



January 21, 2000

HOUSE BILL No. 1352

DIGEST OF HB 1352 (Updated January 20, 2000 11:47 AM - DI 58)

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

Synopsis: Disproportionate share hospital payments. Changes the structure of and payments to providers for the disproportionate share hospital (DSH) program in the following ways: (1) Eliminates the distinction between basic and enhanced disproportionate share hospitals. (2) Provides that all DSH payments to general acute care hospitals will be based on each hospital's hospital specific limit. (Current law provides that payments to basic DSH providers are based on Medicaid days and discharges.) (3) Provides that for most disproportionate share hospitals, DSH payments will be made as close as possible to each hospital's hospital specific limit. Simplifies administration of the DSH program and shifts implementation and payment detail from statute to the state's Medicaid plan. Eliminates the requirement of an independent audit for all qualifying hospitals and provides the office of Medicaid policy and planning (office) with discretion to request an audit of any qualifying hospital to determine the hospital's hospital specific limit. Allows the office to use trending and other reliable data to determine hospital specific limits. Provides the office with broad discretion to develop a DSH payment methodology. Makes conforming amendments.

Effective: July 1, 1997 (retroactive); July 1, 1998 (retroactive); July 1, 1999 (retroactive).

Crawford, Buell

January 11, 2000, read first time and referred to Committee on Ways and Means.
January 20, 2000, reported — Do Pass.

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January 21, 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.

HOUSE BILL No. 1352

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 12-15-2.2-3 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 3.
3 (a) An entity described in section 1(2) of this chapter may apply to the
4 office, on a form provided by the office, for authorization to be a
5 qualified entity under this chapter.
6 (b) Notwithstanding section 1(2) of this chapter and subsection (a),
7 the office shall consider the following to be qualified entities:
8 (1) A disproportionate share provider under IC 12-15-16-1(a) **or**
9 **IC 12-15-16-1(b).**
10 ~~(2) An enhanced disproportionate share provider under~~
11 ~~IC 12-15-16-1(b).~~
12 ~~(3) (2) A federally qualified health clinic.~~
13 ~~(4) (3) A rural health clinic.~~
14 SECTION 2. IC 12-15-15-1.1 IS AMENDED TO READ AS
15 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 1.1.
16 (a) This section applies to a hospital that is:
17 (1) licensed under IC 16-21; and

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

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

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

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

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

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

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

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

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

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

39 SECTION 3. IC 12-15-15-9 IS AMENDED TO READ AS
40 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 9.

41 (a) For each state fiscal year beginning on or after July 1, 1997, a
42 hospital is entitled to a payment under this section.

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

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

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

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

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

18 (d) Following the transfer of funds under subsection (b), an amount
 19 equal to the amount determined in the following STEPS shall be
 20 deposited in the Medicaid indigent care trust fund under
 21 ~~IC 12-15-20-2(1)~~ **IC 12-15-20-2(2)** and used to **pay fund a portion of**
 22 the state's share of the ~~enhanced~~ disproportionate share payments to
 23 providers for the state fiscal year:

24 STEP ONE: Determine the difference between:

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

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

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

31 SECTION 4. IC 12-15-16-1 IS AMENDED TO READ AS
 32 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 1.

33 (a) A provider ~~under IC 12-15-17~~ **that is an acute care hospital**
 34 **licensed under IC 16-21, a state mental health institution listed in**
 35 **IC 12-24-1-3, or a private psychiatric institution licensed under**
 36 **IC 12-25** is a ~~basic~~ disproportionate share provider if the ~~provider's~~
 37 **provider meets either of the following conditions:**

38 (1) **The provider's** Medicaid inpatient utilization rate is at least
 39 one (1) standard deviation above the mean Medicaid inpatient
 40 utilization rate for providers receiving Medicaid payments in
 41 Indiana. However, the Medicaid inpatient utilization **rate** of
 42 providers whose low income utilization rate exceeds twenty-five

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1 percent (25%) must be excluded in calculating the statewide
2 mean Medicaid inpatient utilization rate. ~~or~~

3 (2) **The provider's** low income utilization rate exceeds
4 twenty-five percent (25%).

