LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS
FISCAL IMPACT STATEMENT

LS 7699
BILL NUMBER: HB 1004

NOTE PREPARED: Feb 20, 2025
BILL AMENDED: Feb 19, 2025

SUBJECT: Nonprofit Hospitals.

FIRST AUTHOR: Rep. Carbaugh
FIRST SPONSOR: Sen. Garten

BILL STATUS: As Passed House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State & Local

Summary of Legislation: *Hospital Facility Fee Excess Tax:* The bill 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. It excludes a critical access hospital from the excise tax statute. The bill 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. The bill makes an appropriation.

Assessment Fees: It establishes:

(1) a state directed payment program (SDP) for hospitals; and

(2) a managed care assessment fee;

subject to the approval of the United States Department of Health and Human Services.

Nonprofit Hospital: The bill 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.

Community Benefits: The bill limits what may constitute community benefits for certain nonprofit hospitals.

Billing Comparison: It requires, before November 1 of each state fiscal year, nonprofit hospitals (that are not county hospitals) to provide to the Department of Insurance (DOI) 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. It also 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. The bill allows a nonprofit hospital to reestablish the nonprofit hospital's status as a nonprofit hospital. The bill provides that all nonprofit hospitals are subject to an annual audit by, and at the discretion of, the DOI.

Form 990: The bill requires, before August 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.

Effective Date: Upon passage; July 1, 2025.

Explanation of State Expenditures: *Hospital Facility Fee Excess Tax:* The Secretary of Health and Family Services will have a potentially significant workload increase to determine each hospital's Medicare facility fee for each service provided by a hospital. Licensed hospitals, excluding critical access hospitals, will be subject to an excise tax for facility fees charged to a nonMedicare patient in excess of 265% of the hospital's modified Medicare facility for the service received. The excise tax is remitted monthly to the Department of Revenue (DOR). The DOR's initial cost to implement the new tax could be at least $400,000 in the first two years, including personnel and technology costs.

The excise tax revenue is to be deposited into the newly established Hospital Facility Fee Excise Tax account and is to be used for the Medicaid program (75%) and for developing the health care workforce in rural areas of Indiana (25%). Money in the account is continuously appropriated. Administrative decisions for the use of the funds will determine how the state may benefit, including reduced state General Fund expenditures for the Medicaid program, additional federal funds leveraged, or funding for new programs.

Assessment Fees: The bill establishes the authority to implement a new SDP and a new assessment fee, the Managed Care Assessment Fee (MCAF), to pay the state's share of Medicaid costs. If federally approved, the SDP includes changes to the participants in the Disproportionate Share Hospital (DSH) program, the payors of the Hospital Assessment Fee (HAF), and the uses of the HAF revenue. The bill eliminates the HAF Committee and exempts physician owned hospitals from paying the HAF. [IC 16-21-10 expires on June 30, 2025. This fiscal note assumes continuation of this chapter beyond this date.]

These provisions of the bill will have indeterminate impact on the workload of the Office of the Secretary of Family and Social Services (FSSA) depending on administrative decisions on the SDP and the amount of actuarial and accounting services needed. The additional funds and resources required could be supplied through existing staff and resources currently being used in another program or with new appropriations. Ultimately, the source of funds and resources required to satisfy the requirements of this bill will depend on legislative and administrative actions.

Billing Comparison and Form 990: The bill's requirements for annual audit of nonprofit hospitals represent an increase in workload outside of the duties of the Department of Insurance (DOI). To the extent that the DOI may use discretion to conduct the audits, the increase in workload is indeterminable. Also, the bill's provisions represent a minimal workload increase for the Indiana Department of Health, General Assembly, and the Legislative Services Agency. [*The DOI is funded through a dedicated agency fund.*]

Additional Information -

Hospital Facility Fee Excess Tax: The DOR estimate is based on the reported cost of implementing the Electronic Cigarette Tax and Closed System Cartridge Tax. The cost could be higher depending on the complexity of the tax and requirements of the bill.

Assessment Fees: The SDP will increase the FSSA administrative workload and costs in the following ways:

- The SDP increases the supplemental payment limit from the Medicare upper payment limit program up to the federally approved rate. The federal program allows three different state directed payment arrangements, each requiring different methodology and documentation for implementation. The FSSA could have additional costs for repricing, accounting, and actuary services. These services are

currently provided through contract services, but may be provided with additional staff.
- Similarly, tiered payments of assessment fees by hospitals or managed care organizations are authorized under the bill, potentially increasing accounting and actuary services.
- The bill removes the HAF committee. The HAF committee receives no compensation and currently receives administrative support from the FSSA.
- The bill allows for the audit of managed care organizations with regard to the MCAF.
- The bill establishes the Managed Care Assessment Fund administered by the FSSA to hold fees collected from the MCAF. Money in the fund consists of the MCAF fees and penalties for failure to pay, donations, gifts, appropriations, interest, and money received from other sources. Money in the fund at the end of the fiscal year does not revert to the state General Fund.

The bill also requires the DOI to provide a list of managed care organizations in the state to the FSSA, and to update the list at the start of each state fiscal year. For MCAF installments outstanding over 60 days, the DOI may suspend or revoke the managed care organization's certificate of authority. The bill's requirements are within the agency's routine administrative functions and should be able to be implemented with no additional appropriations, assuming near customary agency staffing and resource levels. *[The DOI is funded through an agency fund*.]

