

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.

SENATE ENROLLED ACT No. 455

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 12-7-2-110 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 110. "Hospital" means the following:

(1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.

(+) (2) For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.

(-) (3) For purposes of IC 12-16, except IC 12-16-1, the term refers to a hospital licensed under IC 16-21.

SECTION 2. IC 12-15-11.5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 11.5. Lake County Disproportionate Share Hospitals

Sec. 1. As used in this chapter, "hospital" refers to an acute care hospital provider that:

(1) is licensed under IC 16-21;

(2) qualifies as a disproportionate share hospital under IC 12-15-16; and

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



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(700,000).

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

- (1) is eligible to receive services under IC 12-15 and has enrolled in the office's managed care services program;**
- (2) resides in the same city in which the hospital is located; and**
- (3) has selected a primary care provider who:**
 - (A) is a contracted provider with the office's managed care contractor; and**
 - (B) has medical staff privileges at the hospital.**

(b) This section expires December 31, 2000.

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

(b) A hospital that provides services to individuals described in section 2 of this chapter shall comply with eligibility verification and medical management programs negotiated under the hospital's most recent contract or agreement with the office's managed care contractor.

(c) This section expires December 31, 2000.

Sec. 4. (a) A hospital that:

- (1) does not have a contract in effect with the office's managed care contractor; but**
- (2) previously contracted or entered into an agreement with the office's managed care contractor for the provision of services under the office's managed care program;**

shall be reimbursed for services provided to individuals described in section 2 of this chapter at rates equivalent to the rates negotiated under the hospital's most recent contract or agreement with the office's managed care contractor, as adjusted for inflation by the inflation adjustment factor described in subsection (b). However, the adjusted rates may not exceed the established Medicaid rates paid to Medicaid providers who are not contracted providers in the office's managed health care services program. This subsection expires December 31, 2000.

(b) For each state fiscal year beginning after June 30, 2001, an

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inflation adjustment factor shall be applied under subsection (a) that is the average of the percentage increase in the medical care component of the Consumer Price Index for all Urban Consumers and the percentage increase in the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics, for the twelve (12) month period ending in March preceding the beginning of the state fiscal year. This subsection expires July 1, 2001.

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

(b) This section expires December 31, 2000.

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

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

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

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

- (1)** That submission of disputed claims must be made to an independent arbitrator selected under subsection (b).
- (2)** Each claim must set forth with specificity the issues to be arbitrated, the amount involved, and the relief sought.
- (3)** That the hospital and the office's managed care contractor



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shall attempt in good faith to resolve all disputed claims.

(4) The hospital shall submit to the arbitrator any claims that remain in dispute sixty (60) calendar days after the hospital receives written notice as provided under section 7 of this chapter.

(5) That resolution of disputes by the arbitrator must occur not later than ninety (90) calendar days after submission of disputed claims to the arbitrator, unless the parties mutually agree otherwise.

(6) That determinations of the arbitrator are final and binding and not subject to any appeal or review procedure.

(7) That the arbitrator does not have the authority to award any punitive or exemplary damages or to vary or ignore the terms of any contract between the parties and shall be bound by controlling law.

(8) That judgment upon the award rendered by the arbitrator may be entered and enforced in and is subject to the jurisdiction of a court with jurisdiction in Indiana.

(9) That the cost of the arbitrator must be shared equally by the parties, and each party must bear its own attorney and witness fees.

(b) The parties to a contract described in subsection (a) shall mutually agree on an independent arbitrator, or, if the parties are unable to reach agreement on an independent arbitrator, the following procedure must be followed:

(1) Each party shall select an independent representative, and the independent representatives shall select a panel of three (3) independent arbitrators who have experience in institutional and professional health care delivery practices and procedures and have had no prior dealing with either party other than as an arbitrator.

(2) The parties will each strike one (1) arbitrator from the panel selected under subdivision (1), and the remaining arbitrator serves as the arbitrator of the disputed claims under subsection (a).

(3) The procedures for selecting an arbitrator under this section must be completed not later than twenty (20) calendar days after the hospital provides written notice of at least one (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



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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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President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Approved: _____

Governor of the State of Indiana

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