

PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION _____

MR. SPEAKER:

I move that Engrossed Senate Bill 213 be amended to read as follows:

- 1 Delete the title and insert the following:
- 2 A BILL FOR AN ACT to amend the Indiana Code concerning health.
- 3 Page 1, between the enacting clause and line 1, begin a new
- 4 paragraph and insert:
- 5 "SECTION 1. IC 12-15-15-9, AS AMENDED BY P.L.255-2003,
- 6 SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 7 JULY 1, 2004]: Sec. 9. (a) For purposes of this section and
- 8 IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable
- 9 claim is submitted to the division by a hospital licensed under
- 10 IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the
- 11 hospital to an individual who qualifies for the hospital care for the
- 12 indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:
- 13 (1) who is a resident of the county;
- 14 (2) who is not a resident of the county and for whom the onset of
- 15 the medical condition that necessitated the care occurred in the
- 16 county; or
- 17 (3) whose residence cannot be determined by the division and for
- 18 whom the onset of the medical condition that necessitated the care
- 19 occurred in the county.
- 20 (b) For each state fiscal year ending after June 30, 2003, a hospital
- 21 licensed under IC 16-21-2 that submits to the division during the state
- 22 fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment
- 23 under this section.
- 24 (c) ~~For a state fiscal year;~~ **Except as provided under section 9.8**

1 **of this chapter and** subject to section 9.6 of this chapter, **for a state**
2 **fiscal year**, the office shall pay to a hospital referred to in subsection
3 (b) an amount equal to the amount, based on information obtained from
4 the division and the calculations and allocations made under
5 IC 12-16-7.5-4.5, that the office determines for the hospital under
6 STEP SIX of the following STEPS:

7 STEP ONE: Identify:
8 (A) each hospital that submitted to the division one (1) or more
9 payable claims under IC 12-16-7.5 during the state fiscal year;
10 and
11 (B) the county to which each payable claim is attributed.

12 STEP TWO: For each county identified in STEP ONE, identify:
13 (A) each hospital that submitted to the division one (1) or more
14 payable claims under IC 12-16-7.5 attributed to the county
15 during the state fiscal year; and
16 (B) the total amount of all hospital payable claims submitted to
17 the division under IC 12-16-7.5 attributed to the county during
18 the state fiscal year.

19 STEP THREE: For each county identified in STEP ONE, identify
20 the amount of county funds transferred to the Medicaid indigent
21 care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

22 STEP FOUR: For each hospital identified in STEP ONE, with
23 respect to each county identified in STEP ONE, calculate the
24 hospital's percentage share of the county's funds transferred to the
25 Medicaid indigent care trust fund under STEP FOUR of
26 IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on
27 the total amount of the hospital's payable claims submitted to the
28 division under IC 12-16-7.5 attributed to the county during the
29 state fiscal year, calculated as a percentage of the total amount of
30 all hospital payable claims submitted to the division under
31 IC 12-16-7.5 attributed to the county during the state fiscal year.

32 STEP FIVE: Subject to subsection (j), for each hospital identified
33 in STEP ONE, with respect to each county identified in STEP
34 ONE, multiply the hospital's percentage share calculated under
35 STEP FOUR by the amount of the county's funds transferred to
36 the Medicaid indigent care trust fund under STEP FOUR of
37 IC 12-16-7.5-4.5(b).

38 STEP SIX: Determine the sum of all amounts calculated under
39 STEP FIVE for each hospital identified in STEP ONE with respect
40 to each county identified in STEP ONE.

41 (d) A hospital's payment under subsection (c) is in the form of a
42 Medicaid add-on payment. The amount of a hospital's add-on payment
43 is subject to the availability of funding for the non-federal share of the
44 payment under subsection (e). The office shall make the payments
45 under subsection (c) before December 15 that next succeeds the end
46 of the state fiscal year.

1 (e) The non-federal share of a payment to a hospital under
 2 subsection (c) is funded from the funds transferred to the Medicaid
 3 indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of
 4 each county to which a payable claim under IC 12-16-7.5 submitted to
 5 the division during the state fiscal year by the hospital is attributed.

