Reprinted
February 20, 2025

HOUSE BILL No. 1004

DIGEST OF HB 1004 (Updated February 19, 2025 3:31 pm - DI 147)

Citations Affected: IC 6-8; IC 6-8.1; IC 12-15; IC 16-18; IC 16-21; IC 27-1; noncode.

Synopsis: Nonprofit hospitals. Establishes a hospital facility fee excise tax imposed when a hospital charges a facility fee that exceeds 265% of the hospital's Medicare facility fee. Excludes a critical access hospital from the excise tax statute. Requires the excise taxes to be used for the lawful purposes of the Medicaid program and for developing the health care workforce serving rural areas of Indiana. Establishes: (1) a state directed payment program (program) for hospitals; and (2) a managed care assessment fee; subject to the approval of the United States Department of Health and Human Services. Specifies that a nonprofit hospital is a hospital organized as a nonprofit corporation or a charitable trust under the laws of Indiana or the laws of any other state or country. Limits what may constitute community benefits for certain nonprofit hospitals. Requires, before November 1 of each state fiscal year, nonprofit hospitals (that are not county hospitals) to provide to the department of insurance (department) a report including aggregate data on all billed services
(Continued next page)

Effective: Upon passage; July 1, 2025.

Carbaugh, McGuire, Smaltz, Gore

January 21, 2025, read first time and referred to Committee on Public Health.
February 11, 2025, amended, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 126.3.
February 17, 2025, amended, reported — Do Pass.
February 19, 2025, read second time, amended, ordered engrossed.

and items and a comparison of the charges for those services and items to their respective Medicare reimbursement rates. Provides that a nonprofit hospital that charges an amount for a service or item in excess of 300% of the nonprofit hospital's modified Medicare reimbursement rate at the time of the charge forfeits its status as a nonprofit hospital. Allows a nonprofit hospital to reestablish the nonprofit hospital's status as a nonprofit hospital. Provides that all nonprofit hospitals are subject to an annual audit by, and at the discretion of, the department. Requires, before November 1 of each year, every nonprofit hospital to provide the health care cost oversight task force with, and make available for publication on the general assembly's website, the entirety of the Schedule H portion of the nonprofit hospital's previous taxable year's federal Form 990, including specified forms. Makes an appropriation.

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February 20, 2025

First Regular Session of the 124th General Assembly (2025)

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 2024 Regular Session of the General Assembly.

HOUSE BILL No. 1004

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

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

SECTION 1. IC 6-8-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 15.8. Hospital Facility Fee Excise Tax

Sec. 1. This chapter applies to a facility fee charged to a qualifying patient for medical care provided after December 31, 2025.

Sec. 2. As used in this chapter, "account" refers to the hospital facility fee excise tax account established by section 11 of this chapter.

Sec. 3. As used in this chapter, "department" means the department of state revenue.

Sec. 4. As used in this chapter, "facility fee" refers to a fee that is charged by a hospital:

(1) to recover costs incurred to maintain the hospital's facilities; and

(2) in addition to the amounts charged for services,

medications, supplies, nutrition, and hydration provided by the hospital.

Sec. 5. As used in this chapter, "hospital" refers to a hospital licensed under IC 16-21 that is not a critical access hospital that meets the criteria under 42 CFR 485.601 et seq.

Sec. 6. As used in this chapter, "Medicare facility fee" means a facility fee, based on a hospital's modified Medicare reimbursement rate, charged to individuals enrolled in Medicare for a particular service.

Sec. 7. As used in this chapter, "qualifying patient" refers to a patient who is not enrolled in Medicare and is charged a facility fee that exceeds two hundred sixty-five percent (265%) of the hospital's Medicare facility fee charged for the same services.

Sec. 8. For services provided after December 31, 2025, the hospital facility fee excise tax is imposed upon a hospital each time the hospital charges a qualifying patient a facility fee that exceeds two hundred sixty-five percent (265%) of the hospital's Medicare facility fee. The hospital facility fee excise tax is imposed upon the hospital at the following rates:

(1) For calendar year 2026, thirty-three percent (33%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the hospital's Medicare facility fee.

(2) For calendar year 2027, sixty-six percent (66%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the hospital's Medicare facility fee.

(3) For calendar year 2028 and each year thereafter, one hundred percent (100%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the hospital's Medicare facility fee.

Sec. 9. Before the tenth day of each month, a hospital shall remit the hospital facility fee excise taxes imposed upon the hospital in the previous calendar month to the department in the manner prescribed by the department.

Sec. 10. The department shall transfer the hospital facility fee excise taxes received each month to the treasurer of state for deposit in the account established by section 11 of this chapter.

Sec. 11. (a) The hospital facility fee excise tax account is established within the state general fund. The account consists of the hospital facility fee excise taxes remitted to the department

under this chapter.

(b) Except as provided in subsection (c), money in the account must be used as follows:

(1) Seventy-five percent (75%) for any lawful purpose of the Medicaid program under IC 12-15.

(2) Twenty-five percent (25%) for developing the health care workforce serving rural areas of Indiana.

(c) The secretary of health and family services may change the allocation of money set forth in subsection (b) after making and publishing on an appropriate website a finding that the new allocation will be more beneficial to the people of Indiana.

Sec. 12. Money in the account is continuously appropriated to the secretary of health and family services for the purposes described in section 11 of this chapter.

SECTION 2. IC 6-8.1-1-1, AS AMENDED BY P.L.1-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1. "Listed taxes" or "taxes" includes only the pari-mutuel taxes (IC 4-31-9-3 through IC 4-31-9-5); the supplemental wagering tax (IC 4-33-12); the riverboat wagering tax (IC 4-33-13); the slot machine wagering tax (IC 4-35-8); the type II gambling game excise tax (IC 4-36-9); the gross income tax (IC 6-2.1) (repealed); the utility receipts and utility services use taxes (IC 6-2.3) (repealed); the state gross retail and use taxes (IC 6-2.5); the adjusted gross income tax (IC 6-3); the pass through entity tax (IC 6-3-2.1); the supplemental net income tax (IC 6-3-8) (repealed); the county adjusted gross income tax (IC 6-3.5-1.1) (repealed); the county option income tax (IC 6-3.5-6) (repealed); the county economic development income tax (IC 6-3.5-7) (repealed); the local income tax (IC 6-3.6); the auto rental excise tax (IC 6-6-9); the financial institutions tax (IC 6-5.5); the gasoline tax (IC 6-6-1.1); the special fuel tax (IC 6-6-2.5); the motor carrier fuel tax (IC 6-6-4.1); a motor fuel tax collected under a reciprocal agreement under IC 6-8.1-3; the vehicle excise tax (IC 6-6-5); the aviation fuel excise tax (IC 6-6-13); the commercial vehicle excise tax (IC 6-6-5.5); the excise tax imposed on recreational vehicles and truck campers (IC 6-6-5.1); the hazardous waste disposal tax (IC 6-6-6.6) (repealed); the heavy equipment rental excise tax (IC 6-6-15); the vehicle sharing excise tax (IC 6-6-16); the cigarette tax (IC 6-7-1); the closed system cartridge tax (IC 6-7-2-7.5); the electronic cigarette tax (IC 6-7-4); the beer excise tax (IC 7.1-4-2); the liquor excise tax (IC 7.1-4-3); the wine excise tax (IC 7.1-4-4); the hard cider excise tax (IC 7.1-4-4.5); the petroleum severance tax (IC 6-8-1); **the hospital facility fee excise tax (IC 6-8-15.8);** the various innkeeper's taxes (IC 6-9); the various food

and beverage taxes (IC 6-9); the county admissions tax (IC 6-9-13 and IC 6-9-28); the oil inspection fee (IC 16-44-2); the penalties assessed for oversize vehicles (IC 9-20-3 and IC 9-20-18); the fees and penalties assessed for overweight vehicles (IC 9-20-4 and IC 9-20-18); and any other tax or fee that the department is required to collect or administer.

SECTION 3. IC 12-15-16-1, AS AMENDED BY P.L.76-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) A provider that is an acute care hospital licensed under IC 16-21, a state mental health institution under IC 12-24-1-3, or a private psychiatric institution licensed under IC 12-25 is a disproportionate share provider if the provider meets either of the following conditions:

(1) The provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana. However, the Medicaid inpatient utilization rate of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient utilization rate.

(2) The provider's low income utilization rate exceeds twenty-five percent (25%).

(b) An acute care hospital licensed under IC 16-21 is a municipal disproportionate share provider if the hospital:

(1) has a Medicaid utilization rate greater than one percent (1%); and

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

(c) A community mental health center:

(1) that is identified in IC 12-29-2-1;

(2) for which a county provides funds under:

(A) IC 12-29-1-7(b) before January 1, 2004; or

(B) IC 12-29-2 after December 31, 2018;

or from other county sources; and

(3) that provides inpatient services to Medicaid patients;

is a community mental health center disproportionate share provider if the community mental health center's Medicaid inpatient utilization rate is greater than one percent (1%).

(d) A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency

obstetric procedures. However, this obstetric service requirement does not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

(e) The determination of a provider's status as a disproportionate share provider under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office.

(f) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 4. IC 12-15-16-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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 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 5. IC 12-15-16-7, AS AMENDED BY P.L.108-2019, SECTION 195, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. (a) Except as provided in **subsection (j) and** ~~sections 7.5 and~~ **section** 7.7 of this chapter, this section applies to Medicaid disproportionate share payments for the state fiscal year beginning:

(1) July 1, 2012, if hospital fees authorized under P.L.229-2011, SECTION 281 or authorized to be transferred and used for payments are used as state share dollars for the payments; and

(2) July 1, 2013, and for each state fiscal year after, for which hospital fees authorized under IC 16-21-10 are used as state share dollars for the payments.

~~(b) As used in this section, "hospital assessment fee committee" refers to the committee established by IC 16-21-10-7.~~

~~(c)~~ **(b)** As used in this section, "hospital specific limit" refers to the hospital specific limit provided under 42 U.S.C. 1396r-4(g).

~~(d)~~ **(c)** As used in this section, "municipal hospital payment amount" means, concerning a hospital established and operated under IC 16-22-2 or IC 16-23, an amount equal to the lesser of:

(1) the hospital specific limit for the hospital for the state fiscal year; or

(2) the hospital's net 2009 supplemental payment amount.

~~(e)~~ **(d)** As used in this section, "nongovernmental hospital" refers to a hospital that is licensed under IC 16-21-2, that is not a unit of state or local government, and is not owned or operated by a unit of state or local government.

~~(f) As used in this section, "SECTION 281 hospital assessment fee committee" refers to the hospital assessment fee committee established by P.L.229-2011, SECTION 281, subsection (e).~~

~~(g)~~ **(e) Subject to subsection (j),** the following providers are eligible for Medicaid disproportionate share payments under this section:

(1) A hospital or psychiatric institution described in Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect July 1, 2011.

(2) A hospital that satisfies the following for the state fiscal year for which Medicaid disproportionate share payments are made under this section:

(A) A nongovernmental hospital that:

(i) has a Medicaid inpatient utilization rate for the state fiscal year that is at least equal to the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but does not equal or exceed one (1) standard deviation above the mean Medicaid inpatient utilization rate; and

(ii) satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

(B) A hospital established and operated under IC 16-22-2 or IC 16-23 that:

(i) has a Medicaid inpatient utilization rate for the state fiscal year greater than one percent (1%); and

(ii) satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

(3) A nongovernmental hospital that satisfies the following for the

state fiscal year for which Medicaid disproportionate share payments are made under this section:

(A) The hospital has a Medicaid inpatient utilization rate for the state fiscal year that is less than the mean Medicaid inpatient utilization rate, as calculated for purposes of determining Medicaid disproportionate share eligibility, but is at least greater than one percent (1%).

(B) The hospital satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

~~(h)~~ **(f)** This subsection applies to a payment of Medicaid disproportionate share payments, if any, to hospitals described in subsection ~~(g)(2)~~ **(e)(2)** and ~~(g)(3).~~ **(e)(3).** For Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2012, the office ~~subject to approval by the SECTION 281 hospital assessment fee committee,~~ may develop and implement a Medicaid state plan amendment that provides Medicaid disproportionate share payments for the hospitals described in:

(1) subsection ~~(g)(2),~~ **(e)(2),** as long as each hospital and psychiatric institution described in subsection ~~(g)(1)~~ **(e)(1)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to either:

(A) the hospital specific limit; or

(B) the municipal hospital payment amount;

for the hospital or psychiatric institution for the state fiscal year; and

(2) subsection ~~(g)(3),~~ **(e)(3),** as long as each hospital described in subsection ~~(g)(2)~~ **(e)(2)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the hospital specific limit for the hospital for the state fiscal year.

~~(i)~~ **(g)** This subsection applies to a payment of Medicaid disproportionate share payments, if any, to hospitals described in subsection ~~(g)(2)~~ **(e)(2)** and ~~(g)(3).~~ **(e)(3).** For Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter under this section, the office ~~subject to the approval by the hospital assessment fee committee,~~ may develop and implement a Medicaid state plan amendment that:

(1) renews, for state fiscal year beginning July 1, 2013, and each state fiscal year thereafter under this section, the Medicaid disproportionate share provisions of Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect on July 1, 2011;

(2) provides Medicaid disproportionate share payments for the

hospitals described in subsection ~~(g)(2),~~ **(e)(2),** as long as each hospital and psychiatric institution described in subsection ~~(g)(1)~~ **(e)(1)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the:

(A) hospital specific limit; or

(B) municipal hospital payment amount;

for the hospital or psychiatric institution for the state fiscal year; and

(3) provides Medicaid disproportionate share payments for the hospitals described in subsection ~~(g)(3),~~ **(e)(3),** as long as each hospital described in subsection ~~(g)(2)~~ **(e)(2)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the hospital specific limit of the hospital for the state fiscal year.

