

SENATE BILL No. 19

DIGEST OF SB 19 (Updated February 2, 1998 4:23 pm - DI 88)

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

Synopsis: Increases for one year the family income eligibility standard for Medicaid for a child who is less than 19 years of age to 150% of the federal income poverty level. Requires the office of Medicaid policy and planning to use all funds appropriated for outreach to conduct outreach activities in order to encourage children who are less than 19 years of age and who are eligible for Medicaid but who are not enrolled in the Medicaid program to enroll in the Medicaid program. Requires for one year that the office of Medicaid policy and planning provide Medicaid services to a child who is less than 19 years of age and who is eligible for Medicaid for 12 consecutive months from the date when
(Continued next page)

Effective: Upon Passage; July 1, 1998.

Johnson

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

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

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

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

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

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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.

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SENATE BILL No. 19

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

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

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

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

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

3 (2) Any:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 SECTION 3. IC 12-15-1-18 IS ADDED TO THE INDIANA CODE
 27 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
 28 UPON PASSAGE]: **Sec. 18. The office shall use all funds that are**
 29 **appropriated to the office for outreach purposes to conduct**
 30 **outreach activities in order to encourage children who are:**

- 31 (1) less than nineteen (19) years of age;
- 32 (2) eligible for Medicaid; and
- 33 (3) not enrolled in the Medicaid program;

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

35 SECTION 4. IC 12-15-2-15.6 IS ADDED TO THE INDIANA
 36 CODE AS A NEW SECTION TO READ AS FOLLOWS
 37 [EFFECTIVE JULY 1, 1998]: **Sec. 15.6. (a) Notwithstanding sections**
 38 **15 and 15.5 of this chapter, an individual:**

- 39 (1) whose family income does not exceed one hundred fifty
 40 percent (150%) of the federal income poverty level for the
 41 same size family;
- 42 (2) who is otherwise eligible for Medicaid under section 15 or



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

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

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

10 SECTION 5. IC 12-15-2-15.7 IS ADDED TO THE INDIANA
 11 CODE AS A NEW SECTION TO READ AS FOLLOWS
 12 [EFFECTIVE JULY 1, 1998]: **Sec. 15.7. (a) An individual who is less**
 13 **than nineteen (19) years of age and who is eligible for Medicaid**
 14 **under sections 14 through 15.6 of this chapter is eligible to receive**
 15 **Medicaid until the earlier of the following:**

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

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

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

21 SECTION 6. IC 12-15-2.2 IS ADDED TO THE INDIANA CODE
 22 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 23 JULY 1, 1998]:

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

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

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

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

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

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

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

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



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1 **IC 12-15-2.**

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

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

7 **(i) participate in a Head Start program under 42 U.S.C.**
 8 **9831 et seq.;**

9 **(ii) receive child care services for which financial**
 10 **assistance is provided under the Child Care and**
 11 **Development Block Grant Act of 1990 under 42 U.S.C.**
 12 **9858 et seq.; or**

13 **(iii) receive assistance under the women, infants, and**
 14 **children nutrition program (as defined in**
 15 **IC 16-35-1.5-5); and**

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

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

21 **(1) Medicaid under IC 12-15-2-11 through IC 12-15-2-15.6; or**

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

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

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

29 **(1) A disproportionate share provider under IC 12-15-16-1(a).**

30 **(2) An enhanced disproportionate share provider under**
 31 **IC 12-15-16-1(b).**

32 **(3) A federally qualified health clinic.**

33 **(4) A rural health clinic.**

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

36 **(1) Application forms for Medicaid.**

37 **(2) Information on how to assist pregnant women, parents,**
 38 **guardians, and other individuals in completing and filing the**
 39 **application forms.**

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

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1 (1) begins on the date on which a qualified entity determines
 2 on the basis of preliminary information that the family
 3 income of the child or pregnant woman does not exceed the
 4 applicable family income level of eligibility for the child or
 5 pregnant woman for Medicaid under IC 12-15-2; and

6 (2) ends on the earlier of the following:

7 (A) The date on which a determination is made by a
 8 representative of the county office with respect to the
 9 eligibility of the child or pregnant woman for Medicaid
 10 under IC 12-15-2.

