
ENGROSSED HOUSE BILL No. 1349

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

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

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

Effective: See text of bill.

Crawford, Buell

(SENATE SPONSORS — JOHNSON, ROGERS)

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

SENATE ACTION

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

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

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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 ENROLLED ACT No. 1349

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:

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

- (1) Whether the child is eligible for assistance under this article.
 - (2) The amount of assistance.
 - (3) The date assistance begins.
- (b) The county office may not consider:
- (1) money in an individual development account under IC 4-4-28 that belongs to the child or a member of the child's family; **or**
 - (2) **five thousand dollars (\$5,000) of equity value (as defined in 470 IAC 10.1-3-1) in one (1) motor vehicle that belongs to a member of the child's family;**

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

SECTION 2. IC 12-15-2-22 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

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1, 1998]: **Sec. 22. When the office applies a resource standard to determine an applicant's or a recipient's eligibility for Medicaid under this chapter, the office may not consider five thousand dollars (\$5,000) of equity value (as defined in 470 IAC 10.1-3-1) in one (1) motor vehicle belonging to:**

- (1) the applicant or recipient; or**
- (2) a member of the applicant's or recipient's family.**

SECTION 3. 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.

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

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

- (1) licensed under IC 16-21; and**
- (2) established and operated under IC 16-22-2 or IC 16-23.**

(b) For a state fiscal year ending after June 30, 1997, in addition to reimbursement received under section 1 of this chapter, a

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hospital is entitled to reimbursement in an amount calculated from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

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

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

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

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

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

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

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

(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.

SECTION 5. 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



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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 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.

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

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

(1) Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana; however, the Medicaid inpatient utilization of providers whose low income utilization rate exceeds twenty-five percent (25%) must be

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excluded in calculating the statewide mean Medicaid inpatient utilization rate; **or**

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

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

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

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

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

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

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

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

(d) A community mental health center that:

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

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

(3) provides inpatient services to Medicaid patients;

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

~~(e)~~ (e) A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. However, this obstetric service requirement does



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not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

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

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

- (1) the numerator is the provider's total number of Medicaid and hospital care for the indigent program (IC 12-16-2) inpatient days ~~for a fixed cost reporting period specified in state rules; in the most recent year for which an audited cost report is on file with the office;~~ and
- (2) the denominator is the total number of the provider's inpatient days in the ~~same reporting period determined under section 1(b) of this chapter.~~ **most recent year for which an audited cost report is on file with the office.**

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

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

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

(c) If federal financial participation is approved for less than all of the amounts paid into the Medicaid indigent care trust fund with respect to a fiscal year, the office may reduce payments attributable to that fiscal year under IC 12-15-19-1 ~~and IC 12-15-19-2~~ by a percentage sufficient to compensate for the aggregate reduction in federal financial

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participation. If additional federal financial participation is subsequently approved with respect to payments into the Medicaid indigent care trust fund for the same fiscal year, the office shall distribute such amounts using the percentage that was used to compensate for the prior reduction in federal financial participation.

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

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

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

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

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

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

(4) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars (\$2,000,000) shall be distributed to all private psychiatric institutions licensed under IC 12-25 that qualify under either section 1(a)(1) or 1(a)(2) of this chapter. The funds in the pool must be distributed to the qualifying institutions in proportion to each institution's Medicaid day utilization rate, as determined based on data from the most recent audited cost report on file with the office.

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

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

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

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

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

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

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

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

SECTION 10. IC 12-15-18-5.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 5.1. (a) For state fiscal years ending on or after June 30, 1998, the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 are authorized to make intergovernmental transfers to the Medicaid indigent care trust fund in amounts to be determined jointly by the office and the trustees, and the office and**



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each municipal health and hospital corporation.

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

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

- (1) produce payments to each hospital licensed under IC 16-21 that qualifies as an enhanced disproportionate share provider under IC 12-15-16-1(b); and
- (2) both individually and in the aggregate do not exceed limits prescribed by the United States Health Care Financing Administration.

The trustees and a municipal health and hospital corporation are not required to make intergovernmental transfers under this section. 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).

(d) A municipal disproportionate share provider (as defined in IC 12-15-16-1(c)) shall transfer to the Medicaid indigent care trust fund an amount determined jointly by the office and the municipal disproportionate share provider. A municipal disproportionate share provider is not required to make intergovernmental transfers under this section. 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).

