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 ENROLLED ACT No. 1004

AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 12-7-2-137.8 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 137.8. "Phase out period", for purposes of IC 12-15-44.5, has the meaning set forth in IC 12-15-44.5-1.~~

SECTION 2. IC 12-15-1-18.5, AS ADDED BY P.L.203-2023, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18.5. (a) The payer affordability penalty fund is established for the purpose of receiving fines collected under IC 16-21-6-3, ~~and fines collected under~~ **IC 16-21-6-13, IC 16-21-19, IC 27-1-46.5, and** IC 27-2-25.5 to be used for:

(1) the state's share of the Medicaid program; and

(2) a study of hospitals that are impacted by changes made in the disproportionate share hospital methodology payments set forth in Section 203 of the federal Consolidated Appropriations Act of 2021.

The office of the secretary shall perform the study and provide the results of the study described in subdivision (2) to the budget committee.

(b) The fund shall be administered by the office of the secretary.

(c) The expenses of administering the fund shall be paid from money in the fund.

(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 money may be invested. Interest that accrues

from these investments shall be deposited in the fund.

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

(f) Money in the fund is continually appropriated.

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) Except as provided in section 7.3 of this chapter, no payments shall be made to disproportionate share hospitals for any 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 may develop and implement a Medicaid state plan amendment that provides Medicaid disproportionate share payments for state mental health institutions under IC 12-24-1-3 that qualify as a disproportionate share provider under section 1(a) of this chapter.

(c) 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, and any applicable payments under subsection (b), 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 (d), 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).

(d) If the total disproportionate share payments under STEP TWO of subsection (c) 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 (c), and any applicable payments under 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 12-15-44.2-17, AS AMENDED BY P.L.213-2015, SECTION 134, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 17. (a) The healthy Indiana plan trust fund is established for the following purposes:

(1) Administering a plan created by the general assembly to provide health insurance coverage for low income residents of Indiana under this chapter and IC 12-15-44.5.

(2) Providing copayments, preventative care services, and premiums for individuals enrolled in the plan.

(3) Funding tobacco use prevention and cessation programs, childhood immunization programs, and other health care initiatives designed to promote the general health and well being of Indiana residents.

(4) Funding amounts necessary to match federal funds for purposes set forth in this section.

The fund is separate from the state general fund.

(b) The fund shall be administered by the office of the secretary of family and social services.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The fund shall consist of the following:

(1) Cigarette tax revenues designated by the general assembly to be part of the fund.

(2) Other funds designated by the general assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the 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 money may be invested.

(f) Money must be appropriated before funds are available for use.

(g) Money in the fund does not revert to the state general fund at the end of any fiscal year.

(h) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency unless the transfer, assignment, or removal is made in accordance with subsection (a)(4).

(i) As used in this subsection, "costs of the healthy Indiana plan 2.0" includes the costs of all expenses set forth in IC 16-21-10-13.3(b)(1)(A) through IC 16-21-10-13.3(b)(1)(F). Notwithstanding subsection (a), funds on deposit in the fund beginning on the date the office implements the healthy Indiana plan 2.0 (IC 12-15-44.5) and until the healthy Indiana plan 2.0 is terminated ~~upon the completion of a phase out period~~ shall be used exclusively for the following:

(1) The state share of the costs of the healthy Indiana plan 2.0 that exceed other available funding sources in any given year.

~~(2) The state share of the costs of the healthy Indiana plan 2.0 incurred during a phase out period of the healthy Indiana plan 2.0.~~

~~(3)~~ **(2)** The state share of the expenses of the plan in effect under this chapter immediately before the implementation of the healthy Indiana plan 2.0 that were incurred in the regular course of the plan's operation.

(j) As used in this subsection, "costs of the healthy Indiana plan 2.0" include the costs of all expenses set forth in IC 16-21-10-13.3(b)(1)(A) through IC 16-21-10-13.3(b)(1)(F). Upon implementation of the healthy Indiana plan 2.0 (IC 12-15-44.5), the entirety of the annual cigarette tax amounts designated to the fund by the general assembly shall be used exclusively to fund the state share of the costs of the healthy Indiana plan 2.0. ~~including the state share of the costs of the healthy Indiana plan 2.0 incurred during a phase out period of the healthy Indiana plan 2.0.~~ This subsection may not be construed to restrict the annual cigarette tax dollars annually appropriated by the general assembly for childhood immunization programs under subsection (a)(3).

