

February 18, 1998

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# ENGROSSED SENATE BILL No. 19

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DIGEST OF SB 19 (Updated February 17, 1998 1:45 pm - DI 73)

**Citations Affected:** IC 5-14; IC 12-7; IC 12-10; IC 12-15; IC 12-26; IC 16-18; IC 16-35; noncode.

**Synopsis:** Increases for one year the family income eligibility standard for Medicaid for a child who is less than 19 years of age to 150% of the federal income poverty level. Requires the office of Medicaid policy and planning to use all funds appropriated for outreach to conduct outreach activities in order to encourage children who are less than 19 years of age and who are eligible for Medicaid but who are not enrolled in the Medicaid program to enroll in the Medicaid program. Requires  
(Continued next page)

**Effective:** Upon Passage; July 1, 1998.

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**Johnson, Simpson, Howard,  
Randolph, Washington**

(HOUSE SPONSORS — CRAWFORD, BUDAK, DAY)

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November 18, 1997, read first time and referred to Committee on Rules and Legislative Procedure.

January 13, 1998, amended, reported favorably; reassigned to Committee on Planning and Public Services.

January 27, 1998, amended, reported favorably — Do Pass.

February 2, 1998, read second time, amended, ordered engrossed.

February 3, 1998, engrossed. Read third time, passed. Yeas 50, nays 0.

HOUSE ACTION

February 10, 1998, read first time and referred to Committee on Ways and Means.

February 17, 1998, amended, reported — Do Pass.

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for one year that the office of Medicaid policy and planning provide Medicaid services to a child who is less than 19 years of age and who is eligible for Medicaid for 12 consecutive months from the date when the child's eligibility is determined or until the child becomes 19 years of age, whichever occurs first. Provides that certain entities may determine that a pregnant woman or child is presumptively eligible for Medicaid. Requires the office to consider certain providers to serve as entities to make presumptive eligibility determinations. Allows a child or pregnant woman to appoint an agent of the entity making the presumptive eligibility determination as the child's or pregnant woman's authorized representative for the purpose of completing all aspects of the Medicaid application process. Provides that presumptive eligibility ends when a determination of Medicaid eligibility is made by an employee of a county office of family and children or the last day of the month following the month during which a presumptive eligibility determination is made, whichever occurs earlier. Provides that Medicaid applications may be made at an enrollment center such as a hospital, school, or clinic. Requires enrollment centers to accept applications for Medicaid, conduct interviews with applicants, and provide each application and accompanying materials to the county office of family and children in the same county as the enrollment center at least once a week. Establishes an office of the children's health insurance program within the state department of health to obtain health insurance for eligible children. Requires the office to contract with providers of health insurance, including health maintenance organizations, limited services health maintenance organizations, and preferred provider plans, to provide health insurance and other required services to children in the program. Requires the office to establish performance criteria and evaluation measures for providers. Provides requirements a child must meet in order to enroll in the program. Provides a list of services for which the program must provide health insurance coverage. Provides that the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses. Provides other requirements under which the office and providers must operate, including requirements to provide incentives to insurers and employers to continue providing private health insurance to insureds and employees. Requires the office, with the assistance of the office of Medicaid policy and planning, to apply for waivers from the Secretary of the United States Department of Health and Human Services that are required to implement the program. Requires the office to submit state plans outlining Indiana's initial and long term children's health insurance program to the Secretary of the United States Department of Health and Human Services. Provides that funds from the Medicaid indigent care trust fund will be used to provide the state's share of funds required to implement the program. Establishes a pilot program to allow political subdivisions to form a community care network for pooling and administering funds to be used in providing or arranging to provide health services and related items to the employees and residents of the political subdivisions. Provides that certain individuals who are Medicaid eligible and reside in a county home, hospital, nursing facility, or community residential facility for the developmentally disabled are allowed to retain a monthly personal allowance of at least \$35 and not more than \$61.32 beginning July 1, 1998.

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February 18, 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 SENATE BILL No. 19

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:*

1 SECTION 1. IC 5-14-3-2, AS AMENDED BY P.L.50-1995,  
2 SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
3 UPON PASSAGE]: Sec. 2. As used in this chapter:  
4 "Copy" includes transcribing by handwriting, photocopying,  
5 xerography, duplicating machine, duplicating electronically stored data  
6 onto a disk, tape, drum, or any other medium of electronic data storage,  
7 and reproducing by any other means.  
8 "Direct cost" means one hundred five percent (105%) of the sum of  
9 the cost of:  
10 (1) the initial development of a program, if any;  
11 (2) the labor required to retrieve electronically stored data; and  
12 (3) any medium used for electronic output;  
13 for providing a duplicate of electronically stored data onto a disk, tape,  
14 drum, or other medium of electronic data retrieval under section 8(g)  
15 of this chapter, or for reprogramming a computer system under section

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- 1 6(c) of this chapter.
- 2 "Electronic map" means copyrighted data provided by a public
- 3 agency from an electronic geographic information system.
- 4 "Enhanced access" means the inspection of a public record by a
- 5 person other than a governmental entity and that:
- 6 (1) is by means of an electronic device other than an electronic
- 7 device provided by a public agency in the office of the public
- 8 agency; or
- 9 (2) requires the compilation or creation of a list or report that does
- 10 not result in the permanent electronic storage of the information.
- 11 "Facsimile machine" means a machine that electronically transmits
- 12 exact images through connection with a telephone network.
- 13 "Inspect" includes the right to do the following:
- 14 (1) Manually transcribe and make notes, abstracts, or memoranda.
- 15 (2) In the case of tape recordings or other aural public records, to
- 16 listen and manually transcribe or duplicate, or make notes,
- 17 abstracts, or other memoranda from them.
- 18 (3) In the case of public records available:
- 19 (A) by enhanced access under section 3.5 of this chapter; or
- 20 (B) to a governmental entity under section 3(c)(2) of this
- 21 chapter;
- 22 to examine and copy the public records by use of an electronic
- 23 device.
- 24 (4) In the case of electronically stored data, to manually transcribe
- 25 and make notes, abstracts, or memoranda or to duplicate the data
- 26 onto a disk, tape, drum, or any other medium of electronic
- 27 storage.
- 28 "Investigatory record" means information compiled in the course of
- 29 the investigation of a crime.
- 30 "Patient" has the meaning set out in IC 16-18-2-272(c).
- 31 "Person" means an individual, a corporation, a limited liability
- 32 company, a partnership, an unincorporated association, or a
- 33 governmental entity.
- 34 "Provider" has the meaning set out in ~~IC 16-18-2-295(b)~~
- 35 **IC 16-18-2-295(c)** and includes employees of the state department of
- 36 health or local boards of health who create patient records at the
- 37 request of another provider or who are social workers and create
- 38 records concerning the family background of children who may need
- 39 assistance.
- 40 "Public agency" means the following:
- 41 (1) Any board, commission, department, division, bureau,
- 42 committee, agency, office, instrumentality, or authority, by

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1 whatever name designated, exercising any part of the executive,  
2 administrative, judicial, or legislative power of the state.

3 (2) Any:

4 (A) county, township, school corporation, city, or town, or any  
5 board, commission, department, division, bureau, committee,  
6 office, instrumentality, or authority of any county, township,  
7 school corporation, city, or town;

8 (B) political subdivision (as defined by IC 36-1-2-13); or

9 (C) other entity, or any office thereof, by whatever name  
10 designated, exercising in a limited geographical area the  
11 executive, administrative, judicial, or legislative power of the  
12 state or a delegated local governmental power.

13 (3) Any entity or office that is subject to:

14 (A) budget review by either the state board of tax  
15 commissioners or the governing body of a county, city, town,  
16 township, or school corporation; or

17 (B) an audit by the state board of accounts.

18 (4) Any building corporation of a political subdivision that issues  
19 bonds for the purpose of constructing public facilities.

20 (5) Any advisory commission, committee, or body created by  
21 statute, ordinance, or executive order to advise the governing  
22 body of a public agency, except medical staffs or the committees  
23 of any such staff.

24 (6) Any law enforcement agency, which means an agency or a  
25 department of any level of government that engages in the  
26 investigation, apprehension, arrest, or prosecution of alleged  
27 criminal offenders, such as the state police department, the police  
28 or sheriff's department of a political subdivision, prosecuting  
29 attorneys, members of the excise police division of the alcoholic  
30 beverage commission, conservation officers of the department of  
31 natural resources, and the security division of the state lottery  
32 commission.

33 (7) Any license branch staffed by employees of the bureau of  
34 motor vehicles commission under IC 9-16.

35 (8) The state lottery commission, including any department,  
36 division, or office of the commission.

37 (9) The Indiana gaming commission established under IC 4-33,  
38 including any department, division, or office of the commission.

39 (10) The Indiana horse racing commission established by IC 4-31,  
40 including any department, division, or office of the commission.

41 "Public record" means any writing, paper, report, study, map,  
42 photograph, book, card, tape recording, or other material that is

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1 created, received, retained, maintained, used, or filed by or with a  
 2 public agency and which is generated on paper, paper substitutes,  
 3 photographic media, chemically based media, magnetic or machine  
 4 readable media, electronically stored data, or any other material,  
 5 regardless of form or characteristics.

6 "Standard-sized documents" includes all documents that can be  
 7 mechanically reproduced (without mechanical reduction) on paper  
 8 sized eight and one-half (8 1/2) inches by eleven (11) inches or eight  
 9 and one-half (8 1/2) inches by fourteen (14) inches.

10 "Trade secret" has the meaning set forth in IC 24-2-3-2.

11 "Work product of an attorney" means information compiled by an  
 12 attorney in reasonable anticipation of litigation and includes the  
 13 attorney's:

- 14 (1) notes and statements taken during interviews of prospective  
 15 witnesses; and  
 16 (2) legal research or records, correspondence, reports, or  
 17 memoranda to the extent that each contains the attorney's  
 18 opinions, theories, or conclusions.