11 (B) The last day of the month following the month in which
 12 the qualified entity makes the determination described in
 13 subdivision (1).

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

15 (1) may only have a presumptive eligibility determination
 16 made by an entity described in section 1(1) of this chapter;
 17 and

18 (2) is eligible to receive only ambulatory prenatal care during
 19 a period of presumptive eligibility.

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

23 (1) Notify the office of the determination within five (5)
 24 working days after the date on which the determination is
 25 made.

26 (2) Inform:

27 (A) the parent, guardian, or custodian of the child; or

28 (B) the pregnant woman;

29 at the time a determination is made that an application for
 30 Medicaid is required to be made at the county office in the
 31 county where the child or the pregnant woman resides or an
 32 enrollment center (as provided in IC 12-15-4-1) not later than
 33 the last day of the month following the month during which
 34 the determination is made.

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

37 (1) child's parent, guardian, or custodian; or

38 (2) pregnant woman;

39 shall complete an application for Medicaid as provided in
 40 IC 12-15-4 not later than the last day of the month following the
 41 month during which the determination is made.

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

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

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

7 the county office shall conduct any face-to-face interview with the
8 child's or pregnant woman's authorized representative that is
9 necessary to determine the child's or pregnant woman's eligibility
10 for Medicaid.

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

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

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

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

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

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

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

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

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

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

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

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

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

40 (E) The county health department.

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



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(G) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(H) The county office.

(I) Any other location approved by the office under subsection (b).

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

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

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

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

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

(e) An enrollment center shall provide:

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

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

SECTION 8. IC 12-26-2-5, AS AMENDED BY P.L.6-1995, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) This section applies under the following statutes:

- (1) IC 12-26-6.
- (2) IC 12-26-7.
- (3) IC 12-26-12.
- (4) IC 12-26-15.

(b) A petitioner may be represented by counsel.

(c) The court may appoint counsel for a petitioner upon a showing of the petitioner's indigency and the court shall pay for such counsel if appointed.

(d) A petitioner, including a petitioner who is a health care provider under ~~IC 16-18-2-295(b)~~, **IC 16-18-2-295(c)**, in the petitioner's individual capacity or as a corporation is not required to be represented by counsel. If a petitioner who is a corporation elects not to be represented by counsel, the individual representing the corporation at the commitment hearing must present the court with written

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1 authorization from:
 2 (1) an officer;
 3 (2) a director;
 4 (3) a principal; or
 5 (4) a manager;
 6 of the corporation that authorizes the individual to represent the interest
 7 of the corporation in the proceedings.

8 (e) The petitioner is required to prove by clear and convincing
 9 evidence that:

- 10 (1) the individual is mentally ill and either dangerous or gravely
 11 disabled; and
- 12 (2) detention or commitment of that individual is appropriate.

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

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

22 SECTION 11. IC 16-18-2-295, AS AMENDED BY P.L.188-1995,
 23 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 24 UPON PASSAGE]: Sec. 295. (a) "Provider", for purposes of IC 16-25,
 25 means a hospice program certified under IC 16-25-1.

26 **(b) "Provider", for purposes of IC 16-35-6, has the meaning set**
 27 **forth in IC 16-35-6-2.**

28 ~~(b)~~ (c) "Provider", for purposes of IC 16-39 except for IC 16-39-7
 29 and for purposes of IC 16-41-1 through IC 16-41-9, means any of the
 30 following:

- 31 (1) An individual (other than an individual who is an employee or
 32 a contractor of a hospital, a facility, or an agency described in
 33 subdivision (2) or (3)) who is licensed, registered, or certified as
 34 a health care professional, including the following:
- 35 (A) A physician.
- 36 (B) A psychotherapist.
- 37 (C) A dentist.
- 38 (D) A registered nurse.
- 39 (E) A licensed practical nurse.
- 40 (F) An optometrist.
- 41 (G) A podiatrist.
- 42 (H) A chiropractor.

