



February 17, 2012

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**ENGROSSED**  
**SENATE BILL No. 225**

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DIGEST OF SB 225 (Updated February 15, 2012 6:21 pm - DI 77)

**Citations Affected:** Noncode.

**Synopsis:** Hospital assessment fee matters. Allows the hospital assessment fee committee, before July 1, 2013, to set a later date for the submission of specified documents. Removes language that required specified documents to have a retroactive implementation of July 1, 2011. Makes technical corrections.

**Effective:** May 10, 2011 (retroactive).

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**Miller, Gard, Breaux**

(HOUSE SPONSORS — BROWN T, BROWN C)

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January 4, 2012, read first time and referred to Committee on Health and Provider Services.

January 12, 2012, reported favorably — Do Pass.

January 17, 2012, read second time, ordered engrossed.

January 18, 2012, engrossed.

January 23, 2012, read third time, passed. Yeas 50, nays 0.

HOUSE ACTION

February 9, 2012, read first time and referred to Committee on Public Health.

February 16, 2012, reported — Do Pass.

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ES 225—LS 6817/DI 104+



February 17, 2012

Second Regular Session 117th General Assembly (2012)

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 2011 Regular Session of the General Assembly.

## ENGROSSED SENATE BILL No. 225

A BILL FOR AN ACT concerning human services.

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

- 1 SECTION 1. P.L.229-2011, SECTION 281, IS AMENDED TO  
2 READ AS FOLLOWS [EFFECTIVE MAY 10, 2011  
3 (RETROACTIVE)]: SECTION 281. (a) The following definitions  
4 apply to this SECTION:  
5 (1) "Committee" refers to the hospital assessment fee committee  
6 established by this SECTION.  
7 (2) "Fee" refers to the hospital assessment fee authorized by this  
8 SECTION.  
9 (3) "Fee period" means the two (2) year state fiscal year period  
10 beginning July 1, 2011, and ending June 30, 2013.  
11 (4) "Hospital" means an entity that meets the definition set forth  
12 in IC 16-18-2-179(b) and is licensed under IC 16-21-2. This term  
13 may include a private psychiatric hospital licensed under  
14 IC 12-25. The term does not include the following:  
15 (A) A state mental health institution operated under  
16 IC 12-24-1-3.  
17 (B) A hospital:  
18 (i) designated by the Medicaid program as a long term care

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- 1 hospital;
- 2 (ii) that has an average inpatient length of stay that is greater
- 3 than twenty-five (25) days, as determined by the office of
- 4 Medicaid policy and planning under the Medicaid program;
- 5 (iii) that is a Medicare certified, freestanding rehabilitation
- 6 hospital; or
- 7 (iv) that is a hospital operated by the federal government.
- 8 (5) "Office" refers to the office of Medicaid policy and planning
- 9 established by IC 12-8-6-1.
- 10 (b) Subject to subsections (c) and (g), the office may charge a
- 11 hospital assessment fee to hospitals under this SECTION during the fee
- 12 period if the following conditions are met:
- 13 (1) The fee may be used only for the purposes described in
- 14 subsections (h)(1), (k), (m), and (p).
- 15 (2) The Medicaid state plan amendments and waiver requests
- 16 required for the implementation of this SECTION are submitted
- 17 by the office to the United States Department of Health and
- 18 Human Services before October 1, 2011.
- 19 (3) The United States Department of Health and Human Services
- 20 approves the Medicaid state plan amendments and waiver
- 21 requests, **or revisions of the Medicaid state plan amendments**
- 22 **and waiver requests**, described in subdivision (2):
- 23 (A) not later than October 1, 2012; and with a retroactive
- 24 implementation of July 1, 2011. or
- 25 (B) after October 1, 2012, if the date is established by the
- 26 committee. The committee may establish a date:
- 27 (i) at any time before July 1, 2013; and
- 28 (ii) an unlimited number of times before July 1, 2013.
- 29 (4) The funds generated from the fee do not revert to the general
- 30 fund.
- 31 (c) The office shall stop collecting a fee, the programs described in
- 32 subsection (f) shall be reconciled and terminated, and the operation of
- 33 subsection (m) shall end if any of the following occur:
- 34 (1) An appellate court makes a final determination that either:
- 35 (A) the fee described in this SECTION; or
- 36 (B) any of the programs described in subsection (f);
- 37 cannot be implemented or maintained.
- 38 (2) The United States Department of Health and Human Services
- 39 makes a final determination that the Medicaid state plan
- 40 amendments or waivers submitted under subsection (b) are not
- 41 approved or cannot be validly implemented.
- 42 (3) The fee is not collected because of circumstances described in