SECTION 10. IC 12-15-44.5-1 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 1. As used in this chapter, "phase out period" refers to the following periods:~~

~~(1) The time during which a:~~

~~(A) phase out plan;~~

~~(B) demonstration expiration plan; or~~

~~(C) similar plan approved by the United States Department of Health and Human Services;~~

~~is in effect for the plan set forth in this chapter.~~

~~(2) The time beginning upon the office's receipt of written notice by the United States Department of Health and Human Services of its decision to:~~

~~(A) terminate or suspend the waiver demonstration for the plan; or~~

~~(B) withdraw the waiver or expenditure authority for the plan;~~

~~and ending on the effective date of the termination, suspension, or withdrawal of the waiver or expenditure authority.~~

~~(3) The time beginning upon:~~

~~(A) the office's determination to terminate the plan; or~~

~~(B) the termination of the plan under section 4(b) of this chapter;~~

~~if subdivisions (1) through (2) do not apply, and ending on the~~

~~effective date of the termination of the plan.~~

SECTION 11. 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~~ **before termination** 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 12. IC 12-15-44.5-4, AS AMENDED BY HEA 1004-2025, SECTION 11, AND AS AMENDED BY SEA 2-2025, SECTION 10, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: 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.);

(3) except as provided in section 4.2(a) of this chapter, must not grant eligibility under the state Medicaid plan for medical assistance under 42 U.S.C. 1396a; and

(4) must grant eligibility for the plan through an approved demonstration project under 42 U.S.C. 1315.

(b) If ~~*either*~~ *any* 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*~~ *before termination* 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.

(3) The Medicaid waiver approving the plan is revoked, rescinded, vacated, or otherwise altered in a manner that the state cannot comply with the requirements of this chapter.

(c) If federal financial participation for recipients covered under the plan is less than ninety percent (90%), the office may terminate the plan in accordance with section 6(b) of this chapter.

~~*(c)*~~ *(d)* 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)*~~ *(e)* 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)*~~ *(f)* 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 13. 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 14. IC 16-18-2-281.5 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 281.5. "Phase out period", for purposes of IC 16-21-10, has the meaning set forth in IC 16-21-10-5.3.~~

SECTION 15. 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 16. IC 16-21-6-3, AS AMENDED BY P.L.152-2024, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, the state department may grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including inpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(10) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) other revenue from state programs;

(D) revenue from local government programs;

(E) local tax support;

(F) charitable contributions;

(G) other third party payments;

(H) gross inpatient revenue;

(I) gross outpatient revenue;

(J) contractual allowance;

(K) any other deductions from revenue;

(L) charity care provided;

(M) itemization of bad debt expense; and

(N) an estimation of the unreimbursed cost of subsidized health services.

(11) A statement itemizing donations.

(12) A statement describing the total cost of reimbursed and unreimbursed research.

(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.

(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.

(C) Education of patients concerning diseases and home care in response to community needs.

(D) Community health education through informational programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of ~~one~~ **ten** thousand dollars ~~($1,000)~~ **($10,000)** per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

SECTION 17. IC 16-21-6-3, AS AMENDED BY HEA 1004-2025, SECTION 16, AND AS AMENDED BY HEA 1666-2025, SECTION 5, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, the state department may grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.
(5) Accountant notes pertaining to the report.
(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.
(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from

facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services

from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(10) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) other revenue from state programs;

(D) revenue from local government programs;

(E) local tax support;

(F) charitable contributions;

(G) other third party payments;

(H) gross inpatient revenue;

(I) gross outpatient revenue;

(J) contractual allowance;

(K) any other deductions from revenue;

(L) charity care provided;

(M) itemization of bad debt expense; and

(N) an estimation of the unreimbursed cost of subsidized health services.

(11) A statement itemizing donations.

(12) A statement describing the total cost of reimbursed and unreimbursed research.

(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.

(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.

(C) Education of patients concerning diseases and home care

in response to community needs.

(D) Community health education through informational programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(14) The name of each person or entity that has:

(A) either:

(i) an ownership interest of at least five percent (5%); or

(ii) if the person is a practitioner of the hospital, any ownership interest;

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the hospital.

(15) The business address of each person or entity identified under subdivision (14). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(16) The business website, if applicable, of each person or entity identified under subdivision (14).

(17) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (14):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A hospital may not include the Social Security number of any individual.

(18) The ownership stake of each person or entity identified under subdivision (14).

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection

(a) by the date required shall pay to the state department a fine of ~~*one*~~ *ten* thousand dollars ~~*($1,000)*~~ *($10,000)* per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

SECTION 18. IC 16-21-6-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13. (a) As used in this section, "nonprofit hospital system" refers only to those Indiana nonprofit hospital systems described in IC 16-21-18-2.**

(b) A nonprofit hospital system shall, before June 1 of each year, submit audited financial statements of the nonprofit hospital system to the state department for each year of the immediately preceding two (2) years.

(c) The requirement under this section is in addition to any other reporting requirement under this title.

