

HOUSE BILL No. 1349

DIGEST OF HB1349 (Updated February 2, 1998 7:35 pm - DI 58)

Citations Affected: IC 12-7; IC 12-14; IC 12-15; IC 12-16; IC 12-29; noncode.

Synopsis: Medicaid; disproportionate share providers. Provides that a county office of family and children may not consider \$4,500 of equity value in a motor vehicle when determining the eligibility of a child for assistance under Indiana's Title IV-A program (Temporary Assistance to Needy Families). Provides that the office of Medicaid policy and planning may not consider \$4,500 of equity value in one motor vehicle belonging to an applicant or a recipient or a member of an applicant's or a recipient's family when the office of Medicaid policy and planning applies a resource standard to determine the eligibility of an applicant or to redetermine the eligibility of a recipient for Medicaid. Adds provisions concerning a Medicaid outreach program. Creates a Medicaid shortfall program for governmentally owned hospitals that do not receive reimbursement in an amount that compensates the hospitals for the costs associated with delivering Medicaid services. Finances the
(Continued next page)

Effective: See text of bill.

Crawford, Buell

January 13, 1998, read first time and referred to Committee on Ways and Means.
January 27, 1998, amended, reported — Do Pass.
February 2, 1998, read second time, amended, ordered engrossed.

HB 1349—LS 7249/DI 88



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

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Reprinted
February 3, 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.

HOUSE BILL No. 1349

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

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

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

6 SECTION 2. IC 12-14-2-1, AS AMENDED BY P.L.15-1997,
7 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
8 JULY 1, 1998]: Sec. 1. (a) After the investigation under IC 12-14-1-6,
9 the county office shall decide the following:

- 10 (1) Whether the child is eligible for assistance under this article.
11 (2) The amount of assistance.
12 (3) The date assistance begins.
13 (b) The county office may not consider:
14 (1) money in an individual development account under IC 4-4-28
15 that belongs to the child or a member of the child's family; **or**

HB 1349—LS 7249/DI 88



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1 (2) four thousand five hundred dollars (\$4,500) of equity value
 2 (as defined in 470 IAC 10.1-3-1) in one (1) motor vehicle that
 3 belongs to a member of the child's family;

4 when determining whether the child is eligible for assistance under this
 5 article.

6 SECTION 3. IC 12-15-2-22 IS ADDED TO THE INDIANA CODE
 7 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 8 1, 1998]: **Sec. 22. When the office applies a resource standard to
 9 determine an applicant's or a recipient's eligibility for Medicaid
 10 under this chapter, the office may not consider four thousand five
 11 hundred dollars (\$4,500) of equity value (as defined in 470
 12 IAC 10.1-3-1) in one (1) motor vehicle belonging to:**

13 (1) the applicant or recipient; or

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

15 SECTION 4. IC 12-15-2.2 IS ADDED TO THE INDIANA CODE
 16 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 17 JULY 1, 1998]:

18 **Chapter 2.2. Outreach Efforts**

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

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

25 (1) Enrollment.

26 (2) Eligibility determinations.

27 (3) Access to medical services.

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

30 (1) Allowing qualified entities to determine presumptive
 31 eligibility for pregnant women and children.

32 (2) Allowing outstation locations to accept Medicaid
 33 applications.

34 (3) Designing simplified application forms.

35 (4) Allowing applications to be:

36 (A) filed by mail; or

37 (B) completed by telephone.

38 (5) Other outreach activities as appropriate.

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

42 (1) Which qualified entities may presumptively enroll

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1 **pregnant women and children in the Medicaid program.**

2 **(2) The duties of a qualified entity.**

3 **(b) If a program of presumptive eligibility is established under**
 4 **this section, the office of the secretary may adopt rules under**
 5 **IC 4-22-2 to implement the program.**

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

9 (1) made to the county office ~~of~~ **or another location determined**
 10 **by the office of the secretary in** the county in which the
 11 applicant resides; and

12 (2) in the manner required by the office.

