SENATE BILL No. 137

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12; IC 27-13-10-12.

Synopsis: Change of names of Medicaid bodies. Makes technical changes to reflect the change of name of: (1) the select joint committee on Medicaid oversight to the select joint commission on Medicaid oversight made by P.L.256-2001; and (2) the federal Health Care Financing Administration to the Centers for Medicare and Medicaid Services.

Effective: July 1, 2002.

Miller

January 7, 2002, read first time and referred to Committee on Health and Provider Services.

Introduced

Second Regular Session 112th General Assembly (2002)

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 2001 General Assembly.

SENATE BILL No. 137

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

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

SECTION 1. IC 12-15-12-19, AS ADDED BY P.L.291-2001, SECTION 161, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 19. (a) This section applies to an individual who:

(1) is a Medicaid recipient;

(2) is not enrolled in the risk-based managed care program; and

(3) resides in a county having a population of more than one hundred thousand (100,000).

(b) Subject to subsection (c), the office shall develop the following programs regarding individuals described in subsection (a):

(1) A disease management program for recipients with any of the following diseases:

(A) Asthma.

(B) Diabetes.

(C) Congestive heart failure or coronary heart disease.

(D) HIV or AIDS.

(2) A case management program for recipients whose per

recipient Medicaid cost is in the highest ten percent (10%) of all individuals described in subsection (a).

(c) The office shall contract with an outside vendor or vendors to develop and implement the programs required under subsection (b). The office shall begin the contract procurement process not later than October 1, 2001. The contract required under this subsection must be effective not later than July 1, 2002.

(d) The vendor or vendors with whom the office contracts under subsection (c) shall provide the office and the select joint commission on Medicaid oversight **established by IC 2-5-26-3** with an evaluation and recommendations on the costs, benefits, and health outcomes of the programs required under subsection (b). The evaluations required under this subsection must be provided not more than nine (9) months after the effective date of the contract.

(e) The office shall report to the select joint commission on Medicaid oversight **established by IC 2-5-26-3** not later than December 31, 2002, regarding the programs developed under this section.

SECTION 2. IC 12-15-13-0.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 0.7. The office may adopt rules under IC 4-22-2 that add, delete, or modify the locators contained in section 0.6(a)(1) of this chapter as necessary to conform with:

(1) changes in federal law or regulation; or

(2) directives from the United States **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration).

SECTION 3. IC 12-15-15-1.1, AS AMENDED BY P.L.283-2001, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

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

(b) For a state fiscal year ending after June 30, 2000, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate services reimbursed under this article provided by hospitals established and operated under IC 16-22-2, IC 16-22-8, and IC 16-23.

STEP TWO: For the aggregate services identified under STEP ONE, the office shall calculate the aggregate payments made under this article to hospitals established and operated under IC 16-22-2, IC 16-22-8, and IC 16-23, excluding payments under

IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate an amount equal to one hundred fifty percent (150%) of a reasonable estimate of the amount that would have been paid in the aggregate by the office for services described in STEP ONE under Medicare payment principles.

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

STEP FIVE: From the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the aggregate payments for covered services made under this article to the hospital during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19; and

(B) a reasonable estimate of the amount that would have been paid for the services described in clause (A) under Medicare payment principles.

The actual distribution of the amount calculated under this STEP to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under this STEP is not a condition precedent to the tender of payments to hospitals under STEP SEVEN.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals described in subsection (c) in proportion to each hospital's hospital specific limit under 42 U.S.C. 1396r-4(g), as determined by the office.

(c) Subject to subsection (e), reimbursement under this section consists of a single payment made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2000, shall be made before December 31 following the state fiscal year's end. A payment described in this subsection is not due to a hospital unless:

(1) the hospital is licensed under IC 16-21 and is established and operated under IC 16-22-2 or IC 16-23; and

(2) an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after

the close of each state fiscal year. An intergovernmental transfer under this subsection shall be made to the Medicaid indigent care trust fund in an amount equal to eighty-five percent (85%) of the amount to be distributed to the hospital under STEP SEVEN of subsection (b). The intergovernmental transfer must be used to fund the state's share of payments under this section, a portion of the state's share of disproportionate share payments under IC 12-15-20-2(2), and a portion of the state's share of funding for the uninsured parents program as provided under IC 12-15-20-2(5).