(d) If a nonprofit hospital system fails to submit the audited financial statements before June 1 of any year, the state department shall fine the nonprofit hospital system ten thousand dollars ($10,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

SECTION 19. 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 20. 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 21. IC 16-21-10-5.3 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 5.3. As used in this chapter, "phase out period" refers to the following periods:~~

~~(1) The time during which a:~~

~~(A) phase out plan;~~

~~(B) demonstration expiration plan; or~~

~~(C) similar plan approved by the United States Department of Health and Human Services;~~

~~is in effect for the healthy Indiana plan set forth in IC 12-15-44.5.~~

~~(2) The time beginning upon the office's receipt of written notice by the United States Department of Health and Human Services of its decision to:~~

~~(A) terminate or suspend the waiver demonstration for the healthy Indiana plan; or~~

~~(B) withdraw the waiver or expenditure authority for the plan;~~

~~and ending on the effective date of the termination, suspension, or withdrawal of the waiver or expenditure authority.~~

~~(3) The time beginning upon:~~

~~(A) the office's determination to terminate the healthy Indiana plan; or~~

~~(B) the termination of the plan under IC 12-15-44.5-4(b);~~

~~if subdivisions (1) through (2) do not apply, and ending on the effective date of the termination of the healthy Indiana plan.~~

SECTION 22. 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 23. 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 a fee in an amount not to exceed the maximum amount permitted under federal law:

(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 24. 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 25. 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.

(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 26. 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) Subject to subsection (b), 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, as set forth in subsection (c), and 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 state 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. However, the fees collected under this section and sections 8 and 13.3 of this chapter may not fund the state share of the capitation payments of the managed care assessment fee under IC 27-1-50.3.

(B) For plan enrollees described in section 13.3(b)(1)(A) of this chapter, capitation payments at a 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. However, the fees collected under this section and sections 8 and 13.3 of this chapter may not fund the state share of the capitation payments of the managed care assessment fee under IC 27-1-50.3.

(b) The office may only implement a state directed payment program under this section if the budget committee has conducted a review of the state directed payment program.

(c) The classes of hospitals may be constructed as follows:

(1) Class 1 hospitals consist of critical access hospitals and rural hospitals.

(2) Class 2 hospitals consist of a hospital licensed under IC 16-21-2 that is not described in subdivision (1) and that is:

(A) established and governed under IC 16-22-2, IC 16-22-8, or IC 16-23; or

(B) an Indiana nonprofit hospital system that has a net patient revenue derived in Indiana of less than two billion dollars ($2,000,000,000), as determined by the hospital's most recently submitted audited financial statement.

(3) Class 3 hospitals consist of psychiatric hospitals, rehabilitative hospitals, and acute long term care hospitals and that are not described in subdivision (1) or (2).

(4) Class 4 hospitals consist of any hospital not described in subdivision (1) through (3) and that are subject to this chapter.

SECTION 27. 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 28. 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 29. 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 30. 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), 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 **Medicaid program or 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~~ **termination** 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 31. IC 16-21-10-13.5, AS AMENDED BY P.L.30-2016, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13.5. (a) The incremental hospital fee fund is established for the purpose of holding fees collected under section 13.3 of this chapter.

(b) The office shall administer the fund.

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

(1) Fees collected under section 13.3 of this chapter.

(2) Donations, gifts, and money received from any other source.

(3) Interest accrued under this section.

(d) Money in the fund may be used only for the following:

(1) To fund ~~exclusively~~ the state share of the expenses listed in section 13.3(b)(1)(A) through 13.3(b)(1)(F) of this chapter.

(2) To refund hospitals in the same manner as described in subsection (g) as soon as reasonably possible after the beginning of ~~a phase out period of~~ **the termination of** the healthy Indiana plan.

(3) To fund the Medicaid program.

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

(f) 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.

(g) Upon the beginning of ~~a phase out period of~~ **the termination of** the healthy Indiana plan, money collected under section 13.3 of this chapter and any accrued interest remaining in the fund shall be distributed to the hospitals on a pro rata basis based upon the fees authorized by this chapter that were paid by each hospital for the state fiscal year that ended immediately before the beginning of the ~~phase out period.~~ **termination of the healthy Indiana plan.**

SECTION 32. 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.

(c) Subject to budget committee review, for any state fiscal year for which the managed care assessment fee under IC 27-1-50.3 is assessed in an amount that is at least equal to the net amount set forth in subsection (b)(1), the fee may be used to fund a state directed payment, as described in section 8.5 of this chapter.

SECTION 33. 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 34. 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 35. IC 16-21-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 18. Hospital Statewide Average Rate Study and Pricing

Sec. 1. Except as provided in section 2 of this chapter, as used in this chapter, "hospital" refers to a hospital licensed under IC 16-21-2.

Sec. 2. For purposes of this chapter, "Indiana nonprofit hospital

system" means a hospital that:

(1) 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:

(A) eligible for tax exempt bond financing; or

(B) exempt from state or local taxes;

(2) is licensed under IC 16-21-2;

(3) filed jointly one (1) hospital audited financial statement with the Indiana department of health in 2021; and

(4) has an annual patient service revenue derived in Indiana of at least two billion dollars ($2,000,000,000) based on the hospital system's most recently submitted audited financial statements submitted under IC 16-21-6-13. As used in this subdivision, "patient service revenue" includes similar terms, including net patient service revenue and patient care service revenue.

Sec. 3. As used in this chapter, "prices" means the amounts that are paid for patient care services.

