



January 25, 2013

HOUSE BILL No. 1327

DIGEST OF HB 1327 (Updated January 23, 2013 6:09 pm - DI 77)

Citations Affected: IC 12-8; IC 12-15; IC 16-21; IC 16-28.

Synopsis: Hospital and health facility assessment fees. Extends the hospital assessment fee. (Under current law, the fee expires on June 30, 2013.) Extends the health facility quality assessment fee. (Under current law, the fee expires on June 30, 2014.) Repeals a provision that provides for the expiration of the health facility quality assessment fee. Updates statutory references to the hospital assessment fee.

Effective: Upon passage.

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January 17, 2013, read first time and referred to Committee on Public Health.
January 24, 2013, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 127.

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HB 1327—LS 7362/DI 104+



January 25, 2013

First Regular Session 118th General Assembly (2013)

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 2012 Regular Session of the General Assembly.

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HOUSE BILL No. 1327

A BILL FOR AN ACT to amend the Indiana Code concerning health.

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

- 1 SECTION 1. IC 12-8-6.5-12 IS ADDED TO THE INDIANA CODE
2 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE
3 UPON PASSAGE]: **Sec. 12. (a) As used in this section, "SECTION**
4 **281" refers to P.L.229-2011, SECTION 281.**
5 **(b) Notwithstanding the expiration of SECTION 281, the office**
6 **of Medicaid policy and planning may:**
7 **(1) collect an unpaid hospital assessment fee under SECTION**
8 **281 owed by a hospital;**
9 **(2) refund a hospital assessment fee paid by the hospital under**
10 **SECTION 281;**
11 **(3) make payments for programs described in subsection (f)**
12 **of SECTION 281; and**
13 **(4) make distributions to hospitals under subsection (m) of**
14 **SECTION 281;**
15 **at any time, including after the expiration of SECTION 281.**
16 **(c) The office of Medicaid policy and planning may:**
17 **(1) collect an unpaid hospital assessment fee under**

HB 1327—LS 7362/DI 104+



- 1 **IC 16-21-10 owed by a hospital;**
- 2 **(2) refund a hospital assessment fee paid by a hospital under**
- 3 **IC 16-21-10;**
- 4 **(3) make payments for programs described in**
- 5 **IC 16-21-10-8(a); and**
- 6 **(4) make distributions to a hospital under IC 16-21-10-11;**
- 7 **at any time.**

8 SECTION 2. IC 12-15-15-1.1, AS AMENDED BY P.L.229-2011,
 9 SECTION 128, IS AMENDED TO READ AS FOLLOWS
 10 [EFFECTIVE UPON PASSAGE]: Sec. 1.1. (a) This section applies to
 11 a hospital that is:

- 12 (1) licensed under IC 16-21; and
- 13 (2) established and operated under IC 16-22-2, IC 16-22-8, or
- 14 IC 16-23.

15 This section does not apply during the period that the office is
 16 assessing a hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**

17 (b) For a state fiscal year ending after June 30, 2003, in addition to
 18 reimbursement received under section 1 of this chapter, a hospital is
 19 entitled to reimbursement in an amount calculated as follows:

20 STEP ONE: The office shall identify the aggregate inpatient
 21 hospital services, reimbursable under this article and under the
 22 state Medicaid plan, that were provided during the state fiscal
 23 year by hospitals established and operated under IC 16-22-2,
 24 IC 16-22-8, or IC 16-23.

25 STEP TWO: For the aggregate inpatient hospital services
 26 identified under STEP ONE, the office shall calculate the
 27 aggregate payments made under this article and under the state
 28 Medicaid plan to hospitals established and operated under
 29 IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under
 30 IC 12-15-16, IC 12-15-17, and IC 12-15-19.

31 STEP THREE: The office shall calculate a reasonable estimate of
 32 the amount that would have been paid in the aggregate by the
 33 office for the inpatient hospital services described in STEP ONE
 34 under Medicare payment principles.

35 STEP FOUR: Subtract the amount calculated under STEP TWO
 36 from the amount calculated under STEP THREE.

37 STEP FIVE: Subject to subsection (g), from the amount
 38 calculated under STEP FOUR, allocate to a hospital established
 39 and operated under IC 16-22-8 an amount not to exceed one
 40 hundred percent (100%) of the difference between:

- 41 (A) the total cost for the hospital's provision of inpatient
- 42 services covered under this article for the hospital's fiscal year

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1 ending during the state fiscal year; and
 2 (B) the total payment to the hospital for its provision of
 3 inpatient services covered under this article for the hospital's
 4 fiscal year ending during the state fiscal year, excluding
 5 payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.
 6 STEP SIX: Subtract the amount calculated under STEP FIVE
 7 from the amount calculated under STEP FOUR.
 8 STEP SEVEN: Distribute an amount equal to the amount
 9 calculated under STEP SIX to the eligible hospitals established
 10 and operated under IC 16-22-2 or IC 16-23 described in
 11 subsection (c) in an amount not to exceed each hospital's
 12 Medicaid shortfall as defined in subsection (f).
 13 (c) Subject to subsection (e), reimbursement for a state fiscal year
 14 under this section consists of payments made after the close of each
 15 state fiscal year. A hospital is not eligible for a payment described in
 16 this subsection unless an intergovernmental transfer or certification of
 17 expenditures is made under subsection (d).
 18 (d) Subject to subsection (e):
 19 (1) an intergovernmental transfer may be made by or on behalf of
 20 the hospital; or
 21 (2) a certification of expenditures as eligible for federal financial
 22 participation may be made;
 23 after the close of each state fiscal year. An intergovernmental transfer
 24 under this subsection must be made to the Medicaid indigent care trust
 25 fund in an amount equal to a percentage, as determined by the office,
 26 of the amount to be distributed to the hospital under this section. The
 27 office shall use the intergovernmental transfer to fund payments made
 28 under this section.
 29 (e) A hospital that makes a certification of expenditures or makes or
 30 has an intergovernmental transfer made on the hospital's behalf under
 31 this section may appeal under IC 4-21.5 the amount determined by the
 32 office to be paid the hospital under subsection (b). The periods
 33 described in subsections (c) and (d) for the hospital or another entity to
 34 make an intergovernmental transfer or certification of expenditures are
 35 tolled pending the administrative appeal and any judicial review
 36 initiated by the hospital under IC 4-21.5. The distribution to other
 37 hospitals under subsection (b) may not be delayed due to an
 38 administrative appeal or judicial review instituted by a hospital under
 39 this subsection. If necessary, the office may make a partial distribution
 40 to the other eligible hospitals under subsection (b) pending the
 41 completion of a hospital's administrative appeal or judicial review, at
 42 which time the remaining portion of the payments due to the eligible

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1 hospitals shall be made. A partial distribution may be based upon
2 estimates and trends calculated by the office.

3 (f) For purposes of this section:

4 (1) the Medicaid shortfall of a hospital established and operated
5 under IC 16-22-2 or IC 16-23 is calculated as follows:

6 STEP ONE: The office shall identify the inpatient hospital
7 services, reimbursable under this article and under the state
8 Medicaid plan, that were provided during the state fiscal year
9 by the hospital.

10 STEP TWO: For the inpatient hospital services identified
11 under STEP ONE, the office shall calculate the payments
12 made under this article and under the state Medicaid plan to
13 the hospital, excluding payments under IC 12-15-16,
14 IC 12-15-17, and IC 12-15-19.

15 STEP THREE: The office shall calculate a reasonable estimate
16 of the amount that would have been paid by the office for the
17 inpatient hospital services described in STEP ONE under
18 Medicare payment principles; and

19 (2) a hospital's Medicaid shortfall is equal to the amount by which
20 the amount calculated in STEP THREE of subdivision (1) is
21 greater than the amount calculated in STEP TWO of subdivision
22 (1).

23 (g) The actual distribution of the amount calculated under STEP
24 FIVE of subsection (b) to a hospital established and operated under
25 IC 16-22-8 shall be made under the terms and conditions provided for
26 the hospital in the state plan for medical assistance. Payment to a
27 hospital under STEP FIVE of subsection (b) is not a condition
28 precedent to the tender of payments to hospitals under STEP SEVEN
29 of subsection (b).

30 SECTION 3. IC 12-15-15-1.3, AS AMENDED BY P.L.229-2011,
31 SECTION 129, IS AMENDED TO READ AS FOLLOWS
32 [EFFECTIVE UPON PASSAGE]: Sec. 1.3. (a) This section applies to
33 a hospital that is:

34 (1) licensed under IC 16-21; and

35 (2) established and operated under IC 16-22-2, IC 16-22-8, or
36 IC 16-23.