5 ~~(b)~~ An acute care hospital licensed under IC 16-21 is an enhanced
6 disproportionate share provider under either of the following
7 conditions:

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

15 ~~(2)~~ If the provider's low income utilization rate exceeds
16 twenty-five percent (25%):

17 ~~(e)~~ (b) An acute care hospital licensed under 16-21 is a municipal
18 disproportionate share provider if the hospital:

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

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

22 ~~(d)~~ (c) A community mental health center that:

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

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

26 (3) provides inpatient services to Medicaid patients;

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

30 ~~(e)~~ (d) A disproportionate share provider under IC 12-15-17 must
31 have at least two (2) obstetricians who have staff privileges and who
32 have agreed to provide obstetric services under the Medicaid program.
33 For a hospital located in a rural area (as defined in Section 1886 of the
34 Social Security Act), an obstetrician includes a physician with staff
35 privileges at the hospital who has agreed to perform nonemergency
36 obstetric procedures. However, this obstetric service requirement does
37 not apply to a provider whose inpatients are predominantly individuals
38 less than eighteen (18) years of age or that did not offer nonemergency
39 obstetric services as of December 21, 1987.

40 ~~(f)~~ (e) The determination of a provider's status as a disproportionate
41 share provider under this section shall be based on utilization and
42 revenue data from the most recent year for which an audited cost report



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1 from the provider is on file with the office.

2 SECTION 5. IC 12-15-16-2 IS AMENDED TO READ AS
3 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 2.

4 (a) For purposes of ~~basic, enhanced, municipal, and community mental~~
5 ~~health center~~ disproportionate share **eligibility**, a provider's Medicaid
6 inpatient utilization rate is a fraction (expressed as a percentage)
7 where:

8 (1) the numerator is the provider's total number of Medicaid and
9 hospital care for the indigent program (IC 12-16-2) inpatient days
10 in the most recent year for which an audited cost report is on file
11 with the office; and

12 (2) the denominator is the total number of the provider's inpatient
13 days in the most recent year for which an audited cost report is on
14 file with the office.

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

20 SECTION 6. IC 12-15-16-3 IS AMENDED TO READ AS
21 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 3.

22 (a) For purposes of ~~basic and enhanced~~ disproportionate share
23 **eligibility**, a provider's low income utilization rate is the sum of:

24 (1) a fraction (expressed as a percentage) for which:

25 (A) for a fixed cost reporting period specified in state rules,
26 the numerator is the sum of:

27 (i) the total Medicaid ~~inpatient patient~~ revenues paid to the
28 provider based on final cost settlement; plus

29 (ii) the amount of the cash subsidies received directly from
30 state and local governments, including payments made
31 under the hospital care for the indigent program (IC
32 12-16-2); and

33 (B) the denominator is the total amount of the provider's
34 ~~inpatient~~ revenues for ~~inpatient patient~~ services, including
35 cash subsidies, in the same fixed cost reporting period; and

36 (2) a fraction (expressed as a percentage) for which:

37 (A) the numerator is the total amount of the provider's charges
38 for inpatient services that are attributable to care provided to
39 individuals who have no source of payment or third party or
40 personal resources in a fixed cost reporting period specified in
41 state rules; and

42 (B) the denominator is the total amount of charges for

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1 inpatient services in the same fixed cost reporting period.

2 (b) The numerator in subsection (a)(1)(A) does not include
3 contractual allowances and discounts other than for indigent patients
4 not eligible for Medicaid.

5 SECTION 7. IC 12-15-16-6 IS AMENDED TO READ AS
6 FOLLOWS [EFFECTIVE JULY 1, 1998 (RETROACTIVE)]: Sec. 6.

7 (a) As used in this section, "low income utilization rate" refers to the
8 low income utilization rate described in section 3 of this chapter.

9 (b) As used in this section, "Medicaid inpatient utilization rate"
10 refers to the Medicaid inpatient utilization rate described in section
11 2(a) of this chapter.