Sec. 4. (a) The office of management and budget shall develop a methodology to conduct the study of commercial:

(1) inpatient hospital prices; and

(2) outpatient hospital prices;

including using Indiana hospital pricing data from calendar years 2023 and 2024 to determine Indiana's statewide average inpatient and outpatient hospital prices.

(b) The office of management and budget shall present the methodology to the budget committee for review.

Sec. 5. (a) Before June 30, 2026, the office of management and budget shall conduct the study described in section 4 of this chapter, using the methodology that was reviewed by the budget committee.

(b) The office of management and budget shall submit a report to the governor and to the general assembly in an electronic format under IC 5-14-6 of the office of management and budget's findings under the study.

Sec. 6. A hospital shall provide the office of management and budget in:

(1) the manner prescribed by the office of management and budget; and

(2) a timely manner;

with any data requested by the office of management and budget to conduct a study required under this chapter.

Sec. 7. (a) Not later than June 30, 2029, an Indiana nonprofit hospital system's aggregate average inpatient and outpatient hospital prices shall at least be equal to or less than the statewide average inpatient and outpatient hospital prices determined by the office of management and budget under this chapter.

(b) If the Indiana nonprofit hospital system violates subsection (a), the Indiana nonprofit hospital system shall forfeit its nonprofit status for purposes of IC 6 for at least one (1) year.

(c) An Indiana nonprofit hospital system that forfeits its status as a nonprofit hospital under subsection (b) may reestablish the Indiana nonprofit hospital system's nonprofit tax exempt status under IC 6 if the office of management and budget determines that the Indiana nonprofit hospital system's average inpatient and outpatient hospital prices comply with this section.

(d) An Indiana nonprofit hospital system's forfeiture of its status as a nonprofit hospital under this section is subject to IC 4-21.5.

SECTION 36. 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. (a) Before October 1 of each year, every nonprofit hospital shall provide the state department with the entirety of the Schedule H portion of the nonprofit hospital's previous taxable year's federal Form 990, including the following forms and the itemized data used to complete these 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.

(b) Not later than November 1 of each year, the state department shall submit the forms provided by a nonprofit hospital under subsection (a) to the health care cost oversight task force (established by IC 2-5-47-3) in an electronic format under IC 5-14-6 and in a manner that allows for publication of the forms on the general assembly's website.

Sec. 3. Prior to providing 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).

Sec. 4. If a nonprofit hospital fails to submit the forms required under section 2 of this chapter before October 1 of any year, the state department shall fine the nonprofit hospital system ten thousand dollars ($10,000) per day for which the forms are past due. A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-18.5.

SECTION 37. IC 16-51-1-1, AS ADDED BY P.L.203-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) This chapter applies to an Indiana nonprofit hospital system.

(b) This chapter does not apply to the following:

(1) A hospital licensed under IC 16-21-2 that is operated by:

(A) a county;

(B) a city pursuant to IC 16-23; or

(C) the health and hospital corporation established under IC 16-22-8.

(2) A critical access hospital that meets the criteria under 42 CFR 485.601 through 42 CFR 485.647.

(3) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(4) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(5) An oncology treatment facility, even if owned or operated by a hospital.

(6) A health facility licensed under IC 16-28.

(7) A community mental health center certified under IC 12-21-2-3(5)(C).

(8) A private mental health institution licensed under IC 12-25, including a service facility location for a private mental health institution and reimbursed as a hospital-based outpatient service site.

(9) A facility that:

(A) has a place of service code 20, as published in the place of service code set maintained by the federal Centers for Medicare and Medicaid Services; and

(B) is located in a municipality with a population of less than twenty thousand (20,000).

~~(9)~~ **(10)** Services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders in:

(A) any part of a hospital, whether or not a distinct part; or

(B) an outpatient off campus site that is within thirty-five (35) miles of a hospital.

~~(10)~~ **(11)** Billing under the Medicare program or a Medicare advantage plan.

~~(11)~~ **(12)** Billing under the Medicaid program.

SECTION 38. IC 27-1-15.6-13.5, AS ADDED BY P.L.50-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13.5. (a) This section applies only to the following:

(1) ~~A~~ **An individual,** group, **franchise, or blanket** policy of accident and sickness insurance, as defined in IC 27-8-5-1. However, this section does not apply to the types of insurance and coverage described in IC 27-8-5-2.5(a).

(2) ~~A~~ **An individual or** group health maintenance organization contract entered into under IC 27-13.

(b) As used in this section, "third party administrator" means a person who:

(1) is licensed under IC 27-1-25; and

(2) administers a policy of accident and sickness insurance described in subsection (a)(1) or a health maintenance organization contract described in subsection (a)(2).