37 This section does not apply during the period that the office is
38 assessing a hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**

39 (b) For a state fiscal year ending after June 30, 2003, in addition to
40 reimbursement received under section 1 of this chapter, a hospital is
41 entitled to reimbursement in an amount calculated as follows:

42 STEP ONE: The office shall identify the aggregate outpatient

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1 hospital services, reimbursable under this article and under the
 2 state Medicaid plan, that were provided during the state fiscal
 3 year by hospitals established and operated under IC 16-22-2,
 4 IC 16-22-8, or IC 16-23.
 5 STEP TWO: For the aggregate outpatient hospital services
 6 identified under STEP ONE, the office shall calculate the
 7 aggregate payments made under this article and under the state
 8 Medicaid plan to hospitals established and operated under
 9 IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under
 10 IC 12-15-16, IC 12-15-17, and IC 12-15-19.
 11 STEP THREE: The office shall calculate a reasonable estimate of
 12 the amount that would have been paid in the aggregate by the
 13 office under Medicare payment principles for the outpatient
 14 hospital services described in STEP ONE.
 15 STEP FOUR: Subtract the amount calculated under STEP TWO
 16 from the amount calculated under STEP THREE.
 17 STEP FIVE: Subject to subsection (g), from the amount
 18 calculated under STEP FOUR, allocate to a hospital established
 19 and operated under IC 16-22-8 an amount not to exceed one
 20 hundred percent (100%) of the difference between:
 21 (A) the total cost for the hospital's provision of outpatient
 22 services covered under this article for the hospital's fiscal year
 23 ending during the state fiscal year; and
 24 (B) the total payment to the hospital for its provision of
 25 outpatient services covered under this article for the hospital's
 26 fiscal year ending during the state fiscal year, excluding
 27 payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.
 28 STEP SIX: Subtract the amount calculated under STEP FIVE
 29 from the amount calculated under STEP FOUR.
 30 STEP SEVEN: Distribute an amount equal to the amount
 31 calculated under STEP SIX to the eligible hospitals established
 32 and operated under IC 16-22-2 or IC 16-23 described in
 33 subsection (c) in an amount not to exceed each hospital's
 34 Medicaid shortfall as defined in subsection (f).
 35 (c) A hospital is not eligible for a payment described in this section
 36 unless:
 37 (1) an intergovernmental transfer is made by the hospital or on
 38 behalf of the hospital; or
 39 (2) the hospital or another entity certifies the hospital's
 40 expenditures as eligible for federal financial participation.
 41 (d) Subject to subsection (e):
 42 (1) an intergovernmental transfer may be made by or on behalf of

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1 the hospital; or

2 (2) a certification of expenditures as eligible for federal financial
3 participation may be made;

4 after the close of each state fiscal year. An intergovernmental transfer
5 under this subsection must be made to the Medicaid indigent care trust
6 fund in an amount equal to a percentage, as determined by the office,
7 of the amount to be distributed to the hospital under subsection (b). The
8 office shall use the intergovernmental transfer to fund payments made
9 under this section.

10 (e) A hospital that makes a certification of expenditures or makes or
11 has an intergovernmental transfer made on the hospital's behalf under
12 this section may appeal under IC 4-21.5 the amount determined by the
13 office to be paid by the hospital under subsection (b). The periods
14 described in subsections (c) and (d) for the hospital or other entity to
15 make an intergovernmental transfer or certification of expenditures are
16 tolled pending the administrative appeal and any judicial review
17 initiated by the hospital under IC 4-21.5. The distribution to other
18 hospitals under subsection (b) may not be delayed due to an
19 administrative appeal or judicial review instituted by a hospital under
20 this subsection. If necessary, the office may make a partial distribution
21 to the other eligible hospitals under subsection (b) pending the
22 completion of a hospital's administrative appeal or judicial review, at
23 which time the remaining portion of the payments due to the eligible
24 hospitals must be made. A partial distribution may be calculated by the
25 office based upon estimates and trends.

26 (f) For purposes of this section:

27 (1) the Medicaid shortfall of a hospital established and operated
28 under IC 16-22-2 or IC 16-23 is calculated as follows:

29 STEP ONE: The office shall identify the outpatient hospital
30 services, reimbursable under this article and under the state
31 Medicaid plan, that were provided during the state fiscal year
32 by the hospital.

33 STEP TWO: For the outpatient hospital services identified
34 under STEP ONE, the office shall calculate the payments
35 made under this article and under the state Medicaid plan to
36 the hospital, excluding payments under IC 12-15-16,
37 IC 12-15-17, and IC 12-15-19.

38 STEP THREE: The office shall calculate a reasonable estimate
39 of the amount that would have been paid by the office for the
40 outpatient hospital services described in STEP ONE under
41 Medicare payment principles; and

42 (2) a hospital's Medicaid shortfall is equal to the amount by which

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1 the amount calculated in STEP THREE of subdivision (1) is
 2 greater than the amount calculated in STEP TWO of subdivision
 3 (1).

4 (g) The actual distribution of the amount calculated under STEP
 5 FIVE of subsection (b) to a hospital established and operated under
 6 IC 16-22-8 shall be made under the terms and conditions provided for
 7 the hospital in the state plan for medical assistance. Payment to a
 8 hospital under STEP FIVE of subsection (b) is not a condition
 9 precedent to the tender of payments to hospitals under STEP SEVEN
 10 of subsection (b).

11 SECTION 4. IC 12-15-15-1.5, AS AMENDED BY P.L.229-2011,
 12 SECTION 130, IS AMENDED TO READ AS FOLLOWS
 13 [EFFECTIVE UPON PASSAGE]: Sec. 1.5. (a) This section applies to
 14 a hospital that:

- 15 (1) is licensed under IC 16-21;
 16 (2) is not a unit of state or local government; and
 17 (3) is not owned or operated by a unit of state or local
 18 government.

19 This section does not apply during the period that the office is
 20 assessing a hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**

21 (b) For a state fiscal year ending after June 30, 2003, and before July
 22 1, 2007, in addition to reimbursement received under section 1 of this
 23 chapter, a hospital eligible under this section is entitled to
 24 reimbursement in an amount calculated as follows:

25 STEP ONE: The office shall identify the total inpatient hospital
 26 services and the total outpatient hospital services, reimbursable
 27 under this article and under the state Medicaid plan, that were
 28 provided during the state fiscal year by the hospitals described in
 29 subsection (a).

30 STEP TWO: For the total inpatient hospital services and the total
 31 outpatient hospital services identified under STEP ONE, the
 32 office shall calculate the aggregate payments made under this
 33 article and under the state Medicaid plan to hospitals described in
 34 subsection (a), excluding payments under IC 12-15-16,
 35 IC 12-15-17, and IC 12-15-19.

36 STEP THREE: The office shall calculate a reasonable estimate of
 37 the amount that would have been paid in the aggregate by the
 38 office for the inpatient hospital services and the outpatient
 39 hospital services identified in STEP ONE under Medicare
 40 payment principles.

41 STEP FOUR: Subtract the amount calculated under STEP TWO
 42 from the amount calculated under STEP THREE.



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STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payment, the first ten million dollars (\$10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than sixty thousand (60,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state and paid Medicaid fee for service and managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the nonfederal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals:

- (i) on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days; or
- (ii) other payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(c) As used in this subsection, "Medicaid supplemental payments" means Medicaid payments for hospitals that are in addition to Medicaid fee-for-service payments, Medicaid risk-based managed care payments, and Medicaid disproportionate share payments, and that are included in the Medicaid state plan, including Medicaid safety-net payments,

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1 and payments made under this section and sections 1.1, 1.3, 9, and 9.5
 2 of this chapter. For a state fiscal year ending after June 30, 2007, in
 3 addition to the reimbursement received under section 1 of this chapter,
 4 a hospital eligible under this section is entitled to reimbursement in an
 5 amount calculated as follows:

6 STEP ONE: The office shall identify the total inpatient hospital
 7 services and the total outpatient hospital services reimbursable
 8 under this article and under the state Medicaid plan that were
 9 provided during the state fiscal year for all hospitals described in
 10 subsection (a).

11 STEP TWO: For the total inpatient hospital services and the total
 12 outpatient hospital services identified in STEP ONE, the office
 13 shall calculate the total payments made under this article and
 14 under the state Medicaid plan to all hospitals described in
 15 subsection (a). A calculation under this STEP excludes a payment
 16 made under the following:

17 (A) IC 12-15-16.

18 (B) IC 12-15-17.

19 (C) IC 12-15-19.

20 STEP THREE: The office shall calculate, under Medicare
 21 payment principles, a reasonable estimate of the total amount that
 22 would have been paid by the office for the inpatient hospital
 23 services and the outpatient hospital services identified in STEP
 24 ONE.

25 STEP FOUR: Subtract the amount calculated under STEP TWO
 26 from the amount calculated under STEP THREE.

27 STEP FIVE: Distribute an amount equal to the amount calculated
 28 under STEP FOUR to the eligible hospitals described in
 29 subsection (a) as follows:

30 (A) As used in this clause, "Medicaid inpatient days" are the
 31 hospital's in-state paid Medicaid fee for service and risk-based
 32 managed care days for the state fiscal year for which services
 33 are identified under STEP ONE, as determined by the office.
 34 Subject to the availability of funds transferred to the Medicaid
 35 indigent care trust fund under STEP FOUR of
 36 IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent
 37 care trust fund under IC 12-15-20-2(8)(G) to serve as the
 38 nonfederal share of the payments, the amount calculated under
 39 STEP FOUR for a state fiscal year shall be paid to all hospitals
 40 described in subsection (a). The payments shall be made on a
 41 pro rata basis, based on the hospitals' Medicaid inpatient days
 42 or in accordance with another payment methodology

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determined by the office and approved by the Centers for Medicare and Medicaid Services.

(B) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid as described in clauses (C) and (D) to a hospital that is described in subsection (a) and that is described as eligible under this clause. A hospital is eligible for a payment under clause (C) only if the hospital:

- (i) has less than sixty thousand (60,000) Medicaid inpatient days annually;
- (ii) was eligible for Medicaid disproportionate share hospital payments in the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and
- (iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The payment amount under clause (C) for an eligible hospital is subject to the availability of the nonfederal share of the hospital's payment being provided by the hospital or on behalf of the hospital.