6 (f) The amount of a county's transferred funds available to be used
 7 to fund the non-federal share of a payment to a hospital under
 8 subsection (c) is an amount that bears the same proportion to the total
 9 amount of funds of the county transferred to the Medicaid indigent care
 10 trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total
 11 amount of the hospital's payable claims under IC 12-16-7.5 attributed
 12 to the county submitted to the division during the state fiscal year bears
 13 to the total amount of all hospital payable claims under IC 12-16-7.5
 14 attributed to the county submitted to the division during the state fiscal
 15 year.

16 (g) Any county's funds identified in subsection (f) that remain after
 17 the non-federal share of a hospital's payment has been funded are
 18 available to serve as the non-federal share of a payment to a hospital
 19 under section 9.5 of this chapter.

20 (h) For purposes of this section, "payable claim" has the meaning set
 21 forth in IC 12-16-7.5-2.5(b)(1).

22 (i) For purposes of this section:

23 (1) the amount of a payable claim is an amount equal to the
 24 amount the hospital would have received under the state's
 25 fee-for-service Medicaid reimbursement principles for the hospital
 26 care for which the payable claim is submitted under IC 12-16-7.5
 27 if the individual receiving the hospital care had been a Medicaid
 28 enrollee; and

29 (2) a payable hospital claim under IC 12-16-7.5 includes a payable
 30 claim under IC 12-16-7.5 for the hospital's care submitted by an
 31 individual or entity other than the hospital, to the extent permitted
 32 under the hospital care for the indigent program.

33 (j) The amount calculated under STEP FIVE of subsection (c) for
 34 a hospital with respect to a county may not exceed the total amount of
 35 the hospital's payable claims attributed to the county during the state
 36 fiscal year.

37 SECTION 2. IC 12-15-15-9.5, AS ADDED BY P.L.255-2003,
 38 SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 39 JULY 1, 2004]: Sec. 9.5. (a) For purposes of this section and
 40 IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable
 41 claim is submitted to the division by a hospital licensed under
 42 IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the
 43 hospital to an individual who qualifies for the hospital care for the
 44 indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

45 (1) who is a resident of the county;

46 (2) who is not a resident of the county and for whom the onset of

1 the medical condition that necessitated the care occurred in the
2 county; or

3 (3) whose residence cannot be determined by the division and for
4 whom the onset of the medical condition that necessitated the care
5 occurred in the county.

6 (b) For each state fiscal year ending after June 30, 2003, a hospital
7 licensed under IC 16-21-2:

8 (1) that submits to the division during the state fiscal year a
9 payable claim under IC 12-16-7.5; and

10 (2) whose payment under section 9(c) of this chapter was less
11 than the total amount of the hospital's payable claims under
12 IC 12-16-7.5 submitted by the hospital to the division during the
13 state fiscal year;

14 is entitled to a payment under this section.

15 (c) ~~For a state fiscal year,~~ **Except as provided in section 9.8 of this**
16 **chapter and** subject to section 9.6 of this chapter, **for a state fiscal**
17 **year,** the office shall pay to a hospital referred to in subsection (b) an
18 amount equal to the amount, based on information obtained from the
19 division and the calculations and allocations made under
20 IC 12-16-7.5-4.5, that the office determines for the hospital under
21 STEP EIGHT of the following STEPS:

22 STEP ONE: Identify each county whose transfer of funds to the
23 Medicaid indigent care trust fund under STEP FOUR of
24 IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total
25 amount of all hospital payable claims attributed to the county and
26 submitted to the division during the state fiscal year.

27 STEP TWO: For each county identified in STEP ONE, calculate
28 the difference between the amount of funds of the county
29 transferred to the Medicaid indigent care trust fund under STEP
30 FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital
31 payable claims attributed to the county and submitted to the
32 division during the state fiscal year.