19 This definition does not restrict the application of any exception under  
 20 section 4 of this chapter.

21 SECTION 2. IC 12-7-2-154.8 IS ADDED TO THE INDIANA  
 22 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 23 [EFFECTIVE UPON PASSAGE]: **Sec. 154.8. "Qualified entity", for**  
 24 **purposes of IC 12-15-2.2, has the meaning set forth in**  
 25 **IC 12-15-2.2-1.**

26 SECTION 3. IC 12-10-6-1, AS AMENDED BY P.L.24-1997,  
 27 SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 28 JULY 1, 1998]: Sec. 1. (a) An individual who:

- 29 (1) is at least sixty-five (65) years of age, blind, or disabled; and  
 30 (2) is a resident of a county home;

31 is eligible to receive assistance payments from the state if the  
 32 individual would be eligible for assistance under the federal  
 33 Supplemental Security Income program except for the fact that the  
 34 individual is residing in a county home.

35 (b) The amount of nonmedical assistance to be paid on behalf of a  
 36 resident in a county home must be based on the daily rate established  
 37 by the division. The rate for facilities under this section and licensed  
 38 under IC 16-28 may not exceed an upper rate limit established by a rule  
 39 adopted by the division.

40 (c) The rate for facilities under this section but not licensed under  
 41 IC 16-28 must be the lesser of:

- 42 (1) an upper rate limit established by a rule adopted by the

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- 1 division; or  
 2 (2) a reasonable and adequate rate to meet the costs, determined  
 3 by generally accepted accounting principles, that are incurred by  
 4 efficiently and economically operated facilities in order to provide  
 5 care and services in conformity with quality and safety standards  
 6 and applicable laws and rules.
- 7 (d) The recipient shall be paid or allowed to retain from the  
 8 recipient's income a **monthly** personal allowance in an amount to be  
 9 established by the division. The amount:  
 10 (1) may be not less than ~~twenty-eight dollars and fifty cents~~  
 11 ~~(\$28.50)~~ **thirty-five dollars (\$35)** and not more than ~~thirty-five~~  
 12 ~~dollars (\$35) monthly; sixty-one dollars and thirty-two cents~~  
 13 **(\$61.32);**  
 14 (2) is exempt from income eligibility consideration by the  
 15 division; and  
 16 (3) may be exclusively used by the recipient for personal needs.
- 17 (e) In addition to the amount that may be retained as a personal  
 18 allowance under this section, an individual is allowed to retain an  
 19 amount equal to the individual's state and local income tax liability.  
 20 The amount that may be retained during a month may not exceed  
 21 one-third (1/3) of the individual's state and local income tax liability for  
 22 the calendar quarter in which the month occurs. This amount is exempt  
 23 from income eligibility consideration by the division. The amount  
 24 retained shall be used by the individual to pay state or local income  
 25 taxes owed.
- 26 (f) The division of disability, aging, and rehabilitative services, in  
 27 cooperation with the state department of health taking into account  
 28 licensure requirements under IC 16-28, shall adopt rules under  
 29 IC 4-22-2 governing the reimbursement to facilities under this section.  
 30 The rules must be designed to determine the costs that must be incurred  
 31 by efficiently and economically operated facilities to provide room,  
 32 board, laundry, and other services, along with minimal administrative  
 33 direction to individuals who receive residential care in the facilities  
 34 under this section. A rule adopted under this subsection by:  
 35 (1) the division; or  
 36 (2) the state department of health;  
 37 must conform to the rules for residential care facilities that are licensed  
 38 under IC 16-28.
- 39 (g) A rate established under this section may be appealed according  
 40 to the procedures under IC 4-21.5.
- 41 (h) The division shall annually review each facility's rate using the  
 42 following:

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1 (1) Generally accepted accounting principles.

2 (2) The costs incurred by efficiently and economically operated  
3 facilities in order to provide care and services in conformity with  
4 quality and safety standards and applicable laws and rules.

5 SECTION 4. IC 12-10-6-2, AS AMENDED BY P.L.24-1997,  
6 SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
7 JULY 1, 1998]: Sec. 2. (a) An individual who is incapable of residing  
8 in the individual's own home may apply for residential care assistance  
9 under this section. The determination of eligibility for residential care  
10 assistance is the responsibility of the division. Except as provided in  
11 subsections (f) and (h), an individual is eligible for residential care  
12 assistance if the division determines that the individual:

13 (1) is a recipient of Medicaid or the federal Supplemental Security  
14 Income program;

15 (2) is incapable of residing in the individual's own home because  
16 of dementia, mental illness, or a physical disability;

17 (3) requires a degree of care less than that provided by a health  
18 care facility licensed under IC 16-28; and

19 (4) can be adequately cared for in a residential care setting.

20 (b) Individuals suffering from mental retardation may not be  
21 admitted to a home or facility that provides residential care under this  
22 section.

23 (c) A service coordinator employed by the division may:

24 (1) evaluate a person seeking admission to a home or facility  
25 under subsection (a); or

26 (2) evaluate a person who has been admitted to a home or facility  
27 under subsection (a), including a review of the existing  
28 evaluations in the person's record at the home or facility.

29 If the service coordinator determines the person evaluated under this  
30 subsection is mentally retarded, the service coordinator may  
31 recommend an alternative placement for the person.

32 (d) Except as provided in section 5 of this chapter, residential care  
33 consists of only room, board, and laundry, along with minimal  
34 administrative direction. State financial assistance may be provided for  
35 such care in a boarding or residential home of the applicant's choosing  
36 that is licensed under IC 16-28 or a Christian Science facility listed and  
37 certified by the Commission for Accreditation of Christian Science  
38 Nursing Organizations/Facilities, Inc., that meets certain life safety  
39 standards considered necessary by the state fire marshal. Payment for  
40 such care shall be made to the provider of the care according to  
41 division directives and supervision. The amount of nonmedical  
42 assistance to be paid on behalf of a recipient living in a boarding home,



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1 residential home, or Christian Science facility shall be based on the  
 2 daily rate established by the division. The rate for facilities that are  
 3 referred to in this section and licensed under IC 16-28 may not exceed  
 4 an upper rate limit established by a rule adopted by the division. The  
 5 recipient may retain from the recipient's income a **monthly** personal  
 6 allowance in an amount to be established by the division, but not less  
 7 than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars**  
 8 **(\$35)** or more than ~~thirty-five dollars (\$35) monthly~~ **sixty-one dollars**  
 9 **and thirty-two cents (\$61.32)**. This amount is exempt from income  
 10 eligibility consideration by the division and may be exclusively used by  
 11 the recipient for the recipient's personal needs. However, if the  
 12 recipient's income is less than the amount of the personal allowance,  
 13 the division shall pay to the recipient the difference between the  
 14 amount of the personal allowance and the recipient's income. A reserve  
 15 or an accumulated balance from such a source, together with other  
 16 sources, may not be allowed to exceed the state's resource allowance  
 17 allowed for adults eligible for state supplemental assistance or  
 18 Medicaid as established by the rules of the office of Medicaid policy  
 19 and planning.

20 (e) In addition to the amount that may be retained as a personal  
 21 allowance under this section, an individual shall be allowed to retain  
 22 an amount equal to the individual's state and local income tax liability.  
 23 The amount that may be retained during a month may not exceed  
 24 one-third (1/3) of the individual's state and local income tax liability for  
 25 the calendar quarter in which that month occurs. This amount is  
 26 exempt from income eligibility consideration by the division. The  
 27 amount retained shall be used by the individual to pay any state or local  
 28 income taxes owed.

29 (f) The rate of payment to the provider shall be determined in  
 30 accordance with a prospective prenegotiated payment rate predicated  
 31 on a reasonable cost related basis, with a growth of profit factor, as  
 32 determined in accordance with generally accepted accounting  
 33 principles and methods, and written standards and criteria, as  
 34 established by the division. The division shall establish an  
 35 administrative appeal procedure to be followed if rate disagreement  
 36 occurs if the provider can demonstrate to the division the necessity of  
 37 costs in excess of the allowed or authorized fee for the specific  
 38 boarding or residential home. The amount may not exceed the  
 39 maximum established under subsection (d).

40 (g) The personal allowance for one (1) month for an individual  
 41 described in subsection (a) whose employment is part of the  
 42 individual's personal habilitation plan or who is working in a sheltered



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1 workshop or day activity center is the amount that an individual would  
 2 be entitled to retain under subsection (d) plus an amount equal to  
 3 one-half (1/2) of the remainder of:

4 (1) gross earned income for that month; minus

5 (2) the sum of:

6 (A) sixteen dollars (\$16); plus

7 (B) the amount withheld from the person's paycheck for that  
 8 month for payment of state income tax, federal income tax,  
 9 and the tax prescribed by the federal Insurance Contribution  
 10 Act (26 U.S.C. 3101 et seq.); plus

11 (C) transportation expenses for that month.

12 (h) An individual who, before September 1, 1983, has been admitted  
 13 to a home or facility that provides residential care under this section is  
 14 eligible for residential care in the home or facility.

15 (i) The director of the division may contract with the division of  
 16 mental health or the division of disability, aging, and rehabilitative  
 17 services to purchase services for individuals suffering from mental  
 18 illness or a developmental disability by providing money to supplement  
 19 the appropriation for community residential care programs established  
 20 under IC 12-22-2 or community residential programs established under  
 21 IC 12-11-1-1.

22 (j) A person with a mental illness may not be placed in a Christian  
 23 Science facility listed and certified by the Commission for  
 24 Accreditation of Christian Science Nursing Organizations/Facilities,  
 25 Inc., unless the facility is licensed under IC 16-28.

