

---

---

## ENGROSSED SENATE BILL No. 19

---

DIGEST OF SB 19 (Updated February 20, 1998 4:11 pm - DI 88)

**Citations Affected:** IC 12-7; IC 12-10; IC 12-15; IC 12-17; IC 27-8; 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 appropriate federal funds to conduct 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. Provides that Medicaid  
(Continued next page)

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

---

---

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

(HOUSE SPONSORS — CRAWFORD, BUDAK, DAY)

---

---

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

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

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

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

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

HOUSE ACTION

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

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

February 20, 1998, read second time, amended, ordered engrossed.

---

---

SE 19—LS 6218/DI 13+



C  
O  
P  
Y

applications may be made at an enrollment center such as a hospital, school, or clinic. Allows 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. Allows the office of the secretary of family and social services to establish an office of the children's health insurance program within family and social services to obtain health insurance for eligible children. Allows the office to contract with insurers, including health maintenance organizations, limited services health maintenance organizations, and preferred provider plans, to arrange to provide health insurance and other required services to children in the children's health insurance program. Requires the office to establish performance criteria and evaluation measures for insurers. Requires the office to establish requirements a child must meet in order to enroll in the program. Provides a list of services for which the children's health insurance 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 insurers 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. Allows funds from the Medicaid indigent care trust fund to be used to provide the state's share of funds required to implement the children's health insurance program. Requires the office of Medicaid policy and planning and the division of family and children to provide a report to the state budget committee not later than September 1, 1998, that includes recommendations regarding the design and implementation of a presumptive eligibility policy to increase enrollment of Medicaid eligible pregnant women and children. Establishes a pilot program to allow political subdivisions to form a community care network for pooling and administering funds to be used in providing or arranging to provide health services and related items to the employees and residents of the political subdivisions. Provides that certain individuals who are Medicaid eligible and reside in a county home, hospital, nursing facility, or community residential facility for the developmentally disabled are allowed to retain a monthly personal allowance of at least \$35 and not more than \$61.32 beginning July 1, 1998.

C  
O  
P  
Y



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.

## SENATE ENROLLED ACT No. 19

---

AN ACT to amend the Indiana Code concerning human services.

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

SECTION 1. IC 12-7-2-134, AS AMENDED BY P.L.108-1997, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 134. "Office" means the following:

- (1) Except as provided in ~~subdivision~~ **subdivisions (2) and (3)**, the office of Medicaid policy and planning established by IC 12-8-6-1.
- (2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.
- (3) **For purposes of IC 12-17-18, the meaning set forth in IC 12-17-18-1.**

SECTION 2. IC 12-7-2-139.1 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 139.1. "Physicians' services", for purposes of IC 12-17-18-18, has the meaning set forth in IC 12-17-18-18(a).**

SECTION 3. IC 12-7-2-149, AS AMENDED BY P.L.1-1994, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 149. "Provider" means the following:

- (1) For purposes of IC 12-10-7, the meaning set forth in

SEA 19—CC.No.01+



C  
O  
P  
Y

IC 12-10-7-3.

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17-10.

(D) IC 12-17-11.

(3) For purposes of IC 12-17-9, the meaning set forth in IC 12-17-9-2.

**(4) For purposes of IC 12-17-18, the meaning set forth in IC 12-17-18-2.**

~~(4)~~ **(5)** For the purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

~~(5)~~ **(6)** For purposes of IC 12-17.4, a person who operates a child caring institution, foster family home, group home, or child placing agency under IC 12-17.4.

SECTION 4. IC 12-7-2-154.8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 1998]: **Sec. 154.8. "Qualified entity", for purposes of IC 12-15-2.2, has the meaning set forth in IC 12-15-2.2-1.**

SECTION 5. IC 12-15-1-18 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 18. The office shall use all funds that are appropriated to the office under 42 U.S.C. 1397ee to conduct activities allowed under 42 U.S.C. 1397bb(c)(1) in order to encourage children who are:**

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

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

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

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

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

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

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



C  
O  
P  
Y

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

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

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

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

- (1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.**
- (2) The individual becomes nineteen (19) years of age.**

**(b) This section expires August 31, 1999.**

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

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

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

- (1) To determine presumptive eligibility for a pregnant woman, the term means an entity:**
  - (A) that is eligible to receive payments and provide items and services under this article;**
  - (B) that provides outpatient hospital services, rural health clinic services and any other ambulatory services offered by a rural health clinic, or clinic services furnished by or under the direction of a licensed physician;**
  - (C) that meets all other requirements set forth in 42 U.S.C. 1396r-1(b)(2)(D); and**
  - (D) 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.**
- (2) To determine presumptive eligibility for a child, the term**

C  
O  
P  
Y



means a provider that is eligible to receive payments under this article and is approved by the office or an entity that is authorized:

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

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

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

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

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

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

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

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

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

- (1) Application forms for:
  - (A) Medicaid; and
  - (B) the children's health insurance program under IC 16-35-6.
- (2) Information on how to assist pregnant women, parents, guardians, and other individuals in completing and filing the application forms.

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



C  
O  
P  
Y

period that:

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

(2) ends on the earlier of the following:

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

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

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

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

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

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

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

(2) Inform:

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

(B) the pregnant woman;

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

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

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

(2) pregnant woman;

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

C  
O  
P  
Y



**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 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; 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.

