopted under this section must
25 meet the following conditions:

26 (1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

27 (2) Be adjusted at least one (1) time every two (2) years.

28 **(c) The income and eligibility standards established under this**
29 **section do not include any spend down provisions available under**
30 **IC 12-15-21-2 or IC 12-15-21-3.**

31 SECTION 17. IC 12-16-7-11 IS ADDED TO THE INDIANA
32 CODE AS NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
33 JULY 1, 1997 (RETROACTIVE)]: **Sec. 11. Providers eligible for**
34 **payment under IC 12-15-15-9 may not receive payment under this**
35 **chapter.**

36 SECTION 18. IC 12-16-7-12 IS ADDED TO THE INDIANA
37 CODE AS NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
38 UPON PASSAGE]: **Sec. 12. All providers receiving payment under**
39 **this chapter agree to accept, as payment in full, the amount paid**
40 **for the hospital care for the indigent program for those claims**
41 **submitted for payment under the program, with the exception of**
42 **authorized deductibles, co-insurance, co-payment, or similar**

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1 **cost-sharing charges.**

2 SECTION 19. IC 12-16-14-8 IS AMENDED TO READ AS
3 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. The division
4 shall administer the state hospital care for the indigent fund and shall
5 use the money currently in the fund to defray the expenses and
6 obligations incurred by the division for hospital care for the indigent.

7 **The money in the fund is hereby appropriated.**

8 SECTION 20. IC 12-29-1-7 IS AMENDED TO READ AS
9 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 7.

10 (a) On the first Monday in October, the county auditor shall certify to:

11 (1) the division of mental health, for a community mental health
12 center;

13 (2) the division of disability, aging, and rehabilitative services, for
14 a community mental retardation and other developmental
15 disabilities center; and

16 (3) the president of the board of directors of each center;
17 the amount of money that will be provided to the center under this
18 chapter.

19 (b) The county payment to the center shall be paid by the county
20 treasurer to the treasurer of each center's board of directors in the
21 following manner:

22 (1) One-half (1/2) of the county payment to the center shall be
23 made on the second Monday in July.

24 (2) One-half (1/2) of the county payment to the center shall be
25 made on the second Monday in December.

26 **A county treasurer making a payment under this subsection or**
27 **from other county sources to a community mental health center**
28 **that qualifies as a community mental health center**
29 **disproportionate share provider under IC 12-15-16-1(d) shall**
30 **certify that the payment represents expenditures eligible for**
31 **financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR**
32 **433.51. The office of Medicaid policy and planning shall assist a**
33 **county treasurer in making this certification.**

34 (c) Payments by the county fiscal body:

35 (1) must be in the amounts:

36 (A) determined by IC 12-29-2-1 through IC 12-29-2-6; and

37 (B) authorized by section 1 of this chapter; and

38 (2) are in place of grants from agencies supported within the
39 county solely by county tax money.

40 SECTION 21. THE FOLLOWING ARE REPEALED [EFFECTIVE
41 JULY 1, 1997 (RETROACTIVE)]: IC 12-15-15-8; IC 12-15-18-5;
42 IC 12-15-19-2.

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1 SECTION 22. IC 12-15-15-5 IS REPEALED [EFFECTIVE UPON
2 PASSAGE].
3 SECTION 23. **An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1349, 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:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning human services and to make an appropriation.

Page 1, delete lines 1 through 4.

Page 2, line 21, delete "UPON PASSAGE]" and insert "JULY 1, 1998]".

Page 2, delete lines 22 through 42, begin a new paragraph and insert:

"Chapter 2.2. Outreach Efforts

Sec. 1. As used in this chapter, "qualified entity" means an entity approved by the office of the secretary to determine presumptive eligibility for pregnant women and children to receive services under the Medicaid program.

Sec. 2. (a) The office of the secretary shall initiate efforts to improve the following elements of the Medicaid program:

- (1) Enrollment.
- (2) Eligibility determinations.
- (3) Access to medical services.