~~(j)~~ **(h)** This subsection does not apply to Medicaid disproportionate share payments made to hospitals described in subsection ~~(g)(2)(B)~~ **(e)(2)(B)** under Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect on July 1, 2011, or any renewal. Nothing in this section:

(1) requires that the hospitals described in subsection ~~(g)(2)~~ **(e)(2)** or ~~(g)(3)~~ **(e)(3)** receive Medicaid disproportionate share payments for a state fiscal year;

(2) requires that the hospitals described in subsection ~~(g)(2)~~ **(e)(2)** or ~~(g)(3)~~ **(e)(3)** receive Medicaid disproportionate share payments for a state fiscal year in an amount equal to the respective hospital specific limits for the state fiscal year; or

(3) prescribes how Medicaid disproportionate share payments are to be distributed among the hospitals described in:

(A) subsection ~~(g)(2);~~ **(e)(2);** or

(B) subsection ~~(g)(3).~~ **(e)(3).**

~~(k)~~ **(i)** Nothing in this section prohibits the use of unexpended federal Medicaid disproportionate share allotments for a state fiscal year under a program, ~~authorized by the SECTION 281 hospital assessment fee committee or the hospital assessment fee committee~~, as long as each hospital listed in subsection ~~(g)(1),~~ ~~(g)(2),~~ **(e)(1), (e)(2),** and ~~(g)(3)~~ **(e)(3)** has received Medicaid disproportionate share payments for the state fiscal year equal to the hospital specific limit for the hospital for the state fiscal year.

(j) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 6. IC 12-15-16-7.3 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 7.3. (a) This section applies to disproportionate share payments for any state fiscal year during which the state directed payment program under IC 16-21-10-8.5 is in effect.**

(b) The office shall develop and implement a Medicaid state plan amendment that provides Medicaid disproportionate share payments for hospitals pursuant to the following STEPS:

STEP ONE: Each acute care hospital licensed under IC 16-21 that qualifies as a disproportionate share provider under section 1(a) of this chapter, including acute care hospitals licensed under IC 16-21 and established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23 that qualify as a disproportionate share provider under section 1(a) of this chapter, shall be paid a disproportionate share payment for the state fiscal year in the amount of one thousand dollars ($1,000).

STEP TWO: Of the state's disproportionate share payment allotment under 42 CFR 447.297 that remains for the state fiscal year following STEP ONE, disproportionate share payments shall be paid to municipal disproportionate share providers described in section 1(b) of this chapter, and to acute care hospitals licensed under IC 16-21 and established and operated under IC 16-22-8 that qualify as a disproportionate share provider under section 1(a) of this chapter, that fund the state's share of their disproportionate share payment for the state fiscal year through an intergovernmental transfer. Subject to subsection (c), each hospital's payment shall be an amount equal to its hospital specific limit for the state fiscal year calculated pursuant to 42 U.S.C. 1396r-4(g).

(c) If the total disproportionate share payments under STEP TWO of subsection (b) for a state fiscal year would be greater than the state's disproportionate share payment allotment under 42 CFR 447.297 that remains following STEP ONE of subsection (b), the disproportionate share payments to each hospital eligible under STEP TWO shall be made on a pro rata basis, based on each hospital's hospital specific limit in relation to the remaining disproportionate share payment allotment.

SECTION 7. IC 12-15-16-7.7, AS AMENDED BY P.L.156-2020, SECTION 55, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7.7. (a) As used in this section, "CMS" refers

to the federal Centers for Medicare and Medicaid Services.

~~(b) As used in this section, "default plan" refers to a plan for distributing Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2020, and, at the discretion of the hospital assessment fee committee, for any state fiscal year beginning after July 1, 2020, and meets the requirements set forth in subsection (i).~~

~~(c)~~ **(b)** As used in this section, "disproportionate share payment plan" refers to a plan for distributing disproportionate share payments for the state fiscal year beginning July 1, 2020, ~~and at the discretion of the hospital assessment fee committee,~~ for any state fiscal year beginning after July 1, 2020, and that meets the requirements set forth in ~~subsection (h).~~ **this section.**

~~(d)~~ **(c)** As used in this section, "federal DSH allotment" refers to the allotment of federal disproportionate share funds calculated for the state under 42 U.S.C. 1396r-4.

~~(e) As used in this section, "hospital assessment fee committee" refers to the committee established by IC 16-21-10-7.~~

~~(f)~~ **(d)** As used in this section, "reduced federal DSH allotment" refers to a federal DSH allotment for the state for the federal fiscal year beginning October 1, 2020, that, by operation of 42 U.S.C. 1396r-4(f)(7), is less than the federal DSH allotment for the state for the federal fiscal year beginning October 1, 2018.

~~(g)~~ **(e)** As used in this section, "terminating event" refers to federal legislation (including an amendment to 42 U.S.C. 1396r-4), a regulation or sub-regulatory policy or directive issued by CMS, or a judicial ruling, that is enacted or issued on or before March 30, 2021, that:

(1) cancels, or postpones to a subsequent federal fiscal year, a reduced federal DSH allotment; and

(2) does not cause the state to incur a reduced federal DSH allotment.

~~(h)~~ **(f)** ~~Subject to subsection (i),~~ The ~~hospital assessment fee committee~~ **office** shall develop a disproportionate share payment plan. ~~and submit the disproportionate share payment plan to the office.~~ The following apply to the disproportionate share payment plan developed under this subsection:

(1) The disproportionate share payment plan must:

(A) specify the amount or amounts of disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 and private mental health institutions licensed under IC 12-25 for the state fiscal year beginning on or after July 1, 2020; or

(B) specify the formula to be used by the office for purposes of determining the amount or amounts of disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 and private mental health institutions licensed under IC 12-25 for the state fiscal year beginning on or after July 1, 2020.

(2) In developing the disproportionate share payment plan, the ~~hospital assessment fee committee~~ **office** is not required to:

(A) follow paragraphs 1 through 7 of Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019;

(B) provide for disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 or private mental health institutions licensed under IC 12-25 that, for purposes of the state fiscal year beginning on or after July 1, 2020, do not meet the definition of a "disproportionate share hospital" as set forth in Section II(E) of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019; or

(C) follow the provisions set forth in section 7.5 of this chapter.

(3) In developing the disproportionate share payment plan, the ~~hospital assessment fee committee~~ **office** shall take into consideration the percentage of a hospital's patients whose health care coverage is provided by a governmental health care program.

~~(i) If the hospital assessment fee committee is unable to develop a disproportionate share payment plan, the hospital assessment fee committee shall submit the default plan to the office. The following apply to the default plan:~~

~~(1) The disproportionate share payments that would otherwise be paid to an acute care hospital under Step Two, Step Three, or Step Four of Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019, without the reduction provided for in section 7.5 of this chapter, shall be reduced by a single percentage that is applied uniformly to all hospitals described in this subdivision.~~

~~(2) The percentage of the reduction in disproportionate share payments under subdivision (1) shall be the percentage determined by the hospital assessment fee committee to cause the total disproportionate share payments made to maximize the expenditure of, without exceeding, the reduced federal DSH allotment.~~

~~If agreed to by the hospital assessment fee committee, the default plan may also include other terms and conditions that the committee determines to be necessary for the proper implementation and administration of the default plan.~~

~~(j)~~ **(g)** After the office submits the state plan amendment described in section 7.5 of this chapter, but before October 1, 2020, the office shall file with CMS and, if approved by CMS, the office shall implement, a proposed Medicaid state plan amendment that is based upon ~~either~~ the disproportionate share payment plan developed by the ~~hospital assessment fee committee or the default plan submitted by the hospital assessment fee committee,~~ **office,** subject to the following:

(1) The proposed Medicaid state plan amendment referred to in this subsection shall include language that, in the event a terminating event occurs after the Medicaid state plan amendment is approved by the CMS but before March 30, 2021, would operate to cause the state plan amendment to be immediately and automatically void and without effect, and to cause Subsection A of Section III of Attachment 4.19-A of the state's Medicaid state plan, in effect on January 1, 2019, to be immediately and automatically reinstated and effective.

(2) Subdivision (1) does not prevent the office from submitting a subsequent Medicaid state plan amendment for approval by CMS after CMS's approval of the state plan amendment referenced in subdivision (1) and that applies to a state fiscal year beginning on or after July 1, 2021, and that amends or replaces the state plan amendment described in this subsection.

~~(k) Before filing the proposed Medicaid state plan amendment with CMS, the proposed Medicaid state plan amendment referenced in subsection (j) shall be submitted by the office to the hospital assessment fee committee for the committee's approval.~~

~~(l) The hospital assessment fee committee shall coordinate with the office so that the disproportionate share payment plan, or the default plan, if applicable, is prepared and submitted to the office under subsection (h) or (i), if applicable, and the committee's approval of the proposed state plan amendment under subsection (k), is obtained in sufficient time so as to enable the office to file the proposed Medicaid state plan amendment with CMS before October 1, 2020.~~

~~(m) The office shall regularly update the hospital assessment fee committee regarding the status of the proposed Medicaid state plan amendment. All questions, proposals, directives, requirements, and other communications received by the office from CMS concerning the proposed Medicaid state plan amendment shall be provided to the~~

~~committee within a reasonable time after receipt by the office. Upon request by the hospital assessment fee committee or the office, the office and the hospital assessment fee committee shall meet to confer concerning the proposed state plan amendment.~~

~~(m) If:~~

~~(1) a terminating event occurs before the office submits the proposed Medicaid state plan amendment to CMS under subsection (j), the hospital assessment fee committee and the office shall cease their work on the disproportionate share payment plan, or the default plan if applicable, and the proposed Medicaid state plan amendment, and the office shall not submit the proposed state plan amendment to CMS; or~~

~~(2) a terminating event occurs after the office submits the proposed Medicaid state plan amendment to CMS under subsection (h), but before CMS approves a state plan amendment that implements the disproportionate share payment plan, or the default plan if applicable, the office shall immediately notify CMS of the office's intent to withdraw the proposed Medicaid state plan amendment and otherwise act so as to accomplish the immediate withdrawal of the proposed Medicaid state plan amendment.~~

~~(o) In the event a provision of this section conflicts with another provision of this article, the provisions of this section shall control.~~

SECTION 8. IC 12-15-18-5.1, AS AMENDED BY P.L.76-2018, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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.

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:

(1) IC 12-29-1-7(b) before January 1, 2004; or

(2) IC 12-29-2 after December 31, 2018;

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.

(f) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 9. IC 12-15-44.5-4, AS AMENDED BY P.L.30-2016, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The plan:

(1) is not an entitlement program; and

(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(b) If either of the following occurs, the office shall terminate the plan in accordance with section 6(b) of this chapter:

(1) The:

(A) percentages of federal medical assistance available to the plan for coverage of plan participants described in Section

1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are less than the percentages provided for in Section 2001(a)(3)(B) of the federal Patient Protection and Affordable Care Act; and

(B) ~~hospital assessment committee (IC 16-21-10),~~ **office,** after considering the modification and the reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance; **or**

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in federal medical assistance.

For purposes of this subdivision, "coverage of plan participants" includes **reimbursement,** payments, contributions, and amounts referred to in IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and IC 16-21-10-13.3(b)(1)(D), including **reimbursement,** payments, contributions, and amounts incurred during a phase out period of the plan.

(2) The:

(A) methodology of calculating the incremental fee set forth in IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) ~~hospital assessment fee committee (IC 16-21-10),~~ **office,** after considering the modification and reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in fees; **or**

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in fees; and

(C) office does not use alternative financial support to cover the amount of the reduction in fees.

(c) If the plan is terminated under subsection (b), the secretary may implement a plan for coverage of the affected population in a manner consistent with the healthy Indiana plan (IC 12-15-44.2 (before its repeal)) in effect on January 1, 2014:

(1) subject to prior approval of the United States Department of Health and Human Services; and

(2) ~~without~~ **using** funding from the incremental fee set forth in

IC 16-21-10-13.3.

(d) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(e) The office of the secretary shall submit annually to the budget committee an actuarial analysis of the plan that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan.

SECTION 10. IC 12-15-44.5-6, AS AMENDED BY P.L.93-2024, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) For a state fiscal year beginning July 1, 2018, and before July 1, 2024, the office, after review by the state budget committee, may determine that no incremental fees collected under IC 16-21-10-13.3 are required to be deposited into the phase out trust fund established under section 7 of this chapter. This subsection expires July 1, 2024.

(b) If the plan is to be terminated for any reason, the office shall,

~~(1)~~ if required, provide notice of termination of the plan to the United States Department of Health and Human Services and begin the process of phasing out the plan. ~~or~~

~~(2) if notice and a phase out plan is not required under federal law, notify the hospital assessment fee committee (IC 16-21-10) of the office's intent to terminate the plan and the plan shall be phased out under a procedure approved by the hospital assessment fee committee.~~

~~The office may not submit any phase out plan to the United States Department of Health and Human Services or accept any phase out plan proposed by the Department of Health and Human Services without the prior approval of the hospital assessment fee committee.~~

(c) Before submitting:

(1) an extension of; or

(2) a material amendment to;

the plan to the United States Department of Health and Human Services, the office shall inform the Indiana Hospital Association of the extension or material amendment to the plan.