Billing Comparison and Form 990: In November 2024, 105 nonprofit and presumed nonprofit hospitals were licensed in Indiana. Of those hospitals, 73 are short-term or critical access hospitals, and the remaining are rehabilitative, long-term, or psychiatric hospitals. Form 990H is available for 2022 and 2023 on the Indiana Department of Health website, with 66 hospitals reporting in 2022 and 27 in 2023.

Explanation of State Revenues: *Hospital Facility Fee Excess Tax:* The amount of excise tax collected is indeterminate, but potentially minimal if hospitals reduce facility fees so they do not exceed 265% of hospital's Medicare facility fees for each service. Also, if for-profit hospitals reduce facility fees to avoid the Hospital Facility Fee Excise Tax, then revenue from business corporate taxes may be reduced by an indeterminable amount.

Assessment Fees: On average between FY 2020 and FY 2024, $246 M from the HAF was deposited directly in the state General Fund to reimburse state Medicaid expenses. If federally approved, the HAF, IHAF, and MCAF would pay the state's share of Medicaid costs for inpatient and outpatient hospital care and for capitation rates, potentially leveraging additional federal funds and eliminating the existing HAF contribution to the state General Fund. The state's share of most Medicaid medical services is 34% and of the Healthy Indiana Plan expansion population is 10%.

Billing Comparison: Depending on the determination of the IDOH, a nonprofit hospital violating the requirements of the bill may have to apply for a business license as a for profit corporation. The fee for filing articles of incorporation is $100, which is deposited in the state General Fund. Any impact is expected to be minimal due to hospitals being able to reestablish their nonprofit status, as prescribed in the bill.

Additional Information - *MCAF Penalties:* The bill authorizes a 10% penalty of an installment payment not paid by a managed care organization, plus a 10% penalty on the balance owed, assessed every 30 days. If a managed care organization is granted a grace period but fails to pay the installment payment, the penalty is 5% of the installment payment, plus 5% on the balanced owed, assessed every 30 days. Penalty revenue will be deposited in the Managed Care Assessment Fund.

Exempt Hospitals: The bill exempts physician owned hospitals from the HAF and IHAF. This will not

change the amount of state revenue collected from the HAF or Incremental HAF under the current structure. However, Medicaid is administered by the state with policies set within a federal framework. Federal requirements on assessment fees, including being broad based, uniform, and no guarantee of repayment, may affect the federal approval that provides for reimbursement above state Medicaid rates. In the model approved by the federal Centers for Medicare and Medicaid Services, the HAF and IHAF pool of costs is allocated among hospitals based on a formula involving the total inpatient revenue per inpatient day and equivalent outpatient days.

Exempted from the allocation of HAF and IHAF fees are certain long-term care hospitals, state-owned hospitals, federally operated hospitals, freestanding rehabilitation hospitals, out-of-state hospitals, and freestanding psychiatric hospitals with more than 40% of admissions with a diagnosis of chemical dependency or greater than 90% of admissions for individuals at least 55 years of age having a primary diagnosis of Alzheimer's or other disorders related to trauma. The fee rate is also reduced by specific percentages for certain hospitals meeting defined low-income utilization rates, Medicaid inpatient utilization rates, or that provide more than 25% of Medicaid days to nonstate residents. Each hospital's HAF is limited to 6% of the total annual revenues and to certain other federally defined maximums.

Explanation of Local Expenditures: *Assessment Fee Redistribution:* Pending approval of the SDP, the fee allocation to municipal hospitals is indeterminate, and most likely the impact will vary by hospital. The state's share of the fee for supplemental payments could increase depending on the payment arrangement determined. Conversely, the state's share of DSH payments will not be paid through the HAF, nor will the 28.5% state General Fund reimbursement. Ultimately, the supplemental limit chosen and the potential use of tiered payments will determine the net increase or decrease for municipal hospitals.

Disproportionate Share Hospital: If federally approved, the SDP will make changes to the recipients of the DSH program. Hospitals that can make intergovernmental transfers (IGT), including municipal and acute care hospitals, will make an IGT equal to the state's share of its hospital specific limit. (The hospital specific limit is the costs of providing inpatient and outpatient services to Medicaid patients, less any reimbursement through the Medicaid program.)

Exempt Hospitals: The exemption of certain hospitals that currently pay HAF and IHAF will result in a redistribution of the fee amounts paid by hospitals if the SDP is enacted. Any change is indeterminate, but municipal hospitals will potentially pay a larger share of these costs.

Explanation of Local Revenues: *Assessment Fees:* Patient revenues could increase from enhanced supplemental payment limits.

State Agencies Affected: Department of Insurance; Family and Social Services Administration; Indiana Department of Health; Department of Revenue; Governor's Office; General Assembly, Legislative Services Agency.

Local Agencies Affected: Municipal hospitals.

Information Sources: Indiana Handbook of Taxes, Revenue, and Appropriations, FY 2024; https://www.in.gov/health/cshcr/reports-on-health-care-facilities/hospital-community-benefit-reports/2021-reports/; https://www.in.gov/health/reports/QAMIS/hosdir/wdirhos.htm; https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf.

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