~~(b)~~ **(c)** Except as provided in subsection ~~(c),~~ **(f),** an insurer that issues an insurance policy, ~~or~~ a health maintenance organization that enters into a health maintenance organization contract, **or a third party administrator** shall disclose to the policyholder or subscriber in a separate written notification:

(1) any commission, service fee, or brokerage fee that has been or will be paid to an insurance producer for selling, soliciting, or negotiating the policy or contract; and

(2) whether the amount disclosed under subdivision (1) is based on a percentage of total plan premiums or a flat per member fee.

~~(c)~~ **(d)** An insurer, ~~or~~ **a** health maintenance organization, **or a third party administrator** shall provide a copy of the written notification described in subsection ~~(b)~~ **(c)** to the policyholder or subscriber:

(1) when the insurance policy is issued or the contract is entered into; and

(2) each time the insurance policy or contract is renewed.

~~(d)~~ **(e)** Each copy of a written notification described in subsection ~~(b)~~ **(c)** must include a signature line on which the policyholder may sign to acknowledge receiving the written notification.

~~(c)~~ **(f)** This section does not require the disclosure to the policyholder of a commission, service fee, or brokerage fee in connection with the issuance of an insurance policy if a federal law or regulation requires disclosure of the commission, service fee, or brokerage fee to the policyholder.

(g) An insurer, a health maintenance organization, and a third party administrator shall submit the information described in subsection (c) to the executive director of the all payer claims data base established under IC 27-1-44.5 for inclusion in the data base.

(h) The department shall perform an examination under IC 27-1-3.1 for any alleged violation of this section.

SECTION 39. IC 27-1-15.6-13.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13.6. (a) This section applies to the sale, solicitation, or negotiation by an insurance producer of the following:**

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1) issued on a group, a franchise, or a blanket basis. However, this section does not apply to the types of insurance and coverage described in IC 27-8-5-2.5(a).

(2) A group health maintenance organization contract entered into under IC 27-13.

(b) An insurance producer shall comply with 29 U.S.C. 1108(b)(2).

(c) Before or at the time of sale of a group policy, an insurance producer and a third party administrator shall do the following:

(1) Provide the plan sponsor with a statement from the insurer or health maintenance organization that discloses the amount that will be paid to the insurance producer or third party administrator for the sale of the group policy. The plan sponsor shall sign the statement in acknowledgment of receipt of the statement.

(2) Disclose any additional fees other than those disclosed under subdivision (1) that the insurance producer or third party administrator may receive, including any planning fee.

(d) Before January 1, 2026, the department shall establish a process for a person to report a violation of this section.

(e) Upon receiving a report of a violation under this section, the department shall:

(1) issue a notice to the insurance producer of the report of a violation of this section;

(2) investigate the report; and

(3) if the department determines that the insurance producer has violated this section at least three (3) times in a twelve (12) month period, the commissioner shall assess the insurance producer with an appropriate penalty set forth in section 12 of this chapter.

SECTION 40. IC 27-1-24.5-25, AS AMENDED BY P.L.152-2024, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 25. (a) A contract holder may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the contract holder, the audit shall include full

disclosure of the following data specific to the contract holder:

(1) Rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer. The information provided under this subdivision must identify the prescription drugs by therapeutic category.

(2) Pharmaceutical and device claims received by the pharmacy benefit manager on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any other revenue and fees derived by the pharmacy benefit manager from the contract, including all direct and indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee, or another term.

(b) A pharmacy benefit manager may not impose the following:

(1) Fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the pharmacy benefit manager.

(2) Conditions that would restrict a contract holder's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

(c) A pharmacy benefit manager shall disclose, upon request from a contract holder, to the contract holder the actual amounts directly or indirectly paid by the pharmacy benefit manager to the pharmacist or pharmacy for the drug and for pharmacist services related to the drug.

(d) A pharmacy benefit manager shall provide notice to a contract holder contracting with the pharmacy benefit manager of any consideration, including direct or indirect remuneration, that the pharmacy benefit manager receives from a pharmaceutical manufacturer or group purchasing organization for formulary placement or any other reason.

(e) The commissioner may establish a procedure to release information from an audit performed by the department to a contract holder that has requested an audit under this section in a manner that does not violate confidential or proprietary information laws.

(f) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(g) A pharmacy benefit manager shall:

(1) obtain any information requested in an audit under this section from a group purchasing organization or other partner entity of the pharmacy benefit manager; and

(2) ~~confirm receipt of a request for an audit under this section~~ **provide claims data** to the contract holder not later than ~~ten (10)~~ **fifteen (15)** business days after the information **or claims data** is requested.

(h) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 41. IC 27-1-24.6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 24.6. Disclosure of Negotiated Rate

Sec. 1. This chapter applies to generic drugs covered under a

health plan after December 31, 2025.

Sec. 2. As used in this chapter, "generic drug" has the meaning set forth in IC 27-1-24.5-4.

Sec. 3. As used in this chapter, "health plan" means the following:

(1) A state employee health plan (as described in IC 5-10-8-7).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) that provides coverage for basic health care services (as defined in IC 27-13-1-4.

Sec. 4. As used in this chapter, "national average drug acquisition cost" means the average price pharmacies pay for a prescription drug. The term does not include a dispensing fee or a professional fee.