26 SECTION 5. IC 12-15-1-18 IS ADDED TO THE INDIANA CODE  
 27 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE  
 28 UPON PASSAGE]: **Sec. 18. The office shall use all funds that are**  
 29 **appropriated to the office for outreach purposes to conduct**  
 30 **outreach activities in order to encourage children who are:**

31 (1) **less than nineteen (19) years of age;**

32 (2) **eligible for Medicaid; and**

33 (3) **not enrolled in the Medicaid program;**

34 **to apply for and enroll in the Medicaid program.**

35 SECTION 6. IC 12-15-2-15.6 IS ADDED TO THE INDIANA  
 36 CODE AS A **NEW SECTION** TO READ AS FOLLOWS  
 37 [EFFECTIVE JULY 1, 1998]: **Sec. 15.6. (a) Notwithstanding sections**  
 38 **15 and 15.5 of this chapter, an individual:**

39 (1) **whose family income does not exceed one hundred fifty**  
 40 **percent (150%) of the federal income poverty level for the**  
 41 **same size family;**

42 (2) **who is otherwise eligible for Medicaid under section 15 or**

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1           **15.5 of this chapter; and**  
 2           **(3) who is not otherwise eligible for Medicaid under this**  
 3           **chapter;**  
 4           **is eligible for Medicaid.**

5           **(b) The state's share of any treatment received by an individual**  
 6           **who is eligible for Medicaid under this section is calculated under**  
 7           **Section 1905(u) of the federal Social Security Act (42 U.S.C.**  
 8           **1396d(u)).**

9           **(c) This section expires June 30, 1999.**

10          SECTION 7. IC 12-15-2-15.7 IS ADDED TO THE INDIANA  
 11          CODE AS A NEW SECTION TO READ AS FOLLOWS  
 12          [EFFECTIVE JULY 1, 1998]: **Sec. 15.7. (a) An individual who is less**  
 13          **than nineteen (19) years of age and who is eligible for Medicaid**  
 14          **under sections 14 through 15.6 of this chapter is eligible to receive**  
 15          **Medicaid until the earlier of the following:**

16               **(1) The end of a period of twelve (12) consecutive months**  
 17               **following a determination of the individual's eligibility for**  
 18               **Medicaid.**

19               **(2) The individual becomes nineteen (19) years of age.**

20          **(b) This section expires June 30, 1999.**

21          SECTION 8. IC 12-15-2.2 IS ADDED TO THE INDIANA CODE  
 22          AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
 23          JULY 1, 1998]:

24          **Chapter 2.2. Presumptive Eligibility for Pregnant Women and**  
 25          **Children**

26          **Sec. 1. As used in this chapter, "qualified entity" means one (1)**  
 27          **of the following:**

28               **(1) To determine presumptive eligibility for a pregnant**  
 29               **woman, the term means an entity:**

30                       **(A) that is eligible to receive payments and provide items**  
 31                       **and services under this article;**

32                       **(B) that provides outpatient hospital services, rural health**  
 33                       **clinic services and any other ambulatory services offered**  
 34                       **by a rural health clinic, or clinic services furnished by or**  
 35                       **under the direction of a licensed physician;**

36                       **(C) that is determined by the office to be capable of making**  
 37                       **a determination described in section 5(1) of this chapter;**

38                       **(D) that meets all other requirements set forth in 42 U.S.C.**  
 39                       **1396r-1(b)(2)(D); and**

40                       **(E) that the office has determined is capable of making a**  
 41                       **determination that the family income of a pregnant woman**  
 42                       **does not exceed the income level of eligibility under**



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**IC 12-15-2.**

**(2) To determine presumptive eligibility for a child, the term means a provider that is eligible to receive payments under this article and is approved by the office or an entity that is authorized:**

**(A) to determine the eligibility of a child to:**

- (i) participate in a Head Start program under 42 U.S.C. 9831 et seq.;**
- (ii) receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 under 42 U.S.C. 9858 et seq.; or**
- (iii) receive assistance under the women, infants, and children nutrition program (as defined in IC 16-35-1.5-5); and**

**(B) by the office to be capable of making a determination that the family income of a child does not exceed the income level of eligibility under IC 12-15-2.**

**Sec. 2. A qualified entity may establish the presumptive eligibility of an individual who may be eligible for:**

- (1) Medicaid under IC 12-15-2-11 through IC 12-15-2-15.6; or**
- (2) services from the children's health insurance program under IC 16-35-6.**

**Sec. 3. (a) An entity described in section 1(2) of this chapter may apply to the office, on a form provided by the office, for authorization to be a qualified entity under this chapter.**

**(b) Notwithstanding section 1(2) of this chapter and subsection (a), the office shall consider the following to be qualified entities:**

- (1) A disproportionate share provider under IC 12-15-16-1(a).**
- (2) An enhanced disproportionate share provider under IC 12-15-16-1(b).**
- (3) A federally qualified health clinic.**
- (4) A rural health clinic.**

**Sec. 4. The office shall provide each qualified entity with the following:**

- (1) Application forms for Medicaid.**
- (2) Information on how to assist pregnant women, parents, guardians, and other individuals in completing and filing the application forms.**

**Sec. 5. Subject to section 6(2) of this chapter, the office shall provide Medicaid services to a child or pregnant woman during a period that:**

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- 1 (1) begins on the date on which a qualified entity determines
- 2 on the basis of preliminary information that the family
- 3 income of the child or pregnant woman does not exceed the
- 4 applicable family income level of eligibility for the child or
- 5 pregnant woman for Medicaid under IC 12-15-2; and
- 6 (2) ends on the earlier of the following:
- 7 (A) The date on which a determination is made by a
- 8 representative of the county office with respect to the
- 9 eligibility of the child or pregnant woman for Medicaid
- 10 under IC 12-15-2.
- 11 (B) The last day of the month following the month in which
- 12 the qualified entity makes the determination described in
- 13 subdivision (1).

14 **Sec. 6. A pregnant woman:**

- 15 (1) may only have a presumptive eligibility determination
- 16 made by an entity described in section 1(1) of this chapter;
- 17 and
- 18 (2) is eligible to receive only ambulatory prenatal care during
- 19 a period of presumptive eligibility.

20 **Sec. 7. A qualified entity that determines that a child or**  
21 **pregnant woman is presumptively eligible for Medicaid shall do the**  
22 **following:**

- 23 (1) Notify the office of the determination within five (5)
- 24 working days after the date on which the determination is
- 25 made.
- 26 (2) Inform:
- 27 (A) the parent, guardian, or custodian of the child; or
- 28 (B) the pregnant woman;
- 29 at the time a determination is made that an application for
- 30 Medicaid is required to be made at the county office in the
- 31 county where the child or the pregnant woman resides or an
- 32 enrollment center (as provided in IC 12-15-4-1) not later than
- 33 the last day of the month following the month during which
- 34 the determination is made.

35 **Sec. 8. If a child or pregnant woman is determined to be**  
36 **presumptively eligible for Medicaid under this chapter, the:**

- 37 (1) child's parent, guardian, or custodian; or
- 38 (2) pregnant woman;
- 39 shall complete an application for Medicaid as provided in
- 40 IC 12-15-4 not later than the last day of the month following the
- 41 month during which the determination is made.

42 **Sec. 9. If a child or pregnant woman:**

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1 (1) is determined to be presumptively eligible for Medicaid  
2 under this chapter; and

3 (2) appoints, in writing, an agent of a qualified entity under  
4 section 3(b)(1) or 3(b)(2) of this chapter as the child's or  
5 pregnant woman's authorized representative for purposes of  
6 completing all aspects of the Medicaid application process;  
7 the county office shall conduct any face-to-face interview with the  
8 child's or pregnant woman's authorized representative that is  
9 necessary to determine the child's or pregnant woman's eligibility  
10 for Medicaid.

11 **Sec. 10. If a child or pregnant woman is:**

12 (1) determined to be presumptively eligible for Medicaid  
13 under this chapter; and

14 (2) subsequently determined not to be eligible for Medicaid  
15 after filing an application for Medicaid as required under  
16 section 8 of this chapter;

17 a qualified entity under section 3(b)(1) or 3(b)(2) of this chapter  
18 that determined that the child or pregnant woman was  
19 presumptively eligible for Medicaid shall reimburse the office for  
20 all funds expended by the office in paying for care for the child or  
21 pregnant woman during the child's or pregnant woman's period of  
22 presumptive eligibility.

23 **Sec. 11. The office shall adopt rules under IC 4-22-2 to**  
24 **implement this chapter, including rules that may impose additional**  
25 **requirements for qualified entities that are consistent with federal**  
26 **regulations.**

27 SECTION 9. IC 12-15-4-1 IS AMENDED TO READ AS  
28 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An application  
29 or a request for Medicaid for an individual must be **made:**

30 (1) made to the county office of the county in which the applicant  
31 resides; and

32 (2) in the manner required by the office; and

33 (2) at one (1) of the following locations in the county where the  
34 applicant resides:

35 (A) A hospital licensed under IC 16-21.

36 (B) The office of a provider who is eligible to receive  
37 payments under this article.

38 (C) A public or private elementary or secondary school.

39 (D) A day care center licensed under IC 12-17.2.

40 (E) The county health department.

41 (F) A federally qualified health center (as defined in 42  
42 U.S.C. 1396d(l)(2)(B)).



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- 1 (G) A rural health clinic (as defined in 42 U.S.C.
- 2 1396d(l)(1)).
- 3 (H) The county office.
- 4 (I) Any other location approved by the office under
- 5 subsection (b).

6 (b) An entity described in subsection (a)(2) other than the  
 7 county office may apply to the office, on a form provided by the  
 8 office, for authorization to serve as an enrollment center where  
 9 individuals may apply for Medicaid.

10 (c) One (1) or more employees at each enrollment center shall:  
 11 (1) accept applications for Medicaid; and  
 12 (2) conduct interviews with applicants;  
 13 during hours and days of the week agreed upon by the office and  
 14 the enrollment center.

15 (d) The office shall provide each enrollment center with the  
 16 materials and training needed by the enrollment center to comply  
 17 with this section.

18 (e) An enrollment center shall provide:  
 19 (1) each application taken by the enrollment center; and  
 20 (2) any accompanying materials;  
 21 to the county office located in the same county as the enrollment  
 22 center at least one (1) time each week by any reasonable means.  
 23 The county office shall then make the final determination of an  
 24 applicant's eligibility for Medicaid.