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

15 SECTION 6. IC 12-15-14-2, AS AMENDED BY P.L.257-1996,
 16 SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 17 UPON PASSAGE]: Sec. 2. (a) Payment of nursing facility services
 18 **under shall be determined in accordance with** 42 U.S.C.
 19 1396a(a)(13)(A). ~~shall be determined in accordance with a prospective~~
 20 ~~payment rate that meets the following conditions:~~

21 (1) ~~Is reasonable and adequate to meet the costs that must be~~
 22 ~~incurred by efficiently and economically operated facilities to~~
 23 ~~provide care and services in conformity with state and federal:~~

24 ~~(A) laws, rules, and regulations; and~~

25 ~~(B) quality and safety standards.~~

26 (2) ~~Is determined in accordance with and as defined by generally~~
 27 ~~accepted accounting principles.~~

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

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

36 (1) is confidential; and

37 (2) may only be disclosed:

38 (A) in the aggregate; or

39 (B) for an individual facility;

40 if the office removes all non-Medicaid data.

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

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1 SECTION 7. IC 12-15-15-1.1 IS ADDED AS A NEW SECTION
2 TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.1.**

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

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

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

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

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

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

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

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

22 (c) **Subject to subsection (e), reimbursement under this section**
23 **consists of a single payment made after the close of each state fiscal**
24 **year. A payment described in this subsection is not due to a**
25 **hospital unless an intergovernmental transfer is made under**
26 **subsection (d).**

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

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

42 (f) **The office may not implement this section until the federal**

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1 Health Care Financing Administration has issued its approval of
 2 the amended state plan for medical assistance. The office may
 3 determine not to continue to implement this section if federal
 4 financial participation is not available.

5 SECTION 8. IC 12-15-15-9 IS ADDED TO THE INDIANA CODE
 6 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 7 1, 1997 (RETROACTIVE)]: Sec. 9. (a) For each state fiscal year
 8 beginning on or after July 1, 1997, a hospital is entitled to a
 9 payment under this section.

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

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

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

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

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

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

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

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

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

38 **STEP TWO: Multiply the amount determined under STEP**
 39 **ONE by the federal medical assistance percentage for the**
 40 **state fiscal year.**

41 SECTION 9. IC 12-15-16-1 IS AMENDED TO READ AS
 42 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1.



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

3 (1) Medicaid inpatient utilization rate is at least one (1) standard
4 deviation above the mean Medicaid inpatient utilization rate for
5 providers receiving Medicaid payments in Indiana; however, the
6 Medicaid inpatient utilization of providers whose low income
7 utilization rate exceeds twenty-five percent (25%) must be
8 excluded in calculating the statewide mean Medicaid inpatient
9 utilization rate; **or**

10 (2) low income utilization rate exceeds twenty-five percent
11 (25%). **or**

12 (3) **Medicaid inpatient days are equal or greater than twenty**
13 **thousand (20,000) days per year.**

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

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

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

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

32 (1) **has a Medicaid utilization rate greater than one percent**
33 **(1%); and**

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

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

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

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

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

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



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1 (e) A disproportionate share provider under IC 12-15-17 must
 2 have at least two (2) obstetricians who have staff privileges and who
 3 have agreed to provide obstetric services under the Medicaid program.
 4 For a hospital located in a rural area (as defined in Section 1886 of the
 5 Social Security Act), an obstetrician includes a physician with staff
 6 privileges at the hospital who has agreed to perform nonemergency
 7 obstetric procedures. However, this obstetric service requirement does
 8 not apply to a provider whose inpatients are predominantly individuals
 9 less than eighteen (18) years of age or that did not offer nonemergency
 10 obstetric services as of December 21, 1987.

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

16 SECTION 10. IC 12-15-16-2, AS AMENDED BY P.L.156-1995,
 17 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 18 JULY 1, 1997 (RETROACTIVE)]: Sec. 2. (a) For purposes of basic,
 19 ~~and~~ enhanced, **municipal, and community mental health center**
 20 disproportionate share, a provider's Medicaid inpatient utilization rate
 21 is a fraction (expressed as a percentage) where:

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

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

31 (b) For purposes of this section, "inpatient days" includes days
 32 provided by an acute care excluded distinct part subprovider unit of the
 33 provider and inpatient days attributable to Medicaid beneficiaries from
 34 other states. The term also includes inpatient days attributable to
 35 Medicaid managed care recipients.

36 SECTION 11. IC 12-15-16-5, AS AMENDED BY P.L.156-1995,
 37 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 38 JULY 1, 1997 (RETROACTIVE)]: Sec. 5. (a) The office may not
 39 implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, or
 40 IC 12-15-20 until the federal Health Care Financing Administration has
 41 issued its approval of the amended state plan for medical assistance.