Sec. 5. As used in this chapter, "plan sponsor" means:

(1) an employer or organization that offers health insurance coverage to its employees or members under a health plan; or

(2) for purposes of an individual policy of accident and sickness insurance or an individual contract, the policyholder.

Sec. 6. A health plan must provide the amount of the national average drug acquisition cost for a generic drug to the plan sponsor.

SECTION 42. IC 27-1-24.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 24.7. Disclosure of Rebates

Sec. 1. This chapter applies to an agreement between a pharmacy benefit manager and a health plan regarding prescription drugs that is entered into, renewed, or renegotiated after December 31, 2025. This chapter does not apply to a health plan, with point of sale rebates, if at least eighty-five percent (85%) of the estimated rebates are deducted from the cost of prescription drugs dispensed at a pharmacy or via mail order before a covered individual's cost sharing requirement is determined.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 3. As used in this chapter, "health plan" means the following:

(1) A state employee health plan (as described in IC 5-10-8-7).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(3) An individual contract (as defined in IC 27-13-1-21) and a group contract (as defined in IC 27-13-1-16).

(4) Any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for the cost of prescription drugs.

Sec. 4. As used in this chapter, "policyholder" means an individual in whose name a health plan is held.

Sec. 5. As used in this chapter, "prescription drug" means a controlled substance or a legend drug (as defined in IC 16-18-2-199).

Sec. 6. (a) As used in this chapter, "rebate" means a discount or other price concession that is:

(1) based on the use of a prescription drug; and

(2) paid by a manufacturer or a third party to a pharmacy benefit manager (as defined in IC 27-1-24.5-12), pharmacy services administrative organization (as defined in IC 27-1-24.5-15), or pharmacy (as defined in IC 27-1-24.5-11) after a claim has been processed and paid at a pharmacy.

(b) The term includes an incentive and a disbursement.

Sec. 7. An agreement to which this chapter applies must contain a contractual provision that requires the pharmacy benefit manager to provide on an annual basis, not later than sixty (60) days after the end of each policy year, a notice to a policyholder that states the following:

(1) An explanation of what a rebate is.

(2) An explanation of how rebates accrue to a health plan from a manufacturer.

(3) The aggregate amount of rebates for all prescription drugs dispensed or administered to covered individuals on the policyholder's health plan that accrued to the health plan during the previous policy year. This information may not include any information about an individual prescription drug, including the name, manufacturer, quantity, or dosage of a prescription drug.

The notice required by this section may be provided by first class mail or electronic mail.

SECTION 43. IC 27-1-36.8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 36.8. Hospital Health Care Provider Contracts

Sec. 1. This chapter applies to a hospital health care provider contract entered into, amended, or renewed after June 30, 2025.

Sec. 2. (a) As used in this chapter, "health carrier" means an entity that enters into a contract to:

(1) provide health care services;

(2) deliver health care services;

(3) arrange for health care services; or

(4) pay for or reimburse any of the cost of health care services.

(b) The term includes the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1(a)).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization.

(4) A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

(5) An employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), including any third party administrator or an employee benefit plan.

(6) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

Sec. 3. As used in this chapter, "hospital" means a hospital licensed under IC 16-21.

Sec. 4. As used in this chapter, "hospital health care provider contract" means an agreement between a hospital and a health carrier concerning terms and conditions of reimbursement for health care services provided to an individual under any of the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1(a)).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization.

(4) A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

(5) An employee benefit plan that is subject to the federal

Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), including any third party administrator or an employee benefit plan.

Sec. 5. A hospital may not enter into a hospital health care provider contract that includes a provision that links to or negotiates reimbursement or terms under a separate:

(1) hospital health care provider contract; or

(2) product.

SECTION 44. IC 27-1-37-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6.5. (a) As used in this section, "health plan" means any of the following that provides coverage for health care services:**

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) Before July 1, 2026, the office of management and budget shall study the effect, including the fiscal impact, of requiring physician reimbursement rates under a commercial health plan to be at a minimum rate.

(c) The office of management and budget shall report the findings of the study under this section to:

(1) the governor; and

(2) the general assembly in an electronic format under IC 5-14-6.

(d) This section expires December 31, 2026.

SECTION 45. IC 27-1-44.5-2, AS AMENDED BY P.L.190-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. As used in this chapter, "health payer" includes the following:

(1) Medicare.

(2) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that has contracted with Medicaid to provide services to a Medicaid recipient.

(3) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).

(6) An administrator (as defined in IC 27-1-25-1).

(7) A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

(8) An employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), including a third party administrator of an employee benefit plan.

(9) A state employee health plan (as defined in IC 5-10-8-6.7(a)).

(10) An insurance producer, for purposes of the required reporting under IC 27-1-15.6-13.6.

~~(10)~~ **(11)** Any other person identified by the commissioner for participation in the data base described in this chapter.