(C) For state fiscal years ending after June 30, 2007, but before July 1, 2009, payments to eligible hospitals described in clause (B) shall be made as follows:

- (i) The payment to an eligible hospital that merged two (2) hospitals under a single Medicaid provider number effective January 1, 2004, shall equal one hundred percent (100%) of the hospital's hospital-specific limit for the state fiscal year ending June 30, 2005, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.
- (ii) The payment to an eligible hospital described in clause (B) other than a hospital described in item (i) shall equal one hundred percent (100%) of the hospital's hospital specific limit for the state fiscal year ending June 30, 2004, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and

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other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(D) For state fiscal years beginning after June 30, 2009, payments to an eligible hospital described in clause (B) shall be made in a manner determined by the office.

(E) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A) and clauses (C) or (D), the remaining amount may be paid as described in clause (F) to a hospital described in subsection (a) that is described as eligible under this clause. A hospital is eligible for a payment for a state fiscal year under clause (F) if the hospital:

- (i) is eligible to receive Medicaid disproportionate share payments for the state fiscal year for which the Medicaid disproportionate share payment is attributable under IC 12-15-19-2.1, for a state fiscal year ending after June 30, 2007; and
- (ii) does not receive a payment under clauses (C) or (D) for the state fiscal year.

A payment to a hospital under this clause is subject to the availability of nonfederal matching funds.

(F) Payments to eligible hospitals described in clause (E) shall be made:

- (i) to best use federal matching funds available for hospitals that are eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and
- (ii) by using a methodology that allocates available funding under this clause, Medicaid supplemental payments, and payments under IC 12-15-19-2.1, in a manner in which all hospitals eligible under clause (E) receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for Medicaid disproportionate share payments and ensures that payments for eligible hospitals are equitable.

(G) If the Centers for Medicare and Medicaid Services does not approve the payment methodologies in clauses (A) through (F), the office may implement alternative payment methodologies that are eligible for federal financial participation to implement a program consistent with the payments for hospitals described in clauses (A) through (F).

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital

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1 under STEP FIVE of subsections (b) or (c). The distribution to other
 2 hospitals under STEP FIVE of subsection (b) or (c) may not be delayed
 3 due to an administrative appeal or judicial review instituted by a
 4 hospital under this subsection. If necessary, the office may make a
 5 partial distribution to the other eligible hospitals under STEP FIVE of
 6 subsection (b) or (c) pending the completion of a hospital's
 7 administrative appeal or judicial review, at which time the remaining
 8 portion of the payments due to the eligible hospitals shall be made. A
 9 partial distribution may be based on estimates and trends calculated by
 10 the office.

11 SECTION 5. IC 12-15-15-1.6, AS AMENDED BY P.L.229-2011,
 12 SECTION 131, IS AMENDED TO READ AS FOLLOWS
 13 [EFFECTIVE UPON PASSAGE]: Sec. 1.6. (a) This section applies
 14 only if the office determines, based on information received from the
 15 United States Centers for Medicare and Medicaid Services, that
 16 payments made under section 1.5(b) STEP FIVE (A), (B), or (C) of this
 17 chapter will not be approved for federal financial participation. This
 18 section does not apply during the period that the office is assessing a
 19 hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**

20 (b) If the office determines that payments made under section 1.5(b)
 21 STEP FIVE (A) of this chapter will not be approved for federal
 22 financial participation, the office may make alternative payments to
 23 payments under section 1.5(b) STEP FIVE (A) of this chapter if:

- 24 (1) the payments for a state fiscal year are made only to a hospital
- 25 that would have been eligible for a payment for that state fiscal
- 26 year under section 1.5(b) STEP FIVE (A) of this chapter; and
- 27 (2) the payments for a state fiscal year to each hospital are an
- 28 amount that is as equal as possible to the amount each hospital
- 29 would have received under section 1.5(b) STEP FIVE (A) of this
- 30 chapter for that state fiscal year.

31 (c) If the office determines that payments made under section 1.5(b)
 32 STEP FIVE (B) of this chapter will not be approved for federal
 33 financial participation, the office may make alternative payments to
 34 payments under section 1.5(b) STEP FIVE (B) of this chapter if:

- 35 (1) the payments for a state fiscal year are made only to a hospital
- 36 that would have been eligible for a payment for that state fiscal
- 37 year under section 1.5(b) STEP FIVE (B) of this chapter; and
- 38 (2) the payments for a state fiscal year to each hospital are an
- 39 amount that is as equal as possible to the amount each hospital
- 40 would have received under section 1.5(b) STEP FIVE (B) of this
- 41 chapter for that state fiscal year.

42 (d) If the office determines that payments made under section 1.5(b)

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1 STEP FIVE (C) of this chapter will not be approved for federal
2 financial participation, the office may make alternative payments to
3 payments under section 1.5(b) STEP FIVE (C) of this chapter if:

- 4 (1) the payments for a state fiscal year are made only to a hospital
- 5 that would have been eligible for a payment for that state fiscal
- 6 year under section 1.5(b) STEP FIVE (C) of this chapter; and
- 7 (2) the payments for a state fiscal year to each hospital are an
- 8 amount that is as equal as possible to the amount each hospital
- 9 would have received under section 1.5(b) STEP FIVE (C) of this
- 10 chapter for that state fiscal year.

11 (e) If the office determines, based on information received from the
12 United States Centers for Medicare and Medicaid Services, that
13 payments made under subsection (b), (c), or (d) will not be approved
14 for federal financial participation, the office shall use the funds that
15 would have served as the nonfederal share of these payments for a state
16 fiscal year to serve as the nonfederal share of a payment program for
17 hospitals to be established by the office. The payment program must
18 distribute payments to hospitals for a state fiscal year based upon a
19 methodology determined by the office to be equitable under the
20 circumstances.

21 SECTION 6. IC 12-15-15-9, AS AMENDED BY P.L.229-2011,
22 SECTION 132, IS AMENDED TO READ AS FOLLOWS
23 [EFFECTIVE UPON PASSAGE]: Sec. 9. (a) For purposes of this
24 section and IC 12-16-7.5-4.5, a payable claim is attributed to a county
25 if the payable claim is submitted to the division by a hospital licensed
26 under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by
27 the hospital to an individual who qualifies for the hospital care for the
28 indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

- 29 (1) who is a resident of the county;
- 30 (2) who is not a resident of the county and for whom the onset of
- 31 the medical condition that necessitated the care occurred in the
- 32 county; or
- 33 (3) whose residence cannot be determined by the division and for
- 34 whom the onset of the medical condition that necessitated the care
- 35 occurred in the county.

36 This section does not apply during the period that the office is
37 assessing a hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**

38 (b) For each state fiscal year ending after June 30, 2003, and before
39 July 1, 2007, a hospital licensed under IC 16-21-2 that submits to the
40 division during the state fiscal year a payable claim under IC 12-16-7.5
41 is entitled to a payment under subsection (c).

42 (c) Except as provided in section 9.8 of this chapter and subject to

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

6 STEP ONE: Identify:

7 (A) each hospital that submitted to the division one (1) or
8 more payable claims under IC 12-16-7.5 during the state fiscal
9 year; and

10 (B) the county to which each payable claim is attributed.

11 STEP TWO: For each county identified in STEP ONE, identify:

12 (A) each hospital that submitted to the division one (1) or
13 more payable claims under IC 12-16-7.5 attributed to the
14 county during the state fiscal year; and

15 (B) the total amount of all hospital payable claims submitted
16 to the division under IC 12-16-7.5 attributed to the county
17 during the state fiscal year.

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

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

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

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

39 (d) For state fiscal years beginning after June 30, 2007, a hospital
40 that received a payment determined under STEP SIX of subsection (c)
41 for the state fiscal year ending June 30, 2007, shall be paid in an
42 amount equal to the amount determined for the hospital under STEP

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1 SIX of subsection (c) for the state fiscal year ending June 30, 2007.
2 (e) A hospital's payment under subsection (c) or (d) is in the form
3 of a Medicaid supplemental payment. The amount of a hospital's
4 Medicaid supplemental payment is subject to the availability of funding
5 for the non-federal share of the payment under subsection (f). The
6 office shall make the payments under subsection (c) and (d) before
7 December 15 that next succeeds the end of the state fiscal year.
8 (f) The non-federal share of a payment to a hospital under
9 subsection (c) or (d) is funded from the funds transferred to the
10 Medicaid indigent care trust fund under IC 12-16-7.5-4.5.
11 (g) The amount of a county's transferred funds available to be used
12 to fund the non-federal share of a payment to a hospital under
13 subsection (c) is an amount that bears the same proportion to the total
14 amount of funds of the county transferred to the Medicaid indigent care
15 trust fund under IC 12-16-7.5-4.5 that the total amount of the hospital's
16 payable claims under IC 12-16-7.5 attributed to the county submitted
17 to the division during the state fiscal year bears to the total amount of
18 all hospital payable claims under IC 12-16-7.5 attributed to the county
19 submitted to the division during the state fiscal year.
20 (h) Any county's funds identified in subsection (g) that remain after
21 the non-federal share of a hospital's payment has been funded are
22 available to serve as the non-federal share of a payment to a hospital
23 under section 9.5 of this chapter.
24 (i) For purposes of this section, "payable claim" has the meaning set
25 forth in IC 12-16-7.5-2.5(b)(1).
26 (j) For purposes of subsection (c):
27 (1) the amount of a payable claim is an amount equal to the
28 amount the hospital would have received under the state's
29 fee-for-service Medicaid reimbursement principles for the
30 hospital care for which the payable claim is submitted under
31 IC 12-16-7.5 if the individual receiving the hospital care had been
32 a Medicaid enrollee; and
33 (2) a payable hospital claim under IC 12-16-7.5 includes a
34 payable claim under IC 12-16-7.5 for the hospital's care submitted
35 by an individual or entity other than the hospital, to the extent
36 permitted under the hospital care for the indigent program.
37 (k) The amount calculated under STEP FIVE of subsection (c) for
38 a hospital with respect to a county may not exceed the total amount of
39 the hospital's payable claims attributed to the county during the state
40 fiscal year.
41 SECTION 7. IC 12-15-15-9.5, AS AMENDED BY P.L.229-2011,
42 SECTION 133, IS AMENDED TO READ AS FOLLOWS

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1 [EFFECTIVE UPON PASSAGE]: Sec. 9.5. (a) For purposes of this
2 section and IC 12-16-7.5-4.5, a payable claim is attributed to a county
3 if the payable claim is submitted to the division by a hospital licensed
4 under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by
5 the hospital to an individual who qualifies for the hospital care for the
6 indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

- 7 (1) who is a resident of the county;
- 8 (2) who is not a resident of the county and for whom the onset of
9 the medical condition that necessitated the care occurred in the
10 county; or
- 11 (3) whose residence cannot be determined by the division and for
12 whom the onset of the medical condition that necessitated the care
13 occurred in the county.