25 SECTION 10. IC 12-15-7-2 IS AMENDED TO READ AS  
 26 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. Not less than  
 27 ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)**  
 28 or more than ~~thirty-five dollars (\$35)~~ **sixty-one dollars and thirty-two**  
 29 **cents (\$61.32)** monthly may be exempt from income eligibility  
 30 consideration.

31 SECTION 11. IC 12-15-32-6 IS AMENDED TO READ AS  
 32 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. The office shall  
 33 allow a resident of a facility who is receiving Medicaid to retain a  
 34 **monthly** personal allowance of at least ~~twenty-eight dollars and fifty~~  
 35 ~~cents (\$28.50)~~ **thirty-five dollars (\$35)** but not more than ~~fifty dollars~~  
 36 ~~(\$50)~~ **each month: sixty-one dollars and thirty-two cents (\$61.32).**

37 SECTION 12. IC 12-26-2-5, AS AMENDED BY P.L.6-1995,  
 38 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 39 UPON PASSAGE]: Sec. 5. (a) This section applies under the following  
 40 statutes:

- 41 (1) IC 12-26-6.
- 42 (2) IC 12-26-7.

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1 (3) IC 12-26-12.  
 2 (4) IC 12-26-15.  
 3 (b) A petitioner may be represented by counsel.  
 4 (c) The court may appoint counsel for a petitioner upon a showing  
 5 of the petitioner's indigency and the court shall pay for such counsel if  
 6 appointed.  
 7 (d) A petitioner, including a petitioner who is a health care provider  
 8 under ~~IC 16-18-2-295(b)~~, **IC 16-18-2-295(c)**, in the petitioner's  
 9 individual capacity or as a corporation is not required to be represented  
 10 by counsel. If a petitioner who is a corporation elects not to be  
 11 represented by counsel, the individual representing the corporation at  
 12 the commitment hearing must present the court with written  
 13 authorization from:  
 14 (1) an officer;  
 15 (2) a director;  
 16 (3) a principal; or  
 17 (4) a manager;  
 18 of the corporation that authorizes the individual to represent the interest  
 19 of the corporation in the proceedings.  
 20 (e) The petitioner is required to prove by clear and convincing  
 21 evidence that:  
 22 (1) the individual is mentally ill and either dangerous or gravely  
 23 disabled; and  
 24 (2) detention or commitment of that individual is appropriate.  
 25 SECTION 13. IC 16-18-2-255.5 IS ADDED TO THE INDIANA  
 26 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 27 [EFFECTIVE JULY 1, 1998]: **Sec. 255.5. "Office", for purposes of**  
 28 **IC 16-35-6, has the meaning set forth in IC 16-35-6-1.**  
 29 SECTION 14. IC 16-18-2-282.2 IS ADDED TO THE INDIANA  
 30 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 31 [EFFECTIVE JULY 1, 1998]: **Sec. 282.2. (a) "Physicians' services",**  
 32 **for purposes of IC 16-35-6-18, has the meaning set forth in**  
 33 **IC 16-35-16-18(a).**  
 34 SECTION 15. IC 16-18-2-295, AS AMENDED BY P.L.188-1995,  
 35 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 36 UPON PASSAGE]: Sec. 295. (a) "Provider", for purposes of IC 16-25,  
 37 means a hospice program certified under IC 16-25-1.  
 38 **(b) "Provider", for purposes of IC 16-35-6, has the meaning set**  
 39 **forth in IC 16-35-6-2.**  
 40 ~~(b)~~ (c) "Provider", for purposes of IC 16-39 except for IC 16-39-7  
 41 and for purposes of IC 16-41-1 through IC 16-41-9, means any of the  
 42 following:

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1 (1) An individual (other than an individual who is an employee or  
 2 a contractor of a hospital, a facility, or an agency described in  
 3 subdivision (2) or (3)) who is licensed, registered, or certified as  
 4 a health care professional, including the following:

- 5 (A) A physician.  
 6 (B) A psychotherapist.  
 7 (C) A dentist.  
 8 (D) A registered nurse.  
 9 (E) A licensed practical nurse.  
 10 (F) An optometrist.  
 11 (G) A podiatrist.  
 12 (H) A chiropractor.  
 13 (I) A physical therapist.  
 14 (J) A psychologist.  
 15 (K) An audiologist.  
 16 (L) A speech-language pathologist.  
 17 (M) A dietitian.  
 18 (N) An occupational therapist.  
 19 (O) A respiratory therapist.  
 20 (P) A pharmacist.

21 (2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or  
 22 described in IC 12-24-1 or IC 12-29.

23 (3) A health facility licensed under IC 16-28-2.

24 (4) A home health agency licensed under IC 16-27-1.

25 (5) An employer of a certified emergency medical technician, a  
 26 certified advanced emergency medical technician, or a certified  
 27 paramedic.

28 (c) (d) "Provider", for purposes of IC 16-39-7-1, has the meaning set  
 29 forth in IC 16-39-7-1(a).

30 SECTION 16. IC 16-35-6 IS ADDED TO THE INDIANA CODE  
 31 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE  
 32 UPON PASSAGE]:

33 **Chapter 6. Children's Health Insurance Program**

34 **Sec. 1. As used in this chapter, "office" refers to the office of the**  
 35 **children's health insurance program established under this**  
 36 **chapter.**

37 **Sec. 2. (a) As used in this chapter, "provider" means any person**  
 38 **who provides health insurance in Indiana. The term includes the**  
 39 **following:**

- 40 (1) A licensed insurance company.  
 41 (2) A health maintenance organization.  
 42 (3) A multiple employer welfare arrangement.



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1           **(4) Any person providing a plan of health insurance subject to**  
2           **state insurance law.**  
3           **(b) For purposes of section 7(b) of this chapter, the term**  
4           **includes a limited service health maintenance organization (as**  
5           **defined in IC 27-13-34-4) and a preferred provider plan (as defined**  
6           **in IC 27-8-11-1).**  
7           **Sec. 3. The children's health insurance program is established**  
8           **within the state department.**  
9           **Sec. 4. A child may apply at an enrollment center or at the office**  
10          **of a qualified entity under IC 12-15-2.2 to receive health care**  
11          **services if the child:**  
12               **(1) meets the qualifications described in section 12 of this**  
13               **chapter; or**  
14               **(2) receives health care services through the Hoosier**  
15               **Healthwise program under IC 12-15.**  
16          **Sec. 5. A child who enrolls in the children's health insurance**  
17          **program shall receive the health care services described in section**  
18          **18 of this chapter regardless of whether the child is described in**  
19          **section 4(1) of this chapter or section 4(2) of this chapter.**  
20          **Sec. 6. The office shall design and administer a system to obtain**  
21          **health insurance for eligible children.**  
22          **Sec. 7. (a) The office shall contract with providers under IC 5-22**  
23          **to provide health insurance and other services to a child who is**  
24          **enrolled in the children's health insurance program. A contract**  
25          **under this subsection must require a provider to do the following:**  
26               **(1) Serve as a qualified entity (as defined in IC 12-15-2.2-1) in**  
27               **order to determine the presumptive eligibility for pregnant**  
28               **women and children for Medicaid as provided in IC 12-15-2.2.**  
29               **(2) Assist a presumptively eligible individual under**  
30               **subdivision (1) to select a primary care provider.**  
31               **(3) Establish locations where an applicant may apply to**  
32               **receive services provided by the children's health insurance**  
33               **program.**  
34               **(4) Provide education concerning the following:**  
35                   **(A) The responsible use of health facilities and**  
36                   **information.**  
37                   **(B) Preventive care.**  
38                   **(C) Parental responsibilities for a child's health care.**  
39               **(5) Provide outreach and evaluation activities for the**  
40               **children's health insurance program.**  
41          **(b) The office may contract with providers to provide the**  
42          **services described in section 18(c) of this chapter. A provider under**

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**this subsection must:**

- (1) be eligible to receive reimbursement from the office; and**
- (2) comply with subsection (a)(3), (a)(4), and (a)(5).**

**Sec. 8. (a) The office shall establish performance criteria and evaluation measures for a provider that the office contracts with under section 7 of this chapter.**

**(b) The office shall assess monetary penalties on a provider that fails to comply with the requirements of this chapter or a rule adopted under this chapter.**

**Sec. 9. The office shall adopt a sliding scale formula that specifies the premiums, if any, to be paid by the parent or guardian of a child enrolled in the children's health insurance program based on the parent's or guardian's annual income.**

**Sec. 10. (a) The office shall annually adjust the participation requirements to reflect the amount of money available to obtain health insurance for children enrolled in the children's health insurance program.**

**(b) The office shall operate the children's health insurance program within available funds appropriated to the office.**

**Sec. 11. The office shall establish and administer a children's health insurance program fund to provide premium assistance from the state to children enrolled in the children's health insurance program.**

**Sec. 12. In order to enroll in the children's health insurance program, a child must meet the following requirements:**

- (1) The child and the child's family may not have access to affordable health insurance through an employer.**
- (2) The child and the child's family may not have not participated in a health insurance program for at least one (1) year before enrolling in the children's health insurance program.**
- (3) The child's family agrees to provide copayments for services based on a sliding fee scale developed by the office.**

**Sec. 13. To be eligible to receive reimbursement from the office, a provider shall offer health care services required by this chapter to an eligible child without:**

- (1) regard to the child's health status; and**
- (2) imposing a preexisting condition exclusion;**

**except that a preexisting condition exclusion may be applied if health care services are provided through a group health plan or group health insurance coverage, consistent with the limitations on imposing preexisting condition exclusions provided in state and**

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**federal law.**

**Sec. 14. Premium and cost sharing amounts established by the office are limited to the following:**

**(1) Deductibles, coinsurance, or other cost sharing are not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.**

**(2) For children whose family income is equal to or less than one hundred fifty percent (150%) of the federal income poverty level:**

