



Reprinted
February 22, 2000

ENGROSSED SENATE BILL No. 455

DIGEST OF SB 455 (Updated February 21, 2000 6:39 PM - DI 75)

Citations Affected: IC 12-7; IC 12-15; noncode.

Synopsis: Disproportionate share providers. Requires the office of Medicaid policy and planning's (OMPP) managed care contractor to consider disproportionate share hospitals in East Chicago and Gary as providers in the Medicaid program. Provides that OMPP or the managed care contractor may not provide incentives or mandates to direct patients to hospitals other than in a city where the patient resides. Establishes reimbursement procedures for a hospital who does not have a contract with OMPP's managed care contractor but has previously contracted to provide services under OMPP's managed care program. Establishes procedures for a disputed claim.

Effective: Upon passage.

Smith S, Rogers, Breaux, Miller
(HOUSE SPONSOR — BROWN C)

January 10, 2000, read first time and referred to Committee on Health and Provider Services.

January 27, 2000, amended, reported favorably — Do Pass.

January 31, 2000, read second time, ordered engrossed.

February 1, 2000, engrossed.

February 7, 2000, read third time, passed. Yeas 50, nays 0.

HOUSE ACTION

February 10, 2000, read first time and referred to Committee on Public Health.

February 17, 2000, amended, reported — Do Pass.

February 21, 2000, read second time, amended, ordered engrossed.

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ES 455—LS 7088/DI 88+



Reprinted
February 22, 2000

Second Regular Session 111th General Assembly (2000)

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 1999 General Assembly.

ENGROSSED SENATE BILL No. 455

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 12-7-2-110 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 110. "Hospital"
3 means the following:
4 (1) For purposes of IC 12-15-11.5, the meaning set forth in
5 IC 12-15-11.5-1.
6 (±) (2) For purposes of IC 12-15-18, the meaning set forth in
7 IC 12-15-18-2.
8 (±) (3) For purposes of IC 12-16, except IC 12-16-1, the term
9 refers to a hospital licensed under IC 16-21.
10 SECTION 2. IC 12-15-11.5 IS ADDED TO THE INDIANA CODE
11 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
12 UPON PASSAGE]:
13 **Chapter 11.5. Lake County Disproportionate Share Hospitals**
14 **Sec. 1. As used in this chapter, "hospital" refers to an acute care**
15 **hospital provider that:**
16 (1) is licensed under IC 16-21;
17 (2) qualifies as a disproportionate share hospital under

ES 455—LS 7088/DI 88+



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1 **IC 12-15-16; and**

2 **(3) is the sole disproportionate share hospital in a city located**
 3 **in a county having a population of more than four hundred**
 4 **thousand (400,000) but less than seven hundred thousand**
 5 **(700,000).**

6 **Sec. 2. (a) The office's managed care contractor shall regard a**
 7 **hospital as a contracted provider in the office's managed care**
 8 **services program, which provides a capitated prepayment**
 9 **managed care system, for the provision of medical services to each**
 10 **individual who:**

11 **(1) is eligible to receive services under IC 12-15 and has**
 12 **enrolled in the office's managed care services program;**

13 **(2) resides in the same city in which the hospital is located;**
 14 **and**

15 **(3) has selected a primary care provider who:**

16 **(A) is a contracted provider with the office's managed care**
 17 **contractor; and**

18 **(B) has medical staff privileges at the hospital.**

19 **(b) This section expires December 31, 2000.**

20 **Sec. 3. (a) The office or the office's managed care contractor**
 21 **may not provide incentives or mandates to the primary medical**
 22 **provider to direct individuals described in section 2 of this chapter**
 23 **to contracted hospitals other than a hospital in a city where the**
 24 **patient resides.**

25 **(b) A hospital that provides services to individuals described in**
 26 **section 2 of this chapter may enter into an agreement with the**
 27 **office's managed care contractor on procedures for eligibility**
 28 **verification and medical management programs. If an agreement**
 29 **is entered into under this subsection, the hospital must comply with**
 30 **the procedures covered by the agreement.**

31 **(c) This section expires December 31, 2000.**

32 **Sec. 4. (a) A hospital that:**

33 **(1) does not have a contract in effect with the office's managed**
 34 **care contractor; but**

35 **(2) previously contracted or entered into an agreement with**
 36 **the office's managed care contractor for the provision of**
 37 **services under the office's managed care program;**

38 **shall be reimbursed for services provided to individuals described**
 39 **in section 2 of this chapter at rates equivalent to the rates**
 40 **negotiated under the hospital's previous contract or agreement**
 41 **with the office's managed care contractor, as adjusted for inflation**
 42 **by the inflation adjustment factor described in subsection (b).**



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1 However, the adjusted rates may not exceed the established
 2 Medicaid rates paid to Medicaid providers who are not contracted
 3 providers in the office's managed health care services program.