SECTION 11. IC 16-18-2-339.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 339.5. "State directed payment program", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-5.7.**

SECTION 12. IC 16-21-9-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1. As used in this

chapter, "community benefits" means **either of the following:**

(1) For a county owned hospital, a critical access hospital, and a rural emergency hospital, the unreimbursed cost to a hospital of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services. The term does not include the cost to the hospital of paying any taxes or other governmental assessments.

(2) For any other nonprofit hospital not described in subdivision (1), only uncompensated care provided by the hospital and only if the uncompensated care meets the following conditions:

(A) The service was billed to the patient and the bill remained unpaid and was at least one hundred eighty (180) days past the due date.

(B) The nonprofit hospital received less than the Medicaid reimbursement rate for the service.

SECTION 13. IC 16-21-10-1 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 1. As used in this chapter, "committee" refers to the hospital assessment fee committee established by section 7 of this chapter.~~

SECTION 14. IC 16-21-10-4, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) As used in this chapter, "hospital" means either of the following:

(1) A hospital (as defined in IC 16-18-2-179(b)) licensed under this article.

(2) A private psychiatric hospital licensed under IC 12-25.

(b) The term does not include the following:

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

(2) A hospital:

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

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

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

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

(c) As used in this section, "physician owned hospital" means an acute care hospital licensed under IC 16-21-2 that has:

(1) physician ownership; or

(2) ownership by a legal entity with one hundred percent (100%) physician ownership;

or ownership described in both subdivisions (1) and (2), and such ownership of the hospital is at least fifty-one percent (51%).

(d) The office may, subject to approval from the United States Department of Health and Human Services, exclude any of the following from the term for purposes of this chapter:

(1) A physician owned hospital.

(2) A class of hospitals, as determined by the office.

SECTION 15. IC 16-21-10-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5.7. As used in this chapter, "state directed payment program" means a payment arrangement under section 8.5 of this chapter and authorized under 42 CFR 438.6(c) that allows the office to direct specific payments to a hospital by the managed care organizations that contract with the office to provide health coverage to Medicaid recipients.**

SECTION 16. IC 16-21-10-6, AS AMENDED BY P.L.213-2015, SECTION 141, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) Subject to subsection ~~(b)~~ **(d)** and section 8(b) of this chapter, the office may assess a hospital assessment fee to hospitals during the fee period if the following conditions are met:

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

(A) Section 8(c)(1) of this chapter.

(B) Section 8.5 of this chapter.

~~(B)~~ **(C)** Section 9 of this chapter.

~~(C)~~ **(D)** Section 11 of this chapter.

~~(D)~~ **(E)** Section 13.3 of this chapter.

~~(E)~~ **(F)** Section 14 of this chapter.

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

~~(3) The United States Department of Health and Human Services approves the Medicaid state plan amendments and waiver requests, or revisions of the Medicaid state plan amendments and waiver requests, described in subdivision (2):~~

~~(A) not later than October 1, 2014; or~~

~~(B) after October 1, 2014, if a date is established by the committee.~~

~~(4)~~ **(2)** The funds generated from the fee do not revert to the state general fund.

(b) The office may request a waiver from the United States Department of Health and Human Services of the broad based and uniformity requirements set forth in 42 CFR 433.68 concerning the assessment under this chapter.

(c) Subject to subsection (a), the office may assess the fee:

(1) on a tiered basis among the hospitals; and

(2) based on net patient revenue, inpatient days, or another methodology approved by the United States Department of Health and Human Services.

~~(b)~~ **(d)** The office shall stop collecting a fee, the programs described in section 8(a) of this chapter shall be reconciled and terminated subject to section 9(c) of this chapter, and the operation of section 11 of this chapter, **subject to section 11(d) and 11(e) of this chapter,** ends subject to section 9(c) of this chapter, if any of the following occurs:

(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)~~ **(e)** The office shall keep records of the fees collected by the office and report the amount of fees collected under this chapter to the budget committee.

SECTION 17. IC 16-21-10-7 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~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 appointed under IC 12-8-1.5-2 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.~~

~~The committee members described in subdivision (3) serve at the pleasure of the governor. If a vacancy occurs among the members appointed under subdivision (3), the governor shall appoint a replacement committee member from a list of at least two (2) 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. The committee shall also develop a disproportionate share payment plan or submit to the office the default plan, if applicable, as set forth in IC 12-15-16-7.5 and IC 12-15-16-7.7.~~

~~(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 necessary to approve Medicaid state plan amendments, waiver requests, revisions to the Medicaid state plan or waiver requests, and the approvals and other determinations required of the committee under IC 12-15-44.5 and section 13.3 of this chapter.~~

~~(e) The following apply to the approvals and any other determinations required by the committee under IC 12-15-44.5 and section 13.3 of this chapter:~~

~~(1) The committee shall be guided and subject to the intent of the general assembly in the passage of IC 12-15-44.5 and section 13.3 of this chapter.~~

~~(2) The chair of the committee shall report any approval and other determination by the committee to the budget committee.~~

~~(3) If, in taking action, the committee's vote is tied, the committee shall follow the following procedure:~~

~~(A) The chair of the committee shall notify the chairman of the budget committee of the tied vote and provide a summary of that matter that was the subject of the vote.~~

~~(B) The chairman of the budget committee shall provide each committee member who voted an opportunity to appear before the budget committee to present information and materials to the budget committee concerning the matter that was the subject of the tied vote.~~

~~(C) Following a presentation of the information and the materials described in clause (B), the budget committee may~~

~~make recommendations to the committee concerning the matter that was the subject of the tied vote.~~

SECTION 18. IC 16-21-10-8, AS AMENDED BY P.L.213-2015, SECTION 143, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) This section does not apply to the use of the incremental fee described in section 13.3 of this chapter. Subject to subsection (b), the office ~~shall~~ **may** develop the following programs designed to increase ~~to the extent allowable under federal law,~~ Medicaid reimbursement for inpatient and outpatient hospital services provided by a hospital to Medicaid recipients:

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

(2) A program concerning reimbursement for the Medicaid risk based managed care program that, in the aggregate, will result in payments equivalent to the level of payment that would be paid under federal Medicare payment principles, **and up to any reimbursement approved under a state directed payment program set forth in section 8.5 of this chapter.**

(b) The office shall not submit to the United States Department of Health and Human Services 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 until the ~~committee has reviewed and approved the amendments, waivers, or revisions described in this subsection and~~ **office** has submitted a written report to the budget committee concerning the amendments, waivers, or revisions described in this subsection, including the following:

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

(2) The methodology to be used by the office in calculating, imposing, or collecting the fee, or any other matter relating to the fee.

(3) The determination of Medicaid disproportionate share allotments under section 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** that are to be funded by the fee, including the formula for distributing the Medicaid disproportionate share allotments.

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

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

(1) Fees paid under this chapter.

(2) The hospital care for the indigent funds allocated under section 10 of this chapter **(before its repeal).**

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

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

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

~~(1) the committee:~~

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

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

~~(2)~~ the United States Department of Health and Human Services does not approve an increase in the fee,

the office shall cease to collect the fee and the programs described in subsection (a) are terminated.

SECTION 19. IC 16-21-10-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8.5. (a) Beginning July 1, 2025, or thereafter, the office may implement a state directed payment program in which payments are made for inpatient and outpatient hospital services as follows:**

(1) Subject to available state share funding and federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act in effect on January 1, 2025, the reimbursement rates for inpatient and outpatient hospital services under the state directed payment program may be established at a rate greater than Medicare equivalent reimbursement rates, but may not exceed the maximum

reimbursement rates established by federal law.

(2) The office may implement the state directed payment program through the establishment of classes of hospitals with different rates of reimbursement among the classes, in a manner that is consistent with federal law.

(3) Before January 1, 2026, the office shall apply to the United States Department of Health and Human Services for the review and approval of a state directed payment program. The office may receive input from hospitals and other interested parties in the development of the documentation submitted with the application under this subdivision.

(4) The office may not implement the state directed payment program without the approval of the United States Department of Health and Human Services. To the extent allowed by the United States Department of Health and Human Services, the office shall implement the self directed payment program on or after July 1, 2025.

(5) The office may not implement a fee under the state directed payment program without the approval of the fee by the United States Department of Health and Human Services, including any waiver related to the fee, to fund the state share of the payments under the state directed payment program. To the extent allowed by the United States Department of Health and Human Services, the office shall use the fee to fund the state directed payment program on or after July 1, 2025.

(6) The office shall make payments under the state directed payment program to managed care organizations that contract with the office to provide medical assistance to Medicaid recipients as follows:

(A) Except as provided in clause (B), capitation payments at levels necessary to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates established under subdivision (1). The fee must be used to pay the state share of the part of the capitation payments that fund the portion of the reimbursement rates that exceed the reimbursement rates in effect on June 30, 2011.

(B) For plan enrollees described in section 13.3(b)(1)(A) of this chapter, capitation payments at level sufficient to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates

established by subdivision (1). The incremental fee shall fund the entire state share of these capitation payments.

SECTION 20. IC 16-21-10-9, AS AMENDED BY P.L.213-2015, SECTION 144, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. (a) This section is effective upon implementation of the fee. The hospital Medicaid fee fund is established for the purpose of holding fees collected under section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 ~~if~~ **of** this chapter, that are not necessary to match federal funds.

(b) The office shall administer the fund.

(c) Money in the fund at the end of a state fiscal year attributable to fees collected to fund the programs described in section 8 of this chapter does not revert to the state general fund. However, money remaining in the fund after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be used for the payments described in sections 8(a) and 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter).** Any money not required for the payments described in sections 8(a) and 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be distributed to the hospitals on a pro rata basis based upon the fees paid by each hospital for the state fiscal year that ended immediately before the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

SECTION 21. IC 16-21-10-10, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. This section:

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

(2) does not apply to funds under IC 12-16-17.

Notwithstanding any other law, the part of the amounts appropriated for or transferred to the hospital care for the indigent program for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter that are not required to be paid to the office by law shall be used exclusively as state share dollars for the payments described in sections 8(a) and 11 of this chapter. Any hospital care for the indigent funds that are not required for the payments described in sections 8(a) and 11 of this chapter after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be used for the state share

dollars of the payments in IC 12-15-20-2(8)(G)(ii) through IC 12-15-20-2(8)(G)(x).

SECTION 22. IC 16-21-10-11, AS AMENDED BY P.L.30-2016, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. (a) This section:

(1) does not apply to the incremental fee described in section 13.3 of this chapter;

(2) is effective upon the implementation of the fee described in section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 of this chapter; and

(3) applies to the Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter.

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

(c) **Subject to subsections (d) and (e),** the federal Medicaid disproportionate share allotments for the state fiscal years beginning July 1, 2013, and each state fiscal year thereafter shall be allocated in their entirety to acute care hospitals licensed under IC 16-21-2 that qualify as disproportionate share providers or municipal disproportionate share providers under IC 12-15-16-1(a) or IC 12-15-16-1(b). No part of the federal disproportionate share allotments applicable for disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter may be allocated to institutions for mental disease or other mental health facilities, as defined by applicable federal law.

(d) Subsections (b) and (c) do not apply for any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect.

(e) For any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect, the state share of the disproportionate share payments described in STEP ONE of IC 12-15-16-7.3(c) shall be funded by the fee.

SECTION 23. IC 16-21-10-13.3, AS AMENDED BY P.L.93-2024, SECTION 128, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13.3.(a) This section is effective beginning February 1, 2015. As used in this section, "plan"

refers to the healthy Indiana plan established in IC 12-15-44.5.

(b) Subject to subsections (c) through ~~(e),~~ **(g),** the incremental fee under this section may be used to fund the state share of the expenses specified in this subsection if, after January 31, 2015, but before the collection of the fee under this section, the following occur:

(1) The ~~committee~~ **office** establishes a fee formula to be used to fund the state share of the following expenses described in this subdivision:

(A) The state share of the capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees other than plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act, **including portions of the capitation attributed to a state directed payment program under section 8.5 of this chapter.**

(B) The state share of capitated payments described in clause (A) for plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act that are limited to the difference between:

(i) the capitation rates effective September 1, 2014, developed using Medicaid reimbursement rates; and

(ii) the capitation rates applicable for the plan developed using the plan's Medicare reimbursement rates described in IC 12-15-44.5-5(a)(2), **or higher reimbursement amounts for any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect.**

(C) The state share of the state's contributions to plan enrollee accounts.

(D) The state share of amounts used to pay premiums for a premium assistance plan implemented under IC 12-15-44.2-20.

(E) The state share of the costs of increasing reimbursement rates for physician services provided to individuals enrolled in Medicaid programs other than the plan, but not to exceed the difference between the Medicaid fee schedule for a physician service that was in effect before the implementation of the plan and the amount equal to seventy-five percent (75%) of the previous year federal Medicare reimbursement rate for a physician service. The incremental fee may not be used for the amount that exceeds seventy-five percent (75%) of the federal Medicare reimbursement rate for a physician service.

(F) The state share of the state's administrative costs that, for purposes of this clause, may not exceed one hundred seventy dollars ($170) per person per plan enrollee per year, and adjusted annually by the Consumer Price Index.

(2) The ~~committee~~ **office** approves a process to be used for reconciling:

(A) the state share of the costs of the plan;

(B) the amounts used to fund the state share of the costs of the plan; and

(C) the amount of fees assessed for funding the state share of the costs of the plan.