14 This section does not apply during the period that the office is
15 assessing a hospital fee authorized by ~~HEA 1001-2011~~ **IC 16-21-10**.

16 (b) For each state fiscal year ending after June 30, 2003, but before
17 July 1, 2007, a hospital licensed under IC 16-21-2:

- 18 (1) that submits to the division during the state fiscal year a
19 payable claim under IC 12-16-7.5; and
- 20 (2) whose payment under section 9(c) of this chapter was less
21 than the total amount of the hospital's payable claims under
22 IC 12-16-7.5 submitted by the hospital to the division during the
23 state fiscal year;

24 is entitled to a payment under subsection (c).

25 (c) Subject to section 9.6 of this chapter, for a state fiscal year, the
26 office shall pay to a hospital referred to in subsection (b) an amount
27 equal to the amount, based on information obtained from the division
28 and the calculations and allocations made under IC 12-16-7.5-4.5, that
29 the office determines for the hospital under STEP EIGHT of the
30 following STEPS:

31 STEP ONE: Identify each county whose transfer of funds to the
32 Medicaid indigent care trust fund under IC 12-16-7.5-4.5 for the
33 state fiscal year was less than the total amount of all hospital
34 payable claims attributed to the county and submitted to the
35 division during the state fiscal year.

36 STEP TWO: For each county identified in STEP ONE, calculate
37 the difference between the amount of funds of the county
38 transferred to the Medicaid indigent care trust fund under
39 IC 12-16-7.5-4.5 and the total amount of all hospital payable
40 claims attributed to the county and submitted to the division
41 during the state fiscal year.

42 STEP THREE: Calculate the sum of the amounts calculated for

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1 the counties under STEP TWO.
 2 STEP FOUR: Identify each hospital whose payment under section
 3 9(c) of this chapter was less than the total amount of the hospital's
 4 payable claims under IC 12-16-7.5 submitted by the hospital to
 5 the division during the state fiscal year.
 6 STEP FIVE: Calculate for each hospital identified in STEP FOUR
 7 the difference between the hospital's payment under section 9(c)
 8 of this chapter and the total amount of the hospital's payable
 9 claims under IC 12-16-7.5 submitted by the hospital to the
 10 division during the state fiscal year.
 11 STEP SIX: Calculate the sum of the amounts calculated for each
 12 of the hospitals under STEP FIVE.
 13 STEP SEVEN: For each hospital identified in STEP FOUR,
 14 calculate the hospital's percentage share of the amount calculated
 15 under STEP SIX. Each hospital's percentage share is based on the
 16 amount calculated for the hospital under STEP FIVE calculated
 17 as a percentage of the sum calculated under STEP SIX.
 18 STEP EIGHT: For each hospital identified in STEP FOUR,
 19 multiply the hospital's percentage share calculated under STEP
 20 SEVEN by the sum calculated under STEP THREE. The amount
 21 calculated under this STEP for a hospital may not exceed the
 22 amount by which the hospital's total payable claims under
 23 IC 12-16-7.5 submitted during the state fiscal year exceeded the
 24 amount of the hospital's payment under section 9(c) of this
 25 chapter.
 26 (d) For state fiscal years beginning after June 30, 2007, a hospital
 27 that received a payment determined under STEP EIGHT of subsection
 28 (c) for the state fiscal year ending June 30, 2007, shall be paid an
 29 amount equal to the amount determined for the hospital under STEP
 30 EIGHT of subsection (c) for the state fiscal year ending June 30, 2007.
 31 (e) A hospital's payment under subsection (c) or (d) is in the form
 32 of a Medicaid supplemental payment. The amount of the hospital's
 33 add-on payment is subject to the availability of funding for the
 34 nonfederal share of the payment under subsection (f). The office shall
 35 make the payments under subsection (c) or (d) before December 15
 36 that next succeeds the end of the state fiscal year.
 37 (f) The nonfederal share of a payment to a hospital under subsection
 38 (c) or (d) is derived from funds transferred to the Medicaid indigent
 39 care trust fund under IC 12-16-7.5-4.5 and not expended under section
 40 9 of this chapter.
 41 (g) Except as provided in subsection (h), the office may not make a
 42 payment under this section until the payments due under section 9 of

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1 this chapter for the state fiscal year have been made.
2 (h) If a hospital appeals a decision by the office regarding the
3 hospital's payment under section 9 of this chapter, the office may make
4 payments under this section before all payments due under section 9 of
5 this chapter are made if:
6 (1) a delay in one (1) or more payments under section 9 of this
7 chapter resulted from the appeal; and
8 (2) the office determines that making payments under this section
9 while the appeal is pending will not unreasonably affect the
10 interests of hospitals eligible for a payment under this section.
11 (i) Any funds transferred to the Medicaid indigent care trust fund
12 under IC 12-16-7.5-4.5 remaining after payments are made under this
13 section shall be used as provided in IC 12-15-20-2(8).
14 (j) For purposes of subsection (c):
15 (1) "payable claim" has the meaning set forth in
16 IC 12-16-7.5-2.5(b);
17 (2) the amount of a payable claim is an amount equal to the
18 amount the hospital would have received under the state's
19 fee-for-service Medicaid reimbursement principles for the
20 hospital care for which the payable claim is submitted under
21 IC 12-16-7.5 if the individual receiving the hospital care had been
22 a Medicaid enrollee; and
23 (3) a payable hospital claim under IC 12-16-7.5 includes a
24 payable claim under IC 12-16-7.5 for the hospital's care submitted
25 by an individual or entity other than the hospital, to the extent
26 permitted under the hospital care for the indigent program.
27 SECTION 8. IC 12-15-16-6, AS AMENDED BY P.L.229-2011,
28 SECTION 134, IS AMENDED TO READ AS FOLLOWS
29 [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) As used in this section,
30 "low income utilization rate" refers to the low income utilization rate
31 described in section 3 of this chapter.
32 (b) Hospitals that qualify for basic disproportionate share under
33 section 1(a) of this chapter shall receive disproportionate share
34 payments as follows:
35 (1) For the state fiscal year ending June 30, 1999, a pool not
36 exceeding twenty-one million dollars (\$21,000,000) shall be
37 distributed to all hospitals licensed under IC 16-21 that qualify
38 under section 1(a)(1) of this chapter. The funds in the pool must
39 be distributed to qualifying hospitals in proportion to each
40 hospital's Medicaid day utilization rate and Medicaid discharges,
41 as determined based on data from the most recent audited cost
42 report on file with the office. Any funds remaining in the pool

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1 referred to in this subdivision following distribution to all
 2 qualifying hospitals shall be transferred to the pool distributed
 3 under subdivision (3).
 4 (2) Hospitals licensed under IC 16-21 that qualify under both
 5 section 1(a)(1) and 1(a)(2) of this chapter shall receive a
 6 disproportionate share payment in accordance with subdivision
 7 (1).
 8 (3) For the state fiscal year ending June 30, 1999, a pool not
 9 exceeding five million dollars (\$5,000,000), subject to adjustment
 10 by the transfer of any funds remaining in the pool referred to in
 11 subdivision (1), following distribution to all qualifying hospitals,
 12 shall be distributed to all hospitals licensed under IC 16-21 that:
 13 (A) qualify under section 1(a)(1) or 1(a)(2) of this chapter; and
 14 (B) have at least twenty-five thousand (25,000) Medicaid
 15 inpatient days per year, based on data from each hospital's
 16 Medicaid cost report for the fiscal year ended during state
 17 fiscal year 1996.

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

24 (c) This subsection does not apply during the period that the office
 25 is assessing a hospital fee authorized by ~~HEA 1001-2011~~ **IC 16-21-10**.
 26 Other institutions that qualify as disproportionate share providers under
 27 section 1 of this chapter, in each state fiscal year, shall receive
 28 disproportionate share payments as follows:

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

37 (2) A pool not exceeding one hundred ninety-one million dollars
 38 (\$191,000,000) for all state fiscal years ending after June 30,
 39 1995, shall be distributed to all state mental health institutions
 40 under IC 12-24-1-3 that qualify under either section 1(a)(1) or
 41 1(a)(2) of this chapter. The funds in the pool must be distributed
 42 to each qualifying institution in proportion to each institution's

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1 low income utilization rate, as determined based on the most
2 recent data on file with the office.

