HOUSE BILL No. 1393

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15; IC 16-21-10; IC 27-1-3-10.

Synopsis: Managed care and hospital assessment fee. Authorizes the managed care assessment fee to be assessed against specified insurers and administered by the office of the secretary of family and social services. Establishes the managed care assessment fee committee. Sets forth requirements of the managed care assessment fee. Establishes the high risk pool fund. Expires the managed care assessment fee on June 30, 2025. Allows certain providers to contractually agree to a different reimbursement rate with a managed care organization as part of a value based services contract. Excludes hospitals and private psychiatric hospitals. Provides for payments to hospitals out of the phase out trust fund and expires the fund. Exempts: (1) physician owned hospitals; and (2) hospitals that only provide respite care to certain individuals; from the hospital assessment fee. Makes assessment of the hospital assessment fee subject to federal approval of changes made by this act. Requires the hospital assessment fee committee to: (1) review and approve the quality program; and (2) be guided to ensure hospitals are reimbursed at a rate that meets specified requirements. Specifies components of a state directed payment program. Specifies uses of the hospital assessment fee and that hospital assessment fees will not be used for disproportionate share payments if the state directed payment program is implemented. Reduces the hospital fee assessment by the managed care assessment fee and the payment from the phase out trust fund. Requires the commissioner of the department of insurance to revoke or suspend the authority of a managed care organization to do business in Indiana if the managed care organization fails to pay the

(Continued next page)

Effective: Upon passage.

Barrett

January 11, 2024, read first time and referred to Committee on Public Health.

managed care assessment fee. Repeals language concerning the hospital care for the indigent program. Repeals language specifying the distribution of the hospital assessment fee.

Introduced

Second Regular Session of the 123rd General Assembly (2024)

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 2023 Regular Session of the General Assembly.

HOUSE BILL No. 1393

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

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

SECTION 1. IC 12-7-2-16.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 16.7. "Assessment period", for purposes of IC 12-15-29.5, has the meaning set forth in IC 12-15-29.5-1.**

SECTION 2. IC 12-7-2-35, AS AMENDED BY P.L.184-2017, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 35. **(a) "Committee", for purposes of IC 12-15-29.5, has the meaning set forth in IC 12-15-29.5-2.**

(b) "Committee", for purposes of IC 12-15-33, has the meaning set forth in IC 12-15-33-1.

SECTION 3. IC 12-7-2-57.5, AS AMENDED BY P.L.146-2008, SECTION 378, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 57.5. **(a)** "Department", for purposes of IC 12-13-14, has the meaning set forth in IC 12-13-14-1.

(b) "Department", for purposes of IC 12-15-29.5, has the

meaning set forth in IC 12-15-29.5-3.

SECTION 4. IC 12-7-2-85.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 85.7. "Fee", for purposes of IC 12-15-29.5, has the meaning set forth in IC 12-15-29.5-4.**

SECTION 5. IC 12-7-2-91, AS AMENDED BY P.L.246-2023, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 91. "Fund" means the following:

(1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.

(2) For purposes of IC 12-15-20, the meaning set forth in IC 12-15-20-1.

(3) For purposes of IC 12-15-29.5, the meaning set forth in IC 12-15-29.5-5.

~~(3)~~ **(4)** For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.

~~(4)~~ **(5)** For purposes of IC 12-17.2-7.2, the meaning set forth in IC 12-17.2-7.2-4.7.

~~(5)~~ **(6)** For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-3.

~~(6)~~ **(7)** For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.

~~(7)~~ **(8)** For purposes of IC 12-23-18, the meaning set forth in IC 12-23-18-4.

~~(8)~~ **(9)** For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.

~~(9)~~ **(10)** For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.

~~(10)~~ **(11)** For purposes of IC 12-30-7, the meaning set forth in IC 12-30-7-3.

SECTION 6. IC 12-7-2-126.9, AS ADDED BY P.L.152-2017, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 126.9. **(a)** "Managed care organization", **except as provided in subsection (b),** means a person that has a comprehensive risk contract with the office of Medicaid policy and planning under IC 12-15.

(b) "Managed care organization", for purposes of IC 12-15-29.5, has the meaning set forth in IC 12-15-29.5-6.

SECTION 7. IC 12-7-2-143.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 143.3. "Premium revenue", for purposes of IC 12-15-29.5, has the meaning set forth in**

IC 12-15-29.5-8.