42 (b) The office may determine not to continue to implement this

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1 chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, and IC 12-15-20 if
2 federal financial participation is not available.

3 (c) If federal financial participation is approved for less than all of
4 the amounts paid into the Medicaid indigent care trust fund with
5 respect to a fiscal year, the office may reduce payments attributable to
6 that fiscal year under IC 12-15-19-1 and ~~IC 12-15-19-2~~ by a percentage
7 sufficient to compensate for the aggregate reduction in federal financial
8 participation. If additional federal financial participation is
9 subsequently approved with respect to payments into the Medicaid
10 indigent care trust fund for the same fiscal year, the office shall
11 distribute such amounts using the percentage that was used to
12 compensate for the prior reduction in federal financial participation.

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

18 (b) As used in this section, "Medicaid inpatient utilization rate"
19 refers to the Medicaid inpatient utilization rate described in section
20 2(a) of this chapter.

21 (c) Hospitals that qualify for basic disproportionate share under
22 section 1(a) of this chapter shall receive disproportionate share
23 payments as follows:

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

32 (2) For each of the state fiscal years ending June 30, 1994 and
33 1995, a pool of zero dollars (\$0) shall be distributed to all
34 hospitals licensed under IC 16-21 that qualify under section
35 1(a)(2) of this chapter. The funds in the pool must be distributed
36 to qualifying hospitals in proportion to each hospital's low income
37 utilization rate.

38 (3) Hospitals licensed under IC 16-21 that qualify under both
39 section 1(a)(1) and 1(a)(2) of this chapter shall receive a
40 disproportionate share payment in accordance with subdivision
41 (1).

42 (4) For each of the state fiscal years ending after June 30, 1995,

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1 a pool not exceeding two million dollars (\$2,000,000) shall be
 2 distributed to all private psychiatric institutions licensed under
 3 IC 12-25 that qualify under either section 1(a)(1) or 1(a)(2) of this
 4 chapter. The funds in the pool must be distributed to the
 5 qualifying institutions in proportion to each institution's Medicaid
 6 day utilization rate, as determined based on data from the most
 7 recent audited cost report on file with the office.

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

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

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

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

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

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

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

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

42 SECTION 13. IC 12-15-18-5.1 IS ADDED TO THE INDIANA



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1 CODE AS A NEW SECTION TO READ AS FOLLOWS
 2 [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 5.1. (a) For
 3 state fiscal years ending on or after June 30, 1998, the trustees and
 4 each municipal health and hospital corporation established under
 5 IC 16-22-8-6 are authorized to make intergovernmental transfers
 6 to the Medicaid indigent care trust fund in amounts to be
 7 determined jointly by the office and the trustees, and the office and
 8 each municipal health and hospital corporation.

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

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

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

20 (2) both individually and in the aggregate do not exceed limits
 21 prescribed by the United States Health Care Financing
 22 Administration.

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

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

40 (e) A county treasurer making a payment under IC 12-29-1-7(b)
 41 to a community mental health center qualifying as a community
 42 mental health center disproportionate share provider shall certify



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1 **that the payment represents expenditures that are eligible for**
 2 **federal financial participation under 42 U.S.C. 1396b(w)(6)(A) and**
 3 **42 CFR 433.51. The office shall assist a county treasurer in making**
 4 **this certification.**

5 SECTION 14. IC 12-15-19-1, AS AMENDED BY P.L.24-1997,
 6 SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 7 JULY 1, 1997 (RETROACTIVE)]: Sec. 1. (a) For the state fiscal year
 8 ending June 30, 1997, each hospital licensed under IC 16-21 that
 9 qualifies as an enhanced disproportionate share provider under
 10 IC 12-15-16-1(b) shall receive additional enhanced disproportionate
 11 share adjustments, based on utilization data for the hospital's cost
 12 reporting period ending during calendar year 1991, subject to the
 13 hospital specific limit specified in subsection (d), as follows:

14 (1) For hospitals with a Medicaid inpatient utilization rate of
 15 fifteen percent (15%) or less and less than twenty-five thousand
 16 (25,000) total adult and pediatric days of Medicaid care:

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

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

21 (2) For hospitals with a Medicaid inpatient utilization rate of
 22 greater than fifteen percent (15%) and less than twenty thousand
 23 (20,000) total adult and pediatric Medicaid days:

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

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

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

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

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

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

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

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

42 (5) For hospitals with at least four thousand (4,000) Medicaid

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1 discharges and at least twenty-five thousand (25,000) total adult
2 and pediatric Medicaid days:

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

5 (B) three thousand seven hundred sixty-five dollars (\$3,765)
6 for each Medicaid discharge.