**(A) premiums, enrollment fees, or similar charges may not exceed the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) of the Social Security Act, (42 U.S.C. 301 et seq.); and**

**(B) deductibles and other cost sharing shall not exceed a nominal amount that is consistent with standards provided under Section 1916(a)(3) of the Social Security Act (42 U.S.C. 301 et seq.), as adjusted.**

**(3) For children whose family income is greater than one hundred fifty percent (150%) of the federal income poverty level, premiums, deductibles, and other cost sharing may be imposed on a sliding scale related to family income; however, the total annual aggregate cost sharing with respect to all children in a family under this chapter may not exceed five percent (5%) of the family's income for the year.**

**Sec. 15. Providers shall use existing health insurance sales and marketing methods, including the use of agents and payment of commissions, to inform families of the availability of the children's health insurance program and assist families in obtaining health insurance coverage for children under the children's health insurance program.**

**Sec. 16. A child who is eligible to participate in the children's health insurance program is eligible for coverage with a participating plan regardless of the child's health status.**

**Sec. 17. (a) A child who is participating in the children's health insurance program may change between participating plans only during an annual coverage renewal period, unless the child moves outside of the geographic service area of the participating plan in which the child is enrolled.**

**(b) A child who moves to an area outside the geographic service area of the participating plan in which the child is enrolled shall provide notice to the participating plan at least sixty (60) days before the child may change participating plans.**

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1           **Sec. 18. (a)** As used in this section, "physicians' services" has the  
2 meaning set forth in 42 U.S.C. 1395x(q).

3           **(b)** The office shall offer health insurance coverage for the  
4 following basic services:

- 5           **(1)** Inpatient and outpatient hospital services.
- 6           **(2)** Physicians' services.
- 7           **(3)** Laboratory and x-ray services.
- 8           **(4)** Well-baby and well-child care, including age appropriate  
9 immunizations.

10           **(c)** The office shall offer health insurance coverage for the  
11 following additional services if the coverage for the services has an  
12 actuarial value equal to the actuarial value of the services provided  
13 by the benchmark program for the following:

- 14           **(1)** Coverage of prescription drugs.
- 15           **(2)** Mental health services.
- 16           **(3)** Vision services.
- 17           **(4)** Hearing services.
- 18           **(5)** Dental services.

19           **(d)** Notwithstanding subsections (b) and (c), the office shall offer  
20 health insurance coverage for the same services provided under the  
21 early and periodic screening, diagnosis, and treatment program  
22 (EPSDT) under IC 12-15.

23           **(e)** Notwithstanding subsections (b), (c), and (d), the office may  
24 not impose treatment limitations or financial requirements on the  
25 coverage of services for a mental illness if similar treatment  
26 limitations or financial requirements are not imposed on coverage  
27 for services for other illnesses.

28           **Sec. 19.** The office shall do the following:

- 29           **(1)** Establish a penalty to be paid by the following:
  - 30           **(A)** An insurer, insurance agent, or insurance broker, for  
31 knowingly or intentionally referring an insured or the  
32 dependent of an insured to the children's health insurance  
33 program in order to receive health care when the insured  
34 receives health insurance through an employer's health  
35 care plan that is underwritten by the insurer.
  - 36           **(B)** An employer, for knowingly or intentionally referring  
37 an employee or the dependent of an employee to the  
38 children's health insurance program in order to receive  
39 health care when the employee receives health insurance  
40 through the employer's health care plan.
  - 41           **(C)** An employer that knowingly or intentionally changes  
42 the terms of coverage for or premiums paid by an

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1           employee in order to force an employee or the dependent  
2           of an employee to apply to the children's health insurance  
3           program in order to receive health care.

4           (2) Create standards to minimize the incentive for:

5           (A) an employer to eliminate or reduce health care  
6           coverage for an employee's dependents; or

7           (B) an individual to eliminate or reduce health care  
8           coverage for a dependent of the individual.

9           Sec. 20. The office of the secretary of family and social services  
10          shall provide information and assistance to the office as requested  
11          by the office.

12          Sec. 21. Not later than March 1 of each year, the office shall  
13          provide a report describing the office's activities during the  
14          preceding calendar year to the state budget committee.

15          Sec. 22. The office shall adopt rules under IC 4-22-2 to  
16          implement this chapter.

17          SECTION 17. [EFFECTIVE UPON PASSAGE]: (a) As used in this  
18          SECTION, "office" refers to the office of the children's health  
19          insurance program under IC 16-35-6, as added by this act.

20          (b) The office, with the assistance of the office of Medicaid  
21          policy and planning, shall apply under Section 1115 of the federal  
22          Social Security Act to the Secretary of the United States  
23          Department of Health and Human Services for any waivers  
24          required to implement the children's health insurance program.  
25          The intent of a waiver under this SECTION is to allow the state to  
26          offer the same health care services both to children who enroll in  
27          the children's health insurance program and to children who  
28          currently receive health care services under the Medicaid  
29          program.

30          (c) This SECTION expires January 1, 2001.

31          SECTION 18. [EFFECTIVE UPON PASSAGE] (a) As used in this  
32          SECTION, "office" refers to the office of the children's health  
33          insurance program under IC 16-35-6, as added by this act.

34          (b) The office shall submit a state plan outlining Indiana's initial  
35          children's health insurance program to the Secretary of the United  
36          States Department of Health and Human Services before July 1,  
37          1998.

38          (c) The office shall amend the state plan outlining Indiana's  
39          children's health insurance program to describe a children's health  
40          insurance program, including the elements required under  
41          IC 16-35-6, as added by this act, before April 1, 1999. The state  
42          plan amendment required under this SECTION must include



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1 identification of the benchmark program that will be used by the  
2 office, as provided in IC 16-35-6-18, as added by this act.

3 (d) The state shall transfer funds from the Medicaid indigent  
4 care trust fund under IC 12-15-20 to pay for the state's share of  
5 funds required to receive federal financial participation under the  
6 program.

7 (e) This SECTION expires January 1, 2001.

8 SECTION 19. [EFFECTIVE JULY 1, 1998]: (a) This SECTION  
9 does not apply to services provided by a facility licensed under  
10 IC 16-28.

11 (b) As used in this SECTION, "community care network"  
12 means a system of providing or arranging for health services and  
13 related items for the residents of a community within the needs and  
14 resources of the community.

15 (c) As used in this SECTION, "political subdivision" has the  
16 meaning set forth in IC 34-4-16.5-2.

17 (d) One (1) or more political subdivisions may elect to  
18 participate in a pilot program under this SECTION by forming a  
19 community care network for the purpose of pooling and  
20 administering funds to be used in providing or arranging to  
21 provide health services and related items to at least one (1) of the  
22 following groups:

- 23 (1) The employees of the political subdivisions.
- 24 (2) Enrollees whose health services and items are provided  
25 under IC 12-15, if approved by the office of the secretary.
- 26 (3) The enrollees of the children's health insurance program  
27 under IC 16-35-6.
- 28 (4) The employees of private employers, if appropriate.
- 29 (5) Other groups of residents approved for inclusion by the  
30 board of directors as provided under subsection (f).

31 (e) A community care network is authorized to pool funds  
32 provided to the community care network by:

- 33 (1) the political subdivisions participating in the community  
34 care network;
- 35 (2) private employers;
- 36 (3) state and federal entities;
- 37 (4) grants; and
- 38 (5) any other source;

39 for financing and arranging to provide health services and related  
40 items to the employees and residents of the political subdivisions.

41 (f) A community care network is governed by a board of  
42 directors.



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1 (g) A board of directors must have an odd number of members  
2 that is not less than five (5) members but not more than eleven (11)  
3 members.

4 (h) Members of a board of directors must include the following:

5 (1) Representatives of the political subdivisions establishing  
6 the community care network.

7 (2) Representatives of the employees of the political  
8 subdivisions establishing the community care network.

9 (3) Representatives of the residents, if applicable, of the  
10 political subdivisions establishing the community care  
11 network.

12 (4) Representatives of providers that will provide health  
13 services and related items to individuals receiving health care  
14 through the community care network.

15 The political subdivisions establishing the community care network  
16 must agree to the number of representatives under subdivisions (1)  
17 through (4).

18 (i) Each member of a board of directors must have  
19 demonstrated expertise in health care financing or health care  
20 delivery systems, or both.

21 (j) The executives of the political subdivisions establishing the  
22 community care network must:

23 (1) agree to the number of members each executive may  
24 appoint; and

25 (2) after reaching agreement under subdivision (1), appoint  
26 members;

27 to the board of directors.

28 (k) The board of directors of each community care network  
29 shall establish a community care network fund to pay for health  
30 services and related items for participants in the network.

31 (l) The board of directors shall establish guidelines for the  
32 community care network that include the following:

33 (1) Quality assurance.

34 (2) Benefit levels.

35 (3) Improved access to health care.

36 (4) Cost containment through early intervention.

37 (5) Medical staff expertise.

38 (6) Coordination of community resources.

39 (7) Community, parental, and school involvement.

40 (m) A community care network must be approved annually by:

41 (1) the department of insurance; and

42 (2) the office of the secretary of family and social services.



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1           (n) The department of insurance must certify that a community  
2 care network possesses necessary financial reserves.

3           (o) A community care network may contract with:

4               (1) an accident and sickness insurance company, including  
5 reimbursement agreements under IC 27-8-11;

6               (2) a health care provider (as defined in IC 27-12-2-14); or

7               (3) a nonprofit agency that provides health care services;

8 to provide or arrange for the provision of health services and items  
9 for the employees and residents of the political subdivisions  
10 establishing the community care network.

11           (p) A contract under subsection (o) may be awarded only after  
12 the community care network uses a public bidding process for the  
13 contract.

14           (q) A community care network established under this  
15 SECTION:

16               (1) may contract with the state to provide services under  
17 IC 12-14, IC 12-15, and IC 16-35-6; and

18               (2) is a body corporate and politic.

19           (r) Any plan of self-insurance must include an aggregate  
20 stop-loss provision.