33 STEP THREE: Calculate the sum of the amounts calculated for the
34 counties under STEP TWO.

35 STEP FOUR: Identify each hospital whose payment under section
36 9(c) of this chapter was less than the total amount of the hospital's
37 payable claims under IC 12-16-7.5 submitted by the hospital to the
38 division during the state fiscal year.

39 STEP FIVE: Calculate for each hospital identified in STEP FOUR
40 the difference between the hospital's payment under section 9(c)
41 of this chapter and the total amount of the hospital's payable
42 claims under IC 12-16-7.5 submitted by the hospital to the division
43 during the state fiscal year.

44 STEP SIX: Calculate the sum of the amounts calculated for each
45 of the hospitals under STEP FIVE.

1 STEP SEVEN: For each hospital identified in STEP FOUR,
2 calculate the hospital's percentage share of the amount calculated
3 under STEP SIX. Each hospital's percentage share is based on the
4 amount calculated for the hospital under STEP FIVE calculated as
5 a percentage of the sum calculated under STEP SIX.

6 STEP EIGHT: For each hospital identified in STEP FOUR,
7 multiply the hospital's percentage share calculated under STEP
8 SEVEN by the sum calculated under STEP THREE. The amount
9 calculated under this STEP for a hospital may not exceed the
10 amount by which the hospital's total payable claims under
11 IC 12-16-7.5 submitted during the state fiscal year exceeded the
12 amount of the hospital's payment under section 9(c) of this
13 chapter.

14 (d) A hospital's payment under subsection (c) is in the form of a
15 Medicaid add-on payment. The amount of the hospital's add-on
16 payment is subject to the availability of funding for the non-federal
17 share of the payment under subsection (e). The office shall make the
18 payments under subsection (c) before December 15 that next succeeds
19 the end of the state fiscal year.

20 (e) The non-federal share of a payment to a hospital under
21 subsection (c) is derived from funds transferred to the Medicaid
22 indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and
23 not expended under section 9 of this chapter. To the extent possible, the
24 funds shall be derived on a proportional basis from the funds
25 transferred by each county identified in subsection (c), STEP ONE:

26 (1) to which at least one (1) payable claim submitted by the
27 hospital to the division during the state fiscal year is attributed; and
28 (2) whose funds transferred to the Medicaid indigent care trust
29 fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not
30 completely expended under section 9 of this chapter.

31 The amount available to be derived from the remaining funds
32 transferred to the Medicaid indigent care trust fund under STEP FOUR
33 of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment
34 to a hospital under subsection (c) is an amount that bears the same
35 proportion to the total amount of funds transferred by all the counties
36 identified in subsection (c), STEP ONE, that the amount calculated for
37 the hospital under subsection (c), STEP FIVE, bears to the amount
38 calculated under subsection (c), STEP SIX.

39 (f) Except as provided in subsection (g), the office may not make a
40 payment under this section until the payments due under section 9 of
41 this chapter for the state fiscal year have been made.

42 (g) If a hospital appeals a decision by the office regarding the
43 hospital's payment under section 9 of this chapter, the office may make
44 payments under this section before all payments due under section 9 of
45 this chapter are made if:

46 (1) a delay in one (1) or more payments under section 9 of this

1 chapter resulted from the appeal; and
 2 (2) the office determines that making payments under this section
 3 while the appeal is pending will not unreasonably affect the
 4 interests of hospitals eligible for a payment under this section.

5 (h) Any funds transferred to the Medicaid indigent care trust fund
 6 under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments
 7 are made under this section shall be used as provided in
 8 IC 12-15-20-2(8)(D).

9 (i) For purposes of this section:

10 (1) "payable claim" has the meaning set forth in
 11 IC 12-16-7.5-2.5(b);

12 (2) the amount of a payable claim is an amount equal to the
 13 amount the hospital would have received under the state's
 14 fee-for-service Medicaid reimbursement principles for the hospital
 15 care for which the payable claim is submitted under IC 12-16-7.5
 16 if the individual receiving the hospital care had been a Medicaid
 17 enrollee; and

18 (3) a payable hospital claim under IC 12-16-7.5 includes a payable
 19 claim under IC 12-16-7.5 for the hospital's care submitted by an
 20 individual or entity other than the hospital, to the extent permitted
 21 under the hospital care for the indigent program.