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- 1 (I) A physical therapist.
- 2 (J) A psychologist.
- 3 (K) An audiologist.
- 4 (L) A speech-language pathologist.
- 5 (M) A dietitian.
- 6 (N) An occupational therapist.
- 7 (O) A respiratory therapist.
- 8 (P) A pharmacist.
- 9 (2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or
- 10 described in IC 12-24-1 or IC 12-29.
- 11 (3) A health facility licensed under IC 16-28-2.
- 12 (4) A home health agency licensed under IC 16-27-1.
- 13 (5) An employer of a certified emergency medical technician, a
- 14 certified advanced emergency medical technician, or a certified
- 15 paramedic.

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

18 SECTION 12. IC 16-35-6 IS ADDED TO THE INDIANA CODE
 19 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
 20 UPON PASSAGE]:

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

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

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

- 28 (1) A licensed insurance company.
- 29 (2) A health maintenance organization.
- 30 (3) A multiple employer welfare arrangement.
- 31 (4) Any person providing a plan of health insurance subject to
- 32 state insurance law.

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

37 **Sec. 3. The children's health insurance program is established**
 38 **within the state department.**

39 **Sec. 4. A child may apply at an enrollment center or at the office**
 40 **of a qualified entity under IC 12-15-2.2 to receive health care**
 41 **services if the child:**

- 42 (1) meets the qualifications described in section 12 of this

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chapter; or
(2) receives health care services through the Hoosier Healthwise program under IC 12-15.

Sec. 5. A child who enrolls in the children's health insurance program shall receive the health care services described in section 18 of this chapter regardless of whether the child is described in section 4(1) of this chapter or section 4(2) of this chapter.

Sec. 6. The office shall design and administer a system to obtain health insurance for eligible children.

Sec. 7. (a) The office shall contract with providers under IC 5-22 to provide health insurance and other services to a child who is enrolled in the children's health insurance program. A contract under this subsection must require a provider to do the following:

- (1) Serve as a qualified entity (as defined in IC 12-15-2.2-1) in order to determine the presumptive eligibility for pregnant women and children for Medicaid as provided in IC 12-15-2.2.
- (2) Assist a presumptively eligible individual under subdivision (1) to select a primary care provider.
- (3) Establish locations where an applicant may apply to receive services provided by the children's health insurance program.
- (4) Provide education concerning the following:
 - (A) The responsible use of health facilities and information.
 - (B) Preventive care.
 - (C) Parental responsibilities for a child's health care.
- (5) Provide outreach and evaluation activities for the children's health insurance program.

(b) The office may contract with providers to provide the services described in section 18(c) of this chapter. A provider under this subsection must:

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

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

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

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

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based on the parent's or guardian's annual income.

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

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

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

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

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

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

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

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

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

- (1)** Deductibles, coinsurance, or other cost sharing are not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.
- (2)** For children whose family income is equal to or less than one hundred fifty percent (150%) of the federal income poverty level:
 - (A)** premiums, enrollment fees, or similar charges may not exceed the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1)

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

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

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

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

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

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

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

33 (b) The office shall offer health insurance coverage for the
 34 following basic services:

- 35 (1) Inpatient and outpatient hospital services.
- 36 (2) Physicians' services.
- 37 (3) Laboratory and x-ray services.
- 38 (4) Well-baby and well-child care, including age appropriate
 39 immunizations.

40 (c) The office shall offer health insurance coverage for the
 41 following additional services if the coverage for the services has an
 42 actuarial value equal to the actuarial value of the services provided

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by the benchmark program for the following:

- (1) Coverage of prescription drugs.
- (2) Mental health services.
- (3) Vision services.
- (4) Hearing services.
- (5) Dental services.