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

15 (1) For ~~each of the state fiscal years year~~ ending after June 30,
16 ~~1996; 1999~~, a pool not exceeding ~~eight~~ **twenty-one** million
17 dollars ~~(\$8,000,000)~~ **(\$21,000,000)** shall be distributed to all
18 hospitals licensed under IC 16-21 that qualify under section
19 1(a)(1) of this chapter. The funds in the pool must be distributed
20 to qualifying hospitals in proportion to each hospital's Medicaid
21 day utilization and Medicaid discharge rate, as determined based
22 on data from the most recent audited cost report on file with the
23 office.

24 ~~(2) For each of the state fiscal years ending June 30, 1994 and~~
25 ~~1995; a pool of zero dollars (\$0) shall be distributed to all~~
26 ~~hospitals licensed under IC 16-21 that qualify under section~~
27 ~~1(a)(2) of this chapter. The Any funds remaining in the pool~~
28 ~~must be distributed referred to in this subdivision following~~
29 ~~distribution to all qualifying hospitals in proportion to each~~
30 ~~hospital's low income utilization rate; shall be transferred to the~~
31 ~~pool distributed under subdivision (3).~~

32 ~~(3) (2)~~ Hospitals licensed under IC 16-21 that qualify under both
33 section 1(a)(1) and 1(a)(2) of this chapter shall receive a
34 disproportionate share payment in accordance with subdivision
35 (1).

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

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1 recent audited cost report on file with the office.

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

10 ~~(6)~~ (3) For each of the state fiscal years year ending after June 30,
11 ~~1994, 1999~~, a pool not exceeding ~~eighteen five~~ million dollars
12 ~~(\$18,000,000)~~ (\$5,000,000), subject to adjustment by the
13 transfer of any funds remaining in the pool referred to in
14 subdivision (1), following distribution to all qualifying
15 hospitals, shall be distributed to all hospitals licensed under
16 IC 16-21 that:

- 17 (A) qualify under section 1(a)(1) or 1(a)(2) of this chapter; and
18 (B) have at least ~~twenty~~ **twenty-five** thousand ~~(20,000)~~
19 **(25,000)** Medicaid inpatient days per year, based on data
20 from each hospital's Medicaid cost report for the fiscal
21 year ending during state fiscal year 1996.

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

28 (d) Other institutions that qualify as disproportionate share
29 providers under section 1 of this chapter, in each state fiscal year,
30 shall receive disproportionate share payments as follows:

31 (1) For each of the state fiscal years ending after June 30,
32 1995, a pool not exceeding two million dollars (\$2,000,000)
33 shall be distributed to all private psychiatric institutions
34 licensed under IC 12-25 that qualify under section 1(a)(1) or
35 1(a)(2) of this chapter. The funds in the pool must be
36 distributed to the qualifying institutions in proportion to each
37 institution's Medicaid day utilization rate as determined
38 based on data from the most recent audited cost report on file
39 with the office.

40 (2) A pool not exceeding one hundred ninety-one million dollars
41 (\$191,000,000) for all state fiscal years ending after
42 June 30, 1995, shall be distributed to all state mental health

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1 institutions listed under IC 12-24-1-3 that qualify under either
 2 section 1(a)(1) or 1(a)(2) of this chapter. The funds in the pool
 3 must be distributed to each qualifying institution in
 4 proportion to each institution's low income utilization rate, as
 5 determined based on the most recent data on file with the
 6 office.

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

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

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

21 SECTION 8. IC 12-15-17-1 IS AMENDED TO READ AS
 22 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 1.
 23 A basic disproportionate share payment shall be made to:

24 (1) a hospital licensed under IC 16-21;
 25 (2) a state mental health institution under IC 12-24-1-3; and
 26 (3) a private psychiatric institution licensed under IC 12-25;
 27 that serves a disproportionate share of Medicaid recipients and other
 28 low income patients as determined under ~~IC 12-15-16-1(a)~~.
 29 **IC 12-15-16-1**. However, a provider may not be defined as a
 30 disproportionate share provider under ~~IC 12-15-16-1(a)~~ **IC 12-15-16-1**
 31 unless the provider has a Medicaid inpatient utilization rate (as defined
 32 in 42 U.S.C. 1396r-4(b)(2)) of at least one percent (1%).