(b) To carry out the requirements described in subsection (a), the office of the secretary shall consider the following:

- (1) Allowing qualified entities to determine presumptive eligibility for pregnant women and children.
- (2) Allowing outstation locations to accept Medicaid applications.
- (3) Designing simplified application forms.
- (4) Allowing applications to be:
 - (A) filed by mail; or
 - (B) completed by telephone.
- (5) Other outreach activities as appropriate.

Sec. 3. (a) If the office of the secretary establishes a program of presumptive eligibility, the office of the secretary shall determine the following:

- (1) Which qualified entities may presumptively enroll pregnant women and children in the Medicaid program.
- (2) The duties of a qualified entity.

(b) If a program of presumptive eligibility is established under this section, the office of the secretary may adopt rules under



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IC 4-22-2 to implement the program.

SECTION 5. IC 12-15-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An application or a request for Medicaid for an individual must be:

- (1) made to the county office ~~of~~ **or another location determined by the office of the secretary** in the county in which the applicant resides; and
- (2) in the manner required by the office.

(b) The office of the secretary shall adopt rules under IC 4-22-2 to carry out this section."

Delete pages 3 through 4.

Page 5, delete lines 1 through 14, begin a new paragraph and insert:

"SECTION 6. IC 12-15-14-2, AS AMENDED BY P.L.257-1996, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) Payment of nursing facility services ~~under shall be determined in accordance with~~ 42 U.S.C. 1396a(a)(13)(A). ~~shall be determined in accordance with a prospective payment rate that meets the following conditions:~~

- (1) ~~Is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with state and federal:~~
 - (A) ~~laws, rules, and regulations; and~~
 - (B) ~~quality and safety standards.~~
- (2) ~~Is determined in accordance with and as defined by generally accepted accounting principles.~~

(b) The office may not require a provider to submit non-Medicaid revenue information in the provider's annual historical financial report. Non-Medicaid revenue information obtained by Medicaid auditors in the course of their audits may not be used for public reporting purposes.

(c) The office may only request complete balance sheet data that applies directly to the provider's facility. Complete balance sheet data acquired by the office under this subsection:

- (1) is confidential; and
- (2) may only be disclosed:
 - (A) in the aggregate; or
 - (B) for an individual facility;

if the office removes all non-Medicaid data.

(d) The office of the secretary shall adopt rules under IC 4-22-2 to implement the reimbursement system required by this section."

Page 5, line 16, delete the effective date "[EFFECTIVE APRIL 1, 1998]" and insert the effective date "[EFFECTIVE UPON

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PASSAGE]".

Page 5, line 19, delete "owned" and insert "**established**".

Page 5, line 19, delete "IC 16-22" and insert "**IC 16-22-2**".

Page 5, line 37, delete "as follows:" and insert "**after the close of each state fiscal year.**".

Page 5, delete lines 38 through 42.

Page 6, delete lines 1 through 10.

Page 6, line 15, delete ", as follows:" and insert "**after the close of each state fiscal year.**".

Page 6, delete lines 16 through 29.

Page 6, delete line 42, begin a new paragraph and insert:

"(f) The office may not implement this section until the federal Health Care Financing Administration has issued its approval of the amended state plan for medical assistance. The office may determine not to continue to implement this section if federal financial participation is not available."

Page 7, delete lines 1 through 20, begin a new paragraph and insert:

"SECTION 8. IC 12-15-15-9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 9. (a) For each state fiscal year beginning on or after July 1, 1997, a hospital is entitled to a payment under this section.

(b) Total payments to hospitals under this section for a state fiscal year shall be equal to all amounts transferred from the hospital care for the indigent fund for Medicaid current obligations during the state fiscal year, including amounts of the fund appropriated for Medicaid current obligations.

(c) The payment due to a hospital under this section must be based on a policy developed by the office. The policy:

(1) is not required to provide for equal payments to all hospitals;

(2) must attempt, to the extent practicable as determined by the office, to establish a payment rate that minimizes the difference between the aggregate amount paid under this section to all hospitals in a county for a state fiscal year and the amount of the county's hospital care for the indigent property tax levy for that state fiscal year; and

(3) must provide that no hospital will receive a payment under this section less than the amount the hospital received under IC 12-15-15-8 for the state fiscal year ending June 30, 1997.