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

SECTION 11. IC 12-15-19-1, AS AMENDED BY P.L.24-1997, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1. (a) For the state fiscal year



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ending June 30, 1997, each hospital licensed under IC 16-21 that qualifies as an enhanced disproportionate share provider under IC 12-15-16-1(b) shall receive additional enhanced disproportionate share adjustments, based on utilization data for the hospital's cost reporting period ending during calendar year 1991, subject to the hospital specific limit specified in subsection (d), as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

However, the office may adjust the rates specified in this subsection

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only to the extent necessary to obtain approval from the federal government of the amendments to the Indiana Medicaid plan that are required to implement the rates specified in this subsection and may make additional payments as provided in subsection (c).

(b) For each state fiscal year ending on or after June 30, 1998, the office shall develop an enhanced disproportionate share payment methodology that ensures that each enhanced disproportionate share provider receives total disproportionate share payments that do not exceed its hospital specific limit specified in subsection (d). The methodology developed by the office shall ensure that hospitals operated by the governmental entities described in ~~IC 12-15-18-5(a)~~ **IC 12-15-18-5.1(a)** receive, to the extent practicable, basic and enhanced disproportionate share payments equal to their hospital specific limits. **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.

(c) The office shall include a provision in each amendment to the state plan regarding enhanced disproportionate share payments, **municipal disproportionate share payments, and community mental health center disproportionate share payments** that the office submits to the federal Health Care Financing Administration that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional enhanced disproportionate share expenditures, **municipal disproportionate share expenditures, and community mental health center disproportionate share expenditures** after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible hospital **or community mental health center** may receive an additional enhanced, **municipal, or community mental health center** disproportionate share adjustment based on utilization data for the hospital's cost reporting period that ended during calendar year ~~1991~~, if:

(1) additional intergovernmental transfers **or certifications** are



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made as authorized under ~~IC 12-15-18-5(c)~~; **IC 12-15-18-5.1**; and

(2) the total disproportionate share payments to:

(A) each individual hospital; and

(B) all qualifying hospitals in the aggregate;

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

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

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

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

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

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

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

(2) For each municipal disproportionate share provider qualifying under IC 12-15-16-1(c) to receive basic disproportionate share payments under IC 12-15-16-1(a) or enhanced disproportionate share payments under IC 12-15-16-1(b), the amount in subdivision (1) shall be reduced by the amount of basic disproportionate share payments and enhanced disproportionate share payments



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received by the provider. The office shall develop a municipal disproportionate share provider payment methodology that ensures that each municipal disproportionate share provider receives municipal disproportionate share payments that do not exceed the provider's hospital specific limit specified in subsection (b). The methodology developed by the office shall ensure that a municipal disproportionate share provider receives, to the extent possible, municipal disproportionate share payments that, when combined with any basic disproportionate share payments or enhanced disproportionate share payments owed to the provider, equals the provider's hospital specific limits.

(b) Total basic, enhanced, and municipal disproportionate share payments to a provider under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital for the hospital'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 ending at the end of the most recent state fiscal year, as certified to the office by an independent certified public accounting firm.

SECTION 13. IC 12-15-19-9 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 ending after June 30, 1997, a community mental health center that qualifies as a community health center disproportionate share provider under IC 12-15-16-1(d) shall receive disproportionate share payments in an amount determined under STEP 3 of the following formula:**

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

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



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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 14. 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).
- (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make municipal disproportionate share provider payments under IC 12-15-16-1(c).
- (4) After the state makes all payments under subdivision (3), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health



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center disproportionate share provider payments under IC 12-15-16-1(d).

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

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

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

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

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

SECTION 16. 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 17. 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.**

SECTION 18. 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 19. IC 12-16-14-8 IS AMENDED TO READ AS



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

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

- (1) the division of mental health, for a community mental health center;
- (2) the division of disability, aging, and rehabilitative services, for a community mental retardation and other developmental disabilities center; and
- (3) the president of the board of directors of each center;

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

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

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

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

(c) Payments by the county fiscal body:

- (1) must be in the amounts:
 - (A) determined by IC 12-29-2-1 through IC 12-29-2-6; and
 - (B) authorized by section 1 of this chapter; and
- (2) are in place of grants from agencies supported within the county solely by county tax money.

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

SECTION 22. IC 12-15-15-5 IS REPEALED [EFFECTIVE UPON PASSAGE].

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SECTION 23. An emergency is declared for this act.

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