33 SECTION 9. IC 12-15-18-5.1 IS AMENDED TO READ AS
 34 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 5.1.

35 (a) For state fiscal years ending on or after June 30, 1998, the trustees
 36 and each municipal health and hospital corporation established under
 37 IC 16-22-8-6 are authorized to make intergovernmental transfers to the
 38 Medicaid indigent care trust fund in amounts to be determined jointly
 39 by the office and the trustees, and the office and each municipal health
 40 and hospital corporation.

41 (b) The treasurer of state shall annually transfer from appropriations
 42 made for the division of mental health sufficient money to provide the

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1 state's share of payments under ~~IC 12-15-16-6(e)(5)~~.
 2 **IC 12-15-16-6(d)(2).**

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

7 (1) produce payments to each hospital licensed under IC 16-21
 8 that qualifies as ~~an enhanced~~ a disproportionate share provider
 9 under ~~IC 12-15-16-1(b)~~; **IC 12-15-16-1(a)**; and

10 (2) both individually and in the aggregate do not exceed limits
 11 prescribed by the ~~United States~~ **federal** Health Care Financing
 12 Administration.

13 The trustees and a municipal health and hospital corporation are not
 14 required to make intergovernmental transfers under this section. The
 15 trustees and a municipal health and hospital corporation may make
 16 additional transfers to the Medicaid indigent care trust fund to the
 17 extent necessary to make additional payments from the Medicaid
 18 indigent care trust fund apply to a prior federal fiscal year as provided
 19 in ~~IC 12-15-19-1(c)~~. **IC 12-15-19-1(b).**

20 (d) A municipal disproportionate share provider (as defined in
 21 ~~IC 12-15-16-1(c)~~) **IC 12-15-16-1(b)**) shall transfer to the Medicaid
 22 indigent care trust fund an amount determined jointly by the office and
 23 the municipal disproportionate share provider. A municipal
 24 disproportionate share provider is not required to make
 25 intergovernmental transfers under this section. A municipal
 26 disproportionate share provider may make additional transfers to the
 27 Medicaid indigent care trust fund to the extent necessary to make
 28 additional payments from the Medicaid indigent care trust fund apply
 29 to a prior federal fiscal year as provided in ~~IC 12-15-19-1(c)~~.
 30 **IC 12-15-19-1(b).**

31 (e) A county treasurer making a payment under IC 12-29-1-7(b) or
 32 from other county sources to a community mental health center
 33 qualifying as a community mental health center disproportionate share
 34 provider shall certify that the payment represents expenditures that are
 35 eligible for federal financial participation under 42 U.S.C.
 36 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county
 37 treasurer in making this certification.

38 SECTION 10. IC 12-15-19-1 IS AMENDED TO READ AS
 39 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1.
 40 (a) For the state fiscal year ending June 30, 1997, each hospital
 41 licensed under IC 16-21 that qualifies as an enhanced disproportionate
 42 share provider under ~~IC 12-15-16-1(b)~~ shall receive additional



1 enhanced disproportionate share adjustments, based on utilization data
 2 for the hospital's cost reporting period ending during calendar year
 3 1991, subject to the hospital specific limit specified in subsection (d);
 4 as follows:

5 (1) For hospitals with a Medicaid inpatient utilization rate of
 6 fifteen percent (15%) or less and less than twenty-five thousand
 7 (25,000) total adult and pediatric days of Medicaid care:

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

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

12 (2) For hospitals with a Medicaid inpatient utilization rate of
 13 greater than fifteen percent (15%) and less than twenty thousand
 14 (20,000) total adult and pediatric Medicaid days:

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

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

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

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

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

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

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

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

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

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

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

40 However, the office may adjust the rates specified in this subsection
 41 only to the extent necessary to obtain approval from the federal
 42 government of the amendments to the Indiana Medicaid plan that are



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1 required to implement the rates specified in this subsection and may
2 make additional payments as provided in subsection (c):

3 ~~(b)~~ (a) For ~~each the~~ state fiscal year years ending on or after June
4 30, 1998, and **June 30, 1999**, the office shall develop an enhanced
5 disproportionate share payment methodology that ensures that each
6 enhanced disproportionate share provider receives total
7 disproportionate share payments that do not exceed its hospital specific
8 limit specified in subsection ~~(d)~~: (c). The methodology developed by
9 the office shall ensure that hospitals operated by the governmental
10 entities described in IC 12-15-18-5.1(a) receive, to the extent
11 practicable, basic and enhanced possible, disproportionate share
12 payments equal to their hospital specific limits. The funds shall be
13 distributed to qualifying hospitals in proportion to each qualifying
14 hospital's percentage of the total net hospital specific limits of all
15 qualifying hospitals. A hospital's net hospital specific limit **for state**
16 **fiscal years ending on or before June 30, 1999**, is determined under
17 STEP THREE of the following formula:

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

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

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

26 ~~(c)~~ (b) The office shall include a provision in each amendment to
27 the state plan regarding ~~enhanced~~ disproportionate share payments,
28 municipal disproportionate share payments, and community mental
29 health center disproportionate share payments that the office submits
30 to the federal Health Care Financing Administration that, as provided
31 in 42 CFR 447.297(d)(3), allows the state to make additional ~~enhanced~~
32 disproportionate share expenditures, municipal disproportionate share
33 expenditures, and community mental health center disproportionate
34 share expenditures after the end of each federal fiscal year that relate
35 back to ~~the a~~ prior federal fiscal year. Each eligible hospital or
36 community mental health center may receive an additional ~~enhanced~~;
37 ~~municipal~~; or ~~community mental health center~~ disproportionate share
38 adjustment if:

39 (1) additional intergovernmental transfers or certifications are
40 made as authorized under IC 12-15-18-5.1; and

41 (2) the total disproportionate share payments to:

42 (A) each individual hospital; and



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1 (B) all qualifying hospitals in the aggregate;
 2 do not exceed the limits provided by federal law and regulation.
 3 ~~(d)~~ (c) For state fiscal years ending on or before June 30, 1999,
 4 total basic and enhanced disproportionate share payments to a hospital
 5 under this chapter and IC 12-15-16 shall not exceed the hospital
 6 specific limit provided under 42 U.S.C. 1396r-4(g). The hospital
 7 specific limit for a state fiscal year years ending on or before June 30,
 8 1999, shall be determined by the office taking into account any data
 9 provided by each hospital for each hospital's most recent fiscal year (or
 10 in cases where a change in fiscal year causes the most recent fiscal
 11 period to be less than twelve (12) months, twelve (12) months of data
 12 ending at the end of the most recent fiscal year) as certified to the
 13 office by:

- 14 (1) an independent certified public accounting firm if the hospital
- 15 is a hospital licensed under IC 16-21 that qualifies under
- 16 IC 12-15-16-1(a); or
- 17 (2) the budget agency if the hospital is a state mental health
- 18 institution listed under IC 12-24-1-3 that qualifies under either
- 19 IC 12-15-16-1(a)(1) or IC 12-15-16-1(a)(2);

20 in accordance with this subsection and federal laws, regulations, and
 21 guidelines. **The hospital specific limit for state fiscal years ending**
 22 **after June 30, 1999, shall be determined by the office using the**
 23 **methodology described in section 2.1(b) of this chapter.**