(d) Following the transfer of funds under subsection (b), an amount equal to the amount determined in the following STEPS



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shall be deposited in the Medicaid indigent care trust fund under IC 12-15-20-2(1) and used to pay the state's share of the enhanced disproportionate share payments to providers for the state fiscal year:

STEP ONE: Determine the difference between:

(A) the amount transferred from the state hospital care for the indigent fund under subsection (b); and

(B) thirty-five million dollars (\$35,000,000).

STEP TWO: Multiply the amount determined under STEP ONE by the federal medical assistance percentage for the state fiscal year."

Page 8, line 14, delete "owned" and insert "established".

Page 8, line 14, delete "IC 16-22" and insert "IC 16-22-2".

Page 8, line 15, delete "that" and insert "that:".

Page 8, line 15, before "provides" begin a new line block indented and insert:

"(1) is identified in IC 12-29-2-1;

(2) receives funding under IC 12-29-1-7(b); and

(3)".

Page 8, line 16, after "patients" insert ";".

Page 8, line 16, delete "is", begin a new line blocked left and insert: "is".

Page 8, line 18, after "Medicaid" insert "inpatient".

Page 10, reset in roman lines 34 through 42.

Page 10, line 36, after "that" insert ":".

Page 10, line 36, before "qualify" begin a new line double block indented and insert:

"(A)".

Page 10, line 37, strike "1(a)(3)" and insert "1(a)(1) or 1(a)(2)".

Page 10, line 37, delete "." and insert "; and

(B) have at least twenty thousand (20,000) Medicaid inpatient days per year."

Page 11, line 18, delete "Beginning July 1" and insert "For state fiscal years ending on or after June 30".

Page 11, line 21, delete "," and insert "and".

Page 11, line 22, before "each" insert "the office and".

Page 11, line 39, after "." insert "The trustees and a municipal health and hospital corporation may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(c)".



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Page 12, line 3, after "." insert "**A municipal disproportionate share provider may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(c).**".

Page 12, delete lines 11 through 38.

Page 14, line 13, after "." insert "**The funds shall be distributed to qualifying hospitals in proportion to each qualifying hospital's percentage of the total net hospital specific limits of all qualifying hospitals. A hospital's net hospital specific limit is determined under STEP THREE of the following formula:**

STEP ONE: Determine the hospital's hospital specific limit under subsection (d).

STEP TWO: Subtract basic disproportionate share payments received by the hospital under IC 12-15-16-6 from the amount determined under STEP ONE.

STEP THREE: Subtract intergovernmental transfers paid by or on behalf of the hospital from the amount determined under STEP TWO.".

Page 14, line 15, after "payments" insert ", **municipal disproportionate share payments, and community mental health center disproportionate share payments**".

Page 14, line 18, after "expenditures" insert ", **municipal disproportionate share expenditures, and community mental health center disproportionate share expenditures**".

Page 14, line 20, after "hospital" insert "**or community mental health center**".

Page 14, line 20, after "enhanced" insert ", **municipal, or community mental health center**".

Page 14, line 24, after "transfers" insert "**or certifications**".

Page 15, line 13, delete "a pool" and insert "**an amount**".

Page 15, line 15, delete "pool" and insert "**total amount distributed**".

Page 15, line 17, after "each" insert "**municipal disproportionate share**".

Page 15, line 32, after "with" insert "**any**".

Page 16, line 10, delete "4" and insert "**3**".

Page 16, line 14, delete "Multiply" and insert "**Divide**".

Page 16, delete lines 17 through 18.

Page 16, line 19, delete "4" and insert "**3**".

Page 16, line 19, delete "transferred to the community" and insert "**determined under STEP 1**".



Page 16, delete line 20.

Page 16, line 21, delete "IC 12-29-1-7(b)".

Page 16, line 21, delete "3" and insert "2".

Page 16, line 22, delete "Total basic and" and insert "A".

Page 16, line 23, delete "payments" and insert "payment".