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1 subsection (i).  
 2 (d) The office shall keep records of the fees collected by the office  
 3 and report the amount of fees collected under this SECTION. The  
 4 office may not assess a fee described in this SECTION to a hospital  
 5 after the fee period.  
 6 (e) The hospital assessment fee committee is established. The  
 7 committee consists of the following four (4) voting members:  
 8 (1) The secretary of family and social services established by  
 9 IC 12-8-1-1 or the secretary's designee, who shall serve as the  
 10 chair of the committee.  
 11 (2) The budget director or the budget director's designee.  
 12 (3) Two (2) members appointed by the governor from a list of at  
 13 least four (4) individuals submitted by the Indiana hospital  
 14 association.  
 15 The committee shall review any Medicaid state plan amendments,  
 16 waiver requests, or any revisions to any Medicaid state plan  
 17 amendments or waiver requests, to implement or continue the  
 18 implementation of this SECTION for the purpose of establishing  
 19 favorable review of the amendments, requests, and revisions by the  
 20 United States Department of Health and Human Services. The  
 21 committee shall meet at the call of the chair. The members shall serve  
 22 without compensation. A quorum consists of at least three (3)  
 23 members. An affirmative vote of at least three (3) members of the  
 24 committee ~~are~~ **is** necessary to approve Medicaid state plan amendments  
 25 or waiver requests.  
 26 (f) Subject to subsection (g), the office shall develop the following  
 27 programs designed to increase, to the extent allowable under federal  
 28 law, Medicaid reimbursement for inpatient and outpatient hospital  
 29 services provided by a hospital during the fee period to Medicaid  
 30 recipients:  
 31 (1) A program concerning reimbursement for the Medicaid  
 32 fee-for-service program that, in the aggregate, will result in  
 33 payments equivalent to the level of reimbursement that would be  
 34 paid under federal Medicare payment principles.  
 35 (2) A program concerning reimbursement for the Medicaid risk  
 36 based managed care program that, in the aggregate, will result in  
 37 payments equivalent to the level of reimbursement that would be  
 38 paid under federal Medicare payment principles.  
 39 (g) The office shall not submit to the United States Department of  
 40 Health and Human Services any Medicaid state plan amendments,  
 41 waiver requests, or any revisions to any Medicaid state plan  
 42 amendments or waiver requests, to implement or continue the

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1 implementation of this SECTION until the committee has reviewed and  
 2 approved the amendments, waivers, or revisions described in this  
 3 subsection and submitted a written report to the state budget committee  
 4 concerning the amendments, waivers, or revisions described in this  
 5 subsection, including the following:

6 (1) The methodology to be used by the office in calculating the  
 7 increased Medicaid reimbursement under the programs described  
 8 in subsection (f).

9 (2) The methodology to be used by the office in calculating,  
 10 imposing, collecting, or any other matter relating to the fee  
 11 authorized by this SECTION.

12 (3) The determination of Medicaid disproportionate share  
 13 allotments for the fee period under subsection (m) that are to be  
 14 funded by the fee authorized by this SECTION, including the  
 15 formula for distributing the Medicaid disproportionate share  
 16 payments.

17 (4) The distribution to private psychiatric institutions under  
 18 subsection (o).

19 (h) This subsection applies to the programs described in subsection  
 20 (f). The state share dollars for the programs shall consist of the  
 21 following:

22 (1) Fees paid under this SECTION.

23 (2) The hospital care for the indigent funds allocated under  
 24 subsection (l).

25 (3) Other sources of state share dollars available to the office,  
 26 excluding intergovernmental transfers of funds made by or on  
 27 behalf of a hospital.

28 The money described in subdivisions (1) and (2) may be used only to  
 29 fund the portion of the payments that are in excess to the Medicaid  
 30 reimbursement rates in effect on June 30, 2011.