22 SECTION 3. IC 12-15-15-9.8 IS ADDED TO THE INDIANA
 23 CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
 24 JULY 1, 2004]: **Sec. 9.8. (a) This section applies only if the office
 25 determines, based on information received from the United States
 26 Centers for Medicare and Medicaid Services, that a state Medicaid
 27 plan amendment implementing the payment methodology in:**

28 **(1) section 9(c) of this chapter; or**

29 **(2) section 9.5(c) of this chapter;**

30 **will not be approved by the Centers for Medicare and Medicaid
 31 Services.**

32 **(b) The office may amend the state Medicaid plan to implement
 33 an alternative payment methodology to the payment methodology
 34 under section 9 of this chapter. The alternative payment
 35 methodology must provide each hospital that would have received
 36 a payment under section 9(c) of this chapter during a state fiscal
 37 year with an amount for the state fiscal year that is as equal as
 38 possible to the amount each hospital would have received under
 39 the payment methodology under section 9(c) of this chapter. A
 40 payment methodology implemented under this subsection is in
 41 place of the payment methodology under section 9(c) of this
 42 chapter.**

43 **(c) The office may amend the state Medicaid plan to implement
 44 an alternative payment methodology to the payment methodology**

1 **under section 9.5 of this chapter. The alternative payment**
 2 **methodology must provide each hospital that would have received**
 3 **a payment under section 9.5(c) of this chapter during a state fiscal**
 4 **year with an amount for the state fiscal year that is as equal as**
 5 **possible to the amount each hospital would have received under**
 6 **the payment methodology under section 9.5(c) of this chapter. A**
 7 **payment methodology implemented under this subsection is in**
 8 **place of the payment methodology under section 9.5(c) of this**
 9 **chapter.**

10 SECTION 4. IC 12-15-18-5.1, AS AMENDED BY P.L.66-2002,
 11 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 2003 (RETROACTIVE)]: Sec. 5.1. (a) For state fiscal years
 13 ending on or after June 30, 1998, the trustees and each municipal health
 14 and hospital corporation established under IC 16-22-8-6 are authorized
 15 to make intergovernmental transfers to the Medicaid indigent care trust
 16 fund in amounts to be determined jointly by the office and the trustees,
 17 and the office and each municipal health and hospital corporation.

18 (b) The treasurer of state shall annually transfer from appropriations
 19 made for the division of mental health and addiction sufficient money
 20 to provide the state's share of payments under IC 12-15-16-6(c)(2).

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

25 (1) produce payments to each hospital licensed under IC 16-21
 26 that qualifies as a disproportionate share provider under
 27 IC 12-15-16-1(a); and

28 (2) both individually and in the aggregate do not exceed limits
 29 prescribed by the federal Centers for Medicare and Medicaid
 30 Services.

31 The trustees and a municipal health and hospital corporation are not
 32 required to make intergovernmental transfers under this section. The
 33 trustees and a municipal health and hospital corporation may make
 34 additional transfers to the Medicaid indigent care trust fund to the extent
 35 necessary to make additional payments from the Medicaid indigent care
 36 trust fund apply to a prior federal fiscal year as provided in
 37 IC 12-15-19-1(b).

38 (d) A municipal disproportionate share provider (as defined in
 39 IC 12-15-16-1) shall transfer to the Medicaid indigent care trust fund
 40 an amount determined jointly by the office and the municipal
 41 disproportionate share provider. A municipal disproportionate share
 42 provider is not required to make intergovernmental transfers under this
 43 section. A municipal disproportionate share provider may make
 44 additional transfers to the Medicaid indigent care trust fund to the extent
 45 necessary to make additional payments from the Medicaid indigent care

1 trust fund apply to a prior federal fiscal year as provided in
2 IC 12-15-19-1(b).