21           (s) The political subdivisions establishing the community care  
22 network:

23               (1) shall appropriate to the community care network any  
24 funds necessary to provide health services and related items  
25 for employees of the political subdivisions; and

26               (2) may appropriate funds for health services and items  
27 provided to other residents of the political subdivisions.

28           (t) If Medicaid funds are used by a community care network to  
29 pay for health services and related items, the office of Medicaid  
30 policy and planning:

31               (1) shall assure that patients served by federally qualified  
32 health centers, rural health clinics, and other primary care  
33 providers that target uninsured or Medicaid patients have  
34 equal or better access to comprehensive quality primary care  
35 services; and

36               (2) may apply to the Secretary of the United States  
37 Department of Health and Human Services for any waivers  
38 necessary to implement this SECTION.

39           (u) If the office of Medicaid policy and planning seeks a waiver  
40 under IC 12-15 to establish a managed care program or other  
41 demonstration project, the office of Medicaid policy and planning  
42 shall not seek a waiver of:



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- 1           **(1) federally qualified health centers and rural health clinic**
- 2           **services as mandatory Medicaid services under:**
- 3               **(A) 42 U.S.C. 1396a(10)(A);**
- 4               **(B) 42 U.S.C. 1396d(a)(2)(B); and**
- 5               **(C) 42 U.S.C. 1396d(a)(2)(C); or**
- 6           **(2) reasonable cost reimbursement for federally qualified**
- 7           **health centers and rural health clinics under 42 U.S.C.**
- 8           **1396a(a)(13)(E).**
- 9           **(v) A community care network established under this SECTION**
- 10          **shall file a report with the department of insurance and the office**
- 11          **of the secretary of family and social services not later than March**
- 12          **1 of each year that provides information about the community care**
- 13          **network during the preceding calendar year that is requested by**
- 14          **the department of insurance and the office of the secretary of**
- 15          **family and social services.**
- 16          **(w) Not later than January 1, 2002, the department of insurance**
- 17          **and the office of the secretary of family and social services shall**
- 18          **begin to evaluate the community care networks established under**
- 19          **this SECTION.**
- 20          **(x) Not later than November 1, 2002, the department of**
- 21          **insurance and the office of the secretary of family and social**
- 22          **services shall report to the legislative council and the governor**
- 23          **regarding whether community care networks should be established**
- 24          **legislatively on an ongoing basis.**
- 25          **(y) A community care network may not begin operation before**
- 26          **January 1, 1999.**
- 27          **(z) This SECTION expires January 1, 2003.**
- 28          **SECTION 20. An emergency is declared for this act.**

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SENATE MOTION

Mr. President: I move that Senator Garton be removed as author of Senate Bill 19 and that Senator Johnson be substituted therefor.

GARTON

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COMMITTEE REPORT

Mr. President: The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill 19, 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:

Delete the title and insert the following:

"A BILL FOR AN ACT to amend the Indiana Code concerning human services."

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill be reassigned to the Senate Committee on Planning and Public Services.

(Reference is to Senate Bill 19 as introduced.)

GARTON, Chairperson

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## COMMITTEE REPORT

Mr. President: The Senate Committee on Planning and Public Services, to which was referred Senate Bill 19, 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 6, line 16, after "3." insert "(a).

Page 6, between lines 18 and 19, begin a new paragraph and insert:

**"(b) Notwithstanding section 1(2) of this chapter and subsection (a), the office shall consider the following to be qualified entities:**

- (1) A disproportionate share provider under IC 12-15-16-1(a).**
- (2) An enhanced disproportionate share provider under IC 12-15-16-1(b).**
- (3) A federally qualified health clinic.**
- (4) A rural health clinic."**

Page 7, line 17, after "office" insert "or an enrollment center".

Page 7, line 18, after "resides" insert "(as provided in IC 12-15-4-1)".

Page 7, between lines 28 and 29, begin a new paragraph and insert:

**"SECTION 7. 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 made:**

**(1) made to the county office of the county in which the applicant resides; and**

**(2) in the manner required by the office; and**

**(2) at one (1) of the following locations in the county where the applicant resides:**

- (A) A hospital licensed under IC 16-21.**
- (B) The office of a provider who is eligible to receive payments under this article.**
- (C) A public or private elementary or secondary school.**
- (D) A day care center licensed under IC 12-17.2.**
- (E) The county health department.**
- (F) A federally qualified health center (as defined in 42 U.S.C. 1396d(1)(2)(B)).**
- (G) A rural health clinic (as defined in 42 U.S.C. 1396d(1)(1)).**
- (H) The county office.**
- (I) Any other location approved by the office under subsection (b).**

**(b) An entity described in subsection (a)(2) other than the county office may apply to the office, on a form provided by the office, for authorization to serve as an enrollment center where**

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individuals may apply for Medicaid.

(c) One (1) or more employees at each enrollment center shall:

- (1) accept applications for Medicaid; and
- (2) conduct interviews with applicants;

during hours and days of the week agreed upon by the office and the enrollment center.

(d) The office shall provide each enrollment center with the materials and training needed by the enrollment center to comply with this section.

(e) An enrollment center shall provide:

- (1) each application taken by the enrollment center; and
- (2) any accompanying materials;

to the county office located in the same county as the enrollment center at least one (1) time each week by any reasonable means. The county office shall then make the final determination of an applicant's eligibility for Medicaid."

Page 8, delete lines 17 through 20, begin a new paragraph and insert:

"SECTION 9. IC 16-18-2-255.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 255.5. "Office", for purposes of IC 16-35-6, has the meaning set forth in IC 16-35-6-1.**

SECTION 10. IC 16-18-2-282.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 282.2. (a) "Physicians' services", for purposes of IC 16-35-6-18, has the meaning set forth in IC 16-35-16-18(a).**"

Page 9, line 21, delete "program" and insert "office".

Page 9, line 21, after "the" insert "office of the".

Page 9, delete line 28.

Page 9, line 29, delete "(3)" and insert "(2)".

Page 9, line 30, delete "(4)" and insert "(3)".

Page 9, line 31, delete "(5)" and insert "(4)".

Page 9, line 35, delete "to receive services provided by the" and insert "at an enrollment center to receive health care services".

Page 9, line 36, delete "program".

Page 9, line 41, after "in the" insert "children's health insurance".

Page 10, line 3, delete "program" and insert "office".

Page 10, line 5, delete "program" and insert "office".

Page 10, line 7, after "the" insert "children's health insurance".

Page 10, line 15, after "the" insert "children's health insurance".

Page 10, line 21, after "the" insert "children's health insurance".

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- Page 10, line 23, delete "program" and insert "**office**".
- Page 10, line 24, delete "program" and insert "**office**".
- Page 10, line 26, delete "program" and insert "**office**".
- Page 10, line 29, delete "program" and insert "**office**".
- Page 10, line 31, after "in the" insert "**children's health insurance**".
- Page 10, line 33, after "10." insert "(a)".
- Page 10, between lines 35 and 36, begin a new paragraph and insert:  
**"(b) The children's health insurance program shall operate within available funds appropriated to the program."**
- Page 10, line 36, delete "program" and insert "**office**".
- Page 10, line 36, after "a" insert "**children's health insurance**".
- Page 10, line 38, after "the" insert "**children's health insurance**".
- Page 10, line 39, delete "(a)".
- Page 10, line 39, after "the" insert "**children's health insurance**".
- Page 11, delete lines 7 through 8.
- Page 11, line 10, delete "program," and insert "**office**,".
- Page 11, line 10, after "offer" delete "program" and insert "**health care**".
- Page 11, line 10, after "services" insert "**required by this chapter**".
- Page 11, line 15, delete "program" and insert "**health care**".
- Page 11, line 19, delete "under the program" and insert "**established by the office**".
- Page 12, line 2, before "program" insert "**children's health insurance**".
- Page 12, line 4, after "the" insert "**children's health insurance**".
- Page 12, line 5, after "the" insert "**children's health insurance**".
- Page 12, line 6, delete "provider" and insert "**plan**".
- Page 12, line 8, after "the" insert "**children's health insurance**".
- Page 12, line 8, after "may" insert "**change only between participating plans during an annual coverage renewal period, unless the child moves outside of the geographic service area of the participating plan in which the child is enrolled.**".
- Page 12, delete lines 9 through 12.
- Page 12, line 13, delete "The period required for the notice to be sent under" and insert "**A child who moves to an area outside the geographic service area of the participating plan in which the child is enrolled shall provide notice to the participating plan at least sixty (60) days before the child may change participating plans.**".
- Page 12, delete lines 14 through 17.
- Page 12, line 18, after "(a)" insert "**As used in this section, 'physicians' services' has the meaning set forth in 42 U.S.C. 1395x(q).**".



Page 12, line 18, before "The" begin a new paragraph and insert:  
**"(b)".**

Page 12, line 18, delete "program" and insert "**office**".

Page 12, line 21, delete "surgical and medical".

Page 12, line 25, delete "program" and insert "**office**".

Page 12, line 27, delete "of at least seventy-five percent (75%) of the" and insert "**equal to**".

Page 12, line 35, delete "program" and insert "**office**".

Page 12, between lines 38 and 39, begin a new paragraph and insert:

**"(d) Notwithstanding subsections (a) and (b), the office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses."**

Page 12, line 40, delete "program" and insert "**office**".

Page 12, line 41, delete "program" and insert "**office**".

Page 12, line 42, delete "program" and insert "**office**".

Page 13, line 1, delete "program's" and insert "**office's**".

Page 13, line 3, delete "program" and insert "**office**".

Page 13, line 6, delete ""program"" and insert ""**office**"".

Page 13, line 6, after "the" insert "**office of the**".

Page 13, line 8, delete "program" and insert "**office**".

Page 13, line 19, delete ""program"" and insert ""**office**"".

Page 13, line 19, after "the" insert "**office of the**".

Page 13, line 21, delete "program" and insert "**office**".