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

**Sec. 12. This chapter expires August 31, 1999.**

SECTION 9. IC 12-15-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 1998]: Sec. 1. (a) An application or a request for Medicaid for an individual must be **made** (+) made to the county office of the county in which the applicant resides; and (2) in the manner required by the office **at enrollment centers specified by the office.**

**(b) Enrollment centers:**

- (1) shall be located at each county office; and
- (2) may be located at other locations including the following:
  - (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



C  
O  
P  
Y

**U.S.C. 1396d(l)(2)(B)).**

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

**(c) An entity described in subsection (b) other than the county office must enter into an agreement with the office for authorization to serve as an enrollment center where individuals may apply for Medicaid.**

**(d) One (1) or more authorized workers at each enrollment center may:**

- (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.**

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

**(f) 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 staff shall make the final determination of an applicant's eligibility for Medicaid.**

**SECTION 10. IC 12-17-18 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:**

**Chapter 18. Children's Health Insurance Program**

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

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

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

**(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).**



C  
O  
P  
Y

**Sec. 3.** The children's health insurance program is established within the office of the secretary.

**Sec. 4.** A child may apply at an enrollment center as provided in IC 12-15-4-1 or at the office of a qualified entity under IC 12-15-2.2 to receive health care services if the child:

- (1) meets the qualifications described in section 12 of this chapter; or
- (2) receives health care services through the Hoosier Healthwise program under IC 12-15.

**Sec. 5.** A child 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 services for eligible children.

**Sec. 7. (a)** The office may contract with providers under IC 5-22 to arrange to provide health insurance or health 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 arrange 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 with which the office contracts



C  
O  
P  
Y

under section 7 of this chapter.

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

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

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

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

**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'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:



C  
O  
P  
Y

- (A) premiums, enrollment fees, or similar charges may not exceed the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) of the Social Security Act (42 U.S.C. 301 et seq.); and
- (B) deductibles and other cost sharing shall not exceed a nominal amount that is consistent with standards provided under Section 1916(a)(3) of the Social Security Act (42 U.S.C. 301 et seq.), as adjusted.

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

Sec. 15. Providers shall use existing health insurance sales and marketing methods, including the use of agents and payment of commissions, to do the following:

- (1) Inform families of the availability of the children's health insurance program.
- (2) Assist families in obtaining health insurance and health services for children under the children's health insurance program.

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

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

(b) A child who moves to an area outside the geographic service area of the participating plan in which the child is enrolled shall provide notice to the participating plan at least five (5) days before the child may change participating plans.

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

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

- (1) Inpatient and outpatient hospital services.
- (2) Physicians' services.
- (3) Laboratory and x-ray services.



C  
O  
P  
Y

**(4) Well-baby and well-child care, including age appropriate immunizations.**

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

- (1) 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**

C  
O  
P  
Y



coverage for a dependent of the individual.

**Sec. 20.** Not later than March 1 of each year, the office shall provide a report describing the office's activities during the preceding calendar year to the state budget committee.

**Sec. 21.** The office shall adopt rules under IC 4-22-2 to implement this chapter.

**SECTION 11.** [EFFECTIVE JULY 1, 1999] (a) As used in this SECTION, "office" refers to the office of the children's health insurance program under IC 12-17-18, as added by this act.

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

(c) This SECTION expires January 1, 2001.

**SECTION 12.** [EFFECTIVE UPON PASSAGE] (a) The office of Medicaid policy and planning shall submit a state plan outlining Indiana's initial children's health insurance program to the Secretary of the United States Department of Health and Human Services before July 1, 1998.

(b) The office of the children's health insurance program established under IC 12-17-18, as added by this act, shall amend the state plan outlining Indiana's children's health insurance program to describe a children's health insurance program, including the elements required under IC 12-17-18, as added by this act, before July 1, 1999. 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 12-17-18-18, as added by this act.

(c) The state may transfer funds from the Medicaid indigent care trust fund under IC 12-15-20 to pay for the state's share of funds required to receive federal financial participation under the children's health insurance program.

(d) This SECTION expires January 1, 2003.

**SECTION 13.** [EFFECTIVE UPON PASSAGE] (a) The legislative services agency, on approval of the legislative council may perform an audit of the state department of health to include the following:



C  
O  
P  
Y

- (1) Evaluate whether the operation of the agency has been efficient and responsive to public needs.
- (2) Evaluate the management efficiency of the agency and the cost effectiveness and value of the information the agency processes.
- (3) Evaluate the objectives intended for the agency and the problems or needs that the agency is intended to address.
- (4) Evaluate the degree to which the intended objectives of the agency will be achieved.
- (5) Any other criteria identified by members of the budget committee or the legislative council.

(b) The audit required under subsection (a) must begin not later than May 1, 1998.

(c) The legislative services agency shall report to the budget committee and the legislative council the results of the audit conducted under subsection (a) not later than November 1, 1998.

(d) This SECTION expires January 1, 1999.

SECTION 14. [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 12-17-18.
- (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:



C  
O  
P  
Y

- (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).

(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:

C  
O  
P  
Y



- (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:**
  - (1) may contract with the state to provide services under IC 12-14, IC 12-15, and IC 12-17-18; 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**

C  
O  
P  
Y



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.

(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.

SECTION 15. An emergency is declared for this act.

C  
O  
P  
Y