31 (i) This subsection applies to the programs described in subsection  
 32 (f). If the state is unable to maintain the funding under subsection  
 33 (h)(3) for the payments at Medicaid reimbursement levels in effect on  
 34 June 30, 2011, because of budgetary constraints, the office shall reduce  
 35 inpatient and outpatient hospital Medicaid reimbursement rates under  
 36 subsection (f)(1) or (f)(2) or request from the committee and the United  
 37 States Department of Health and Human Services to increase the fee to  
 38 prevent a decrease in Medicaid reimbursement for hospital services. If  
 39 the:

40 (1) committee:

41 (A) does not approve a reimbursement reduction; or

42 (B) does not approve an increase in the fee; or



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1 (2) the United States Department of Health and Human Services  
 2 does not approve an increase in the fee;  
 3 the office shall cease to collect the fee and the programs described in  
 4 subsection (f) shall end.

5 (j) Before August 1, 2011, the office, after review by the committee,  
 6 shall submit to the budget committee established under IC 4-12-1-3 a  
 7 written report that includes the following concerning the program  
 8 described in subsection (f)(2):

9 (1) A reasonable estimate of the Medicaid managed care  
 10 organization payments for hospital services during the fee period  
 11 that will be attributable to state share dollars resulting from the  
 12 fee to be collected under this SECTION. The estimate may not  
 13 include payments for services provided to:

14 (A) adults enrolled in the Indiana check-up plan established by  
 15 IC 12-15-44.2; or

16 (B) individuals enrolled in Medicaid who would have been  
 17 receiving services under the Medicaid fee-for-service program  
 18 before changes to state or federal law or policies that occur  
 19 after March 1, 2011.

20 (2) The extent to which payments under the program will be  
 21 limited by or otherwise affected by the Indiana "Special Terms  
 22 and Conditions" Medicaid demonstration project (Number  
 23 11-W-00237/5), including any:

24 (A) trend rate amount or percentage;

25 (B) per member per month amount; or

26 (C) other limitations established by this demonstration project.

27 (3) Detailed explanations of any estimates, calculations, and  
 28 conclusions included in the report.

29 (k) This subsection is effective upon implementation of the fee. The  
 30 hospital Medicaid fee fund is established for the purpose of holding  
 31 fees collected under this SECTION that are not necessary to match  
 32 federal funds. The office shall administer the fund. Money in the fund  
 33 at the end of a state fiscal year does not revert to the state general fund.  
 34 However, money remaining in the fund after June 30, 2012, shall be  
 35 used for the payments described in subsections (f) and (m). Any money  
 36 not required for the payments described in subsections (f) and (m) upon  
 37 the expiration of this SECTION or at the cessation of collection of the  
 38 fee under subsection (c) shall be distributed to the hospitals on a pro  
 39 rata basis based upon the fees paid by each hospital.

40 (l) This subsection:

41 (1) is effective upon implementation of the fee authorized by this  
 42 SECTION; and

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1 (2) does not apply to funds under IC 12-16-17.  
 2 Notwithstanding any other law, the portion of the amounts appropriated  
 3 for or transferred to the hospital care for the indigent program for the  
 4 fee period that are not required to be paid to the office by law shall be  
 5 used exclusively as state share dollars for the payments described in  
 6 subsections (f) and (m). Any hospital care for the indigent funds that  
 7 are not required for the payments described in subsections (f) and (m)  
 8 upon the expiration of this SECTION or the cessation of the collection  
 9 of the fee shall be used for the state share dollars of the payments in  
 10 IC 12-15-20-2(8)(G)(ii) through IC 12-15-20-2(8)(G)(x).

11 (m) This subsection:  
 12 (1) is effective upon the implementation of the fee authorized by  
 13 this SECTION; and  
 14 (2) applies to the Medicaid disproportionate share payments for  
 15 the fee period.