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

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

Sec. 19. The office shall do the following:

- (1) Establish a penalty to be paid by the following:
 - (A) An insurer, insurance agent, or insurance broker, for knowingly or intentionally referring an insured or the dependent of an insured to the children's health insurance program in order to receive health care when the insured receives health insurance through an employer's health care plan that is underwritten by the insurer.
 - (B) An employer, for knowingly or intentionally referring an employee or the dependent of an employee to the children's health insurance program in order to receive health care when the employee receives health insurance through the employer's health care plan.
 - (C) An employer that knowingly or intentionally changes the terms of coverage for or premiums paid by an employee in order to force an employee or the dependent of an employee to apply to the children's health insurance program in order to receive health care.
- (2) Create standards to minimize the incentive for:
 - (A) an employer to eliminate or reduce health care coverage for an employee's dependents; or
 - (B) an individual to eliminate or reduce health care coverage for a dependent of the individual.

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

Sec. 21. Not later than March 1 of each year, the office shall

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1 provide a report describing the office's activities during the
2 preceding calendar year to the state budget committee.

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

5 SECTION 13. [EFFECTIVE UPON PASSAGE] (a) As used in this
6 SECTION, "office" refers to the office of the children's health
7 insurance program under IC 16-35-6, as added by this act.

8 (b) The office, with the assistance of the office of Medicaid
9 policy and planning, shall apply under Section 1115 of the federal
10 Social Security Act to the Secretary of the United States
11 Department of Health and Human Services for any waivers
12 required to implement the children's health insurance program.
13 The intent of a waiver under this SECTION is to allow the state to
14 offer the same health care services both to children who enroll in
15 the children's health insurance program and to children who
16 currently receive health care services under the Medicaid
17 program.

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

19 SECTION 14. [EFFECTIVE UPON PASSAGE] (a) As used in this
20 SECTION, "office" refers to the office of the children's health
21 insurance program under IC 16-35-6, as added by this act.

22 (b) The office shall submit a state plan outlining Indiana's initial
23 children's health insurance program to the Secretary of the United
24 States Department of Health and Human Services before July 1,
25 1998.

26 (c) The office shall amend the state plan outlining Indiana's
27 children's health insurance program to describe a children's health
28 insurance program, including the elements required under
29 IC 16-35-6, as added by this act, before April 1, 1999. The state
30 plan amendment required under this SECTION must include
31 identification of the benchmark program that will be used by the
32 office, as provided in IC 16-35-6-18, as added by this act.

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

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

38 SECTION 15. [EFFECTIVE JULY 1, 1998]: (a) This SECTION
39 does not apply to services provided by a facility licensed under
40 IC 16-28.

41 (b) As used in this SECTION, "community care network"
42 means a system of providing or arranging for health services and



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1 related items for the residents of a community within the needs and
2 resources of the community.

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

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

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

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

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

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

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

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

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

- 35 (1) Representatives of the political subdivisions establishing
- 36 the community care network.
- 37 (2) Representatives of the employees of the political
- 38 subdivisions establishing the community care network.
- 39 (3) Representatives of the residents, if applicable, of the
- 40 political subdivisions establishing the community care
- 41 network.
- 42 (4) Representatives of providers that will provide health