For purposes of this subdivision, "costs of the plan" includes the costs of the expenses listed in subdivision (1)(A) through (1)(F).

The fees collected ~~under~~ **for the purposes of** subdivision (1)(A) through (1)(F) shall be deposited into the incremental hospital fee fund established by section 13.5 of this chapter. The fees used for purposes of funding the state share of expenses listed in subdivision (1)(A) through (1)(F) may not be used to fund expenses incurred on or after the commencement of a phase out period of the plan.

(c) For each state fiscal year for which the fee authorized by this section is used to fund the state share of the expenses described in subsection (b)(1), the amount of fees shall be reduced by:

(1) the amount of funds annually designated by the general assembly to be deposited in the healthy Indiana plan trust fund established by IC 12-15-44.2-17; less

(2) the annual cigarette tax funds annually appropriated by the general assembly for childhood immunization programs under IC 12-15-44.2-17(a)(3).

(d) The incremental fee described in this section may not:

(1) be assessed before July 1, 2016; and

(2) be assessed or collected on or after the beginning of a phase out period of the plan.

(e) This section is not intended to and may not be construed to change or affect any component of the programs established under section 8 of this chapter.

SECTION 24. IC 16-21-10-14, AS AMENDED BY P.L.213-2015, SECTION 150, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 14. **(a)** This section does not apply to the use of the incremental fee described in section 13.3 of this chapter.

(b) The fees collected under section 8 of this chapter may be used only as described in this chapter or to pay the state's share of the cost

for Medicaid services provided under the federal Medicaid program (42 U.S.C. 1396 et seq.) as follows:

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

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

SECTION 25. IC 16-21-10-19, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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 payments to hospitals in accordance with section 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** may occur at any time, including after collection of the fee is stopped under section ~~6(b)~~ **6(d)** of this chapter, to the extent the funding provided for the payments by this chapter is available under section 9(c) of this chapter. Payments for the program described in section 13 of this chapter may occur at any time, including after the collection of the fee is stopped under section ~~6(b)~~ **6(d)** of this chapter, subject to the reconciliation and termination of the program required by section ~~6(b)~~ **6(d)** of this chapter.

SECTION 26. IC 16-21-10-21, AS AMENDED BY P.L.201-2023, SECTION 148, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 21. This chapter expires June 30, ~~2025.~~ **2027.**

SECTION 27. IC 16-21-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 18. Nonprofit Hospitals

Sec. 1. This chapter does not apply to county hospitals described in IC 16-22.

Sec. 2. As used in this chapter, "nonprofit hospital" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:

(1) eligible for tax exempt bond financing; or

(2) exempt from state or local taxes.

Sec. 3. Before November 1 of each state fiscal year, nonprofit hospitals shall provide to the state department and the department of insurance a report including aggregate data on all billed services and items and a comparison of the charges for those services and items to their respective Medicare reimbursement rates.

Sec. 4. (a) A nonprofit hospital that charges an amount for a service or item in excess of three hundred percent (300%) of the nonprofit hospital's modified Medicare reimbursement rate at the time of the charge forfeits its status as a nonprofit hospital.

(b) This subsection applies to a nonprofit hospital that forfeits its status as a nonprofit hospital under subsection (a). A nonprofit hospital may reestablish the nonprofit hospital's status as a nonprofit hospital if the nonprofit hospital meets the requirement described in subsection (a) for at least ninety (90) consecutive days.

Sec. 5. All nonprofit hospitals shall be subject to an annual audit by, and at the discretion of, the department of insurance.

SECTION 28. IC 16-21-19 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 19. Nonprofit Hospital Reporting

Sec. 1. As used in this chapter, "nonprofit hospital" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country.

Sec. 2. Before November 1 of each year, every nonprofit hospital shall provide the health care cost oversight task force (established by IC 2-5-47-3) with, and make available for publication on the general assembly's website, the entirety of the Schedule H portion of the nonprofit hospital's previous taxable year's federal Form 990, including the following forms:

(1) Federal form 990, Schedule H, Part I, 7(a), financial assistance at cost, worksheet 1 or other similar documentation, or its successor form or schedule.

(2) Federal form 990, Schedule H, Part I, 7(b), Medicaid, worksheet 3, column a, or its successor form or schedule.

(3) Federal form 990, Schedule H, Part I, 7(c), costs of other means-tested government programs, worksheet 3, column b, or its successor form or schedule.

(4) Federal form 990, Schedule H, Part I, 7(e), community health improvement services and community benefit operations, worksheet 4 or other similar documentation, or its successor form or schedule.

(5) Federal form 990, Schedule H, Part I, 7(f), health professions education, worksheet 5 or other similar documentation, or its successor form or schedule.

(6) Federal form 990, Schedule H, Part I, 7(g), subsidized health services, worksheet 6 or other similar documentation,

or its successor form or schedule.

(7) Federal form 990, Schedule H, Part I, 7(h), research, worksheet 7 or other similar documentation, or its successor form or schedule.

(8) Federal form 990, Schedule H, Part I, 7(i), cash and in kind contributions for community benefit, worksheet 8, or its successor form or schedule.

(9) Federal form 990, Schedule H, Part II, community building activities, lines 1 through 9, or its successor form or schedule, and including specific initiatives and related net expenses for each line.

(10) Federal form 990, Schedule H, Part III, section A, bad debt expense, lines 2 through 3, or its successor form or schedule, and including calculations to support the data entered.

(11) Federal form 990, Schedule H, Part III, section B, Medicare, lines 5 through 7, or its successor form or schedule, and including calculations to support the data entered.

Sec. 3. Prior to providing the health oversight task force with, or making available for publication, the information described in section 2 of this chapter, a nonprofit hospital may only make redactions with regard to:

(1) personally identifiable information; and

(2) information required to remain confidential under the federal Health Insurance Portability and Accountability Act (HIPAA).

SECTION 29. IC 27-1-50.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 50.3. Managed Care Assessment Fee

Sec. 1. The following definitions apply throughout this chapter:

(1) "Business day" means a day other than Saturday or Sunday, or a legal holiday listed in IC 1-1-9-1.

(2) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(3) "Department" refers to the department of insurance created by IC 27-1-1-1.

(4) "Fee" refers to the fee on managed care organizations authorized by this chapter.

(5) "Managed care organization" means an organization that holds a certificate of authority, license, or other similar authorization issued by the department and that is a managed

care organization for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8).

(6) "Office" refers to the office of Medicaid policy and planning established by IC 12-8-6.5-1.

(7) "Secretary" refers to the secretary of family and social services appointed under IC 12-8-1.5-2.

(8) "State's share" means the portion of allowable Medicaid expenses funded by the state, by other units of government, or, as permitted by federal Medicaid laws, by other entities other than the federal government.

Sec. 2. (a) Subject to subsections (b) and (c) and this chapter, a fee is authorized.

(b) The fee may not be assessed without approval from the United States Department of Health and Human Services.

(c) The assessment of the fee shall cease upon the Department of Health and Human Service's determination that the fee is no longer a permissible health care related tax that is eligible for federal financial participation.

Sec. 3. The office may, subject to section 6 of this chapter, assess a fee upon managed care organizations to support administration of the state Medicaid program.

Sec. 4. The fee collected under this chapter may only be used to pay the state's share of the cost of Medicaid services provided under the Medicaid program (42 U.S.C. 1396 et seq.).

Sec. 5. (a) Not later than May 30, 2025, and after consulting with the secretary or the secretary's designee regarding compliance with 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8) and the types of managed care organizations recognized under Indiana law, the commissioner or the commissioner's designee shall provide the secretary or the secretary's designee with a list of the managed care organizations that hold a certificate of authority, license, or other similar authorization issued by the department and that are managed care organizations for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8).

(b) The commissioner or the commissioner's designee shall update this list to the secretary or the secretary's designee not sooner than one hundred twenty (120) days, and not later than ninety (90) days, from the start of each state fiscal year for which the fee is assessed.

Sec. 6. (a) The fee must meet the requirements of the federal Medicaid statutes and regulations for permissible health care related taxes.

(b) The office may request a waiver from the United States Department of Health and Human Services of the broad based and uniformity requirements under 42 CFR 433.68 relating to the assessment under this chapter.

(c) Subject to subsection (a):

(1) the office may assess the fee on a tiered basis among the managed care organizations; and

(2) the office may assess the fee based on member months, premium revenue, or any other methodology approved by the United States Department of Health and Human Services.

Sec. 7. The office shall submit a written request to United States Department of Health and Human Services for approval of the managed care assessment fee on or after June 30, 2025. Subject to the requirements of this chapter, the office is authorized to negotiate with the United States Department of Health and Human Services regarding the terms and conditions for the implementation and maintenance of the fee.

Sec. 8. (a) A managed care organization that is assessed under this chapter for a state fiscal year shall pay the assessment in monthly installments, each equaling one-twelfth (1/12) of the assessment for the state fiscal year, on the first business day of each calendar month of the state fiscal year.

(b) Not later than thirty (30) days before the start of each state fiscal year, the office shall notify each managed care organization of the managed care organization's annual assessment and the installment due dates for the assessment.

Sec. 9. (a) The managed care assessment fund is established for the purpose of holding the fees collected under this chapter.

(b) The office shall administer the fund.

(c) Money in the fund consists of the following:

(1) Fees collected under this chapter, including penalty payments under section 11 of this chapter.

(2) Donations, gifts, appropriations by the general assembly, and money received from any other source.

(3) Interest accrued under this section.

(d) Money remaining in the fund at the end of a state fiscal year does not revert to the state general fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

Sec. 10. (a) A managed care organization that is liable for an

assessment under this chapter shall keep accurate and complete records and pertinent documents that are relevant to the organization's assessment under this chapter, as may be required by the department or the office.

(b) The department or the office may audit all records necessary to ensure compliance with this chapter and make adjustments to assessment amounts previously calculated based on the results of any the audit.

Sec. 11. (a) For good cause shown by a managed care organization due to financial or other difficulties, as determined by the office, the office is authorized to grant grace periods, of up to thirty (30) days, for the managed care organization's payment of an installment payment due under this chapter.

(b) If a managed care organization that is liable for an assessment under this chapter fails to make an installment payment by the payment's due date, and no grace period has been granted to the managed care organization for the payment of the installment payment, the managed care organization shall pay a penalty of ten percent (10%) of the amount of the installment payment not paid, plus ten percent (10%) of the portion remaining unpaid on the last day of every thirty (30) day period thereafter. These penalty payments shall be deposited into the managed care assessment fund.

(c) If a managed care organization that is liable for an assessment under this chapter is granted a grace period but fails to make its installment payment by the end of the grace period, the managed care organization shall pay a penalty of five percent (5%) of the amount of the installment payment not paid, plus five percent (5%) of the portion remaining unpaid on the last day of every thirty (30) day period thereafter. These penalty payments shall be deposited into the managed care assessment fund.

(d) Notwithstanding subsections (b) and (c), with respect to a managed care organization that has a comprehensive risk contract with the office under IC 12-15 that fails to make an installment payment not later than sixty (60) days after the due date or, if applicable, not later than sixty (60) days after the end of a grace period, the office may additionally impose a contractual sanction allowed against the managed care organization, and may terminate the contract with the office.

(e) Notwithstanding subsections (b) through (d), with respect to a managed care organization that fails to make an installment payment not later than sixty (60) days after the due date or, if

applicable, not later than sixty (60) days after the end of a grace period, the department may suspend or revoke, after notice and hearing, the managed care organization's certificate of authority, license, or other authority to operate in Indiana.

Sec. 12. The office may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 30. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "preprint" means the document required to be submitted to the United States Department of Health and Human Services that implements the prior approval process for a state directed payment arrangement described in 42 CFR 438.6(c).**

(b) The office of the secretary of family and social services shall amend 405 IAC 1-8-5 and 405 IAC 1-10.5-7 to reflect the amendments in this act and any Medicaid state plan amendment, Medicaid waiver, or preprint submitted for purposes of 42 CFR 438.6(c):

(1) submitted to the budget committee in accordance with IC 12-15-1.3-17.5; and

(2) approved by the United States Department of Health and Human Services.

The office of the secretary may adopt the changes required by this subsection as provisional rules or interim rules in the manner set forth in IC 4-22-2.

(c) The administrative rules amended under subsection (b) are effective and may be retroactive to the date the United States Department of Health and Human Services approved a Medicaid state plan amendment or Medicaid waiver described in subsection (b).

(d) Notwithstanding the expiration dates in IC 4-22-2, if the office of the secretary adopts the changes to the administrative rules as required in subsection (b) through a provisional or an interim rule, the provisional or interim rule expires not later than the earlier of the following:

(1) The date on which a rule that supersedes the provisional or interim rule is adopted by the office of the secretary under IC 4-22-2-19.7 through IC 4-22-2-36.

(2) July 1, 2027.

(d) This SECTION expires July 1, 2027.

SECTION 31. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1004, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 6-8-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 15.8. Hospital Facility Fee Excise Tax

Sec. 1. This chapter applies to a facility fee charged to a qualifying patient for medical care provided after December 31, 2025.

Sec. 2. As used in this chapter, "account" refers to the hospital facility fee excise tax account established by section 11 of this chapter.

Sec. 3. As used in this chapter, "department" means the department of state revenue.