24 SECTION 11. IC 12-15-19-2.1 IS ADDED TO THE INDIANA
 25 CODE AS A NEW SECTION TO READ AS FOLLOWS
 26 [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: **Sec. 2.1. (a) For**
 27 **each state fiscal year ending on or after June 30, 2000, the office**
 28 **shall develop a disproportionate share payment methodology that**
 29 **ensures that each hospital qualifying for disproportionate share**
 30 **payments under section 1(a) of this chapter timely receives total**
 31 **disproportionate share payments that do not exceed the hospital's**
 32 **hospital specific limit provided under 42 U.S.C. 1396r-4(g). The**
 33 **funds shall be distributed to qualifying hospitals in proportion to**
 34 **each qualifying hospital's percentage of the total net hospital**
 35 **specific limits of all qualifying hospitals. A hospital's net hospital**
 36 **specific limit is determined under STEP TWO of the following**
 37 **formula:**

- 38 **STEP ONE: Determine the hospital's hospital specific limit**
- 39 **under subsection (b).**
- 40 **STEP TWO: Subtract intergovernmental transfers paid by or**
- 41 **on behalf of the hospital from the amount determined under**
- 42 **STEP ONE.**



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1 However, the methodology developed by the office under this
 2 subsection shall ensure that hospitals in cities with a population of
 3 less than six hundred thousand (600,000) that qualify for payments
 4 under section 1(a) of this chapter shall receive, to the extent
 5 possible, disproportionate share payments under this subsection
 6 equal to the hospital's hospital specific limit.

7 (b) Total disproportionate share payments to a hospital under
 8 this chapter shall not exceed the hospital specific limit provided
 9 under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state
 10 fiscal year shall be determined by the office taking into account
 11 data provided by each hospital for the hospital's most recent fiscal
 12 year that is considered reliable by the office based on a system of
 13 periodic audits and the use of trending factors. The office may
 14 require an independent audit of any hospital to determine the
 15 hospital's hospital specific limit.

16 (c) The office shall include a provision in each amendment to the
 17 state plan regarding Medicaid disproportionate share payments
 18 that the office submits to the federal Health Care Financing
 19 Administration that, as provided in 42 CFR 447.297(d)(3), allows
 20 the state to make additional disproportionate share expenditures
 21 after the end of each federal fiscal year that relate back to a prior
 22 federal fiscal year. However, the total disproportionate share
 23 payments to:

- 24 (1) each individual hospital; and
- 25 (2) all qualifying hospitals in the aggregate;

26 may not exceed the limits provided by federal law and regulation.

27 (d) The office shall, in each state fiscal year, provide sufficient
 28 funds that, when added to the federal medical assistance
 29 percentage figure described in 42 U.S.C. 1396d(b), total a
 30 minimum of twenty-six million dollars (\$26,000,000) as the state's
 31 share of Medicaid disproportionate share expenditures for
 32 hospitals qualifying for disproportionate share payments under
 33 IC 12-15-16-1(a).

34 SECTION 12. IC 12-15-19-5 IS AMENDED TO READ AS
 35 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 5.
 36 Except as provided in section 6 of this chapter, ~~enhanced~~
 37 disproportionate share payment adjustments under this chapter may not
 38 be withheld by the office unless federal financial participation becomes
 39 unavailable to match state money for the purpose of providing
 40 ~~enhanced~~ disproportionate share payment adjustments.

41 SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS
 42 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 6.



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1 (a) The office is not required to make ~~enhanced~~ disproportionate share
 2 payments under this chapter ~~until from~~ the Medicaid indigent care trust
 3 fund established by IC 12-15-20-1 **until the fund** has received
 4 sufficient deposits to permit the office to make the state's share of the
 5 required ~~enhanced~~ disproportionate share payments.

6 (b) If sufficient deposits have not been received, the office shall
 7 reduce ~~enhanced~~ disproportionate share payments to all eligible
 8 institutions by the same percentage. The percentage reduction shall be
 9 sufficient to ensure that payments do not exceed the amounts that can
 10 be financed with the state share that is in the fund.