(e) A hospital making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under STEP SEVEN of subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under STEP SEVEN of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP SEVEN of subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) The office may not implement this section until the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) has issued its approval of the amended state plan for medical assistance. The office may determine not to continue to implement this section if federal financial participation is not available.

(g) This subsection applies to the state fiscal year beginning July 1, 2000, and ending June 30, 2001. If federal law will not permit the percentage calculation in STEP THREE of subsection (b) to be applied to all services identified in STEP ONE of subsection (b) for the state fiscal year, the amount attributable to the excluded services to which the percentage calculation does not apply shall be the maximum amount available without causing the entire amount calculated in STEP THREE of subsection (b) to exceed the applicable Medicaid upper payment limit.

(h) For purposes of STEP THREE of subsection (b), if federal law limits the calculation of the Medicaid upper payment limit designated for nonstate government owned or operated hospitals to a percentage

less than one hundred fifty percent (150%) of a reasonable estimate of reimbursement under Medicare payment principles, the applicable maximum percentage allowed under federal law will be applied.

SECTION 4. IC 12-15-15-10, AS ADDED BY P.L.113-2000, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 10. (a) This section applies to a hospital that:

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

(2) qualifies as a provider under the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

(1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).

(2) Establish a nominal charge hospital payment program.

(3) Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

(1) intergovernmental transfers; or

(2) funds certified as being eligible for federal financial participation.

(d) The office may not implement a program under this section until the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

SECTION 5. IC 12-15-16-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 5. (a) The office may not implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, or IC 12-15-20 until the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) has issued its approval of the amended state plan for medical assistance.

(b) The office may determine not to continue to implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, and IC 12-15-20 if federal financial participation is not available.

(c) If federal financial participation is approved for less than all of the amounts paid into the Medicaid indigent care trust fund with respect to a fiscal year, the office may reduce payments attributable to that fiscal year under IC 12-15-19-1 by a percentage sufficient to compensate for the aggregate reduction in federal financial participation. If additional federal financial participation is

subsequently approved with respect to payments into the Medicaid indigent care trust fund for the same fiscal year, the office shall distribute such amounts using the percentage that was used to compensate for the prior reduction in federal financial participation.

SECTION 6. IC 12-15-18-5.1, AS AMENDED BY P.L.215-2001, SECTION 44, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 5.1. (a) For state fiscal years ending on or after June 30, 1998, the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 are authorized to make intergovernmental transfers to the Medicaid indigent care trust fund in amounts to be determined jointly by the office and the trustees, and the office and each municipal health and hospital corporation.

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

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

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

(2) both individually and in the aggregate do not exceed limits prescribed by the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration).

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

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

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

SECTION 7. IC 12-15-19-1, AS AMENDED BY P.L.113-2000, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 1. (a) For the state fiscal years ending on June 30, 1998, and June 30, 1999, the office shall develop an enhanced disproportionate share payment methodology that ensures that each enhanced disproportionate share provider receives total disproportionate share payments that do not exceed its hospital specific limit specified in subsection (c). The methodology developed by the office shall ensure that hospitals operated by or affiliated with the governmental entities described in IC 12-15-18-5.1(a) receive, to the extent practicable, disproportionate share payments equal to their hospital specific limits. The funds shall be distributed to qualifying hospitals in proportion to each qualifying hospital's percentage of the total net hospital specific limits of all qualifying hospitals. A hospital's net hospital specific limit for state fiscal years ending on or before June 30, 1999, is determined under STEP THREE of the following formula:

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

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

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

(b) The office shall include a provision in each amendment to the state plan regarding disproportionate share payments, municipal disproportionate share payments, and community mental health center disproportionate share payments that the office submits to the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures, municipal disproportionate share expenditures, and community mental health center disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. Each eligible hospital or community mental health

center may receive an additional disproportionate share adjustment if:

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

(2) the total disproportionate share payments to:

(A) each individual hospital; and

(B) all qualifying hospitals in the aggregate;

do not exceed the limits provided by federal law and regulation.