Sec. 4. As used in this chapter, "facility fee" refers to a fee that is charged by a hospital:

(1) to recover costs incurred to maintain the hospital's facilities; and

(2) in addition to the amounts charged for services, medications, supplies, nutrition, and hydration provided by the hospital.

Sec. 5. As used in this chapter, "hospital" refers to a hospital licensed under IC 16-21 that is not a critical access hospital that meets the criteria under 42 CFR 485.601 et seq.

Sec. 6. As used in this chapter, "Medicare facility fee"refers to the average amount charged as a facility fee to individuals enrolled in Medicare for a particular service as determined by the secretary of health and family services under section 13 of this chapter.

Sec. 7. As used in this chapter, "qualifying patient" refers to a patient who is not enrolled in Medicare and is charged a facility fee that exceeds two hundred sixty-five percent (265%) of the Medicare facility fee charged for the same services.

Sec. 8. For services provided after December 31, 2025, the hospital facility fee excise tax is imposed upon a hospital each time

the hospital charges a qualifying patient a facility fee that exceeds two hundred sixty-five percent (265%) of the Medicare facility fee. The hospital facility fee excise tax is imposed upon the hospital at the following rates:

(1) For calendar year 2026, thirty-three percent (33%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the Medicare facility fee.

(2) For calendar year 2027, sixty-six percent (66%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the Medicare facility fee.

(3) For calendar year 2028 and each year thereafter, one hundred percent (100%) of the amount that the facility fee charged to the qualifying patient exceeded two hundred sixty-five percent (265%) of the Medicare facility fee.

Sec. 9. Before the tenth day of each month, a hospital shall remit the hospital facility fee excise taxes imposed upon the hospital in the previous calendar month to the department in the manner prescribed by the department.

Sec. 10. The department shall transfer the hospital facility fee excise taxes received each month to the treasurer of state for deposit in the account established by section 11 of this chapter.

Sec. 11. (a) The hospital facility fee excise tax account is established within the state general fund. The account consists of the hospital facility fee excise taxes remitted to the department under this chapter.

(b) Except as provided in subsection (c), money in the account must be used as follows:

(1) Seventy-five percent (75%) for any lawful purpose of the Medicaid program under IC 12-15.

(2) Twenty-five percent (25%) for developing the health care workforce serving rural areas of Indiana.

(c) The secretary of health and family services may change the allocation of money set forth in subsection (b) after making and publishing on an appropriate website a finding that the new allocation will be more beneficial to the people of Indiana.

Sec. 12. Money in the account is continuously appropriated to the secretary of health and family services for the purposes described in section 11 of this chapter.

Sec. 13. For each service provided by hospitals subject to this chapter the secretary of health and family services shall determine

the average facility fee charged to individuals enrolled in Medicare for the service.

SECTION 2. IC 6-8.1-1-1, AS AMENDED BY P.L.1-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1. "Listed taxes" or "taxes" includes only the pari-mutuel taxes (IC 4-31-9-3 through IC 4-31-9-5); the supplemental wagering tax (IC 4-33-12); the riverboat wagering tax (IC 4-33-13); the slot machine wagering tax (IC 4-35-8); the type II gambling game excise tax (IC 4-36-9); the gross income tax (IC 6-2.1) (repealed); the utility receipts and utility services use taxes (IC 6-2.3) (repealed); the state gross retail and use taxes (IC 6-2.5); the adjusted gross income tax (IC 6-3); the pass through entity tax (IC 6-3-2.1); the supplemental net income tax (IC 6-3-8) (repealed); the county adjusted gross income tax (IC 6-3.5-1.1) (repealed); the county option income tax (IC 6-3.5-6) (repealed); the county economic development income tax (IC 6-3.5-7) (repealed); the local income tax (IC 6-3.6); the auto rental excise tax (IC 6-6-9); the financial institutions tax (IC 6-5.5); the gasoline tax (IC 6-6-1.1); the special fuel tax (IC 6-6-2.5); the motor carrier fuel tax (IC 6-6-4.1); a motor fuel tax collected under a reciprocal agreement under IC 6-8.1-3; the vehicle excise tax (IC 6-6-5); the aviation fuel excise tax (IC 6-6-13); the commercial vehicle excise tax (IC 6-6-5.5); the excise tax imposed on recreational vehicles and truck campers (IC 6-6-5.1); the hazardous waste disposal tax (IC 6-6-6.6) (repealed); the heavy equipment rental excise tax (IC 6-6-15); the vehicle sharing excise tax (IC 6-6-16); the cigarette tax (IC 6-7-1); the closed system cartridge tax (IC 6-7-2-7.5); the electronic cigarette tax (IC 6-7-4); the beer excise tax (IC 7.1-4-2); the liquor excise tax (IC 7.1-4-3); the wine excise tax (IC 7.1-4-4); the hard cider excise tax (IC 7.1-4-4.5); the petroleum severance tax (IC 6-8-1); **the hospital facility fee excise tax (IC 6-8-15.8);** the various innkeeper's taxes (IC 6-9); the various food and beverage taxes (IC 6-9); the county admissions tax (IC 6-9-13 and IC 6-9-28); the oil inspection fee (IC 16-44-2); the penalties assessed for oversize vehicles (IC 9-20-3 and IC 9-20-18); the fees and penalties assessed for overweight vehicles (IC 9-20-4 and IC 9-20-18); and any other tax or fee that the department is required to collect or administer.".

Page 2, line 16, after "department" insert "**and the department of insurance**".

Page 2, line 21, delete "two hundred percent (200%)" and insert "**three hundred percent (300%)**".

Page 2, line 25, delete "secretary of state." and insert "**department of insurance.**".

Page 2, line 37, delete "shall:" and insert "**shall do the following:**".

Page 2, delete lines 38 through 41, begin a new line block indented and insert:

"**(1) Provide the health care cost oversight task force (established by IC 2-5-47-3) with the entirety of the Schedule H portion of the nonprofit hospital's previous taxable year's federal Form 990, including the following forms:**

(A) Federal form 990, Schedule H, Part I, 7(a), financial assistance at cost, worksheet 1 or other similar documentation, or its successor form or schedule.

(B) Federal form 990, Schedule H, Part I, 7(b), Medicaid, worksheet 3, column a, or its successor form or schedule.

(C) Federal form 990, Schedule H, Part I, 7(c), costs of other means-tested government programs, worksheet 3, column b, or its successor form or schedule.

(D) Federal form 990, Schedule H, Part I, 7(e), community health improvement services and community benefit operations, worksheet 4 or other similar documentation, or its successor form or schedule.

(E) Federal form 990, Schedule H, Part I, 7(f), health professions education, worksheet 5 or other similar documentation, or its successor form or schedule.

(F) Federal form 990, Schedule H, Part I, 7(g), subsidized health services, worksheet 6 or other similar documentation, or its successor form or schedule.

(G) Federal form 990, Schedule H, Part I, 7(h), research, worksheet 7 or other similar documentation, or its successor form or schedule.

(H) Federal form 990, Schedule H, Part I, 7(i), cash and in kind contributions for community benefit, worksheet 8, or its successor form or schedule.

(I) Federal form 990, Schedule H, Part II, community building activities, lines 1 through 9, or its successor form or schedule, and including specific initiatives and related net expenses for each line.

(J) Federal form 990, Schedule H, Part III, section A, bad debt expense, lines 2 through 3, or its successor form or schedule, and including calculations to support the data entered.

(K) Federal form 990, Schedule H, Part III, section B, Medicare, lines 5 through 7, or its successor form or schedule, and including calculations to support the data

entered.".

Page 2, line 42, delete "make" and insert "**Make**".

Page 3, line 2, delete "990." and insert "**990 and the forms described in subdivision (1).**".

Page 3, line 3, delete "Prior to" and insert "**Before**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1004 as introduced.)

BARRETT

Committee Vote: yeas 9, nays 2.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1004, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 3. IC 12-15-16-1, AS AMENDED BY P.L.76-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) A provider that is an acute care hospital licensed under IC 16-21, a state mental health institution under IC 12-24-1-3, or a private psychiatric institution licensed under IC 12-25 is a disproportionate share provider if the provider meets either of the following conditions:

(1) The provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana. However, the Medicaid inpatient utilization rate of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient utilization rate.

(2) The provider's low income utilization rate exceeds twenty-five percent (25%).

(b) An acute care hospital licensed under IC 16-21 is a municipal disproportionate share provider if the hospital:

(1) has a Medicaid utilization rate greater than one percent (1%);

and

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

(c) A community mental health center:

(1) that is identified in IC 12-29-2-1;

(2) for which a county provides funds under:

(A) IC 12-29-1-7(b) before January 1, 2004; or

(B) IC 12-29-2 after December 31, 2018;

or from other county sources; and

(3) that provides inpatient services to Medicaid patients;

is a community mental health center disproportionate share provider if the community mental health center's Medicaid inpatient utilization rate is greater than one percent (1%).

(d) A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. However, this obstetric service requirement does not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

(e) The determination of a provider's status as a disproportionate share provider under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office.

(f) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 4. IC 12-15-16-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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 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 5. IC 12-15-16-7, AS AMENDED BY P.L.108-2019, SECTION 195, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE] : Sec. 7. (a) Except as provided in **subsection (j) and** ~~sections 7.5 and~~ **section** 7.7 of this chapter, this section applies to Medicaid disproportionate share payments for the state fiscal year beginning:

(1) July 1, 2012, if hospital fees authorized under P.L.229-2011, SECTION 281 or authorized to be transferred and used for payments are used as state share dollars for the payments; and

(2) July 1, 2013, and for each state fiscal year after, for which hospital fees authorized under IC 16-21-10 are used as state share dollars for the payments.

~~(b) As used in this section, "hospital assessment fee committee" refers to the committee established by IC 16-21-10-7.~~

~~(c)~~ **(b)** As used in this section, "hospital specific limit" refers to the hospital specific limit provided under 42 U.S.C. 1396r-4(g).

~~(d)~~ **(c)** As used in this section, "municipal hospital payment amount" means, concerning a hospital established and operated under IC 16-22-2 or IC 16-23, an amount equal to the lesser of:

(1) the hospital specific limit for the hospital for the state fiscal year; or

(2) the hospital's net 2009 supplemental payment amount.

~~(e)~~ **(d)** As used in this section, "nongovernmental hospital" refers to a hospital that is licensed under IC 16-21-2, that is not a unit of state or local government, and is not owned or operated by a unit of state or local government.

~~(f) As used in this section, "SECTION 281 hospital assessment fee committee" refers to the hospital assessment fee committee established by P.L.229-2011, SECTION 281, subsection (e).~~

~~(g)~~ **(e) Subject to subsection (j),** the following providers are eligible for Medicaid disproportionate share payments under this section:

(1) A hospital or psychiatric institution described in Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect July 1, 2011.

(2) A hospital that satisfies the following for the state fiscal year

for which Medicaid disproportionate share payments are made under this section:

(A) A nongovernmental hospital that:

(i) has a Medicaid inpatient utilization rate for the state fiscal year that is at least equal to the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but does not equal or exceed one (1) standard deviation above the mean Medicaid inpatient utilization rate; and

(ii) satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

(B) A hospital established and operated under IC 16-22-2 or IC 16-23 that:

(i) has a Medicaid inpatient utilization rate for the state fiscal year greater than one percent (1%); and

(ii) satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

(3) A nongovernmental hospital that satisfies the following for the state fiscal year for which Medicaid disproportionate share payments are made under this section:

(A) The hospital has a Medicaid inpatient utilization rate for the state fiscal year that is less than the mean Medicaid inpatient utilization rate, as calculated for purposes of determining Medicaid disproportionate share eligibility, but is at least greater than one percent (1%).

(B) The hospital satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d).

~~(h)~~ **(f)** This subsection applies to a payment of Medicaid disproportionate share payments, if any, to hospitals described in subsection ~~(g)(2)~~ **(e)(2)** and ~~(g)(3).~~ **(e)(3).** For Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2012, the office ~~subject to approval by the SECTION 281 hospital assessment fee committee,~~ may develop and implement a Medicaid state plan amendment that provides Medicaid disproportionate share payments for the hospitals described in:

(1) subsection ~~(g)(2),~~ **(e)(2),** as long as each hospital and psychiatric institution described in subsection ~~(g)(1)~~ **(e)(1)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to either:

(A) the hospital specific limit; or

(B) the municipal hospital payment amount;

for the hospital or psychiatric institution for the state fiscal year;

and

(2) subsection ~~(g)(3),~~ **(e)(3),** as long as each hospital described in subsection ~~(g)(2)~~ **(e)(2)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the hospital specific limit for the hospital for the state fiscal year.

~~(i)~~ **(g)** This subsection applies to a payment of Medicaid disproportionate share payments, if any, to hospitals described in subsection ~~(g)(2)~~ **(e)(2)** and ~~(g)(3).~~ **(e)(3).** For Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter under this section, the office ~~subject to the approval by the hospital assessment fee committee,~~ may develop and implement a Medicaid state plan amendment that:

(1) renews, for state fiscal year beginning July 1, 2013, and each state fiscal year thereafter under this section, the Medicaid disproportionate share provisions of Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect on July 1, 2011;

(2) provides Medicaid disproportionate share payments for the hospitals described in subsection ~~(g)(2),~~ **(e)(2),** as long as each hospital and psychiatric institution described in subsection ~~(g)(1)~~ **(e)(1)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the:

(A) hospital specific limit; or

(B) municipal hospital payment amount;

for the hospital or psychiatric institution for the state fiscal year; and

(3) provides Medicaid disproportionate share payments for the hospitals described in subsection ~~(g)(3),~~ **(e)(3),** as long as each hospital described in subsection ~~(g)(2)~~ **(e)(2)** has received a Medicaid disproportionate share payment for the state fiscal year in an amount equal to the hospital specific limit of the hospital for the state fiscal year.