3 (e) A county making a payment under IC 12-29-1-7(b) or from
4 other county sources to a community mental health center qualifying as
5 a community mental health center disproportionate share provider **for**
6 **purposes of IC 12-15-19-9.5** shall certify that the payment represents
7 expenditures that are eligible for federal financial participation under 42
8 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a
9 county in making this certification.

10 SECTION 5. IC 12-15-19-9.5 IS ADDED TO THE INDIANA
11 CODE AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE
12 JULY 1, 2003 (RETROACTIVE)]: **Sec. 9.5. (a) For each state fiscal**
13 **year ending after June 30, 2003, a community mental health**
14 **center disproportionate share provider that is:**

15 (1) freestanding from a hospital licensed under IC 16-21; and
16 (2) not operated as part of a hospital licensed under IC 16-21;
17 shall receive a disproportionate share payment as provided in this
18 section.

19 (b) Subject to subsection (f), a community mental health center
20 disproportionate share provider described in subsection (a) shall
21 receive a payment in the amount determined under STEP 3 of the
22 following formula:

23 **STEP 1: Determine the amounts certified for the community**
24 **mental health center disproportionate share provider under**
25 **IC 12-15-18-5.1(e).**

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

29 **STEP 3: Subtract the amount determined under STEP 1 from**
30 **the amount determined under STEP 2.**

31 (c) A disproportionate share payment under this section is
32 comprised of:

33 (1) the amounts certified for the community mental health
34 center disproportionate share provider under
35 IC 12-15-18-5.1(e); and

36 (2) the amount paid to the community mental health center
37 disproportionate share provider under subsection (b).

38 (d) A disproportionate share payment under this section may
39 not exceed the community mental health center disproportionate
40 share provider's institution specific limit under 42 U.S.C.
41 1396r-4(g). The office shall determine the institution specific limit
42 for a state fiscal year by taking into account data provided by the
43 community mental health center disproportionate share provider

1 **that is considered reliable by the office based on:**

- 2 **(1) a periodic audit system;**
 3 **(2) the use of trending factors; and**
 4 **(3) an appropriate base year determined by the office.**

5 **(e) The office may require independent certification of data**
 6 **provided by a community mental health center disproportionate**
 7 **share provider to the office in order to determine the community**
 8 **mental health center disproportionate share provider's institution**
 9 **specific limit.**

10 **(f) Subjection to section 10(b)(2) and 10(b)(3) of this chapter,**
 11 **payments under this section may not result in total**
 12 **disproportionate share payments that exceed the state limit on**
 13 **these expenditures for institutions for mental diseases under 42**
 14 **U.S.C. 1396r-4(h). The office may reduce payments due under this**
 15 **section for a state fiscal year, on a pro rata basis, if the reduction**
 16 **is necessary to avoid exceeding the state limit on disproportionate**
 17 **share expenditures for institutions for mental diseases.**

18 **(g) Subject to section 10(b)(3) of this chapter, total**
 19 **disproportionate share payments under this section for a state**
 20 **fiscal year must equal ten million dollars (\$10,000,000). However,**
 21 **this amount may be reduced based upon the amounts certified for**
 22 **community mental health center disproportionate share providers**
 23 **under IC 12-15-18-5.1(e). The office may reduce the payments due**
 24 **under this section, on a pro rata basis, based upon the institution**
 25 **specific limits under 42 U.S.C. 1396r-4(g) of each community**
 26 **mental health center disproportionate share provider eligible for**
 27 **a payment under this section for that state fiscal year if the**
 28 **reduction is necessary to avoid exceeding the total payment limit**
 29 **established under this subsection.**

30 **(h) The office may recover a payment made under subsection**
 31 **(b) from the community mental health center disproportionate**
 32 **share provider if federal financial participation is disallowed for**
 33 **the funds certified under IC 12-15-18-5.1(e) upon which the**
 34 **payment was based.**