7 However, the office may adjust the rates specified in this subsection
8 only to the extent necessary to obtain approval from the federal
9 government of the amendments to the Indiana Medicaid plan that are
10 required to implement the rates specified in this subsection and may
11 make additional payments as provided in subsection (c).

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

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

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

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

34 (c) The office shall include a provision in each amendment to the
35 state plan regarding enhanced disproportionate share payments,
36 **municipal disproportionate share payments, and community
37 mental health center disproportionate share payments** that the
38 office submits to the federal Health Care Financing Administration
39 that, as provided in 42 CFR 447.297(d)(3), allows the state to make
40 additional enhanced disproportionate share expenditures, **municipal
41 disproportionate share expenditures, and community mental
42 health center disproportionate share expenditures** after the end of



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1 each federal fiscal year that relate back to the prior federal fiscal year.
 2 Each eligible hospital **or community mental health center** may
 3 receive an additional enhanced, **municipal, or community mental**
 4 **health center** disproportionate share adjustment ~~based on utilization~~
 5 ~~data for the hospital's cost reporting period that ended during calendar~~
 6 ~~year 1991~~; if:

7 (1) additional intergovernmental transfers **or certifications** were
 8 made as authorized under ~~IC 12-15-18-5(c)~~; **IC 12-15-18-5.1**; and

9 (2) the total disproportionate share payments to:

10 (A) each individual hospital; and

11 (B) all qualifying hospitals in the aggregate;

12 do not exceed the limits provided by federal law and regulation.

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

22 (1) an independent certified public accounting firm if the hospital
 23 is a hospital licensed under IC 16-21 that qualifies under
 24 ~~IC 12-15-16-1(a)(3)~~; **IC 12-15-16-1(a)**; or

25 (2) the budget agency if the hospital is a state mental health
 26 institution listed under IC 12-24-1-3 that qualifies under either
 27 IC 12-15-16-1(a)(1) or IC 12-15-16-1(a)(2);

28 in accordance with this subsection and federal laws, regulations, and
 29 guidelines.

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

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



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1 (2) For each municipal disproportionate share provider
 2 qualifying under IC 12-15-16-1(c) to receive basic
 3 disproportionate share payments under IC 12-15-16-1(a) or
 4 enhanced disproportionate share payments under
 5 IC 12-15-16-1(b), the amount in subdivision (1) shall be
 6 reduced by the amount of basic disproportionate share
 7 payments and enhanced disproportionate share payments
 8 received by the provider. The office shall develop a municipal
 9 disproportionate share provider payment methodology that
 10 ensures that each municipal disproportionate share provider
 11 receives municipal disproportionate share payments that do
 12 not exceed the provider's hospital specific limit specified in
 13 subsection (b). The methodology developed by the office shall
 14 ensure that a municipal disproportionate share provider
 15 receives, to the extent possible, municipal disproportionate
 16 share payments that, when combined with any basic
 17 disproportionate share payments or enhanced
 18 disproportionate share payments owed to the provider, equals
 19 the provider's hospital specific limits.

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

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

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

41 **STEP 2:** Divide the amount determined under STEP 1 by a
 42 percentage equal to the state's medical assistance percentage

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for the state fiscal year.
STEP 3: Subtract the amount determined under STEP 1 from the sum determined under STEP 2.

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

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

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

(e) This section expires July 1, 2001.

SECTION 17. IC 12-15-19-10 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 10. If the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

- (1) The state shall make basic disproportionate share provider payments under IC 12-15-16-1(a) until the state exceeds the state disproportionate share allocation.**
- (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make enhanced disproportionate share provider payments under IC 12-15-16-1(b).**

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- 1 **(3) After the state makes all payments under subdivision (2),**
- 2 **if the state fails to exceed the state disproportionate share**
- 3 **allocation, the state shall make municipal disproportionate**
- 4 **share provider payments under IC 12-15-16-1(c).**
- 5 **(4) After the state makes all payments under subdivision (3),**
- 6 **if the state fails to exceed the state disproportionate share**
- 7 **allocation, the state shall make community mental health**
- 8 **center disproportionate share provider payments under**
- 9 **IC 12-15-16-1(d).**