~~(j)~~ **(h)** This subsection does not apply to Medicaid disproportionate share payments made to hospitals described in subsection ~~(g)(2)(B)~~ **(e)(2)(B)** under Attachment 4.19-A, Section III, page 6.1(a) of the Medicaid state plan in effect on July 1, 2011, or any renewal. Nothing in this section:

(1) requires that the hospitals described in subsection ~~(g)(2)~~ **(e)(2)** or ~~(g)(3)~~ **(e)(3)** receive Medicaid disproportionate share payments for a state fiscal year;

(2) requires that the hospitals described in subsection ~~(g)(2)~~ **(e)(2)** or ~~(g)(3)~~ **(e)(3)** receive Medicaid disproportionate share payments

for a state fiscal year in an amount equal to the respective hospital specific limits for the state fiscal year; or

(3) prescribes how Medicaid disproportionate share payments are to be distributed among the hospitals described in:

(A) subsection ~~(g)(2);~~ **(e)(2);** or

(B) subsection ~~(g)(3).~~ **(e)(3).**

~~(k)~~ **(i)** Nothing in this section prohibits the use of unexpended federal Medicaid disproportionate share allotments for a state fiscal year under a program, ~~authorized by the SECTION 281 hospital assessment fee committee or the hospital assessment fee committee~~, as long as each hospital listed in subsection ~~(g)(1), (g)(2),~~ **(e)(1), (e)(2),** and ~~(g)(3)~~ **(e)(3)** has received Medicaid disproportionate share payments for the state fiscal year equal to the hospital specific limit for the hospital for the state fiscal year.

(j) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 6. IC 12-15-16-7.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 7.3. (a) This section applies to disproportionate share payments for any state fiscal year during which the state directed payment program under IC 16-21-10-8.5 is in effect.**

(b) The office shall develop and implement a Medicaid state plan amendment that provides Medicaid disproportionate share payments for hospitals pursuant to the following STEPS:

STEP ONE: Each acute care hospital licensed under IC 16-21 that qualifies as a disproportionate share provider under section 1(a) of this chapter, including acute care hospitals licensed under IC 16-21 and established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23 that qualify as a disproportionate share provider under section 1(a) of this chapter, shall be paid a disproportionate share payment for the state fiscal year in the amount of one thousand dollars ($1,000).

STEP TWO: Of the state's disproportionate share payment allotment under 42 CFR 447.297 that remains for the state fiscal year following STEP ONE, disproportionate share payments shall be paid to municipal disproportionate share providers described in section 1(b) of this chapter, and to acute care hospitals licensed under IC 16-21 and established and operated under IC 16-22-8 that qualify as a

disproportionate share provider under section 1(a) of this chapter, that fund the state's share of their disproportionate share payment for the state fiscal year through an intergovernmental transfer. Subject to subsection (c), each hospital's payment shall be an amount equal to its hospital specific limit for the state fiscal year calculated pursuant to 42 U.S.C. 1396r-4(g).

(c) If the total disproportionate share payments under STEP TWO of subsection (b) for a state fiscal year would be greater than the state's disproportionate share payment allotment under 42 CFR 447.297 that remains following STEP ONE of subsection (b), the disproportionate share payments to each hospital eligible under STEP TWO shall be made on a pro rata basis, based on each hospital's hospital specific limit in relation to the remaining disproportionate share payment allotment.

SECTION 7. IC 12-15-16-7.7, AS AMENDED BY P.L.156-2020, SECTION 55, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7.7. (a) As used in this section, "CMS" refers to the federal Centers for Medicare and Medicaid Services.

~~(b) As used in this section, "default plan" refers to a plan for distributing Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2020, and, at the discretion of the hospital assessment fee committee, for any state fiscal year beginning after July 1, 2020, and meets the requirements set forth in subsection (i).~~

~~(c)~~ **(b)** As used in this section, "disproportionate share payment plan" refers to a plan for distributing disproportionate share payments for the state fiscal year beginning July 1, 2020, ~~and at the discretion of the hospital assessment fee committee,~~ for any state fiscal year beginning after July 1, 2020, and that meets the requirements set forth in ~~subsection (h).~~ **this section.**

~~(d)~~ **(c)** As used in this section, "federal DSH allotment" refers to the allotment of federal disproportionate share funds calculated for the state under 42 U.S.C. 1396r-4.

~~(e) As used in this section, "hospital assessment fee committee" refers to the committee established by IC 16-21-10-7.~~

~~(f)~~ **(d)** As used in this section, "reduced federal DSH allotment" refers to a federal DSH allotment for the state for the federal fiscal year beginning October 1, 2020, that, by operation of 42 U.S.C. 1396r-4(f)(7), is less than the federal DSH allotment for the state for the federal fiscal year beginning October 1, 2018.

~~(g)~~ **(e)** As used in this section, "terminating event" refers to federal legislation (including an amendment to 42 U.S.C. 1396r-4), a

regulation or sub-regulatory policy or directive issued by CMS, or a judicial ruling, that is enacted or issued on or before March 30, 2021, that:

(1) cancels, or postpones to a subsequent federal fiscal year, a reduced federal DSH allotment; and

(2) does not cause the state to incur a reduced federal DSH allotment.

~~(h)~~ **(f)** ~~Subject to subsection (i),~~ The ~~hospital assessment fee committee~~ **office** shall develop a disproportionate share payment plan. ~~and submit the disproportionate share payment plan to the office.~~ The following apply to the disproportionate share payment plan developed under this subsection:

(1) The disproportionate share payment plan must:

(A) specify the amount or amounts of disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 and private mental health institutions licensed under IC 12-25 for the state fiscal year beginning on or after July 1, 2020; or

(B) specify the formula to be used by the office for purposes of determining the amount or amounts of disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 and private mental health institutions licensed under IC 12-25 for the state fiscal year beginning on or after July 1, 2020.

(2) In developing the disproportionate share payment plan, the ~~hospital assessment fee committee~~ **office** is not required to:

(A) follow paragraphs 1 through 7 of Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019;

(B) provide for disproportionate share payment adjustments to be paid to acute care hospitals licensed under IC 16-21-2 or private mental health institutions licensed under IC 12-25 that, for purposes of the state fiscal year beginning on or after July 1, 2020, do not meet the definition of a "disproportionate share hospital" as set forth in Section II(E) of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019; or

(C) follow the provisions set forth in section 7.5 of this chapter.

(3) In developing the disproportionate share payment plan, the ~~hospital assessment fee committee~~ **office** shall take into consideration the percentage of a hospital's patients whose health

care coverage is provided by a governmental health care program.

~~(i) If the hospital assessment fee committee is unable to develop a disproportionate share payment plan, the hospital assessment fee committee shall submit the default plan to the office. The following apply to the default plan:~~

~~(1) The disproportionate share payments that would otherwise be paid to an acute care hospital under Step Two, Step Three, or Step Four of Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid state plan in effect on January 1, 2019, without the reduction provided for in section 7.5 of this chapter, shall be reduced by a single percentage that is applied uniformly to all hospitals described in this subdivision.~~

~~(2) The percentage of the reduction in disproportionate share payments under subdivision (1) shall be the percentage determined by the hospital assessment fee committee to cause the total disproportionate share payments made to maximize the expenditure of, without exceeding, the reduced federal DSH allotment.~~

~~If agreed to by the hospital assessment fee committee, the default plan may also include other terms and conditions that the committee determines to be necessary for the proper implementation and administration of the default plan.~~

~~(j)~~ **(g)** After the office submits the state plan amendment described in section 7.5 of this chapter, but before October 1, 2020, the office shall file with CMS and, if approved by CMS, the office shall implement, a proposed Medicaid state plan amendment that is based upon ~~either~~ the disproportionate share payment plan developed by the ~~hospital assessment fee committee or the default plan submitted by the hospital assessment fee committee,~~ **office,** subject to the following:

(1) The proposed Medicaid state plan amendment referred to in this subsection shall include language that, in the event a terminating event occurs after the Medicaid state plan amendment is approved by the CMS but before March 30, 2021, would operate to cause the state plan amendment to be immediately and automatically void and without effect, and to cause Subsection A of Section III of Attachment 4.19-A of the state's Medicaid state plan, in effect on January 1, 2019, to be immediately and automatically reinstated and effective.

(2) Subdivision (1) does not prevent the office from submitting a subsequent Medicaid state plan amendment for approval by CMS after CMS's approval of the state plan amendment referenced in subdivision (1) and that applies to a state fiscal year beginning on

or after July 1, 2021, and that amends or replaces the state plan amendment described in this subsection.

~~(k) Before filing the proposed Medicaid state plan amendment with CMS, the proposed Medicaid state plan amendment referenced in subsection (j) shall be submitted by the office to the hospital assessment fee committee for the committee's approval.~~

~~(l) The hospital assessment fee committee shall coordinate with the office so that the disproportionate share payment plan, or the default plan, if applicable, is prepared and submitted to the office under subsection (h) or (i), if applicable, and the committee's approval of the proposed state plan amendment under subsection (k), is obtained in sufficient time so as to enable the office to file the proposed Medicaid state plan amendment with CMS before October 1, 2020.~~

~~(m) The office shall regularly update the hospital assessment fee committee regarding the status of the proposed Medicaid state plan amendment. All questions, proposals, directives, requirements, and other communications received by the office from CMS concerning the proposed Medicaid state plan amendment shall be provided to the committee within a reasonable time after receipt by the office. Upon request by the hospital assessment fee committee or the office, the office and the hospital assessment fee committee shall meet to confer concerning the proposed state plan amendment.~~

~~(n) If:~~

~~(1) a terminating event occurs before the office submits the proposed Medicaid state plan amendment to CMS under subsection (j), the hospital assessment fee committee and the office shall cease their work on the disproportionate share payment plan, or the default plan if applicable, and the proposed Medicaid state plan amendment, and the office shall not submit the proposed state plan amendment to CMS; or~~

~~(2) a terminating event occurs after the office submits the proposed Medicaid state plan amendment to CMS under subsection (h), but before CMS approves a state plan amendment that implements the disproportionate share payment plan, or the default plan if applicable, the office shall immediately notify CMS of the office's intent to withdraw the proposed Medicaid state plan amendment and otherwise act so as to accomplish the immediate withdrawal of the proposed Medicaid state plan amendment.~~

~~(o) In the event a provision of this section conflicts with another provision of this article, the provisions of this section shall control.~~

SECTION 8. IC 12-15-18-5.1, AS AMENDED BY P.L.76-2018,

SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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.

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:

(1) IC 12-29-1-7(b) before January 1, 2004; or

(2) IC 12-29-2 after December 31, 2018;

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.

(f) This section does not apply for a state fiscal year for which the state directed payment program under IC 16-21-10-8.5 is in effect.

SECTION 9. IC 12-15-44.5-4, AS AMENDED BY P.L.30-2016, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The plan:

(1) is not an entitlement program; and

(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(b) If either of the following occurs, the office shall terminate the plan in accordance with section 6(b) of this chapter:

(1) The:

(A) percentages of federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are less than the percentages provided for in Section 2001(a)(3)(B) of the federal Patient Protection and Affordable Care Act; and

(B) ~~hospital assessment committee (IC 16-21-10),~~ **office,** after considering the modification and the reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance; **or**

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in federal medical assistance.

For purposes of this subdivision, "coverage of plan participants" includes **reimbursement,** payments, contributions, and amounts referred to in IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and IC 16-21-10-13.3(b)(1)(D), including **reimbursement,** payments, contributions, and amounts incurred during a phase out period of the plan.

(2) The:

(A) methodology of calculating the incremental fee set forth in IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) ~~hospital assessment fee committee (IC 16-21-10),~~ **office,** after considering the modification and reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in fees; **or**

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in fees; and

(C) office does not use alternative financial support to cover the amount of the reduction in fees.

(c) If the plan is terminated under subsection (b), the secretary may implement a plan for coverage of the affected population in a manner consistent with the healthy Indiana plan (IC 12-15-44.2 (before its repeal)) in effect on January 1, 2014:

(1) subject to prior approval of the United States Department of Health and Human Services; and

(2) ~~without~~ **using** funding from the incremental fee set forth in IC 16-21-10-13.3.

(d) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(e) The office of the secretary shall submit annually to the budget committee an actuarial analysis of the plan that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan.

SECTION 10. IC 12-15-44.5-6, AS AMENDED BY P.L.93-2024, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) For a state fiscal year beginning July 1, 2018, and before July 1, 2024, the office, after review by the state budget committee, may determine that no incremental fees collected under IC 16-21-10-13.3 are required to be deposited into the phase out trust fund established under section 7 of this chapter. This subsection expires July 1, 2024.

(b) If the plan is to be terminated for any reason, the office shall,

~~(1)~~ if required, provide notice of termination of the plan to the United States Department of Health and Human Services and begin the process of phasing out the plan. ~~or~~

~~(2) if notice and a phase out plan is not required under federal law, notify the hospital assessment fee committee (IC 16-21-10) of the office's intent to terminate the plan and the plan shall be phased out under a procedure approved by the hospital~~

~~assessment fee committee.~~

~~The office may not submit any phase out plan to the United States Department of Health and Human Services or accept any phase out plan proposed by the Department of Health and Human Services without the prior approval of the hospital assessment fee committee.~~

(c) Before submitting:

(1) an extension of; or

(2) a material amendment to;

the plan to the United States Department of Health and Human Services, the office shall inform the Indiana Hospital Association of the extension or material amendment to the plan.