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- 1 services and related items to individuals receiving health care
- 2 through the community care network.
- 3 **The political subdivisions establishing the community care network**
- 4 **must agree to the number of representatives under subdivisions (1)**
- 5 **through (4).**
- 6 (i) Each member of a board of directors must have
- 7 demonstrated expertise in health care financing or health care
- 8 delivery systems, or both.
- 9 (j) The executives of the political subdivisions establishing the
- 10 community care network must:
- 11 (1) agree to the number of members each executive may
- 12 appoint; and
- 13 (2) after reaching agreement under subdivision (1), appoint
- 14 members;
- 15 to the board of directors.
- 16 (k) The board of directors of each community care network
- 17 shall establish a community care network fund to pay for health
- 18 services and related items for participants in the network.
- 19 (l) The board of directors shall establish guidelines for the
- 20 community care network that include the following:
- 21 (1) Quality assurance.
- 22 (2) Benefit levels.
- 23 (3) Improved access to health care.
- 24 (4) Cost containment through early intervention.
- 25 (5) Medical staff expertise.
- 26 (6) Coordination of community resources.
- 27 (7) Community, parental, and school involvement.
- 28 (m) A community care network must be approved annually by:
- 29 (1) the department of insurance; and
- 30 (2) the office of the secretary of family and social services.
- 31 (n) The department of insurance must certify that a community
- 32 care network possesses necessary financial reserves.
- 33 (o) A community care network may contract with:
- 34 (1) an accident and sickness insurance company, including
- 35 reimbursement agreements under IC 27-8-11;
- 36 (2) a health care provider (as defined in IC 27-12-2-14); or
- 37 (3) a nonprofit agency that provides health care services;
- 38 to provide or arrange for the provision of health services and items
- 39 for the employees and residents of the political subdivisions
- 40 establishing the community care network.
- 41 (p) A contract under subsection (o) may be awarded only after
- 42 the community care network uses a public bidding process for the

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contract.

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

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

(2) is a body corporate and politic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 network during the preceding calendar year that is requested by
2 the department of insurance and the office of the secretary of
3 family and social services.
4 (w) Not later than January 1, 2002, the department of insurance
5 and the office of the secretary of family and social services shall
6 begin to evaluate the community care networks established under
7 this SECTION.
8 (x) Not later than November 1, 2002, the department of
9 insurance and the office of the secretary of family and social
10 services shall report to the legislative council and the governor
11 regarding whether community care networks should be established
12 legislatively on an ongoing basis.
13 (y) A community care network may not begin operation before
14 January 1, 1999.
15 (z) This SECTION expires January 1, 2003.
16 SECTION 16. An emergency is declared for this act.

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SENATE MOTION

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

GARTON

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COMMITTEE REPORT

Mr. President: The Senate Committee on Rules and Legislative Procedure, to which was referred Senate Bill 19, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

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

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

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

(Reference is to Senate Bill 19 as introduced.)

GARTON, Chairperson

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COMMITTEE REPORT

Mr. President: The Senate Committee on Planning and Public Services, to which was referred Senate Bill 19, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 16, after "3." insert "(a).

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

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

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

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

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

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

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

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

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

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

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

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



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individuals may apply for Medicaid.

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

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

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

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

(e) An enrollment center shall provide:

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

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

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

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

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

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

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

Page 9, delete line 28.

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

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

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

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

Page 9, line 36, delete "program".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

to the board of directors.

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

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

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

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

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

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

(o) A community care network may contract with:

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

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

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

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

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

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stop-loss provision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

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

JOHNSON, Chairperson

Committee Vote: Yeas 10, Nays 0.

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SENATE MOTION

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

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

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

Page 5, delete line 8.

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

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

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

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

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

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

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

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

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

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

Page 13, line 22, delete "only".

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

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

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

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

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

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

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

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

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

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

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

JOHNSON

 SENATE MOTION

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

Page 5, line 29, delete "that".

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

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

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

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

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

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

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

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

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

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

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

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

"(1)".

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

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

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

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

Page 6, delete line 37.

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

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

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

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

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

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

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

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

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for Medicaid.

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

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

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

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

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

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

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

JOHNSON

SENATE MOTION

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

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

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

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

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

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

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

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



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

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

JOHNSON

SENATE MOTION

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

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

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

"(1)".

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

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

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

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

SIMPSON

SENATE MOTION

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

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

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

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

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

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



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through the employer's health care plan.

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

(2) Create standards to minimize the incentive for:

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

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

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

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

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

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

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