SECTION 8. IC 12-7-2-186.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 186.3. "State share", for purposes of IC 12-15-29.5, has the meaning set forth in IC 12-15-29.5-9.**

SECTION 9. IC 12-15-29.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 29.5. Managed Care Assessment Fee

Sec. 1. As used in this chapter, "assessment period" refers to the state fiscal years for which a fee may be assessed under this chapter.

Sec. 2. As used in this chapter, "committee" means the managed care assessment fee committee established by section 11 of this chapter.

Sec. 3. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

Sec. 4. As used in this chapter, "fee" means the managed care assessment fee authorized under this chapter.

Sec. 5. As used in this chapter, "fund" means the high risk pool fund established by section 15 of this chapter.

Sec. 6. As used in this chapter, "managed care organization" means the following:

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

(2) A Medicaid managed care organization, as defined in IC 12-7-2-126.9.

(3) A preferred provider organization that is subject to the requirements of IC 27-8-11-5.

(4) Any other type of organization recognized as a managed care organization under Indiana law, as determined by the commissioner of the department in accordance with 42 U.S.C. 1396b(w)(7)(A)(viii).

Sec. 7. As used in this chapter, "office of the secretary" refers to the office of the secretary of family and social services.

Sec. 8. As used in this chapter, "premium revenue" means money or any other item of value given in consideration to a managed care organization for coverage of individuals, including policy fees, admission fees, or membership fees.

Sec. 9. As used in this chapter, "state share" means the portion of allowable Medicaid expenses funded by the state or other local

units of government, or as permitted by federal Medicaid laws by other entities other than the federal government.

Sec. 10. For purposes of this chapter, each managed care organization described in section 6(1) through 6(4) of this chapter is considered to be a separate class of a managed care organization.

Sec. 11. (a) The managed care assessment fee committee is established. The committee consists of the following eight (8) 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 chairperson of the committee.

(2) The commissioner of the department, or the commissioner's designee.

(3) The state budget director, or the state budget director's designee.

(4) One (1) member representing a health maintenance organization, appointed by the governor from a list of at least three (3) individuals submitted by the Insurance Institute of Indiana.

(5) One (1) member representing a Medicaid managed care organization, appointed by the governor from a list of at least three (3) individuals submitted by the Insurance Institute of Indiana.

(6) One (1) member representing a preferred provider organization, appointed by the governor.

(7) One (1) member who represents either:

(A) an organization described in section 6(4) of this chapter identified by the commissioner of the department to be included under this chapter; or

(B) if the commissioner of the department does not identify an organization described in section 6(4) of this chapter, a preferred provider organization;

appointed by the governor.

(8) One (1) member with expertise in managed care and managed care organizations, appointed by the governor.

(b) The committee shall perform the actions specified for the committee in this chapter concerning the fee established under this chapter.

(c) The committee shall meet at the call of the chairperson. The members shall serve without compensation.

(d) A quorum consists of at least five (5) members. An affirmative vote of at least five (5) members of the committee is

necessary to approve any matter before the committee.

Sec. 12. (a) Beginning July 1, 2024, except as provided in subsection (b), the office shall assess a managed care assessment fee to a managed care organization at a rate equal to six percent (6%) of the managed care organization's premium revenue for each state fiscal year during the assessment period. However, the office may not use an assessment methodology that would result in a collection from a managed care organization that would exceed the maximum federal indirect threshold of six percent (6%) set forth in 42 CFR 433.68(f)(3)(i). Any state plan amendment or waiver that the office submits to the United States Department of Health and Human Services must request that the fee be implemented on July 1, 2024, even if that requires the assessment to be implemented retroactively.

(b) The office may assess a fee under this section only if the following conditions are met:

(1) The fee is used only for the purposes set forth in section 16 of this chapter.

(2) The committee approves the assessment fee methodology described in subsection (a) or (c).

(3) The United States Department of Health and Human Services approves the assessment fee methodology described in subsection (a) or (c).

(4) The hospital assessment fee committee approves the state directed payment program described in IC 16-21-10-8(a)(2).

(5) The United States Department of Health and Human Services approves the Medicaid state plan amendments and waiver requests, including revisions, that are necessary to implement or maintain the state directed payment program described in IC 16-21-10-8(a)(2).

(6) The money generated from the fee does not revert to the state general fund.