11 SECTION 14. IC 12-15-19-8 IS AMENDED TO READ AS
 12 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 8.

13 (a) A provider that qualifies as a municipal disproportionate share
 14 provider under ~~IC 12-15-16-1(c)~~ **IC 12-15-16-1(b)** shall receive a
 15 disproportionate share adjustment, subject to the provider's hospital
 16 specific limits described in subsection (b), as follows:

17 (1) For ~~each~~ state fiscal ~~year~~ **years** ending on or after June 30,
 18 1998, **and June 30, 1999**, an amount shall be distributed to each
 19 provider qualifying as a municipal disproportionate share
 20 provider under ~~IC 12-15-16-1(c)~~ **IC 12-15-16-1(b)**. The total
 21 amount distributed shall not exceed the sum of all hospital
 22 specific limits for all qualifying providers.

23 (2) For each **state fiscal year ending after June 30, 1999, for**
 24 **each** municipal disproportionate share provider qualifying under
 25 ~~IC 12-15-16-1(c)~~ **IC 12-15-16-1(b)** to receive ~~basic~~
 26 disproportionate share payments, ~~under IC 12-15-16-1(a) or~~
 27 ~~enhanced disproportionate share payments under~~
 28 ~~IC 12-15-16-1(b)~~, the amount in subdivision (1) shall be reduced
 29 by the amount of ~~basic disproportionate share payments and~~
 30 ~~enhanced~~ disproportionate share payments received by the
 31 provider **under section 2.1 of this chapter**. The office shall
 32 develop a ~~municipal~~ disproportionate share provider payment
 33 methodology that ensures that each municipal disproportionate
 34 share provider receives ~~municipal~~ disproportionate share
 35 payments that do not exceed the provider's hospital specific limit
 36 specified in subsection (b). The methodology developed by the
 37 office shall ensure that a municipal disproportionate share
 38 provider receives, to the extent possible, ~~municipal~~
 39 disproportionate share payments that, when combined with any
 40 ~~basic disproportionate share payments or enhanced other~~
 41 disproportionate share payments owed to the provider, equals the
 42 provider's hospital specific limits.



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1 (b) Total ~~basic, enhanced, and municipal~~ disproportionate share
 2 payments to a provider under this chapter and IC 12-15-16 shall not
 3 exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g).
 4 The hospital specific limit for ~~a~~ state fiscal **year years ending on or**
 5 **before June 30, 1999**, shall be determined by the office taking into
 6 account data provided by each hospital for the hospital's most recent
 7 fiscal year or, if a change in fiscal year causes the most recent fiscal
 8 period to be less than twelve (12) months, twelve (12) months of data
 9 **ending at compiled to** the end of the **provider's fiscal year that ends**
 10 **within the** most recent state fiscal year, as certified to the office by an
 11 independent certified public accounting firm. **The hospital specific**
 12 **limit for all state fiscal years ending on or after June 30, 2000, shall**
 13 **be determined by the office taking into account data provided by**
 14 **each hospital that is deemed reliable by the office based on a**
 15 **system of periodic audits and the use of trending factors. The office**
 16 **may require an independent audit of any hospital to determine the**
 17 **hospital's hospital specific limit.**

18 SECTION 15. IC 12-15-19-9 IS AMENDED TO READ AS
 19 FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 9.

20 (a) For each state fiscal year ending after June 30, 1997, a community
 21 mental health center that qualifies as a community health center
 22 disproportionate share provider under ~~IC 12-15-16-1(d)~~
 23 **IC 12-15-16-1(c)** shall receive disproportionate share payments in a
 24 amount determined under STEP 3 of the following formula:

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

28 STEP 2: Divide the amount determined under STEP 1 by a
 29 percentage equal to the state's medical assistance percentage for
 30 the state fiscal year.