Page 13, line 25, delete "program" and insert "**office**".

Page 13, line 26, after "a" insert "**children's health insurance**".

Page 13, line 28, after "." insert "**The state plan amendment required under this SECTION must include identification of the benchmark program that will be used by the office, as provided in IC 16-35-6-18, as added by this act.**".

Page 13, between lines 33 and 34, begin a new paragraph and insert:

**"SECTION 13. [EFFECTIVE JULY 1, 1998] (a) This SECTION does not apply to services provided by a facility licensed under IC 16-28.**

**(b) As used in this SECTION, "community care network" means a system of providing or arranging for health services and related items for the residents of a community within the needs and resources of the community.**

**(c) As used in this SECTION, "political subdivision" has the meaning set forth in IC 34-4-16.5-2.**

**(d) One (1) or more political subdivisions may elect to**



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participate in a pilot program under this SECTION by forming a community care network for the purpose of pooling and administering funds to be used in providing or arranging to provide health services and related items to at least one (1) of the following groups:

- (1) The employees of the political subdivisions.
- (2) Enrollees whose health services and items are provided under IC 12-15, if approved by the office of the secretary.
- (3) The enrollees of the children's health insurance program under IC 16-35-6.
- (4) The employees of private employers, if appropriate.
- (5) Other groups of residents approved for inclusion by the board of directors as provided under subsection (f).

(e) A community care network is authorized to pool funds provided to the community care network by:

- (1) the political subdivisions participating in the community care network;
- (2) private employers;
- (3) state and federal entities;
- (4) grants; and
- (5) any other source;

for financing and arranging to provide health services and related items to the employees and residents of the political subdivisions.

(f) A community care network is governed by a board of directors.

(g) A board of directors must have an odd number of members that is not less than five (5) members but not more than eleven (11) members.

(h) Members of a board of directors must include the following:

- (1) Representatives of the political subdivisions establishing the community care network.
- (2) Representatives of the employees of the political subdivisions establishing the community care network.
- (3) Representatives of the residents, if applicable, of the political subdivisions establishing the community care network.
- (4) Representatives of providers that will provide health services and related items to individuals receiving health care through the community care network.

The political subdivisions establishing the community care network must agree to the number of representatives under subdivisions (1) through (4).



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(i) Each member of a board of directors must have demonstrated expertise in health care financing or health care delivery systems, or both.

(j) The executives of the political subdivisions establishing the community care network must:

- (1) agree to the number of members each executive may appoint; and
- (2) after reaching agreement under subdivision (1), appoint members;

to the board of directors.

(k) The board of directors of each community care network shall establish a community care network fund to pay for health services and related items for participants in the network.

(l) The board of directors shall establish guidelines for the community care network that include the following:

- (1) Quality assurance.
- (2) Benefit levels.
- (3) Improved access to health care.
- (4) Cost containment through early intervention.
- (5) Medical staff expertise.
- (6) Coordination of community resources.
- (7) Community, parental, and school involvement.

(m) A community care network must be approved annually by:

- (1) the department of insurance; and
- (2) the office of the secretary of family and social services.

(n) The department of insurance must certify that a community care network possesses necessary financial reserves.

(o) A community care network may contract with:

- (1) an accident and sickness insurance company, including reimbursement agreements under IC 27-8-11;
- (2) a health care provider (as defined in IC 27-12-2-14); or
- (3) a nonprofit agency that provides health care services;

to provide or arrange for the provision of health services and items for the employees and residents of the political subdivisions establishing the community care network.

(p) A contract under subsection (o) may be awarded only after the community care network uses a public bidding process for the contract.

(q) A community care network established under this SECTION may contract with the state to provide services under IC 12-14, IC 12-15, and IC 16-35-6.

(r) Any plan of self-insurance must include an aggregate

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stop-loss provision.

(s) The political subdivisions establishing the community care network:

(1) shall appropriate to the community care network any funds necessary to provide health services and related items for employees of the political subdivisions; and

(2) may appropriate funds for health services and items provided to other residents of the political subdivisions.

(t) If Medicaid funds are used by a community care network to pay for health services and related items, the office of Medicaid policy and planning:

(1) shall assure that patients served by federally qualified health centers, rural health clinics, and other primary care providers that target uninsured or Medicaid patients have equal or better access to comprehensive quality primary care services; and

(2) may apply to the Secretary of the United States Department of Health and Human Services for any waivers necessary to implement this SECTION.

(u) If the office of Medicaid policy and planning seeks a waiver under IC 12-15 to establish a managed care program or other demonstration project, the office of Medicaid policy and planning shall not seek a waiver of:

(1) federally qualified health centers and rural health clinic services as mandatory Medicaid services under:

(A) 42 U.S.C. 1396a(10)(A);

(B) 42 U.S.C. 1396d(a)(2)(B); and

(C) 42 U.S.C. 1396d(a)(2)(C); or

(2) reasonable cost reimbursement for federally qualified health centers and rural health clinics under 42 U.S.C. 1396a(a)(13)(E).

(v) A community care network established under this SECTION shall file a report with the department of insurance and the office of the secretary of family and social services not later than March 1 of each year that provides information about the community care network during the preceding calendar year that is requested by the department of insurance and the office of the secretary of family and social services.

(w) Not later than January 1, 2002, the department of insurance and the office of the secretary of family and social services shall begin to evaluate the community care networks established under this SECTION.



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**(x) Not later than November 1, 2002, the department of insurance and the office of the secretary of family and social services shall report to the legislative council and the governor regarding whether community care networks should be established legislatively on an ongoing basis.**

**(y) A community care network may not begin operation before January 1, 1999.**

**(z) This SECTION expires January 1, 2003."**

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 19 as printed January 14, 1998.)

JOHNSON, Chairperson

Committee Vote: Yeas 10, Nays 0.

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## SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 5, line 7, delete "Title XXI" and insert "**Section 1905(u)**".

Page 5, line 7, delete "42 U.S.C. 1396aa et" and insert "**42 U.S.C. 1396d(u)**".

Page 5, delete line 8.

Page 5, line 14, delete "11" and insert "**14**".

Page 12, line 2, delete "program" and insert "**office**".

Page 12, line 4, after "the" insert "**children's health insurance**".

Page 12, line 5, delete "children's health insurance program" and insert "**office**".

Page 12, line 5, after "operate" insert "**the children's health insurance program**".

Page 12, line 6, delete "program" and insert "**office**".

Page 12, line 17, after "the" insert "**children's health insurance**".

Page 12, line 20, delete "program" and insert "**office**".

Page 12, line 39, after "fees" insert ",".

Page 13, line 1, delete "(b)" and insert "**(B)**".

Page 13, line 22, delete "only".

Page 13, line 22, after "plans" insert "**only**".

Page 13, line 39, delete "(b)" and insert "**(c)**".

Page 13, line 41, after "to" insert "**the**".

Page 14, line 6, delete "(c)" and insert "**(d)**".

Page 14, line 6, delete "(a) and (b)" and insert "**(b) and (c)**".

Page 14, line 10, delete "(d)" and insert "**(e)**".

Page 14, line 10, delete "(a) and (b)" and insert "**(b), (c), and (d)**".

Page 14, line 30, after "the" insert "**children's health insurance**".

Page 14, line 32, after "the" insert "**children's health insurance**".

Page 15, line 3, after "program" insert ",".

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

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 SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 5, line 29, delete "that".

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Page 5, line 30, after "(A)" insert **"that"**.

Page 5, line 30, after "payments" insert **"and provide items and services"**.

Page 5, line 31, after "(B)" insert **"that"**.

Page 5, line 35, after "(C)" insert **"that"**.

Page 5, line 36, after ";" delete "and".

Page 5, line 37, after "(D)" insert **"that"**.

Page 5, line 38, delete "." and insert **"; and"**.

Page 5, between lines 38 and 39, begin a new line double block indented and insert:

**"(E) that the office has determined is capable of making a determination that the family income of a pregnant woman does not exceed the income level of eligibility under IC 12-15-2."**

Page 6, delete line 12, and insert **"that the family income of a child does not exceed the income level of eligibility under IC 12-15-2."**

Page 6, line 14, after "for" insert ":".

Page 6, line 14, before "Medicaid" begin a new line block indented and insert:

**"(1)"**.

Page 6, line 15, delete "." and insert **"; or"**.

Page 6, between lines 15 and 16, begin a new line block indented and insert:

**"(2) services from the children's health insurance program under IC 16-35-6."**

Page 6, line 36, delete ", including a certified".

Page 6, delete line 37.

Page 7, line 23, before "that" insert **"at the time a determination is made"**.

Page 7, line 24, delete "or an enrollment center".

Page 7, line 25, after "resides" insert **"or an enrollment center"**.

Page 7, between lines 34 and 35, begin a new paragraph and insert:

**"Sec. 9. If a child or pregnant woman:**

**(1) is determined to be presumptively eligible for Medicaid under this chapter; and**

**(2) appoints, in writing, an agent of a qualified entity under section 3(b)(1) or 3(b)(2) of this chapter as the child's or pregnant woman's authorized representative for purposes of completing all aspects of the Medicaid application process;**

**the county office shall conduct any face-to-face interview with the child's or pregnant woman's authorized representative that is necessary to determine the child's or pregnant woman's eligibility**



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for Medicaid.

**Sec. 10. If a child or pregnant woman is:**

- (1) determined to be presumptively eligible for Medicaid under this chapter; and**
- (2) subsequently determined not to be eligible for Medicaid after filing an application for Medicaid as required under section 8 of this chapter;**

**a qualified entity under section 3(b)(1) or 3(b)(2) of this chapter that determined that the child or pregnant woman was presumptively eligible for Medicaid shall reimburse the office for all funds expended by the office in paying for care for the child or pregnant woman during the child's or pregnant woman's period of presumptive eligibility."**

Page 7, line 35, delete "9" and insert "11".

Page 7, line 36, after "chapter" insert "**, including rules that may impose additional requirements for qualified entities that are consistent with federal regulations"**."

