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 16-21-10-5.3

Determination of a phase out period

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.

As added by P.L.213-2015, SEC.140. Amended by P.L.30-2016, SEC.37.

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 13.3 of this chapter.

(E) 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. Amended by P.L.213-2015, SEC.141.

IC 16-21-10-7

Hospital assessment fee committee established; membership; meeting requirements; requirements for approval and determinations concerning the healthy Indiana plan 2.0 and incremental fee

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.

(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.

As added by P.L.205-2013, SEC.214. Amended by P.L.2-2014, SEC.77; P.L.213-2015, SEC.142.

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) 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 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. Amended by P.L.213-2015, SEC.143.

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 section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 if 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) 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.

(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.

As added by P.L.205-2013, SEC.214. Amended by P.L.213-2015, SEC.144.

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) 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) 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) 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. Amended by P.L.213-2015, SEC.145; P.L.30-2016, SEC.38.

IC 16-21-10-12

Repealed

(As added by P.L.205-2013, SEC.214. Amended by P.L.213-2015, SEC.146. Repealed by P.L.30-2016, SEC.39.)

IC 16-21-10-13

Disproportionate share dollars that are unavailable to private psychiatric institutions

Sec. 13. This section does not apply to the use of the incremental fee described in section 13.3 of this chapter. 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. Amended by P.L.213-2015, SEC.147.

IC 16-21-10-13.3

Incremental fees; uses; requirements before collection can occur; deposit of incremental fees; limitations on use of incremental fees to fund the state share of expenses

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 establishes a fee formula to be used to fund the state share of the following expenses described in this subdivision:

(A) The state share of the capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees other than plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act.

(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).

(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 health care services provided to individuals enrolled in Medicaid programs other than the plan.

(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.

(G) The money described in IC 12-15-44.5-6(a) for the phase out period of the plan.

(2) The committee 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)(G).

The fees collected under subdivision (1)(A) through (1)(F) shall be deposited into the incremental hospital fee fund established by section 13.5 of this chapter. Fees described in subdivision (1)(G) shall be deposited into the phase out trust fund described in IC 12-15-44.5-7. The fees used for purposes of funding the state share of expenses listed in subdivision (1)(A) through (1)(F) may not be used to fund expenses incurred on or after the commencement of a phase out period of the plan.

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

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

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

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

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

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

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

As added by P.L.213-2015, SEC.148. Amended by P.L.30-2016, SEC.40.

IC 16-21-10-13.5

Incremental hospital fee fund established; content; administration;

uses; distribution of remaining fund during phase out period to hospitals

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 healthy Indiana plan.

(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 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.

As added by P.L.213-2015, SEC.149. Amended by P.L.30-2016, SEC.41.

IC 16-21-10-14

Permissible uses of hospital assessment fees

Sec. 14. This section does not apply to the use of the incremental fee described in section 13.3 of this chapter. 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.

As added by P.L.205-2013, SEC.214. Amended by P.L.213-2015, SEC.150.

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.