35 SECTION 6. IC 12-15-19-10, AS AMENDED BY P.L.283-2001,
 36 SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 37 JULY 1, 2003 (RETROACTIVE)]: Sec. 10. (a) For the state fiscal year
 38 beginning July 1, 1999, and ending June 30, 2000, the state shall pay
 39 providers as follows:

- 40 (1) The state shall make disproportionate share provider payments
 41 to municipal disproportionate share providers qualifying under
 42 IC 12-15-16-1(b) until the state exceeds the state disproportionate
 43 share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).
 44 (2) After the state makes all payments under subdivision (1), if the

1 state fails to exceed the state disproportionate share allocation (as
 2 defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
 3 disproportionate share expenditures for institutions for mental
 4 diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make
 5 community mental health center disproportionate share provider
 6 payments to providers qualifying under IC 12-15-16-1(c). The
 7 total paid to the qualified community mental health center
 8 disproportionate share providers under section 9(a) of this
 9 chapter, including the amount of expenditures certified as being
 10 eligible for federal financial participation under IC 12-15-18-5.1(e),
 11 must be at least six million dollars (\$6,000,000).

12 (3) After the state makes all payments under subdivision (2), if the
 13 state fails to exceed the state disproportionate share allocation (as
 14 defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make
 15 disproportionate share provider payments to providers qualifying
 16 under IC 12-15-16-1(a).

17 (b) For state fiscal years beginning after June 30, 2000, the state
 18 shall pay providers as follows:

19 (1) The state shall make municipal disproportionate share provider
 20 payments to providers qualifying under IC 12-15-16-1(b) until the
 21 state exceeds the state disproportionate share allocation (as defined
 22 in 42 U.S.C. 1396r-4(f)(2)).

23 (2) After the state makes all payments under subdivision (1), if the
 24 state fails to exceed the state disproportionate share allocation (as
 25 defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make
 26 disproportionate share provider payments to providers qualifying
 27 under IC 12-15-16-1(a). **Beginning in a state fiscal year ending**
 28 **after June 30, 2003, the total disproportionate share**
 29 **payments made to a state mental health institution described**
 30 **in IC 12-24-1-3 must be limited to an amount necessary to**
 31 **permit disproportionate share payments to be made under**
 32 **section 9.5 of this chapter without exceeding the state limit**
 33 **on disproportionate share expenditures for institutions for**
 34 **mental diseases under 42 U.S.C. 1396r-4(h).**

35 (3) After the state makes all payments under subdivision (2), if the
 36 state fails to exceed the state disproportionate share allocation (as
 37 defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
 38 disproportionate share expenditures for institutions for mental
 39 diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make
 40 ~~community mental health center disproportionate share provider~~
 41 ~~payments to providers qualifying under IC 12-15-16-1(c).~~
 42 **disproportionate share payments under section 9.5 of this**
 43 **chapter."**

44 Page 2, after line 10, begin a new paragraph and insert:

45 "SECTION 8. [EFFECTIVE JULY 1, 2004] (a) **The Indiana**

1 prescription drug advisory committee is established to:

- 2 (1) study pharmacy benefit programs and proposals, including
 3 programs and proposals in other states;
 4 (2) make initial and ongoing recommendations to the
 5 governor for programs that address the pharmaceutical costs
 6 of low-income senior citizens; and
 7 (3) review and approve changes to a prescription drug
 8 program that is established or implemented under a Medicaid
 9 waiver that uses money from the Indiana prescription drug
 10 account established under IC 4-12-8-2.

11 (b) The committee consists of eleven (11) members appointed
 12 by the governor and four (4) legislative members. Members
 13 serving on the committee established by P.L.291-2001, SECTION
 14 81, before its expiration on December 31, 2001, continue to serve.
 15 The term of each member expires December 31, 2006. The
 16 members of the committee appointed by the governor are as
 17 follows:

- 18 (1) A physician with a specialty in geriatrics.
 19 (2) A pharmacist.
 20 (3) A person with expertise in health plan administration.
 21 (4) A representative of an area agency on aging.
 22 (5) A consumer representative from a senior citizen advocacy
 23 organization.
 24 (6) A person with expertise in and knowledge of the federal
 25 Medicare program.
 26 (7) A health care economist.
 27 (8) A person representing a pharmaceutical research and
 28 manufacturing association.
 29 (9) A township trustee.
 30 (10) Two (2) other members as appointed by the governor.