16 The state share dollars used to fund disproportionate share payments  
 17 to acute care hospitals licensed under IC 16-21-2 that qualify as  
 18 disproportionate share providers or municipal disproportionate share  
 19 providers under IC 12-15-16-1(a) or IC 12-15-16-1(b) shall be paid  
 20 with money collected by the fee under this SECTION and the hospital  
 21 care for the indigent dollars described in subsection (l). Subject to  
 22 subsection (n) and except as provided in subsection (n), the federal  
 23 Medicaid disproportionate share allotments for the fee period shall be  
 24 allocated in their entirety to acute care hospitals licensed under  
 25 IC 16-21-2 that qualify as disproportionate share providers or  
 26 municipal disproportionate share providers under IC 12-15-16-1(a) or  
 27 IC 12-15-16-1(b). No portion of the federal disproportionate share  
 28 allotments applicable for disproportionate share payments for the fee  
 29 period shall be allocated to institutions for mental disease or other  
 30 mental health facilities, as defined by applicable federal law.

31 (n) For purposes of this SECTION, the entire federal Medicaid  
 32 disproportionate share allotment for Indiana during the fee period does  
 33 not include the portion of allotments that are required to be diverted  
 34 under the following:

- 35 (1) The federally-approved Indiana "Special Terms and
- 36 Conditions" Medicaid demonstration project (Number
- 37 11-W-00237/5).
- 38 (2) Any extension past December 31, 2012, of the Indiana
- 39 check-up plan Medicaid waiver established by IC 12-15-44.2.

40 The office shall inform the committee and the state budget committee  
 41 concerning any extension of the Indiana check-up plan past December  
 42 31, 2012.

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1 (o) Notwithstanding IC 12-15-16-6(c), for the fee period, the annual  
 2 two million dollars (\$2,000,000) pool of disproportionate share dollars  
 3 under IC 12-15-16-6(c) shall not be available to eligible private  
 4 psychiatric institutions. The office shall annually distribute two million  
 5 dollars (\$2,000,000) to eligible private psychiatric institutions that  
 6 would have been eligible for payment under IC 12-15-16-6(c).

7 (p) The fees collected under this SECTION may be used only as  
 8 described in this SECTION or to pay the state's share of the cost for  
 9 Medicaid services provided under the federal Medicaid program (42  
 10 U.S.C. 1396 et seq.) as follows:

11 (1) Twenty-eight and five-tenths percent (28.5%) may be used by  
 12 the office for Medicaid expenses.

13 (2) Seventy-one and five-tenths percent (71.5%) to hospitals.

14 (q) Nothing in this SECTION may be construed to authorize any  
 15 county, municipality, district, authority to impose a fee, tax, or  
 16 assessment on a hospital.

17 (r) Subject to subsection (g), the office shall adopt rules, including  
 18 emergency rules under IC 4-22-2-37.1, necessary to implement this  
 19 SECTION. Rules adopted under this subsection may be retroactive to  
 20 the effective date of the Medicaid state plan amendments or waivers  
 21 approved under this SECTION.

22 (s) The office may enter into an agreement with a hospital to pay the  
 23 fee collected under this SECTION in installments.

24 (t) If a hospital fails to pay the fee established under this SECTION  
 25 within ten (10) days of the payment date, the hospital shall pay to the  
 26 office interest on the fee at the same rate as the rate determined under  
 27 IC 12-15-21-3(6)(A).

28 (u) The office shall report to the state department of health each  
 29 hospital that fails to pay the fee established under this SECTION within  
 30 one hundred twenty (120) days of the date the payment is due. The  
 31 state department shall do the following concerning a hospital described  
 32 in this subsection:

33 (1) Notify the hospital that the hospital's ~~licensed~~ **license** under  
 34 IC 16-21 will be revoked if the fee is not paid.

35 (2) Revoke the hospital's license under IC 16-21 if the hospital  
 36 fails to pay the fee.

37 IC 4-21.5-3-8 and IC 4-21.5-4 apply to this subdivision.

38 (v) Payments for the programs described in subsection (f) shall be  
 39 limited to claims for dates of services provided during the fee period  
 40 and that are timely filed with the office or a contractor of the office.  
 41 Payments for the programs described in subsection (f) during the fee  
 42 period and distributions to hospitals in accordance with this SECTION



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1 may occur after the expiration of this SECTION.  
2 (w) This SECTION expires September 1, 2013. However, the office  
3 may not assess a hospital a fee described in this SECTION after June  
4 30, 2013.  
5 SECTION 2. **An emergency is declared for this act.**

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COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 225, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 225 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 225, 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.

BROWN T, Chair

Committee Vote: yeas 8, nays 0.

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