SECTION 46. IC 27-1-46.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 46.5. Direct to Employer Health Care Arrangements

Sec. 1. As used in this chapter, "direct to employer health care arrangement" means an arrangement between:

(1) a hospital;

(2) a hospital system;

(3) an Indiana nonprofit hospital system; or

(4) a narrow network of hospitals;

and an employer that provides health care benefits for covered services under an employee benefits plan.

Sec. 2. As used in this chapter, "full Medicare" refers to the amount the Medicare program pays for a covered service, including all hospital-specific Medicare adjustments.

Sec. 3. (a) As used in this chapter and except as provided in subsection (b), "hospital" means an acute care hospital licensed under IC 16-21.

(b) The term does not include the following:

(1) A hospital specifically intended to diagnose, care, and treat the following:

(A) Individuals with a mental illness (as defined in IC 12-7-2-117.6).

(B) Individuals with a developmental disability (as defined in IC 12-7-2-61).

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

(3) A hospital that is a Medicare certified, freestanding rehabilitation hospital.

(4) A hospital that is operated by the federal government.

(5) A critical access hospital.

(6) A rural emergency hospital.

Sec. 4. As used in this chapter, "hospital system" means one (1) or more hospitals, all of which are related by direct or indirect common control or ownership.

Sec. 5. As used in this chapter, "Indiana nonprofit hospital system" means a hospital system that:

(1) 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:

(A) eligible for tax exempt bond financing; or

(B) exempt from state or local taxes;

(2) filed jointly one (1) audited financial statement with the Indiana department of health in the preceding calendar year; and

(3) has an annual net patient service revenue derived in Indiana of at least two billion dollars ($2,000,000,000), based on the hospital system's most recently submitted audited financial statement filed with the Indiana department of health. As used in this subdivision, "patient service revenue" includes similar terms, including net patient service revenue and patient care service revenue.

Sec. 6. As used in this chapter, "narrow network" means an arrangement that limits the hospitals that a covered individual may use to obtain covered services under an employee benefit plan.

Sec. 7. As used in this chapter, "prices" means the amounts that are paid for patient care services.

Sec. 8. As used in this chapter, "third party administrator" means an individual or entity that performs administrative services for a direct to employer health care arrangement.

Sec. 9. (a) Beginning September 1, 2025, an Indiana nonprofit hospital system shall offer a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare.

(b) The benchmark described in subsection (a) shall be calculated by taking the sum of:

(1) hospital inpatient facility prices; and

(2) hospital outpatient facility prices;

expressed as a percentage of full Medicare.

(c) An Indiana nonprofit hospital system meets the requirements of subsection (a) by doing any of the following:

(1) Offering a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare at each individual hospital within the Indiana nonprofit hospital system.

(2) Offering a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare as an Indiana nonprofit hospital system.

(3) Participating in a narrow network of hospitals to offer a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare.

(d) Beginning October 1, 2025, and before every October 1 thereafter, an Indiana nonprofit hospital system shall cooperate with an audit by the Indiana department of health to determine compliance with this section.

(e) The Indiana department of health shall assess an Indiana nonprofit hospital system that the Indiana department of health determines through an audit has violated this section with a civil penalty of ten thousand dollars ($10,000) per day per hospital for which the Indiana nonprofit hospital system is unable to demonstrate compliance with this section. A fine collected under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

Sec. 10. (a) Beginning September 1, 2026, a hospital that is not a part of an Indiana nonprofit hospital system shall offer a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare.

(b) The benchmark described in subsection (a) shall be calculated by taking the sum of:

(1) hospital inpatient facility prices;

(2) hospital outpatient facility prices; and

(3) professional fee for services provided to a patient by an employed qualified practitioner;

expressed as a percentage of full Medicare.

(c) A hospital meets the requirements of subsection (a) by doing any of the following:

(1) Offering a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare as an individual hospital.

(2) Offering a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare as a hospital system.

(3) Participating in a narrow network of hospitals to offer a direct to employer health care arrangement that is at or below a benchmark of two hundred sixty percent (260%) of full Medicare.

(d) Beginning October 1, 2026, and before every October 1 thereafter, a hospital shall cooperate with an audit by the Indiana department of health to determine compliance with this section.

(e) The Indiana department of health shall assess a hospital that the Indiana department of health determines through an audit has violated this section with a civil penalty of ten thousand dollars ($10,000) per day per hospital that is unable to demonstrate compliance with this section. A fine collected under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

Sec. 11. (a) Not later than thirty (30) days after a request by a contract holder of a direct to employer health care arrangement, a third party administrator that has contracted to administer a direct to employer health care arrangement shall provide claims data to the contract holder. The claims data must include the following:

(1) The effective date of coverage.

(2) The total number of covered individuals.

(3) The total monthly earned premium.

(4) The total monthly dollar value of paid claims, regardless of the period in which the claims were incurred.