31 The four (4) legislative members shall serve as nonvoting
 32 members. The speaker of the house of representatives and the
 33 president pro tempore of the senate shall each appoint two (2)
 34 legislative members, who may not be from the same political
 35 party, to serve on the committee.

36 (c) The governor shall designate a member to serve as
 37 chairperson. A vacancy with respect to a member shall be filled in
 38 the same manner as the original appointment. Each member is
 39 entitled to reimbursement for traveling expenses and other
 40 expenses actually incurred in connection with the member's
 41 duties. The expenses of the committee shall be paid from the
 42 Indiana prescription drug account created by IC 4-12-8-2. The
 43 office of the secretary of family and social services shall provide

1 staff for the committee. The committee is a public agency for
 2 purposes of IC 5-14-1.5 and IC 5-14-3. The committee is a
 3 governing body for purposes of IC 5-14-1.5.

4 (d) Not later than September 1, 2004, the committee shall
 5 make program design recommendations to the governor and the
 6 family and social services administration concerning the following:

7 (1) Eligibility criteria, including the desirability of
 8 incorporating an income factor based on the federal poverty
 9 level.

10 (2) Benefit structure.

11 (3) Cost-sharing requirements, including whether the
 12 program should include a requirement for copayments or
 13 premium payments.

14 (4) Marketing and outreach strategies.

15 (5) Administrative structure and delivery systems.

16 (6) Evaluation.

17 (e) The recommendations shall address the following:

18 (1) Cost-effectiveness of program design.

19 (2) Coordination with existing pharmaceutical assistance
 20 programs.

21 (3) Strategies to minimize crowd-out of private insurance.

22 (4) Reasonable balance between maximum eligibility levels
 23 and maximum benefit levels.

24 (5) Feasibility of a health care subsidy program where the
 25 amount of the subsidy is based on income.

26 (6) Advisability of entering into contracts with health
 27 insurance companies to administer the program.

28 (f) This SECTION expires December 31, 2006.

29 SECTION 9. P.L.224-2003, SECTION 70, IS AMENDED TO
 30 READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: SECTION 70. (a)
 31 As used in this SECTION, "high Medicaid utilization nursing facility"
 32 means the smallest number of those nursing facilities with the greatest
 33 number of Medicaid patient days for which it is necessary to assess a
 34 lower quality assessment to satisfy the statistical test set forth in 42
 35 CFR 433.68(e)(2)(ii).

36 (b) As used in this SECTION, "nursing facility" means a health
 37 facility that is:

38 (1) licensed under IC 16-28 as a comprehensive care facility; and

39 (2) certified for participation in the federal Medicaid program
 40 under Title XIX of the federal Social Security Act (42 U.S.C.
 41 1396 et seq.).

42 (c) As used in this SECTION, "office" refers to the office of
 43 Medicaid policy and planning established by IC 12-8-6-1.

44 (d) As used in this SECTION, "total annual revenue" does not

1 include revenue from Medicare services provided under Title XVIII of
2 the federal Social Security Act (42 U.S.C. 1395 et seq.).

3 (e) Effective August 1, 2003, the office shall collect a quality
4 assessment from each nursing facility that has:

5 (1) a Medicaid utilization rate of at least twenty-five percent
6 (25%); and

7 (2) at least seven hundred thousand dollars (\$700,000) in annual
8 Medicaid revenue, adjusted annually by the average annual
9 percentage increase in Medicaid rates.

10 (f) The money collected from the quality assessment may be used
11 only to pay the state's share of the costs for Medicaid services provided
12 under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et
13 seq.) as follows:

14 (1) Twenty percent (20%) as determined by the office.

