IC 16-21-10

Chapter 10. Hospital Assessment Fee

IC 16-21-10-1

"Committee"

Sec. 1. As used in this chapter, "committee" refers to the hospital assessment fee committee established by section 7 of this chapter.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-2

"Fee"

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

As added by P.L.205-2013, SEC.214.

IC 16-21-10-3

"Fee period"

Sec. 3. As used in this chapter, "fee period" means the period during which a fee is collected under this chapter.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-4

"Hospital"

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.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-5

"Office"

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

As added by P.L.205-2013, SEC.214.

IC 16-21-10-6

Authority to assess hospital assessment fee; prerequisites;

conditions for terminating the fee; records and reports

Sec. 6. (a) Subject to subsection (b) 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 9 of this chapter.

(C) Section 11 of this chapter.

(D) 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) The funds generated from the fee do not revert to the state general fund.

(b) The office shall stop collecting a fee, the programs described in section 8(a) of this chapter shall be reconciled and terminated subject to section 9(c) of this chapter, and the operation of section 11 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) 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.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-7

Hospital assessment fee committee established; membership; meeting requirements

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.

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.

(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, or revisions to the Medicaid state plan or waiver requests. *As added by P.L.205-2013, SEC.214. Amended by P.L.2-2014, SEC.77.*

IC 16-21-10-8

Mandatory programs for increasing Medicaid reimbursement; committee review of state plan amendments, waivers, or revisions; report to budget committee; state share dollars; termination of fee

Sec. 8. (a) Subject to subsection (b), the office shall 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.

(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 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 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.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-9

Hospital Medicaid fund established; purposes; distribution of excess if fee is terminated

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 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 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) of this chapter shall be used for the payments described in sections 8(a) and 11 of this chapter. Any money 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) 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) of this chapter.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-10

Use of hospital care for the indigent funds as state share dollars

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) 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).

As added by P.L.205-2013, SEC.214.

IC 16-21-10-11

Disproportionate share payments; allocations of federal Medicaid disproportionate share allotments

Sec. 11. (a) This section:

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

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

(b) 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 section 12 of this chapter and except as provided in section 12 of this chapter, 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.
As added by P.L.205-2013, SEC.214.

IC 16-21-10-12
Funds excluded from federal Medicaid disproportionate share allotments

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

(1) The federally approved Indiana "Special Terms and Conditions" Medicaid demonstration project (Number 11-W-00237/5).

(2) Any extension after December 31, 2012, of the Indiana check-up plan established under IC 12-15-44.2.

The office shall inform the committee and the budget committee concerning any extension of the Indiana check-up plan after December 31, 2013.
As added by P.L.205-2013, SEC.214.

IC 16-21-10-13
Disproportionate share dollars that are unavailable to private psychiatric institutions

Sec. 13. Notwithstanding IC 12-15-16-6(c), the annual two million dollar ($2,000,000) pool of disproportionate share dollars under IC 12-15-16-6(c) shall not be available to eligible private psychiatric institutions. The office shall annually distribute two million dollars ($2,000,000) to eligible private psychiatric institutions that would have been eligible for payment under IC 12-15-16-6(c).
As added by P.L.205-2013, SEC.214.

IC 16-21-10-14
Permissible uses of hospital assessment fees

Sec. 14. The fees collected under 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.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-15

Rule of statutory construction; local fees, taxes, or assessments not permitted

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

As added by P.L.205-2013, SEC.214.

IC 16-21-10-16

Rules

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

As added by P.L.205-2013, SEC.214.

IC 16-21-10-17

Installment agreements

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

As added by P.L.205-2013, SEC.214.

IC 16-21-10-18

Interest on late payments; license revocations for payments at least 120 days overdue

Sec. 18. (a) A hospital shall pay to the office interest on any fee that is paid eleven (11) or more days after the payment date. The interest must be applied at the same rate as the rate determined under IC 12-15-21-3(6)(A).

(b) The office shall report to the state department of health each hospital that fails to pay the fee within one hundred twenty (120) days after the payment date. The state department shall do the following concerning a hospital described in this subsection:

(1) Notify the hospital that the hospital's license under IC 16-21 will be revoked if the fee is not paid.

(2) Revoke the hospital's license under IC 16-21 if the hospital fails to pay the fee. IC 4-21.5-3-8 and IC 4-21.5-4 apply to this subdivision.

As added by P.L.205-2013, SEC.214.

IC 16-21-10-19

Program payments

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 may occur at any time, including after collection of the fee is stopped under section 6(b) 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) of this chapter, subject to the reconciliation and termination of the program required by section 6(b) of this chapter.
As added by P.L.205-2013, SEC.214.

IC 16-21-10-20
Collection of unpaid fees; refunds

Sec. 20. The office may collect unpaid fees owed by a hospital under this chapter and may refund fees paid by a hospital under this chapter at any time, including after the cessation of the collection of a fee under this chapter.
As added by P.L.205-2013, SEC.214.

IC 16-21-10-21
Expiration date

Sec. 21. This chapter expires June 30, 2017.
As added by P.L.205-2013, SEC.214.