SECTION 11. IC 16-18-2-339.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 339.5. "State directed payment program", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-5.7.**".

Page 4, between lines 27 and 28, begin a new paragraph and insert:

"SECTION 13. IC 16-21-10-1 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 1. As used in this chapter, "committee" refers to the hospital assessment fee committee established by section 7 of this chapter.~~

SECTION 14. IC 16-21-10-4, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) As used in this chapter, "hospital" means either of the following:

(1) A hospital (as defined in IC 16-18-2-179(b)) licensed under this article.

(2) A private psychiatric hospital licensed under IC 12-25.

(b) The term does not include the following:

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

(2) A hospital:

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

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

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

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

(c) As used in this section, "physician owned hospital" means an acute care hospital licensed under IC 16-21-2 that has:

(1) physician ownership; or

(2) ownership by a legal entity with one hundred percent (100%) physician ownership;

or ownership described in both subdivisions (1) and (2), and such ownership of the hospital is at least fifty-one percent (51%).

(d) The office may, subject to approval from the United States Department of Health and Human Services, exclude any of the following from the term for purposes of this chapter:

(1) A physician owned hospital.

(2) A class of hospitals, as determined by the office.

SECTION 15. IC 16-21-10-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5.7. As used in this chapter, "state directed payment program" means a payment arrangement under section 8.5 of this chapter and authorized under 42 CFR 438.6(c) that allows the office to direct specific payments to a hospital by the managed care organizations that contract with the office to provide health coverage to Medicaid recipients.**

SECTION 16. IC 16-21-10-6, AS AMENDED BY P.L.213-2015, SECTION 141, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) Subject to subsection ~~(b)~~ **(d)** and section 8(b) of this chapter, the office may assess a hospital assessment fee to hospitals during the fee period if the following conditions are met:

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

(A) Section 8(c)(1) of this chapter.

(B) Section 8.5 of this chapter.

~~(B)~~ **(C)** Section 9 of this chapter.

~~(C)~~ **(D)** Section 11 of this chapter.

~~(D)~~ **(E)** Section 13.3 of this chapter.

~~(E)~~ **(F)** Section 14 of this chapter.

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

~~(3) The United States Department of Health and Human Services approves the Medicaid state plan amendments and waiver requests, or revisions of the Medicaid state plan amendments and waiver requests, described in subdivision (2):~~

~~(A) not later than October 1, 2014; or~~

~~(B) after October 1, 2014, if a date is established by the committee.~~

~~(4)~~ **(2)** The funds generated from the fee do not revert to the state general fund.

(b) The office may request a waiver from the United States Department of Health and Human Services of the broad based and uniformity requirements set forth in 42 CFR 433.68 concerning the assessment under this chapter.

(c) Subject to subsection (a), the office may assess the fee:

(1) on a tiered basis among the hospitals; and

(2) based on net patient revenue, inpatient days, or another methodology approved by the United States Department of Health and Human Services.

~~(b)~~ **(d)** The office shall stop collecting a fee, the programs described in section 8(a) of this chapter shall be reconciled and terminated subject to section 9(c) of this chapter, and the operation of section 11 of this chapter, **subject to section 11(d) and 11(e) of this chapter,** ends subject to section 9(c) of this chapter, if any of the following occurs:

(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)~~ **(e)** The office shall keep records of the fees collected by the office and report the amount of fees collected under this chapter to the budget committee.

SECTION 17. IC 16-21-10-7 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~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 appointed under IC 12-8-1.5-2 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.~~

~~The committee members described in subdivision (3) serve at the pleasure of the governor. If a vacancy occurs among the members appointed under subdivision (3), the governor shall appoint a replacement committee member from a list of at least two (2) 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. The committee shall also develop a disproportionate share payment plan or submit to the office the default plan, if applicable, as set forth in IC 12-15-16-7.5 and IC 12-15-16-7.7.~~

~~(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 necessary to approve Medicaid state plan amendments, waiver requests, revisions to the Medicaid state plan or waiver requests, and the approvals and other determinations required of the committee under IC 12-15-44.5 and section 13.3 of this chapter.~~

~~(e) The following apply to the approvals and any other determinations required by the committee under IC 12-15-44.5 and section 13.3 of this chapter:~~

~~(1) The committee shall be guided and subject to the intent of the general assembly in the passage of IC 12-15-44.5 and section 13.3 of this chapter.~~

~~(2) The chair of the committee shall report any approval and other determination by the committee to the budget committee.~~

~~(3) If, in taking action, the committee's vote is tied, the committee shall follow the following procedure:~~

~~(A) The chair of the committee shall notify the chairman of the budget committee of the tied vote and provide a summary of that matter that was the subject of the vote.~~

~~(B) The chairman of the budget committee shall provide each committee member who voted an opportunity to appear before the budget committee to present information and materials to the budget committee concerning the matter that was the subject of the tied vote.~~

~~(C) Following a presentation of the information and the materials described in clause (B), the budget committee may~~

~~make recommendations to the committee concerning the matter that was the subject of the tied vote.~~

SECTION 18. IC 16-21-10-8, AS AMENDED BY P.L.213-2015, SECTION 143, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) This section does not apply to the use of the incremental fee described in section 13.3 of this chapter. Subject to subsection (b), the office ~~shall~~ **may** develop the following programs designed to increase ~~to the extent allowable under federal law,~~ Medicaid reimbursement for inpatient and outpatient hospital services provided by a hospital to Medicaid recipients:

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

(2) A program concerning reimbursement for the Medicaid risk based managed care program that, in the aggregate, will result in payments equivalent to the level of payment that would be paid under federal Medicare payment principles, **and up to any reimbursement approved under a state directed payment program set forth in section 8.5 of this chapter.**

(b) The office shall not submit to the United States Department of Health and Human Services 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 until the ~~committee has reviewed and approved the amendments, waivers, or revisions described in this subsection and~~ **office** has submitted a written report to the budget committee concerning the amendments, waivers, or revisions described in this subsection, including the following:

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

(2) The methodology to be used by the office in calculating, imposing, or collecting the fee, or any other matter relating to the fee.

(3) The determination of Medicaid disproportionate share allotments under section 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** that are to be funded by the fee, including the formula for distributing the Medicaid disproportionate share allotments.

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

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

(1) Fees paid under this chapter.

(2) The hospital care for the indigent funds allocated under section 10 of this chapter **(before its repeal).**

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

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

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

~~(1) the committee:~~

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

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

~~(2)~~ the United States Department of Health and Human Services does not approve an increase in the fee,

the office shall cease to collect the fee and the programs described in subsection (a) are terminated.

SECTION 19. IC 16-21-10-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8.5. (a) Beginning July 1, 2025, or thereafter, the office may implement a state directed payment program in which payments are made for inpatient and outpatient hospital services as follows:**

(1) Subject to available state share funding and federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act in effect on January 1, 2025, the reimbursement rates for inpatient and outpatient hospital services under the state directed payment program may be established at a rate greater than Medicare equivalent reimbursement rates, but may not exceed the maximum

reimbursement rates established by federal law.

(2) The office may implement the state directed payment program through the establishment of classes of hospitals with different rates of reimbursement among the classes, in a manner that is consistent with federal law.

(3) Before January 1, 2026, the office shall apply to the United States Department of Health and Human Services for the review and approval of a state directed payment program. The office may receive input from hospitals and other interested parties in the development of the documentation submitted with the application under this subdivision.

(4) The office may not implement the state directed payment program without the approval of the United States Department of Health and Human Services. To the extent allowed by the United States Department of Health and Human Services, the office shall implement the self directed payment program on or after July 1, 2025.

(5) The office may not implement a fee under the state directed payment program without the approval of the fee by the United States Department of Health and Human Services, including any waiver related to the fee, to fund the state share of the payments under the state directed payment program. To the extent allowed by the United States Department of Health and Human Services, the office shall use the fee to fund the state directed payment program on or after July 1, 2025.

(6) The office shall make payments under the state directed payment program to managed care organizations that contract with the office to provide medical assistance to Medicaid recipients as follows:

(A) Except as provided in clause (B), capitation payments at levels necessary to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates established under subdivision (1). The fee must be used to pay the state share of the part of the capitation payments that fund the portion of the reimbursement rates that exceed the reimbursement rates in effect on June 30, 2011.

(B) For plan enrollees described in section 13.3(b)(1)(A) of this chapter, capitation payments at level sufficient to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates

established by subdivision (1). The incremental fee shall fund the entire state share of these capitation payments.

SECTION 20. IC 16-21-10-9, AS AMENDED BY P.L.213-2015, SECTION 144, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. (a) This section is effective upon implementation of the fee. The hospital Medicaid fee fund is established for the purpose of holding fees collected under section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 ~~if~~ **of** this chapter, that are not necessary to match federal funds.

(b) The office shall administer the fund.

(c) Money in the fund at the end of a state fiscal year attributable to fees collected to fund the programs described in section 8 of this chapter does not revert to the state general fund. However, money remaining in the fund after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be used for the payments described in sections 8(a) and 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter).** Any money not required for the payments described in sections 8(a) and 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be distributed to the hospitals on a pro rata basis based upon the fees paid by each hospital for the state fiscal year that ended immediately before the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

SECTION 21. IC 16-21-10-10, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. This section:

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

(2) does not apply to funds under IC 12-16-17.

Notwithstanding any other law, the part of the amounts appropriated for or transferred to the hospital care for the indigent program for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter that are not required to be paid to the office by law shall be used exclusively as state share dollars for the payments described in sections 8(a) and 11 of this chapter. Any hospital care for the indigent funds that are not required for the payments described in sections 8(a) and 11 of this chapter after the cessation of the collection of the fee under section ~~6(b)~~ **6(d)** of this chapter shall be used for the state share

dollars of the payments in IC 12-15-20-2(8)(G)(ii) through IC 12-15-20-2(8)(G)(x).

SECTION 22. IC 16-21-10-11, AS AMENDED BY P.L.30-2016, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. (a) This section:

(1) does not apply to the incremental fee described in section 13.3 of this chapter;

(2) is effective upon the implementation of the fee described in section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 of this chapter; and

(3) applies to the Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter.

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

(c) **Subject to subsections (d) and (e),** the federal Medicaid disproportionate share allotments for the state fiscal years beginning July 1, 2013, and each state fiscal year thereafter shall be allocated in their entirety to acute care hospitals licensed under IC 16-21-2 that qualify as disproportionate share providers or municipal disproportionate share providers under IC 12-15-16-1(a) or IC 12-15-16-1(b). No part of the federal disproportionate share allotments applicable for disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter may be allocated to institutions for mental disease or other mental health facilities, as defined by applicable federal law.

(d) Subsections (b) and (c) do not apply for any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect.

(e) For any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect, the state share of the disproportionate share payments described in STEP ONE of IC 12-15-16-7.3(c) shall be funded by the fee.

SECTION 23. IC 16-21-10-13.3, AS AMENDED BY P.L.93-2024, SECTION 128, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13.3.(a) This section is effective beginning February 1, 2015. As used in this section, "plan"

refers to the healthy Indiana plan established in IC 12-15-44.5.

(b) Subject to subsections (c) through ~~(c),~~ **(g),** the incremental fee under this section may be used to fund the state share of the expenses specified in this subsection if, after January 31, 2015, but before the collection of the fee under this section, the following occur:

(1) The ~~committee~~ **office** establishes a fee formula to be used to fund the state share of the following expenses described in this subdivision:

(A) The state share of the capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees other than plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act, **including portions of the capitation attributed to a state directed payment program under section 8.5 of this chapter.**

(B) The state share of capitated payments described in clause (A) for plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act that are limited to the difference between:

(i) the capitation rates effective September 1, 2014, developed using Medicaid reimbursement rates; and

(ii) the capitation rates applicable for the plan developed using the plan's Medicare reimbursement rates described in IC 12-15-44.5-5(a)(2), **or higher reimbursement amounts for any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in effect.**

(C) The state share of the state's contributions to plan enrollee accounts.

(D) The state share of amounts used to pay premiums for a premium assistance plan implemented under IC 12-15-44.2-20.

(E) The state share of the costs of increasing reimbursement rates for physician services provided to individuals enrolled in Medicaid programs other than the plan, but not to exceed the difference between the Medicaid fee schedule for a physician service that was in effect before the implementation of the plan and the amount equal to seventy-five percent (75%) of the previous year federal Medicare reimbursement rate for a physician service. The incremental fee may not be used for the amount that exceeds seventy-five percent (75%) of the federal Medicare reimbursement rate for a physician service.

(F) The state share of the state's administrative costs that, for purposes of this clause, may not exceed one hundred seventy dollars ($170) per person per plan enrollee per year, and adjusted annually by the Consumer Price Index.

(2) The ~~committee~~ **office** approves a process to be used for reconciling:

(A) the state share of the costs of the plan;

(B) the amounts used to fund the state share of the costs of the plan; and

(C) the amount of fees assessed for funding the state share of the costs of the plan.