4 (b) For each state fiscal year beginning after June 30, 2000, an
 5 inflation adjustment factor shall be applied under subsection (a)
 6 that is the average of the percentage increase in the medical care
 7 component of the Consumer Price Index for all Urban Consumers
 8 and the percentage increase in the Consumer Price Index for all
 9 Urban Consumers, as published by the United States Bureau of
 10 Labor Statistics, for the twelve (12) month period ending in March
 11 preceding the beginning of the state fiscal year.

12 (c) This section expires December 31, 2000.

13 Sec. 5. (a) A hospital may enter into a contract with the office or
 14 the office's managed care contractor for reimbursement rates
 15 other than the reimbursement rates described in section 4 of this
 16 chapter.

17 (b) This section expires December 31, 2000.

18 Sec. 6. A claim for reimbursement for services shall be treated
 19 as a disputed claim under this chapter if:

- 20 (1) it is submitted within one hundred twenty (120) days after
 21 the date that services are rendered;
- 22 (2) it is denied by the managed care contractor;
- 23 (3) the hospital submits a written notice of dispute for the
 24 claim to the managed care contractor not more than sixty (60)
 25 days after the receipt of the denial notice;
- 26 (4) it is appealed in accordance with the managed care
 27 contractor's internal appeals process; and
- 28 (5) payment for the claim is denied by the managed care
 29 contractor following its internal appeals process.

30 Sec. 7. The office's managed care contractor must conclude an
 31 appeal under section 6(4) of this chapter and notify the hospital of
 32 its decision not more than thirty-five (35) days after the managed
 33 care contractor receives a notice from the hospital disputing the
 34 managed care contractor's denial of a claim.

35 Sec. 8. (a) A contract entered into by a hospital with the office's
 36 managed care contractor for the provision of services under the
 37 office's managed care services program must include a dispute
 38 resolution procedure for all disputed claims. Unless agreed to in
 39 writing by the hospital and the office's managed care contractor,
 40 the dispute resolution procedure must include the following
 41 requirements:

- 42 (1) That submission of disputed claims must be made to an



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- 1 independent arbitrator selected under subsection (b).
2 (2) Each claim must set forth with specificity the issues to be
3 arbitrated, the amount involved, and the relief sought.
4 (3) That the hospital and the office's managed care contractor
5 shall attempt in good faith to resolve all disputed claims.
6 (4) The hospital shall submit to the arbitrator any claims that
7 remain in dispute sixty (60) calendar days after the hospital
8 receives written notice as provided under section 7 of this
9 chapter.
10 (5) That resolution of disputes by the arbitrator must occur
11 not later than ninety (90) calendar days after submission of
12 disputed claims to the arbitrator, unless the parties mutually
13 agree otherwise.
14 (6) That determinations of the arbitrator are final and
15 binding and not subject to any appeal or review procedure.
16 (7) That the arbitrator does not have the authority to award
17 any punitive or exemplary damages or to vary or ignore the
18 terms of any contract between the parties and shall be bound
19 by controlling law.
20 (8) That judgment upon the award rendered by the arbitrator
21 may be entered and enforced in and is subject to the
22 jurisdiction of a court with jurisdiction in Indiana.
23 (9) That the cost of the arbitrator must be shared equally by
24 the parties, and each party must bear its own attorney and
25 witness fees.
26 (b) The parties to a contract described in subsection (a) shall
27 mutually agree on an independent arbitrator, or, if the parties are
28 unable to reach agreement on an independent arbitrator, the
29 following procedure must be followed:
30 (1) Each party shall select an independent representative, and
31 the independent representatives shall select a panel of three
32 (3) independent arbitrators who have experience in
33 institutional and professional health care delivery practices
34 and procedures and have had no prior dealing with either
35 party other than as an arbitrator.
36 (2) The parties will each strike one (1) arbitrator from the
37 panel selected under subdivision (1), and the remaining
38 arbitrator serves as the arbitrator of the disputed claims
39 under subsection (a).
40 (3) The procedures for selecting an arbitrator under this
41 section must be completed not later than twenty (20) calendar
42 days after the hospital provides written notice of at least one



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(1) disputed claim.
Sec. 9. The arbitration process described in section 8 of this chapter shall also be followed for resolution of disputed claims between a hospital and the office's managed care contractor, if the hospital is not a contracted provider in the office's managed health care services program.