Page 11, line 3, after "center" insert "**or at the office of a qualified entity under IC 12-15-2.2"**."

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

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SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 10, line 35, after "2." insert "(a)".

Page 10, after line 42, begin a new paragraph and insert:

**"(b) For purposes of section 7(b) of this chapter, the term includes a limited service health maintenance organization (as defined in IC 27-13-34-4) and a preferred provider plan (as defined in IC 27-8-11-1)."**

Page 11, line 15, after "7." insert "(a)".

Page 11, line 18, delete "section" and insert "**subsection"**."

Page 11, between lines 33 and 34, begin a new paragraph and insert:  
**"(b) The office may contract with providers to provide the services described in section 18(c) of this chapter. A provider under this subsection must:**

- (1) be eligible to receive reimbursement from the office; and**

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**(2) comply with subsection (a)(3), (a)(4), and (a)(5)."**

(Reference is to Senate Bill 19 as printed January 28, 1998.)

JOHNSON

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SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

Page 17, line 19, after "SECTION" insert ":",

Page 17, line 20, before "may" begin a new line block indented and insert:

**"(1)".**

Page 17, line 21, delete "." and insert "; and".

Page 17, between lines 21 and 22, begin a new line block indented and insert:

**"(2) is a body corporate and politic."**

(Reference is to Senate Bill 19 as printed January 28, 1998.)

SIMPSON

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SENATE MOTION

Mr. President: I move that Senate Bill 19 be amended to read as follows:

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

**"Sec. 19. The office shall do the following:**

**(1) Establish a penalty to be paid by the following:**

**(A) An insurer, insurance agent, or insurance broker, for knowingly or intentionally referring an insured or the dependent of an insured to the children's health insurance program in order to receive health care when the insured receives health insurance through an employer's health care plan that is underwritten by the insurer.**

**(B) An employer, for knowingly or intentionally referring an employee or the dependent of an employee to the children's health insurance program in order to receive health care when the employee receives health insurance**



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through the employer's health care plan.

**(C) An employer that knowingly or intentionally changes the terms of coverage for or premiums paid by an employee in order to force an employee or the dependent of an employee to apply to the children's health insurance program in order to receive health care.**

**(2) Create standards to minimize the incentive for:**

**(A) an employer to eliminate or reduce health care coverage for an employee's dependents; or**

**(B) an individual to eliminate or reduce health care coverage for a dependent of the individual."**

Page 14, line 15, delete "19" and insert "20".

Page 14, line 18, delete "20" and insert "21".

Page 14, line 21, delete "21" and insert "22".

(Reference is to Senate Bill 19 as printed January 28, 1998.)

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SENATE MOTION

Mr. President: I move that Senator Simpson be added as second author and Senator Howard and Randolph be added as coauthors of Senate Bill 19.

JOHNSON

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SENATE MOTION

Mr. President: I move that Senator Washington be added as coauthor of Senate Bill 19.

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Senate Bill 19, 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 4, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 3. IC 12-10-6-1, AS AMENDED BY P.L.24-1997, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An individual who:

- (1) is at least sixty-five (65) years of age, blind, or disabled; and
- (2) is a resident of a county home;

is eligible to receive assistance payments from the state if the individual would be eligible for assistance under the federal Supplemental Security Income program except for the fact that the individual is residing in a county home.

(b) The amount of nonmedical assistance to be paid on behalf of a resident in a county home must be based on the daily rate established by the division. The rate for facilities under this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division.

(c) The rate for facilities under this section but not licensed under IC 16-28 must be the lesser of:

- (1) an upper rate limit established by a rule adopted by the division; or
- (2) a reasonable and adequate rate to meet the costs, determined by generally accepted accounting principles, that are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.

(d) The recipient shall be paid or allowed to retain from the recipient's income a **monthly** personal allowance in an amount to be established by the division. The amount:

- (1) may be not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** and not more than ~~thirty-five dollars (\$35) monthly;~~ **sixty-one dollars and thirty-two cents (\$61.32);**
- (2) is exempt from income eligibility consideration by the division; and
- (3) may be exclusively used by the recipient for personal needs.

(e) In addition to the amount that may be retained as a personal allowance under this section, an individual is allowed to retain an amount equal to the individual's state and local income tax liability.

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The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which the month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay state or local income taxes owed.

(f) The division of disability, aging, and rehabilitative services, in cooperation with the state department of health taking into account licensure requirements under IC 16-28, shall adopt rules under IC 4-22-2 governing the reimbursement to facilities under this section. The rules must be designed to determine the costs that must be incurred by efficiently and economically operated facilities to provide room, board, laundry, and other services, along with minimal administrative direction to individuals who receive residential care in the facilities under this section. A rule adopted under this subsection by:

- (1) the division; or
- (2) the state department of health;

must conform to the rules for residential care facilities that are licensed under IC 16-28.

(g) A rate established under this section may be appealed according to the procedures under IC 4-21.5.

(h) The division shall annually review each facility's rate using the following:

- (1) Generally accepted accounting principles.
- (2) The costs incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.

SECTION 5. IC 12-10-6-2, AS AMENDED BY P.L.24-1997, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. (a) An individual who is incapable of residing in the individual's own home may apply for residential care assistance under this section. The determination of eligibility for residential care assistance is the responsibility of the division. Except as provided in subsections (f) and (h), an individual is eligible for residential care assistance if the division determines that the individual:

- (1) is a recipient of Medicaid or the federal Supplemental Security Income program;
- (2) is incapable of residing in the individual's own home because of dementia, mental illness, or a physical disability;
- (3) requires a degree of care less than that provided by a health care facility licensed under IC 16-28; and
- (4) can be adequately cared for in a residential care setting.



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(b) Individuals suffering from mental retardation may not be admitted to a home or facility that provides residential care under this section.

(c) A service coordinator employed by the division may:

- (1) evaluate a person seeking admission to a home or facility under subsection (a); or
- (2) evaluate a person who has been admitted to a home or facility under subsection (a), including a review of the existing evaluations in the person's record at the home or facility.

If the service coordinator determines the person evaluated under this subsection is mentally retarded, the service coordinator may recommend an alternative placement for the person.

(d) Except as provided in section 5 of this chapter, residential care consists of only room, board, and laundry, along with minimal administrative direction. State financial assistance may be provided for such care in a boarding or residential home of the applicant's choosing that is licensed under IC 16-28 or a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life safety standards considered necessary by the state fire marshal. Payment for such care shall be made to the provider of the care according to division directives and supervision. The amount of nonmedical assistance to be paid on behalf of a recipient living in a boarding home, residential home, or Christian Science facility shall be based on the daily rate established by the division. The rate for facilities that are referred to in this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division. The recipient may retain from the recipient's income a **monthly** personal allowance in an amount to be established by the division, but not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** or more than ~~thirty-five dollars (\$35) monthly.~~ **sixty-one dollars and thirty-two cents (\$61.32)**. This amount is exempt from income eligibility consideration by the division and may be exclusively used by the recipient for the recipient's personal needs. However, if the recipient's income is less than the amount of the personal allowance, the division shall pay to the recipient the difference between the amount of the personal allowance and the recipient's income. A reserve or an accumulated balance from such a source, together with other sources, may not be allowed to exceed the state's resource allowance allowed for adults eligible for state supplemental assistance or Medicaid as established by the rules of the office of Medicaid policy and planning.

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(e) In addition to the amount that may be retained as a personal allowance under this section, an individual shall be allowed to retain an amount equal to the individual's state and local income tax liability. The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which that month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay any state or local income taxes owed.

(f) The rate of payment to the provider shall be determined in accordance with a prospective prenegotiated payment rate predicated on a reasonable cost related basis, with a growth of profit factor, as determined in accordance with generally accepted accounting principles and methods, and written standards and criteria, as established by the division. The division shall establish an administrative appeal procedure to be followed if rate disagreement occurs if the provider can demonstrate to the division the necessity of costs in excess of the allowed or authorized fee for the specific boarding or residential home. The amount may not exceed the maximum established under subsection (d).

(g) The personal allowance for one (1) month for an individual described in subsection (a) whose employment is part of the individual's personal habilitation plan or who is working in a sheltered workshop or day activity center is the amount that an individual would be entitled to retain under subsection (d) plus an amount equal to one-half (1/2) of the remainder of:

- (1) gross earned income for that month; minus
- (2) the sum of:
  - (A) sixteen dollars (\$16); plus
  - (B) the amount withheld from the person's paycheck for that month for payment of state income tax, federal income tax, and the tax prescribed by the federal Insurance Contribution Act (26 U.S.C. 3101 et seq.); plus
  - (C) transportation expenses for that month.

(h) An individual who, before September 1, 1983, has been admitted to a home or facility that provides residential care under this section is eligible for residential care in the home or facility.

(i) The director of the division may contract with the division of mental health or the division of disability, aging, and rehabilitative services to purchase services for individuals suffering from mental illness or a developmental disability by providing money to supplement the appropriation for community residential care programs established



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under IC 12-22-2 or community residential programs established under IC 12-11-1-1.

(j) A person with a mental illness may not be placed in a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., unless the facility is licensed under IC 16-28."

Page 9, between lines 24 and 25, begin a new paragraph and insert:

"SECTION 8. IC 12-15-7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. Not less than ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** or more than ~~thirty-five dollars (\$35)~~ **sixty-one dollars and thirty-two cents (\$61.32)** monthly may be exempt from income eligibility consideration.

SECTION 9. IC 12-15-32-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 6. The office shall allow a resident of a facility who is receiving Medicaid to retain a **monthly** personal allowance of at least ~~twenty-eight dollars and fifty cents (\$28.50)~~ **thirty-five dollars (\$35)** but not more than ~~fifty dollars (\$50)~~ **each month: sixty-one dollars and thirty-two cents (\$61.32)**."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to Senate Bill 19 as reprinted February 3, 1998.)

BAUER, Chair

Committee Vote: yeas 22, nays 0.

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