For purposes of this subdivision, "costs of the plan" includes the costs of the expenses listed in subdivision (1)(A) through (1)(F). The fees collected ~~under~~ **for the purposes of** subdivision (1)(A) through (1)(F) shall be deposited into the incremental hospital fee fund established by section 13.5 of this chapter. The fees used for purposes of funding the state share of expenses listed in subdivision (1)(A) through (1)(F) may not be used to fund expenses incurred on or after the commencement of a phase out period of the plan.

(c) For each state fiscal year for which the fee authorized by this section is used to fund the state share of the expenses described in subsection (b)(1), the amount of fees shall be reduced by:

(1) the amount of funds annually designated by the general assembly to be deposited in the healthy Indiana plan trust fund established by IC 12-15-44.2-17; less

(2) the annual cigarette tax funds annually appropriated by the general assembly for childhood immunization programs under IC 12-15-44.2-17(a)(3).

(d) The incremental fee described in this section may not:

(1) be assessed before July 1, 2016; and

(2) be assessed or collected on or after the beginning of a phase out period of the plan.

(e) This section is not intended to and may not be construed to change or affect any component of the programs established under section 8 of this chapter.

SECTION 24. IC 16-21-10-14, AS AMENDED BY P.L.213-2015, SECTION 150, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 14. **(a)** This section does not apply to the use of the incremental fee described in section 13.3 of this chapter.

(b) The fees collected under section 8 of this chapter may be used only as described in this chapter or to pay the state's share of the cost

for Medicaid services provided under the federal Medicaid program (42 U.S.C. 1396 et seq.) as follows:

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

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

SECTION 25. IC 16-21-10-19, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: 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 payments to hospitals in accordance with section 11 of this chapter **(subject to section 11(d) and 11(e) of this chapter)** may occur at any time, including after collection of the fee is stopped under section ~~6(b)~~ **6(d)** of this chapter, to the extent the funding provided for the payments by this chapter is available under section 9(c) of this chapter. Payments for the program described in section 13 of this chapter may occur at any time, including after the collection of the fee is stopped under section ~~6(b)~~ **6(d)** of this chapter, subject to the reconciliation and termination of the program required by section ~~6(b)~~ **6(d)** of this chapter.

SECTION 26. IC 16-21-10-21, AS AMENDED BY P.L.201-2023, SECTION 148, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 21. This chapter expires June 30, ~~2025.~~ **2027.**".

Page 5, line 15, delete "state or" and insert "**state or country.**".

Page 5, delete lines 16 through 42.

Page 6, delete lines 1 through 30, begin a new paragraph and insert:

"**Sec. 2. Before August 1 of each year, every nonprofit hospital shall provide the health care cost oversight task force (established by IC 2-5-47-3) with the entirety of the Schedule H portion of the nonprofit hospital's previous taxable year's federal Form 990, including the following forms:**

(1) Federal form 990, Schedule H, Part I, 7(a), financial assistance at cost, worksheet 1 or other similar documentation, or its successor form or schedule.

(2) Federal form 990, Schedule H, Part I, 7(b), Medicaid, worksheet 3, column a, or its successor form or schedule.

(3) Federal form 990, Schedule H, Part I, 7(c), costs of other means-tested government programs, worksheet 3, column b, or its successor form or schedule.

(4) Federal form 990, Schedule H, Part I, 7(e), community

health improvement services and community benefit operations, worksheet 4 or other similar documentation, or its successor form or schedule.

(5) Federal form 990, Schedule H, Part I, 7(f), health professions education, worksheet 5 or other similar documentation, or its successor form or schedule.

(6) Federal form 990, Schedule H, Part I, 7(g), subsidized health services, worksheet 6 or other similar documentation, or its successor form or schedule.

(7) Federal form 990, Schedule H, Part I, 7(h), research, worksheet 7 or other similar documentation, or its successor form or schedule.

(8) Federal form 990, Schedule H, Part I, 7(i), cash and in kind contributions for community benefit, worksheet 8, or its successor form or schedule.

(9) Federal form 990, Schedule H, Part II, community building activities, lines 1 through 9, or its successor form or schedule, and including specific initiatives and related net expenses for each line.

(10) Federal form 990, Schedule H, Part III, section A, bad debt expense, lines 2 through 3, or its successor form or schedule, and including calculations to support the data entered.

(11) Federal form 990, Schedule H, Part III, section B, Medicare, lines 5 through 7, or its successor form or schedule, and including calculations to support the data entered.".

Page 6, between lines 30 and 31, begin a new paragraph and insert:

"SECTION 30. IC 27-1-50.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 50.3. Managed Care Assessment Fee

Sec. 1. The following definitions apply throughout this chapter:

(1) "Business day" means a day other than Saturday or Sunday, or a legal holiday listed in IC 1-1-9-1.

(2) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(3) "Department" refers to the department of insurance created by IC 27-1-1-1.

(4) "Fee" refers to the fee on managed care organizations authorized by this chapter.

(5) "Managed care organization" means an organization that holds a certificate of authority, license, or other similar

authorization issued by the department and that is a managed care organization for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8).

(6) "Office" refers to the office of Medicaid policy and planning established by IC 12-8-6.5-1.

(7) "Secretary" refers to the secretary of family and social services appointed under IC 12-8-1.5-2.

(8) "State's share" means the portion of allowable Medicaid expenses funded by the state, by other units of government, or, as permitted by federal Medicaid laws, by other entities other than the federal government.

Sec. 2. (a) Subject to subsections (b) and (c) and this chapter, a fee is authorized.

(b) The fee may not be assessed without approval from the United States Department of Health and Human Services.

(c) The assessment of the fee shall cease upon the Department of Health and Human Service's determination that the fee is no longer a permissible health care related tax that is eligible for federal financial participation.

Sec. 3. The office may, subject to section 6 of this chapter, assess a fee upon managed care organizations to support administration of the state Medicaid program.

Sec. 4. The fee collected under this chapter may only be used to pay the state's share of the cost of Medicaid services provided under the Medicaid program (42 U.S.C. 1396 et seq.).

Sec. 5. (a) Not later than May 30, 2025, and after consulting with the secretary or the secretary's designee regarding compliance with 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8) and the types of managed care organizations recognized under Indiana law, the commissioner or the commissioner's designee shall provide the secretary or the secretary's designee with a list of the managed care organizations that hold a certificate of authority, license, or other similar authorization issued by the department and that are managed care organizations for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8).

(b) The commissioner or the commissioner's designee shall update this list to the secretary or the secretary's designee not sooner than one hundred twenty (120) days, and not later than ninety (90) days, from the start of each state fiscal year for which the fee is assessed.

Sec. 6. (a) The fee must meet the requirements of the federal Medicaid statutes and regulations for permissible health care

related taxes.

(b) The office may request a waiver from the United States Department of Health and Human Services of the broad based and uniformity requirements under 42 CFR 433.68 relating to the assessment under this chapter.

(c) Subject to subsection (a):

(1) the office may assess the fee on a tiered basis among the managed care organizations; and

(2) the office may assess the fee based on member months, premium revenue, or any other methodology approved by the United States Department of Health and Human Services.

Sec. 7. The office shall submit a written request to United States Department of Health and Human Services for approval of the managed care assessment fee on or after June 30, 2025. Subject to the requirements of this chapter, the office is authorized to negotiate with the United States Department of Health and Human Services regarding the terms and conditions for the implementation and maintenance of the fee.

Sec. 8. (a) A managed care organization that is assessed under this chapter for a state fiscal year shall pay the assessment in monthly installments, each equaling one-twelfth (1/12) of the assessment for the state fiscal year, on the first business day of each calendar month of the state fiscal year.

(b) Not later than thirty (30) days before the start of each state fiscal year, the office shall notify each managed care organization of the managed care organization's annual assessment and the installment due dates for the assessment.

Sec. 9. (a) The managed care assessment fund is established for the purpose of holding the fees collected under this chapter.

(b) The office shall administer the fund.

(c) Money in the fund consists of the following:

(1) Fees collected under this chapter, including penalty payments under section 11 of this chapter.

(2) Donations, gifts, appropriations by the general assembly, and money received from any other source.

(3) Interest accrued under this section.

(d) Money remaining in the fund at the end of a state fiscal year does not revert to the state general fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

Sec. 10. (a) A managed care organization that is liable for an assessment under this chapter shall keep accurate and complete records and pertinent documents that are relevant to the organization's assessment under this chapter, as may be required by the department or the office.

(b) The department or the office may audit all records necessary to ensure compliance with this chapter and make adjustments to assessment amounts previously calculated based on the results of any the audit.

Sec. 11. (a) For good cause shown by a managed care organization due to financial or other difficulties, as determined by the office, the office is authorized to grant grace periods, of up to thirty (30) days, for the managed care organization's payment of an installment payment due under this chapter.

(b) If a managed care organization that is liable for an assessment under this chapter fails to make an installment payment by the payment's due date, and no grace period has been granted to the managed care organization for the payment of the installment payment, the managed care organization shall pay a penalty of ten percent (10%) of the amount of the installment payment not paid, plus ten percent (10%) of the portion remaining unpaid on the last day of every thirty (30) day period thereafter. These penalty payments shall be deposited into the managed care assessment fund.

(c) If a managed care organization that is liable for an assessment under this chapter is granted a grace period but fails to make its installment payment by the end of the grace period, the managed care organization shall pay a penalty of five percent (5%) of the amount of the installment payment not paid, plus five percent (5%) of the portion remaining unpaid on the last day of every thirty (30) day period thereafter. These penalty payments shall be deposited into the managed care assessment fund.

(d) Notwithstanding subsections (b) and (c), with respect to a managed care organization that has a comprehensive risk contract with the office under IC 12-15 that fails to make an installment payment not later than sixty (60) days after the due date or, if applicable, not later than sixty (60) days after the end of a grace period, the office may additionally impose a contractual sanction allowed against the managed care organization, and may terminate the contract with the office.

(e) Notwithstanding subsections (b) through (d), with respect to a managed care organization that fails to make an installment

payment not later than sixty (60) days after the due date or, if applicable, not later than sixty (60) days after the end of a grace period, the department may suspend or revoke, after notice and hearing, the managed care organization's certificate of authority, license, or other authority to operate in Indiana.

Sec. 12. The office may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 31. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "preprint" means the document required to be submitted to the United States Department of Health and Human Services that implements the prior approval process for a state directed payment arrangement described in 42 CFR 438.6(c).**

(b) The office of the secretary of family and social services shall amend 405 IAC 1-8-5 and 405 IAC 1-10.5-7 to reflect the amendments in this act and any Medicaid state plan amendment, Medicaid waiver, or preprint submitted for purposes of 42 CFR 438.6(c):

(1) submitted to the budget committee in accordance with IC 12-15-1.3-17.5; and

(2) approved by the United States Department of Health and Human Services.

The office of the secretary may adopt the changes required by this subsection as provisional rules or interim rules in the manner set forth in IC 4-22-2.

(c) The administrative rules amended under subsection (b) are effective and may be retroactive to the date the United States Department of Health and Human Services approved a Medicaid state plan amendment or Medicaid waiver described in subsection (b).

(d) Notwithstanding the expiration dates in IC 4-22-2, if the office of the secretary adopts the changes to the administrative rules as required in subsection (b) through a provisional or an interim rule, the provisional or interim rule expires not later than the earlier of the following:

(1) The date on which a rule that supersedes the provisional or interim rule is adopted by the office of the secretary under IC 4-22-2-19.7 through IC 4-22-2-36.

(2) July 1, 2027.

(d) This SECTION expires July 1, 2027.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1004 as printed February 11, 2025.)

THOMPSON

Committee Vote: yeas 16, nays 7.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1004 be amended to read as follows:

Page 2, line 6, delete "refers to" and insert "**means**".

Page 2, line 7, delete "the average amount charged as a facility fee" and insert "**a facility fee, based on a hospital's modified Medicare reimbursement rate, charged**".

Page 2, line 8, delete "service as determined by the secretary" and insert "**service.**".

Page 2, delete line 9.

Page 2, line 12, after "the" insert "**hospital's**".

Page 2, line 17, after "the" insert "**hospital's**".

Page 2, line 22, after "the" insert "**hospital's**".

Page 2, line 26, after "the" insert "**hospital's**".

Page 2, line 31, after "the" insert "**hospital's**".

Page 3, delete lines 14 through 17.

Page 29, line 4, after "4." insert "**(a)**".

Page 29, line 5, after "the" insert "**nonprofit hospital's modified**".

Page 29, between lines 7 and 8, begin a new paragraph and insert:

"**(b) This subsection applies to a nonprofit hospital that forfeits its status as a nonprofit hospital under subsection (a). A nonprofit hospital may reestablish the nonprofit hospital's status as a nonprofit hospital if the nonprofit hospital meets the requirement described in subsection (a) for at least ninety (90) consecutive days.**".

(Reference is to HB 1004 as printed February 17, 2025.)

CARBAUGH

HOUSE MOTION

Mr. Speaker: I move that House Bill 1004 be amended to read as follows:

Page 29, line 18, delete "August" and insert "**November**".

Page 29, line 20, delete "with" and insert "**with, and make available for publication on the general assembly's website,**".

Page 30, between lines 15 and 16, begin a new paragraph and insert:

"**Sec. 3. Prior to providing the health oversight task force with, or making available for publication, the information described in section 2 of this chapter, a nonprofit hospital may only make redactions with regard to:**

(1) personally identifiable information; and

(2) information required to remain confidential under the federal Health Insurance Portability and Accountability Act (HIPAA).".

Renumber all SECTIONS consecutively.

(Reference is to HB 1004 as printed February 17, 2025.)

BAUER M