15 (2) Eighty percent (80%) to nursing facilities.

16 (g) The office may not begin collection of the quality assessment set
17 under this SECTION before the office calculates and begins paying
18 enhanced reimbursement rates set forth in this SECTION.

19 (h) If federal financial participation becomes unavailable to match
20 money collected from the quality assessments for the purpose of
21 enhancing reimbursement to nursing facilities for Medicaid services
22 provided under Title XIX of the federal Social Security Act (42 U.S.C.
23 1396 et seq.), the office shall cease collection of the quality assessment
24 under the SECTION.

25 (i) The office shall adopt rules under IC 4-22-2 to implement this
26 act.

27 (j) Not later than July 1, 2003, the office shall do the following:

28 (1) Request the United States Department of Health and Human
29 Services under 42 CFR 433.72 to approve waivers of 42 CFR
30 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance
31 with 42 CFR 433.68(e)(2)(ii).

32 (2) Submit any state Medicaid plan amendments to the United
33 States Department of Health and Human Services that are
34 necessary to implement this SECTION.

35 (k) After approval of the waivers and state Medicaid plan
36 amendment applied for under subsection (j), the office shall implement
37 this SECTION effective July 1, 2003.

38 (l) The select joint commission on Medicaid oversight, established
39 by IC 2-5-26-3, shall review the implementation of this SECTION. The
40 office may not make any change to the reimbursement for nursing
41 facilities unless the select joint commission on Medicaid oversight
42 recommends the reimbursement change.

43 (m) A nursing facility may not charge the nursing facility's residents
44 for the amount of the quality assessment that the nursing facility pays
45 under this SECTION.

46 (n) This SECTION expires August 1, ~~2004~~ **2006**.

1 SECTION 10. THE FOLLOWING ARE REPEALED [EFFECTIVE
2 JULY 1, 2004]: P.L.2002-107, SECTION 35; P.L.2002-106, SECTION
3 1.

4 SECTION 11. [EFFECTIVE JULY 1, 2004] (a) **In addition to the**
5 **duties specified under IC 2-5-26, the select joint commission on**
6 **Medicaid oversight established by IC 2-5-26-3 shall, to the extent**
7 **the commission determines is feasible after consultation with the**
8 **office of Medicaid policy and planning established by IC 12-8-6-1,**
9 **study the following effects of the repeal of continuous eligibility**
10 **for children under the Indiana Medicaid program and the**
11 **children's health insurance program established under**
12 **IC 12-17.6-2:**

13 (1) **Effects on government, including the following:**

14 (A) **Costs to Medicaid and the division of family and**
15 **children established by IC 12-13-1-1 due to more frequent**
16 **recertification requirements.**

17 (B) **Loss of revenue from federal matching funds that**
18 **could not be obtained because of the repeal of continuous**
19 **eligibility.**

20 (2) **Effects on the economy, including the following:**

21 (A) **Indirect cost shifting to providers due to increased**
22 **charity care because recipients have lapses in eligibility.**

23 (B) **Increased burdens on township assistance (poor**
24 **relief).**

25 (3) **Effects on children, including the following:**

26 (A) **Increases in the level of uninsured children in**
27 **Indiana.**

28 (B) **Decreases in wellness and the effects on the**
29 **educational abilities of sicker children.**

30 (4) **Effects on families, including the following:**

31 (A) **Effects on family income due to the burden of sicker**
32 **children.**

33 (B) **Effects on the ability of parents to maintain stable**
34 **employment due to sicker children or more burdensome**
35 **recertification procedures.**

36 (b) **The select joint commission on Medicaid oversight shall**
37 **submit to the legislative council before November 1, 2004, a report**
38 **of its findings and recommendations concerning the study under**
39 **subsection (a).**

40 (c) **This SECTION expires January 1, 2005.**

41 SECTION 12. **An emergency is declared for this act."**

42 Renumber all SECTIONS consecutively.

(Reference is to ESB 213 as printed February 13, 2004.)

Representative Brown C