(5) The:

(A) beginning and end date of the period for which claims

were paid; and

(B) percentage of claims that were paid in:

(i) less than thirty (30) days;

(ii) thirty (30) days to sixty (60) days;

(iii) sixty-one (61) to ninety (90) days; and

(iv) over ninety (90) days.

(6) The reserve value as of the beginning of the period and the reserve value as of the date through which the paid claims data was obtained.

(7) A description of each large or catastrophic claim exceeding fifty thousand dollars ($50,000), including:

(A) the diagnosis;

(B) the dollar amount of the claim;

(C) whether the claim is opened or closed; and

(D) the length of time the claim was open.

(8) Any other claims data requested by the contract holder.

(b) Information provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act, including 45 CFR Part 160 and Part 164, Subparts A and E.

(c) Before January 1, 2026, the department shall establish a process for a contract holder of a direct to employer health care arrangement to file a complaint with the department that a third party administrator violated this section. The department shall conduct an examination under IC 27-1-3.1 upon receiving a complaint under this subsection.

SECTION 47. 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). The term does not include an organization that only offers a policy, plan, or coverage set forth in IC 27-8-5-2.5(a).

(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 United States Department of Health and Human Services' 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 the 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 fee holding 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 reverts 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 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 fee holding 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 fee holding 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 48. IC 27-2-25.5-1, AS ADDED BY P.L.203-2023, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) Not more than ~~twice annually~~ **four (4) times per calendar year** for a contract holder, a third party administrator, an insurer (as defined in IC 27-1-2-3(x)) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1(a)), or a health maintenance organization (as defined in IC 27-13-1-19) that has contracted to administer a self-funded group plan or a fully insured group plan shall provide claims data to the contract holder for which the contract was entered into not later than fifteen (15) business days from a request for the claims data. The claims data must include the following:

(1) The effective date of coverage.

(2) The total number of covered individuals.

(3) The total monthly earned premium.

(4) The total monthly dollar value of paid claims, regardless of the period in which the claims were incurred.

(5) The:

(A) beginning and ending date of the period for which claims were paid; and

(B) percentage of claims that were paid in:

(i) less than thirty (30) days;

(ii) thirty (30) days to sixty (60) days;

(iii) sixty-one (61) days to ninety (90) days; and

(iv) over ninety (90) days.

(6) For groups insuring at least one hundred (100) employees:

(A) the reserve value as of the beginning of the period; and

(B) the reserve value as of the date through which the paid claims data was obtained.

(7) A description of each large or catastrophic claim exceeding fifty thousand dollars ($50,000), including:

(A) the diagnosis;

(B) the dollar amount of the claim;

(C) whether the claim is opened or closed; and

(D) the length of time the claim was open.

(8) Any other claims data requested by the contract holder.

(b) The department may prescribe the format and manner for the submission of the data described in subsection (a) with the purpose of ensuring that the information is provided in an easily readable manner.

(c) Information provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act, including 45 CFR Part 160 and Part 164, Subparts A and E.

(d) The department shall perform an examination under IC 27-1-3.1 for any alleged violation of this section.

SECTION 49. IC 27-2-25.5-4, AS ADDED BY P.L.152-2024, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure of the following concerning data specific to the plan sponsor, office of the secretary, or state personnel department:

(1) Claims data described in section 1 of this chapter.

(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability

Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any fees charged to the plan sponsor, office of the secretary of family and social services, or state personnel department related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

(b) A third party administrator, managed care organization, or prepaid health care delivery plan may not impose:

(1) fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or

(2) conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

(c) A third party administrator, managed care organization, or prepaid health care delivery plan shall ~~confirm receipt of a request for an audit under this section to the plan sponsor, office of the secretary of family and social services, or state personnel department~~ **provide**

claims data to the contract holder not later than ~~ten (10)~~ **fifteen (15)** business days after the ~~information~~ **claims data** is requested.

(d) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(e) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(f) A violation of this section is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(g) The department may also adopt rules under IC 4-22-2 to set forth fines for a violation under this section.

SECTION 50. IC 27-8-5-1.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.7. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.**

(b) A filer under section 1.5 of this chapter shall file the following information with the commissioner as part of the filing under this chapter:

(1) The change in hospital reimbursement for inpatient and outpatient services from the preceding calendar year.

(2) The impact of the change described in subdivision (1) to policy premiums.

(c) The department shall annually submit a report to:

(1) the general assembly, in an electronic format under IC 5-14-6; and

(2) the governor;

summarizing the information submitted to the department under subsection (b).

SECTION 51. IC 27-13-20-1.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.3. (a) A health maintenance organization shall file the following information with the commissioner as part of the filing under this chapter:**

(1) The change in hospital reimbursement for inpatient and outpatient services from the preceding calendar year.

(2) The impact of the change described in subdivision (1) to policy premiums.

(b) The department shall annually submit a report to:

(1) the general assembly, in an electronic format under IC 5-14-6; and

(2) the governor;

summarizing the information submitted to the department under subsection (a).

SECTION 52. [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.

(e) This SECTION expires July 1, 2027.

SECTION 53. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____