3 (d) This subsection does not apply during the period that the office
4 is assessing a hospital fee authorized by ~~HEA 1001-2011~~. **IC 16-21-10.**
5 Disproportionate share payments described in this section shall be
6 made on an interim basis throughout the year, as provided by the office.

7 SECTION 9. IC 12-15-17-1, AS AMENDED BY P.L.229-2011,
8 SECTION 135, IS AMENDED TO READ AS FOLLOWS
9 [EFFECTIVE UPON PASSAGE]: Sec. 1. A disproportionate share
10 payment shall be made to:

- 11 (1) a hospital licensed under IC 16-21;
- 12 (2) a state mental health institution under IC 12-24-1-3; and
- 13 (3) a private psychiatric institution licensed under IC 12-25;

14 that serves a disproportionate share of Medicaid recipients and other
15 low income patients as determined under IC 12-15-16-1. However, a
16 provider may not be defined as a disproportionate share provider under
17 IC 12-15-16-1 unless the provider has a Medicaid inpatient utilization
18 rate (as defined in 42 U.S.C. 1396r-4(b)(2)) of at least one percent
19 (1%). Subdivisions (2) and (3) do not apply during the period that the
20 office is assessing a hospital fee authorized by ~~HEA 1001-2011~~.
21 **IC 16-21-10.**

22 SECTION 10. IC 12-15-19-2.1, AS AMENDED BY P.L.229-2011,
23 SECTION 136, IS AMENDED TO READ AS FOLLOWS
24 [EFFECTIVE UPON PASSAGE]: Sec. 2.1. (a) This section does not
25 apply during the period that the office is assessing a hospital fee
26 authorized by ~~HEA 1001-2011~~. **IC 16-21-10.** For each state fiscal year
27 ending on or after June 30, 2000, the office shall develop a
28 disproportionate share payment methodology that ensures that each
29 hospital qualifying for disproportionate share payments under
30 IC 12-15-16-1(a) timely receives total disproportionate share payments
31 that do not exceed the hospital's hospital specific limit provided under
32 42 U.S.C. 1396r-4(g). The payment methodology as developed by the
33 office must:

- 34 (1) maximize disproportionate share hospital payments to
35 qualifying hospitals to the extent practicable;
- 36 (2) take into account the situation of those qualifying hospitals
37 that have historically qualified for Medicaid disproportionate
38 share payments; and
- 39 (3) ensure that payments for qualifying hospitals are equitable.

40 (b) Total disproportionate share payments to a hospital under this
41 chapter shall not exceed the hospital specific limit provided under 42
42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year

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1 shall be determined by the office taking into account data provided by
 2 each hospital that is considered reliable by the office based on a system
 3 of periodic audits, the use of trending factors, and an appropriate base
 4 year determined by the office. The office may require independent
 5 certification of data provided by a hospital to determine the hospital's
 6 hospital specific limit.

7 (c) The office shall include a provision in each amendment to the
 8 state plan regarding Medicaid disproportionate share payments that the
 9 office submits to the federal Centers for Medicare and Medicaid
 10 Services that, as provided in 42 CFR 447.297(d)(3), allows the state to
 11 make additional disproportionate share expenditures after the end of
 12 each federal fiscal year that relate back to a prior federal fiscal year.
 13 However, the total disproportionate share payments to:

14 (1) each individual hospital; and

15 (2) all qualifying hospitals in the aggregate;

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

17 SECTION 11. IC 12-15-19-6, AS AMENDED BY P.L.229-2011,
 18 SECTION 137, IS AMENDED TO READ AS FOLLOWS
 19 [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) This section does not
 20 apply during the period that the office is assessing a hospital fee
 21 authorized by ~~HEA 1001-2011~~ **IC 16-21-10**. The office is not required
 22 to make disproportionate share payments under this chapter from the
 23 Medicaid indigent care trust fund established by IC 12-15-20-1 until
 24 the fund has received sufficient deposits, including intergovernmental
 25 transfers of funds and certifications of expenditures, to permit the
 26 office to make the state's share of the required disproportionate share
 27 payments.

28 (b) For state fiscal years beginning after June 30, 2006, if:

29 (1) sufficient deposits have not been received; or

30 (2) the statewide Medicaid disproportionate share allocation is
 31 insufficient to provide federal financial participation for the
 32 entirety of all eligible disproportionate share hospitals'
 33 hospital-specific limits;

34 the office shall reduce disproportionate share payments made under
 35 IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance
 36 with the Medicaid state plan to eligible institutions using an equitable
 37 methodology consistent with subsection (c).

38 (c) For state fiscal years beginning after June 30, 2006, payments
 39 reduced under this section shall, in accordance with the Medicaid state
 40 plan, be made:

41 (1) to best utilize federal matching funds available for hospitals
 42 eligible for Medicaid disproportionate share payments under

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1 IC 12-15-19-2.1; and
 2 (2) by utilizing a methodology that allocates available funding
 3 under this subdivision, and Medicaid supplemental payments as
 4 defined in IC 12-15-15-1.5, in a manner that all hospitals eligible
 5 for Medicaid disproportionate share payments under
 6 IC 12-15-19-2.1 receive payments using a methodology that:
 7 (A) takes into account the situation of the eligible hospitals
 8 that have historically qualified for Medicaid disproportionate
 9 share payments; and
 10 (B) ensures that payments for eligible hospitals are equitable.
 11 (d) The percentage reduction shall be sufficient to ensure that
 12 payments do not exceed the statewide Medicaid disproportionate share
 13 allocation or the amounts that can be financed with:
 14 (1) the amount transferred from the hospital care for the indigent
 15 trust fund;
 16 (2) other intergovernmental transfers;
 17 (3) certifications of public expenditures; or
 18 (4) any other permissible sources of non-federal match.
 19 SECTION 12. IC 12-15-19-8, AS AMENDED BY P.L.229-2011,
 20 SECTION 138, IS AMENDED TO READ AS FOLLOWS
 21 [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) This section does not
 22 apply during the period that the office is assessing a hospital fee
 23 authorized by ~~HEA 1001-2011~~ **IC 16-21-10**. A provider that qualifies
 24 as a municipal disproportionate share provider under IC 12-15-16-1
 25 shall receive a disproportionate share adjustment, subject to the
 26 provider's hospital specific limits described in subsection (b), as
 27 follows:
 28 (1) For each state fiscal year ending on or after June 30, 1998, an
 29 amount shall be distributed to each provider qualifying as a
 30 municipal disproportionate share provider under IC 12-15-16-1.
 31 The total amount distributed shall not exceed the sum of all
 32 hospital specific limits for all qualifying providers.
 33 (2) For each municipal disproportionate share provider qualifying
 34 under IC 12-15-16-1 to receive disproportionate share payments,
 35 the amount in subdivision (1) shall be reduced by the amount of
 36 disproportionate share payments received by the provider under
 37 IC 12-15-16-6 or sections 1 or 2.1 of this chapter. The office shall
 38 develop a disproportionate share provider payment methodology
 39 that ensures that each municipal disproportionate share provider
 40 receives disproportionate share payments that do not exceed the
 41 provider's hospital specific limit specified in subsection (b). The
 42 methodology developed by the office shall ensure that a

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1 municipal disproportionate share provider receives, to the extent
 2 possible, disproportionate share payments that, when combined
 3 with any other disproportionate share payments owed to the
 4 provider, equals the provider's hospital specific limits.

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

22 (c) For each of the state fiscal years:

23 (1) beginning July 1, 1998, and ending June 30, 1999; and

24 (2) beginning July 1, 1999, and ending June 30, 2000;

25 the total municipal disproportionate share payments available under
 26 this section to qualifying municipal disproportionate share providers is
 27 twenty-two million dollars (\$22,000,000).

28 SECTION 13. IC 12-15-19-10, AS AMENDED BY P.L.229-2011,
 29 SECTION 139, IS AMENDED TO READ AS FOLLOWS
 30 [EFFECTIVE UPON PASSAGE]: Sec. 10. This section does not apply
 31 during the period that the office is assessing a hospital fee authorized
 32 by ~~HEA 1001-2011~~ **IC 16-21-10**. For state fiscal years beginning after
 33 June 30, 2000, the state shall pay providers as follows:

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

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

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1 (3) After the state makes all payments under subdivision (2), if
 2 the state fails to exceed the state disproportionate share allocation
 3 (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
 4 disproportionate share expenditures for institutions for mental
 5 diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make
 6 community mental health center disproportionate share provider
 7 payments to providers qualifying under IC 12-15-16-1(c).

8 SECTION 14. IC 12-15-20-2, AS AMENDED BY P.L.229-2011,
 9 SECTION 140, IS AMENDED TO READ AS FOLLOWS
 10 [EFFECTIVE UPON PASSAGE]: Sec. 2. The Medicaid indigent care
 11 trust fund is established to pay the non-federal share of the following:

12 (1) Enhanced disproportionate share payments to providers under
 13 IC 12-15-19-1.

14 (2) Subject to subdivision (8), disproportionate share payments to
 15 providers under IC 12-15-19-2.1.

16 (3) Medicaid payments for pregnant women described in
 17 IC 12-15-2-13 and infants and children described in
 18 IC 12-15-2-14.

19 (4) Municipal disproportionate share payments to providers under
 20 IC 12-15-19-8.

21 (5) Payments to hospitals under IC 12-15-15-9.