31 STEP 3: Subtract the amount determined under STEP 1 from the
 32 sum determined under STEP 2.

33 (b) A community mental health center disproportionate share
 34 payment under this chapter and IC 12-15-16 to a community mental
 35 health center qualifying under ~~IC 12-15-16-1(d)~~ **IC 12-15-16-1(c)** may
 36 not exceed the institution specific limit provided under 42 U.S.C.
 37 1396r-4(g). The institution specific limit for a state fiscal year shall be
 38 determined by the office taking into account data provided by the
 39 community mental health center ~~for~~ **that is considered reliable by the**
 40 **office based on a system of periodic audits and the use of trending**
 41 **factors. The office may require an independent audit of any**
 42 **community health center to determine** the community mental health



1 center's most recent fiscal year or, if a change in fiscal year causes the
 2 most recent fiscal period to be less than twelve (12) months; twelve
 3 (12) months of data compiled to the end of the most recent state fiscal
 4 year; as certified to the office by an independent certified public
 5 accounting firm: **institution specific limit.**

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

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

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

19 SECTION 16. IC 12-15-19-10 IS AMENDED TO READ AS
 20 FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 10.
 21 If the state exceeds the state disproportionate share allocation (as
 22 defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on
 23 disproportionate share expenditures for institutions for mental diseases
 24 (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as
 25 follows:

26 (1) The state shall make ~~basic~~ disproportionate share provider
 27 payments **to providers qualifying** under IC 12-15-16-1(a),
 28 **IC 12-15-16-1(b), and IC 12-15-16-1(c)** until the state exceeds
 29 the state disproportionate share allocation.

30 ~~(2) After the state makes all payments under subdivision (1); if~~
 31 ~~the state fails to exceed the state disproportionate share allocation;~~
 32 ~~the state shall make enhanced disproportionate share provider~~
 33 ~~payments under IC 12-15-16-1(b).~~

34 ~~(3) (2)~~ After the state makes all payments under subdivision ~~(2);~~
 35 ~~(1)~~, if the state fails to exceed the state disproportionate share
 36 allocation, the state shall make ~~municipal~~ disproportionate share
 37 provider payments **to providers qualifying** under
 38 ~~IC 12-15-16-1(c).~~ **IC 12-15-16-1(b).**

39 ~~(4) (3)~~ After the state makes all payments under subdivision ~~(3);~~
 40 ~~(2)~~, if the state fails to exceed the state disproportionate share
 41 allocation, the state shall make ~~community mental health center~~
 42 disproportionate share provider payments **to providers**



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qualifying under ~~IC 12-15-16-1(d)~~. **IC 12-15-16-1(c)**.
SECTION 17. IC 12-15-20-2, AS AMENDED BY P.L.273-1999,
SECTION 174, IS AMENDED TO READ AS FOLLOWS
[EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 2. The Medicaid
indigent care trust fund is established to pay the state's share of the
following:

- (1) Enhanced disproportionate share payments to providers under ~~IC 12-15-19~~. **IC 12-15-19-1.**
- (2) **Disproportionate share payments to providers under IC 12-15-19-2.1.**
- (3) Disproportionate share payments and significant disproportionate share payments for certain outpatient services under IC 12-15-17-3.
- ~~(3)~~ (4) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.
- ~~(4)~~ (5) Municipal disproportionate share payments to providers under IC 12-15-19-8.

SECTION 18. IC 12-29-1-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999 (RETROACTIVE)]: Sec. 7.

- (a) On the first Monday in October, the county auditor shall certify to:
 - (1) the division of mental health, for a community mental health center;
 - (2) the division of disability, aging, and rehabilitative services, for a community mental retardation and other developmental disabilities center; and
 - (3) the president of the board of directors of each center;
 the amount of money that will be provided to the center under this chapter.
- (b) The county payment to the center shall be paid by the county treasurer to the treasurer of each center's board of directors in the following manner:
 - (1) One-half (1/2) of the county payment to the center shall be made on the second Monday in July.
 - (2) One-half (1/2) of the county payment to the center shall be made on the second Monday in December.

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

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1 policy and planning shall assist a county treasurer in making this
2 certification.

3 (c) Payments by the county fiscal body:

4 (1) must be in the amounts:

5 (A) determined by IC 12-29-2-1 through IC 12-29-2-6; and

6 (B) authorized by section 1 of this chapter; and

7 (2) are in place of grants from agencies supported within the
8 county solely by county tax money.

9 **SECTION 19. An emergency is declared for this act.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1352, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

BAUER, Chair

Committee Vote: yeas 22, nays 0.

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