SECTION 3. [EFFECTIVE UPON PASSAGE] A hospital (as defined in IC 12-15-11.5-1, as added by this act) and the managed care contractor of the office (as defined in IC 12-7-2-134) shall use the arbitration procedure in IC 12-15-11.5-8, as added by this act, for the resolution of all disputed claims (as defined in IC 12-15-11.5-6, as added by this act) that have accrued as of the effective date of IC 12-15-11.5, as added by this act.

SECTION 4. An emergency is declared for this act.

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SENATE MOTION

Mr. President: I move that Senator Rogers be removed as author of Senate Bill 455 and that Senator Smith S be substituted therefor and that Senator Rogers be added as second author.

ROGERS

SENATE MOTION

Mr. President: I move that Senator Breaux be added as coauthor of Senate Bill 455.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 455, 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 1, delete lines 1 through 17, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-149.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 149.1. Notwithstanding section 149 of this chapter, "provider", for purposes of IC 12-15-11-4.1(c), has the meaning set forth in IC 12-15-11-4.1(a).**

(b) This section expires March 1, 2001.

SECTION 2. IC 12-15-11-4.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 4.1. (a) As used in subsection (c), "provider" refers to a provider that is the sole disproportionate share hospital in:**

- (1) a city having a population of more than one hundred ten thousand (110,000) but less than one hundred twenty thousand (120,000); or**
- (2) a city having a population of more than thirty-three thousand eight hundred fifty (33,850) but less than thirty-three thousand nine hundred (33,900).**

(b) Notwithstanding section 4 of this chapter, except as provided in subsection (c), a provider desiring to participate in the Medicaid program by providing physician services as a managed care provider must enter into a provider agreement with the office or the contractor under IC 12-15-30 to provide Medicaid services.

(c) A provider must be:

- (1) considered a provider in the Medicaid program;**
- (2) included in the list of managed care providers furnished to each recipient in the city in which the provider provides services; and**
- (3) allowed by the office or the office's managed care contractor to provide services to each individual who:**
 - (A) is eligible to receive services under IC 12-15; and**
 - (B) resides in the same city in which the provider is located;**

if the individual elects to receive services from the provider; if the provider has in good faith attempted to negotiate the terms of a provider agreement with the office or the contractor under



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IC 12-15-30 to provide Medicaid services.

(d) A provider that provides services under subsection (c) must abide by all lawful determinations made by the office's managed care contractor regarding appropriate and medically necessary care.

(e) This section expires March 1, 2001.

SECTION 3. IC 12-15-11-6.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6.1. (a) Notwithstanding section 6 of this chapter, the office may not exclude a provider described in IC 12-15-12-3.1 from participating in the Medicaid program by entering into an exclusive contract with another provider or group of providers, except as provided under section 7 of this chapter.**

(b) This section expires March 1, 2001.

SECTION 4. IC 12-15-12-1.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.1. (a) Notwithstanding section 1 of this chapter, except as provided in sections 6, 7, and 8 of this chapter, a Medicaid recipient may obtain any Medicaid services from a provider described in section 3.1 of this chapter.**

(b) This section expires March 1, 2001.

SECTION 5. IC 12-15-12-2.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.1. (a) Notwithstanding section 2 of this chapter, except as provided in sections 8 and 9 of this chapter, a Medicaid recipient may receive health care services from a provider selected by the recipient from a list of managed care providers and other providers:**

(1) furnished to the recipient by the office under section 3.1 of this chapter; or

(2) otherwise described in IC 12-15-11-4.1(c).

(b) This section expires March 1, 2001.

SECTION 6. IC 12-15-12-3.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.1. (a) Notwithstanding section 3 of this chapter, except as provided in section 9 of this chapter, the list of providers furnished to the recipient must include the names of the following:**

(1) All managed care providers that meet the following requirements:

(A) Have entered into a provider agreement with the office



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under IC 12-15-11 to provide physician services to Medicaid recipients.

(B) Provide Medicaid services in the geographic area in which the recipient resides.

(2) All providers that are described in IC 12-15-11-4.1(c).

(b) This section expires March 1, 2001."

Delete page 2.

Page 3, delete lines 1 through 35.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 455 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 0.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 455, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to SB 455 as printed January 28, 2000.)

BROWN C, Chair

Committee Vote: yeas 8, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 455 be amended to read as follows:

Page 3, line 4, delete "2001," and insert "**2000**,".

(Reference is to ESB 455 as printed February 18, 2000.)

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