22 (6) Payments to hospitals under IC 12-15-15-9.5.

23 (7) Payments, funding, and transfers as otherwise provided in
 24 clauses (8)(D), (8)(F), and (8)(G).

25 (8) Of the intergovernmental transfers deposited into the
 26 Medicaid indigent care trust fund, the following apply:

27 (A) The entirety of the intergovernmental transfers deposited
 28 into the Medicaid indigent care trust fund for state fiscal years
 29 ending on or before June 30, 2000, shall be used to fund the
 30 state's share of the disproportionate share payments to
 31 providers under IC 12-15-19-2.1.

32 (B) Of the intergovernmental transfers deposited into the
 33 Medicaid indigent care trust fund for the state fiscal year
 34 ending June 30, 2001, an amount equal to one hundred percent
 35 (100%) of the total intergovernmental transfers deposited into
 36 the Medicaid indigent care trust fund for the state fiscal year
 37 beginning July 1, 1998, and ending June 30, 1999, shall be
 38 used to fund the state's share of disproportionate share
 39 payments to providers under IC 12-15-19-2.1. The remainder
 40 of the intergovernmental transfers, if any, for the state fiscal
 41 year shall be used to fund the state's share of additional
 42 Medicaid payments to hospitals licensed under IC 16-21

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1 pursuant to a methodology adopted by the office.
 2 (C) Of the intergovernmental transfers deposited into the
 3 Medicaid indigent care trust fund, for state fiscal years
 4 beginning July 1, 2001, and July 1, 2002, an amount equal to:
 5 (i) one hundred percent (100%) of the total
 6 intergovernmental transfers deposited into the Medicaid
 7 indigent care trust fund for the state fiscal year beginning
 8 July 1, 1998; minus
 9 (ii) an amount equal to the amount deposited into the
 10 Medicaid indigent care trust fund under IC 12-15-15-9(d)
 11 for the state fiscal years beginning July 1, 2001, and July 1,
 12 2002;
 13 shall be used to fund the state's share of disproportionate share
 14 payments to providers under IC 12-15-19-2.1. The remainder
 15 of the intergovernmental transfers, if any, must be used to fund
 16 the state's share of additional Medicaid payments to hospitals
 17 licensed under IC 16-21 pursuant to a methodology adopted by
 18 the office.
 19 (D) The intergovernmental transfers, which shall include
 20 amounts transferred under IC 12-16-7.5-4.5, deposited into the
 21 Medicaid indigent care trust fund and the certifications of
 22 public expenditures deemed to be made to the medicaid
 23 indigent care trust fund, for the state fiscal years ending after
 24 June 30, 2005, but before July 1, 2007, shall be used, in
 25 descending order of priority, as follows:
 26 (i) As provided in clause (B) of STEP THREE of
 27 IC 12-16-7.5-4.5(b)(1) and clause (B) of STEP THREE of
 28 IC 12-16-7.5-4.5(b)(2), to fund the amount to be transferred
 29 to the office.
 30 (ii) As provided in clause (C) of STEP THREE of
 31 IC 12-16-7.5-4.5(b)(1) and clause (C) of STEP THREE of
 32 IC 12-16-7.5-4.5(b)(2), to fund the non-federal share of the
 33 payments made under IC 12-15-15-9 and IC 12-15-15-9.5.
 34 (iii) To fund the non-federal share of the payments made
 35 under IC 12-15-15-1.1, IC 12-15-15-1.3, and IC 12-15-19-8.
 36 (iv) As provided under clause (A) of STEP THREE of
 37 IC 12-16-7.5-4.5(b)(1) and clause (A) of STEP THREE of
 38 IC 12-16-7.5-4.5(b)(2), for the payment to be made under
 39 clause (A) of STEP FIVE of IC 12-15-15-1.5(b).
 40 (v) As provided under STEP FOUR of
 41 IC 12-16-7.5-4.5(b)(1) and STEP FOUR of
 42 IC 12-16-7.5-4.5(b)(2), to fund the payments to be made

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1 under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).
 2 (vi) To fund, in an order of priority determined by the office
 3 to best use the available non-federal share, the programs
 4 listed in clause (H).
 5 (E) For state fiscal years ending after June 30, 2007, the total
 6 amount of intergovernmental transfers used to fund the
 7 non-federal share of payments to hospitals under
 8 IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the
 9 amount provided in clause (G)(ii).
 10 (F) As provided in clause (D), for the following:
 11 (i) Each state fiscal year ending after June 30, 2003, but
 12 before July 1, 2005, an amount equal to the amount
 13 calculated under STEP THREE of the following formula
 14 shall be transferred to the office:
 15 STEP ONE: Calculate the product of thirty-five million dollars
 16 (\$35,000,000) multiplied by the federal medical assistance
 17 percentage for federal fiscal year 2003.
 18 STEP TWO: Calculate the sum of the amounts, if any,
 19 reasonably estimated by the office to be transferred or
 20 otherwise made available to the office for the state fiscal year,
 21 and the amounts, if any, actually transferred or otherwise made
 22 available to the office for the state fiscal year, under
 23 arrangements whereby the office and a hospital licensed under
 24 IC 16-21-2 agree that an amount transferred or otherwise made
 25 available to the office by the hospital or on behalf of the
 26 hospital shall be included in the calculation under this STEP.
 27 STEP THREE: Calculate the amount by which the product
 28 calculated under STEP ONE exceeds the sum calculated under
 29 STEP TWO.
 30 (ii) The state fiscal years ending after June 30, 2005, but
 31 before July 1, 2007, an amount equal to thirty million dollars
 32 (\$30,000,000) shall be transferred to the office.
 33 (G) Subject to IC 12-15-20.7-2(b), for each state fiscal year
 34 ending after June 30, 2007, the total amount in the Medicaid
 35 indigent care trust fund, including the amount of
 36 intergovernmental transfers of funds transferred, and the
 37 amounts of certifications of expenditures eligible for federal
 38 financial participation deemed to be transferred, to the
 39 Medicaid indigent care trust fund, shall be used to fund the
 40 following:
 41 (i) Thirty million dollars (\$30,000,000) transferred to the
 42 office for the Medicaid budget.

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- 1 (ii) An amount not to exceed the non-federal share of
- 2 payments to hospitals under IC 12-15-15-9 and
- 3 IC 12-15-15-9.5.
- 4 (iii) An amount not to exceed the non-federal share of
- 5 payments to hospitals made under IC 12-15-15-1.1 and
- 6 IC 12-15-15-1.3.
- 7 (iv) An amount not to exceed the non-federal share of
- 8 disproportionate share payments to hospitals under
- 9 IC 12-15-19-8.
- 10 (v) An amount not to exceed the non-federal share of
- 11 payments to hospitals under clause (A) of STEP FIVE of
- 12 IC 12-15-15-1.5(c).
- 13 (vi) An amount not to exceed the non-federal share of
- 14 Medicaid safety-net payments.
- 15 (vii) An amount not to exceed the non-federal share of
- 16 payments to hospitals made under clauses (C) or (D) of
- 17 STEP FIVE of IC 12-15-15-1.5(c).
- 18 (viii) An amount not to exceed the non-federal share of
- 19 payments to hospitals made under clause (F) of STEP FIVE
- 20 of IC 12-15-15-1.5(c).
- 21 (ix) An amount not to exceed the non-federal share of
- 22 disproportionate share payments to hospitals under
- 23 IC 12-15-19-2.1.
- 24 (x) If additional funds are available after making payments
- 25 under items (i) through (ix), to fund other Medicaid
- 26 supplemental payments for hospitals approved by the office
- 27 and included in the Medicaid state plan.
- 28 Items (ii) through (x) do not apply during the period that the
- 29 office is assessing a hospital fee authorized by ~~HEA 1001-2011~~ **IC 16-21-10**.
- 30
- 31 (H) This clause does not apply during the period that the office
- 32 is assessing a hospital fee authorized by ~~HEA 1001-2011~~ **IC 16-21-10**. For purposes of clause (D)(vi), the office shall
- 33 fund the following:
- 34
- 35 (i) An amount equal to the non-federal share of the
- 36 payments to the hospital that is eligible under this item, for
- 37 payments made under clause (C) of STEP FIVE of
- 38 IC 12-15-15-1.5(b) under an agreement with the office,
- 39 Medicaid safety-net payments and any payment made under
- 40 IC 12-15-19-2.1. The amount of the payments to the hospital
- 41 under this item shall be equal to one hundred percent
- 42 (100%) of the hospital's hospital-specific limit for state

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1 fiscal year 2005, when the payments are combined with
 2 payments made under IC 12-15-15-9, IC 12-15-15-9.5, and
 3 clause (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state
 4 fiscal year. A hospital is eligible under this item if the
 5 hospital was eligible for Medicaid disproportionate share
 6 hospital payments for the state fiscal year ending June 30,
 7 1998, the hospital received a Medicaid disproportionate
 8 share payment under IC 12-15-19-2.1 for state fiscal years
 9 2001, 2002, 2003, and 2004, and the hospital merged two
 10 (2) hospitals under a single Medicaid provider number,
 11 effective January 1, 2004.