Page 16, between lines 33 and 34, begin a new paragraph and insert:

"(c) Subject to IC 12-15-19-10, disproportionate share payments to community mental health centers may not result in total disproportionate share payments in excess of the state limit on such expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h). The office may reduce, on a pro rata basis, payments due under this section for a fiscal year if necessary to avoid exceeding the state limit on disproportionate share expenditures for institutions for mental diseases.

(d) A payment under this section may be recovered by the office from the community mental health center if federal financial participation is disallowed for the funds certified under IC 12-29-1-7(b) upon which such payment was based.

(e) This section expires July 1, 2001."

Page 16, line 38, after "42 U.S.C. 1396r-4(f)(2)" delete "," and insert **"or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)),"**.

Page 17, delete lines 27 through 42, begin a new paragraph and insert:

"SECTION 19. IC 12-16-3-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid under the hospital care for the indigent program.

(b) To the extent possible, rules adopted under this section must meet the following conditions:

- (1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.
- (2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21-2 or IC 12-15-21-3.

SECTION 20. IC 12-16-7-11 IS ADDED TO THE INDIANA CODE AS NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 11. Providers eligible for payment under IC 12-15-15-9 may not receive payment under this chapter.**



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SECTION 21. IC 12-16-7-12 IS ADDED TO THE INDIANA CODE AS NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 12. All providers receiving payment under this chapter agree to accept, as payment in full, the amount paid for the hospital care for the indigent program for those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost-sharing charges.**

SECTION 22. IC 12-16-14-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund to defray the expenses and obligations incurred by the division for hospital care for the indigent. **The money in the fund is hereby appropriated.**

SECTION 23. IC 12-15-15-5 IS REPEALED [EFFECTIVE UPON PASSAGE].

SECTION 24. [EFFECTIVE UPON PASSAGE] **(a) Not later than May 30, 1998, the office of the secretary of family and social services shall report to the state budget committee regarding the efforts of the office of the secretary of family and social services to improve enrollment, eligibility determinations, and access to services under the Medicaid program, as required under IC 12-15-2.2-2, as added by this act.**

(b) This SECTION expires January 1, 1999."

Delete page 18.

Page 19, delete lines 1 through 40.

Page 20, delete lines 35 through 42.

Delete pages 21 through 42.

Page 43, delete lines 1 through 10.

Re-number all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1349 as introduced.)

BAUER, Chair

Committee Vote: yeas 19, nays 0.



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HOUSE MOTION

Mr. Speaker: I move that House Bill 1349 be amended to read as follows:

Page 6, line 34, after "(2)" insert: "**is**".

Page 6, line 37, after "IC 12-29-1-7(b)" insert "**or from other county sources**".

Page 14, line 39, after "IC 12-29-1-7(b)" insert "**or from other county sources**".

Page 17, line 40, after "subsection" insert "**or from other county sources**".

(Reference is to House Bill 1349 as printed January 28, 1998.)

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COMMITTEE REPORT

Mr. President: The Senate Committee on Finance, to which was referred House Bill 1349, 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 1, delete lines 1 through 5.

Page 2, line 1, delete "four thousand five hundred dollars (\$4,500)" and insert "**five thousand dollars (\$5,000)**".

Page 2, line 10, delete "four thousand five" and insert "**five thousand dollars (\$5,000)**".

Page 2, line 11, delete "hundred dollars (\$4,500)".

Page 2, delete lines 15 through 42.

Page 3, delete lines 1 through 14.

Page 4, line 29, after "hospital" insert ",".

Page 10, line 40, after "IC 12-29-1-7(b)" insert "**or from other county sources**".

Page 17, delete lines 13 through 22.

Page 18, line 9, reset in roman "IC 12-29-2-1 through IC 12-29-2-6;".

Page 18, line 10, delete "IC 12-29-2-2 through IC 12-29-2-5;".

Page 18, between lines 16 and 17, begin a new paragraph and insert: "SECTION 27. IC 12-15-15-5 IS REPEALED [EFFECTIVE UPON PASSAGE]."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1349 as reprinted February 3, 1998.)

BORST, Chairperson

Committee Vote: Yeas 14, Nays 0.

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