(c) For state fiscal years ending on or before June 30, 1999, total basic and enhanced disproportionate share payments to a hospital under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for state fiscal years ending on or before June 30, 1999, shall be determined by the office taking into account any data provided by each hospital for each hospital's most recent fiscal year (or in cases where a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data ending at the end of the most recent fiscal year) as certified to the office by:

(1) an independent certified public accounting firm if the hospital is a hospital licensed under IC 16-21 that qualifies under IC 12-15-16-1(a); or

(2) the budget agency if the hospital is a state mental health institution listed under IC 12-24-1-3 that qualifies under either IC 12-15-16-1(a)(1) or IC 12-15-16-1(a)(2);

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

SECTION 8. IC 12-15-19-2.1, AS AMENDED BY P.L.283-2001, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made

by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

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

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

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

(d) The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:

(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and

(2) must be in an amount equal to the amount that results from the following calculation:

STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.

STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).

SECTION 9. IC 12-17.6-2-7, AS ADDED BY P.L.273-1999, SECTION 177, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 7. (a) The office shall contract with an independent organization to evaluate the program.

(b) The office shall report the results of each evaluation to the:

(1) children's health policy board established by IC 4-23-27-2; and

(2) select joint ~~committee~~ **commission** on Medicaid oversight established by ~~P.L.130-1998.~~ **IC 2-5-26-3.**

(c) This section does not modify the requirements of other statutes relating to the confidentiality of medical records.

SECTION 10. IC 12-17.6-2-12, AS ADDED BY P.L.273-1999, SECTION 177, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 12. Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:

(1) budget committee;

(2) legislative council;

(3) children's health policy board established by IC 4-23-27-2; and

(4) select joint ~~committee~~ **commission** on Medicaid oversight established by ~~P.L.130-1998.~~ **IC 2-5-26-3.**

SECTION 11. IC 12-17.7-2-7, AS ADDED BY P.L.283-2001, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 7. Not later than April 1 of each year, the office shall provide a report describing the program's activities during the preceding calendar year to the following:

(1) Budget committee.

(2) Legislative council.

(3) Select joint ~~committee~~ **commission** on Medicaid oversight **established by IC 2-5-26-3.**

SECTION 12. IC 12-17.7-9-1, AS ADDED BY P.L.283-2001, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 1. The uninsured parents program implemented and maintained under this article shall terminate upon either of the following:

(1) A revocation or nonrenewal of the demonstration waiver approved by the federal **Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) for purposes of implementing this article.

(2) Repeal of the federal upper payment limit designated for nonstate government owned or operated hospitals allowing Medicaid reimbursement to nonstate government owned or operated hospitals equal to one hundred fifty percent (150%) of a reasonable estimate of reimbursement under Medicare payment principles.

SECTION 13. IC 27-13-10-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 12. (a) Notwithstanding IC 27-13, the department shall approve the grievance and appeals procedures of a health maintenance organization if:

(1) the health maintenance organization certifies in writing to the

department of the health maintenance organization's compliance with grievance and appeals procedures established by the **federal Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) of the United States Department of Health and Human Services; and

(2) the department certifies that the grievance and appeals procedures established by the **federal Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) of the United States Department of Health and Human Services are substantially similar to the grievance and appeals process in IC 27-13.

(b) Subsection (a) does not:

(1) limit the authority of the department;

(2) limit the responsibility of a health maintenance organization;

(3) release a health maintenance organization from the prohibitions established under section 11 of this chapter; or

(4) require a health maintenance organization to use a grievance and appeals procedure established by the **federal Centers for Medicare and Medicaid Services (formerly the** Health Care Financing Administration) of the United States Department of Health and Human Services.