12 (ii) An amount equal to the non-federal share of payments to
 13 hospitals that are eligible under this item, for payments
 14 made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b)
 15 under an agreement with the office, Medicaid safety-net
 16 payments, and any payment made under IC 12-15-19-2.1.
 17 The amount of payments to each hospital under this item
 18 shall be equal to one hundred percent (100%) of the
 19 hospital's hospital-specific limit for state fiscal year 2004,
 20 when the payments are combined with payments made to the
 21 hospital under IC 12-15-15-9, IC 12-15-15-9.5, and clause
 22 (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state fiscal
 23 year. A hospital is eligible under this item if the hospital did
 24 not receive a payment under item (i), the hospital has less
 25 than sixty thousand (60,000) Medicaid inpatient days
 26 annually, the hospital either was eligible for Medicaid
 27 disproportionate share hospital payments for the state fiscal
 28 year ending June 30, 1998 or the hospital met the office's
 29 Medicaid disproportionate share payment criteria based on
 30 state fiscal year 1998 data and received a Medicaid
 31 disproportionate share payment for the state fiscal year
 32 ending June 30, 2001, and the hospital received a Medicaid
 33 disproportionate share payment under IC 12-15-19-2.1 for
 34 state fiscal years 2001, 2002, 2003, and 2004.

35 (iii) Subject to IC 12-15-19-6, an amount not less than the
 36 non-federal share of Medicaid safety-net payments in
 37 accordance with the Medicaid state plan.

38 (iv) An amount not less than the non-federal share of
 39 payments made under clause (C) of STEP FIVE of
 40 IC 12-15-15-1.5(b) under an agreement with the office to a
 41 hospital having sixty thousand (60,000) Medicaid inpatient
 42 days annually.

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1 (v) An amount not less than the non-federal share of
2 Medicaid disproportionate share payments for hospitals
3 eligible under this item, and made under IC 12-15-19-6 and
4 the approved Medicaid state plan. A hospital is eligible for
5 a payment under this item if the hospital is eligible for
6 payments under IC 12-15-19-2.1.

7 (vi) If additional funds remain after the payments made
8 under (i) through (v), payments approved by the office and
9 under the Medicaid state plan, to fund the non-federal share
10 of other Medicaid supplemental payments for hospitals.

11 SECTION 15. IC 12-15-20.7-2, AS AMENDED BY P.L.6-2012,
12 SECTION 92, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
13 UPON PASSAGE]: Sec. 2. (a) This section does not apply during the
14 period that the office is assessing a hospital fee authorized by ~~HEA~~
15 ~~1001-2011~~. **IC 16-21-10**. For each state fiscal year ending before July
16 1, 2005, and subject to section 3 of this chapter (repealed), the office
17 shall make the payments identified in this section in the following
18 order:

- 19 (1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.
- 20 (2) Second, payments under clauses (A) and (B) of STEP FIVE of
- 21 IC 12-15-15-1.5(b).
- 22 (3) Third, Medicaid inpatient payments for safety-net hospitals
- 23 and Medicaid outpatient payments for safety-net hospitals.
- 24 (4) Fourth, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.
- 25 (5) Fifth, payments under IC 12-15-19-8 for municipal
- 26 disproportionate share hospitals.
- 27 (6) Sixth, payments under IC 12-15-19-2.1 for disproportionate
- 28 share hospitals.
- 29 (7) Seventh, payments under clause (C) of STEP FIVE of
- 30 IC 12-15-15-1.5(b).

31 (b) For each state fiscal year ending after June 30, 2007, the office
32 shall make the payments for the programs identified in
33 IC 12-15-20-2(8)(G) in the order of priority that best utilizes available
34 non-federal share, Medicaid supplemental payments, and Medicaid
35 disproportionate share payments, and may change the order or priority
36 at any time as necessary for the proper administration of one (1) or
37 more of the payment programs listed in IC 12-15-20-2(8)(G).

38 SECTION 16. IC 16-21-10 IS ADDED TO THE INDIANA CODE
39 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
40 UPON PASSAGE]:

41 **Chapter 10. Hospital Assessment Fee**
42 **Sec. 1. As used in this chapter, "committee" refers to the**

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1 hospital assessment fee committee established by section 7 of this
2 chapter.

3 Sec. 2. As used in this chapter, "fee" refers to the hospital
4 assessment fee authorized by this chapter.

5 Sec. 3. As used in this chapter, "fee period" means the time
6 frame in which a fee is collected under this chapter.

7 Sec. 4. (a) As used in this chapter, "hospital" means an entity
8 that meets the definition set forth in IC 16-18-2-179(b) and is
9 licensed under this article. The term may include a private
10 psychiatric hospital licensed under IC 12-25.

11 (b) The term does not include the following:

12 (1) A state mental health institution operated under
13 IC 12-24-1-3.

14 (2) A hospital:

15 (A) designated by the Medicaid program as a long term
16 care hospital;

17 (B) that has an average inpatient length of stay that is
18 greater than twenty-five (25) days, as determined by the
19 office of Medicaid policy and planning under the Medicaid
20 program;

21 (C) that is a Medicare certified, freestanding rehabilitation
22 hospital; or

23 (D) that is a hospital operated by the federal government.

24 Sec. 5. As used in this chapter, "office" refers to the office of
25 Medicaid policy and planning established by IC 12-8-6.5-1.

26 Sec. 6. (a) Subject to subsection (b) and section 8(b) of this
27 chapter, the office may assess a hospital assessment fee to hospitals
28 during the fee period if the following conditions are met:

29 (1) The fee may be used only for the purposes described in the
30 following:

31 (A) Section 8(c) of this chapter.

32 (B) Section 9 of this chapter.

33 (C) Section 11 of this chapter.

34 (D) Section 14 of this chapter.

35 (2) The Medicaid state plan amendments and waiver requests
36 required for the implementation of this chapter are submitted
37 by the office to the United States Department of Health and
38 Human Services before October 1, 2013.

39 (3) The United States Department of Health and Human
40 Services approves the Medicaid state plan amendments and
41 waiver requests, or revisions of the Medicaid state plan
42 amendments and waiver requests, described in subdivision

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- (2):**
 - (A) not later than October 1, 2014; or**
 - (B) after October 1, 2014, if a date is established by the committee.**
- The funds generated from the fee do not revert to the general fund.**
- (b) The office shall stop collecting a fee, the programs described in section 8(a) of this chapter shall be reconciled and terminated, and the operation of section 11 of this chapter ends if any of the following occur:**
 - (1) An appellate court makes a final determination that either:**
 - (A) the fee; or**
 - (B) any of the programs described in section 8(a) of this chapter;**
 - cannot be implemented or maintained.**
 - (2) The United States Department of Health and Human Services makes a final determination that the Medicaid state plan amendments or waivers submitted under this chapter are not approved or cannot be validly implemented.**
 - (3) The fee is not collected because of circumstances described in section 8(d) of this chapter.**
 - (c) The office shall keep records of the fees collected by the office and report the amount of fees collected under this chapter.**
- Sec. 7. (a) The hospital assessment fee committee is established. The committee consists of the following four (4) voting members:**
- (1) The secretary of family and social services established by IC 12-8-1.5-1 or the secretary's designee, who shall serve as the chair of the committee.**
 - (2) The budget director or the budget director's designee.**
 - (3) Two (2) individuals appointed by the governor from a list of at least four (4) individuals submitted by the Indiana Hospital Association.**
- (b) The committee shall review any Medicaid state plan amendments, waiver requests, or revisions to any Medicaid state plan amendments or waiver requests, to implement or continue the implementation of this chapter for the purpose of establishing favorable review of the amendments, requests, and revisions by the United States Department of Health and Human Services.**
 - (c) The committee shall meet at the call of the chair. The members serve without compensation.**
 - (d) A quorum consists of at least three (3) members. An affirmative vote of at least three (3) members of the committee is**

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1 necessary to approve Medicaid state plan amendments or waiver
2 requests.

3 Sec. 8. (a) Subject to subsection (b), the office shall develop the
4 following programs designed to increase, to the extent allowable
5 under federal law, Medicaid reimbursement for inpatient and
6 outpatient hospital services provided by a hospital to Medicaid
7 recipients:

8 (1) A program concerning reimbursement for the Medicaid
9 fee-for-service program that, in the aggregate, will result in
10 payments equivalent to the level of reimbursement that would
11 be paid under federal Medicare payment principles.

12 (2) A program concerning reimbursement for the Medicaid
13 risk based managed care program that, in the aggregate, will
14 result in payments equivalent to the level of reimbursement
15 that would be paid under federal Medicare payment
16 principles.

17 (b) The office shall not submit to the United States Department
18 of Health and Human Services any Medicaid state plan
19 amendments, waiver requests, or revisions to any Medicaid state
20 plan amendments or waiver requests, to implement or continue the
21 implementation of this chapter until the committee has reviewed
22 and approved the amendments, waivers, or revisions described in
23 this subsection and has submitted a written report to the budget
24 committee concerning the amendments, waivers, or revisions
25 described in this subsection, including the following:

26 (1) The methodology to be used by the office in calculating the
27 increased Medicaid reimbursement under the programs
28 described in subsection (a).

29 (2) The methodology to be used by the office in calculating,
30 imposing, collecting, or any other matter relating to the fee
31 authorized by this chapter.

32 (3) The determination of Medicaid disproportionate share
33 allotments under section 11 of this chapter that are to be
34 funded by the fee authorized by this chapter, including the
35 formula for distributing the Medicaid disproportionate share
36 allotments.

37 (4) The distribution to private psychiatric institutions under
38 section 13 of this chapter.

39 (c) This subsection applies to the programs described in
40 subsection (a). The state share dollars for the programs must
41 consist of the following:

42 (1) Fees paid under this chapter.

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1 (2) The hospital care for the indigent funds allocated under
2 section 10 of this chapter.