10 SECTION 18. IC 12-15-20-2, AS AMENDED BY P.L.24-1997,
 11 SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 1997 (RETROACTIVE)]: Sec. 2. The Medicaid indigent care
 13 trust fund is established to pay the state's share of the following:

- 14 (1) Enhanced disproportionate share payments to providers under
- 15 IC 12-15-19.
- 16 (2) Disproportionate share payments and significant
- 17 disproportionate share payments for certain outpatient services
- 18 under IC 12-15-17-3.
- 19 (3) Medicaid payments for pregnant women described in
- 20 IC 12-15-2-13 and infants and children described in
- 21 IC 12-15-2-14, IC 12-15-2-15, and IC 12-15-2-15.5.

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

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

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

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

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

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

41 SECTION 21. IC 12-16-7-12 IS ADDED TO THE INDIANA
 42 CODE AS NEW SECTION TO READ AS FOLLOWS [EFFECTIVE

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1 UPON PASSAGE]: **Sec. 12. All providers receiving payment under**
 2 **this chapter agree to accept, as payment in full, the amount paid**
 3 **for the hospital care for the indigent program for those claims**
 4 **submitted for payment under the program, with the exception of**
 5 **authorized deductibles, co-insurance, co-payment, or similar**
 6 **cost-sharing charges.**

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

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

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

22 (b) **This SECTION expires January 1, 1999.**

23 SECTION 25. IC 12-29-1-7 IS AMENDED TO READ AS
 24 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 7.

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

26 (1) the division of mental health, for a community mental health
 27 center;

28 (2) the division of disability, aging, and rehabilitative services, for
 29 a community mental retardation and other developmental
 30 disabilities center; and

31 (3) the president of the board of directors of each center;

32 the amount of money that will be provided to the center under this
 33 chapter.

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

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

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

41 **A county treasurer making a payment under this subsection or**
 42 **from other county sources to a community mental health center**

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1 that qualifies as a community mental health center
2 disproportionate share provider under IC 12-15-16-1(d) shall
3 certify that the payment represents expenditures eligible for
4 financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR
5 433.51. The office of Medicaid policy and planning shall assist a
6 county treasurer in making this certification.

- 7 (c) Payments by the county fiscal body:
 - 8 (1) must be in the amounts:
 - 9 (A) determined by ~~IC 12-29-2-1~~ through ~~IC 12-29-2-6~~;
 - 10 **IC 12-29-2-2 through IC 12-29-2-5**; and
 - 11 (B) authorized by section 1 of this chapter; and
 - 12 (2) are in place of grants from agencies supported within the
 - 13 county solely by county tax money.

14 SECTION 26. THE FOLLOWING ARE REPEALED [EFFECTIVE
15 JULY 1, 1997 (RETROACTIVE)]: IC 12-15-15-8; IC 12-15-18-5;
16 IC 12-15-19-2.

17 SECTION 27. An emergency is declared for this act.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1349, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

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

Page 1, delete lines 1 through 4.

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

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

"Chapter 2.2. Outreach Efforts

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

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

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

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

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

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

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

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



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IC 4-22-2 to implement the program.

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

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

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

Delete pages 3 through 4.

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

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

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

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

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

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

if the office removes all non-Medicaid data.

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

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

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PASSAGE]".

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

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

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

Page 5, delete lines 38 through 42.

Page 6, delete lines 1 through 10.

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

Page 6, delete lines 16 through 29.

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

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

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

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

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

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

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

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

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

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

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

STEP ONE: Determine the difference between:

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

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

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

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

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

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

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

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

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

(3)".

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

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

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

Page 10, reset in roman lines 34 through 42.

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

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

"(A)".

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

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

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

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

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

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

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



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

Page 12, delete lines 11 through 38.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Page 16, delete lines 17 through 18.

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

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

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Page 16, delete line 20.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

Delete page 18.

Page 19, delete lines 1 through 40.

Page 20, delete lines 35 through 42.

Delete pages 21 through 42.

Page 43, delete lines 1 through 10.

Re-number all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1349 as introduced.)

BAUER, Chair

Committee Vote: yeas 19, nays 0.

C
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HOUSE MOTION

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

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

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

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

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

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

CRAWFORD

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