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

6 The money described in subdivisions (1) and (2) may be used only
7 to fund the part of the payments that exceed the Medicaid
8 reimbursement rates in effect on June 30, 2011.

9 (d) This subsection applies to the programs described in
10 subsection (a). If the state is unable to maintain the funding under
11 subsection (c)(3) for the payments at Medicaid reimbursement
12 levels in effect on June 30, 2011, because of budgetary constraints,
13 the office shall reduce inpatient and outpatient hospital Medicaid
14 reimbursement rates under subsection (a)(1) or (a)(2) or request
15 approval from the committee and the United States Department of
16 Health and Human Services to increase the fee to prevent a
17 decrease in Medicaid reimbursement for hospital services. If:

18 (1) the committee:

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

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

21 (2) the United States Department of Health and Human
22 Services does not approve an increase in the fee;

23 the office shall cease to collect the fee and the programs described
24 in subsection (a) end.

25 Sec. 9. (a) This section is effective upon implementation of the
26 fee. The hospital Medicaid fee fund is established for the purpose
27 of holding fees collected under this chapter that are not necessary
28 to match federal funds.

29 (b) The office shall administer the fund.

30 (c) Money in the fund at the end of a state fiscal year does not
31 revert to the state general fund. However, money remaining in the
32 fund after the cessation of the collection of the fee under section
33 6(b) of this chapter shall be used for the payments described in
34 sections 8(a) and 11 of this chapter. Any money not required for
35 the payments described in sections 8(a) and 11 of this chapter after
36 the cessation of the collection of the fee under section 6(b) of this
37 chapter shall be distributed to the hospitals on a pro rata basis
38 based upon the fees paid by each hospital for the state fiscal year
39 that ended immediately before the cessation of the collection of the
40 fee under section 6(b) of this chapter.

41 Sec. 10. This section:

42 (1) is effective upon implementation of the fee; and

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1 (2) does not apply to funds under IC 12-16-17.
 2 Notwithstanding any other law, the part of the amounts
 3 appropriated for or transferred to the hospital care for the
 4 indigent program for the state fiscal years beginning July 1, 2013,
 5 and each state fiscal year thereafter that are not required to be
 6 paid to the office by law shall be used exclusively as state share
 7 dollars for the payments described in sections 8(a) and 11 of this
 8 chapter. Any hospital care for the indigent funds that are not
 9 required for the payments described in sections 8(a) and 11 of this
 10 chapter after the cessation of the collection of the fee under section
 11 6(b) of this chapter shall be used for the state share dollars of the
 12 payments in IC 12-15-20-2(8)(G)(ii) through
 13 IC 12-15-20-2(8)(G)(x).

14 Sec. 11. (a) This section:

- 15 (1) is effective upon the implementation of the fee; and
 16 (2) applies to the Medicaid disproportionate share payments
 17 for the state fiscal years beginning July 1, 2013, and each state
 18 fiscal year thereafter.

19 (b) The state share dollars used to fund disproportionate share
 20 payments to acute care hospitals licensed under IC 16-21-2 that
 21 qualify as disproportionate share providers or municipal
 22 disproportionate share providers under IC 12-15-16-1(a) or
 23 IC 12-15-16-1(b) shall be paid with money collected through the fee
 24 under this chapter and the hospital care for the indigent dollars
 25 described in section 10 of this chapter.

26 (c) Subject to section 12 of this chapter and except as provided
 27 in section 12 of this chapter, the federal Medicaid disproportionate
 28 share allotments for the state fiscal years beginning July 1, 2013,
 29 and each state fiscal year thereafter shall be allocated in their
 30 entirety to acute care hospitals licensed under IC 16-21-2 that
 31 qualify as disproportionate share providers or municipal
 32 disproportionate share providers under IC 12-15-16-1(a) or
 33 IC 12-15-16-1(b). No part of the federal disproportionate share
 34 allotments applicable for disproportionate share payments for the
 35 state fiscal years beginning July 1, 2013, and each state fiscal year
 36 thereafter may be allocated to institutions for mental disease or
 37 other mental health facilities, as defined by applicable federal law.

38 Sec. 12. For purposes of this chapter, the entire federal
 39 Medicaid disproportionate share allotment for Indiana does not
 40 include the part of allotments that are required to be diverted
 41 under the following:

- 42 (1) The federally-approved Indiana "Special Terms and



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1 **Conditions" Medicaid demonstration project (Number**
 2 **11-W-00237/5).**

3 **(2) Any extension after December 31, 2012, of the Indiana**
 4 **check-up plan Medicaid waiver established by IC 12-15-44.2.**
 5 **The office shall inform the committee and the budget committee**
 6 **concerning any extension of the Indiana check-up plan after**
 7 **December 31, 2013.**

8 **Sec. 13. Notwithstanding IC 12-15-16-6(c), the annual two**
 9 **million dollar (\$2,000,000) pool of disproportionate share dollars**
 10 **under IC 12-15-16-6(c) shall not be available to eligible private**
 11 **psychiatric institutions. The office shall annually distribute two**
 12 **million dollars (\$2,000,000) to eligible private psychiatric**
 13 **institutions that would have been eligible for payment under**
 14 **IC 12-15-16-6(c).**

15 **Sec. 14. The fees collected under this chapter may be used only**
 16 **as described in this chapter or to pay the state's share of the cost**
 17 **for Medicaid services provided under the federal Medicaid**
 18 **program (42 U.S.C. 1396 et seq.) as follows:**

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

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

22 **Sec. 15. This chapter may not be construed to authorize any**
 23 **county, municipality, district, or authority to impose a fee, tax, or**
 24 **assessment on a hospital.**

25 **Sec. 16. Subject to section 8(b) of this chapter, the office may**
 26 **adopt rules, including emergency rules adopted in the manner**
 27 **provided under IC 4-22-2-37.1, necessary to implement this**
 28 **chapter. Rules adopted under this section may be retroactive to the**
 29 **effective date of the Medicaid state plan amendments or waivers**
 30 **approved under this chapter.**

31 **Sec. 17. The office may enter into an agreement with a hospital**
 32 **to pay the fee in installments.**

33 **Sec. 18. (a) If a hospital fails to pay the fee after not later than**
 34 **ten (10) days after the payment date, the hospital shall pay to the**
 35 **office interest on the fee at the same rate as the rate determined**
 36 **under IC 12-15-21-3(6)(A).**

37 **(b) The office shall report to the state department of health each**
 38 **hospital that fails to pay the fee not later than one hundred twenty**
 39 **(120) days after the date the payment is due. The state department**
 40 **shall do the following concerning a hospital described in this**
 41 **subsection:**

42 **(1) Notify the hospital that the hospital's license under**

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**IC 16-21 will be revoked if the fee is not paid.
(2) Revoke the hospital's license under IC 16-21 if the hospital fails to pay the fee. IC 4-21.5-3-8 and IC 4-21.5-4 apply to this subdivision.**

Sec. 19. Payments for the programs described in section 8(a) of this chapter are limited to claims for dates of services provided during the fee period and that are timely filed with the office or a contractor of the office. Payments for the programs described in section 8(a) of this chapter and distributions to hospitals in accordance with this chapter may occur at any time, including after the cessation of the collection of a fee under this chapter.

Sec. 20. The office may collect unpaid fees owed by a hospital under this chapter and may refund fees paid by a hospital under this chapter at any time, including after the cessation of the collection of a fee under this chapter.

SECTION 17. IC 16-28-15-8, AS ADDED BY P.L.229-2011, SECTION 162, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) The money collected from the quality assessment fee during ~~the first year following the enactment state fiscal year 2012~~ may be used only as follows:

- (1) Sixty-seven and one-tenth percent (67.1%) to pay the state's share of costs for Medicaid nursing facility services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).
- (2) Twenty-three and eight-tenths percent (23.8%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).
- (3) Nine and one-tenth percent (9.1%) to pay prior year state nursing facility expenditures.

(b) The money collected from the quality assessment fee during ~~the second year following enactment state fiscal year 2013~~ may be used only as follows:

- (1) Sixty-six and five-tenths percent (66.5%) to pay the state's share of costs for Medicaid nursing facility services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).
- (2) Twenty-nine and four-tenths percent (29.4%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).
- (3) Four and one-tenth percent (4.1%) to pay prior year state nursing facility expenditures.

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1 (c) The money collected from the quality assessment fee after ~~the~~
2 ~~second year following enactment~~ **state fiscal year 2013** may be used
3 only as follows:

4 (1) Seventy and six-tenths percent (70.6%) to pay the state's share
5 of the costs for Medicaid nursing facility services provided under
6 Title XIX of the federal Social Security Act (42 U.S.C. 1396 et
7 seq.).

8 (2) Twenty-nine and four-tenths percent (29.4%) to pay the state's
9 share of costs for other Medicaid services provided under Title
10 XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

11 (d) Any increase in reimbursement for Medicaid nursing facility
12 services resulting from maximizing the quality assessment rate under
13 section 6(b) of this chapter shall be directed exclusively to initiatives
14 determined by the office to promote and enhance improvements in
15 quality of care to nursing facility residents.

16 (e) The office may establish a method to allow a health facility to
17 enter into an agreement to pay the quality assessment fee collected
18 under this chapter under an installment plan.

19 SECTION 18. IC 16-28-15-14 IS REPEALED [EFFECTIVE UPON
20 PASSAGE]. ~~Sec. 14. This chapter expires June 30, 2014.~~

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

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1327, 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.

CLERE, Chair

Committee Vote: yeas 9, nays 0.

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