(c) The office shall assess a fee to a managed care organization in an alternative methodology if the following occur:

(1) Before May 1 of any year, the committee proposes and approves use of any or both of the following alternative fee assessment methodologies:

(A) A percentage of premium revenue received by a managed care organization during a state fiscal year.

(B) A per member per month amount on a state fiscal year basis, which may include the use of a tiered system concerning individual enrollment of a managed care

organization.

The alternative methodology under this subdivision may be applied in a uniform manner within each classification of managed care organization and may exempt a managed care organization from the fee.

(2) The hospital assessment fee committee established by IC 16-21-10-7 approves the alternative methodology proposed by the committee under subdivision (1), determining that the alternative approach:

(A) will not impose an excessive administrative burden on the office; and

(B) is reasonably likely to generate sufficient state share dollars to meet the funding levels specified in section 16(a)(1) through 16(a)(3) of this chapter for each state fiscal year during the assessment period.

An alternative methodology under this subsection may not result in a collection from a managed care organization that would exceed the maximum federal indirect threshold of six percent (6%) set forth in 42 CFR 433.68(f)(3)(i).

(d) Both the committee and the hospital assessment fee committee shall consult with and make available to each other data and other relevant information necessary to make the determinations required in subsection (c).

(e) Before May 31, 2024, the office shall submit the approved fee assessment methodology to the United States Department of Health and Human Services.

(f) If the United States Department of Health and Human Services does not approve the fee assessment methodology or proposes modifications or an alternative methodology to the fee assessment methodology submitted by the office under subsection (e), the office may not submit an alternative methodology or agree to the United States Department of Health and Human Services' modifications or alternative methodology unless the following requirements are met:

(1) The alternative or modified methodology from the United States Department of Health and Human Services complies with the requirements of this chapter.

(2) The committee approves the alternative or modified methodology.

(3) The hospital assessment fee committee determines by an affirmative vote of a quorum that the alternative or modified methodology proposed:

(A) will not impose excessive administrative burdens on the office; and

(B) is reasonably likely to generate sufficient state share dollars to meet the funding levels specified by section 16(a)(1) through 16(a)(3) of this chapter for each state fiscal year during the assessment period.

(g) The office shall keep records of the fees collected under this chapter and report the amount of fees collected to the commissioner of the department.

Sec. 13. The office may seek a waiver under 42 CFR 433.68(e) of any of the following federal requirements in the implementation of an assessment fee methodology under section 12 of this chapter:

(1) The broad based requirement under 42 CFR 433.68(c).

(2) The uniformly imposed requirement under 42 CFR 433.68(d).

Sec. 14. The office shall cease to collect a fee under this chapter if any of the following occur:

(1) An appellate court issues a final order that either:

(A) the fee described in this chapter; or

(B) the hospital assessment fee under IC 16-21-10;

cannot be implemented or continued.

(2) The United States Department of Health and Human Services denies approval of collecting the fee under this chapter.

(3) The hospital assessment fee under IC 16-21-10 ceases to be collected for circumstances set forth under IC 16-21-10-8.

(4) The hospital assessment fee completes a phase out period (as defined in IC 16-21-10-5.3).

Sec. 15. (a) The high risk pool fund is established for the purpose of holding a portion of the fees collected under this chapter.

(b) The department shall administer the fund and keep records of the fees deposited into the fund. The expenses of administering the fund shall be paid from money in the fund.

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

Sec. 16. (a) Beginning July 1, 2024, and for each state fiscal year during the assessment period, the fees collected under this chapter

shall be distributed as follows:

(1) An amount equal to twenty-eight and five-tenths percent (28.5%) of the total fees collected under this IC 16-21-10-8 for state fiscal year 2023, to be used to contribute to the funding of the office's Medicaid expenses.

(2) Twenty percent (20%) of the state share dollars for the state fiscal year for the programs described in IC 16-21-10-8(a).

(3) Twenty percent (20%) of the state share dollars for the state fiscal year for the expenses described in IC 16-21-10-13.3(b)(1).

(4) Ten percent (10%) to be used to create a high risk pool for high cost medical conditions, as determined by the department, to help lower premiums for managed care organizations.

(b) The fees described in subsection (a)(2) shall be deposited into the hospital Medicaid fee fund established by IC 16-21-10-9.

(c) The fees described in subsection (a)(3) shall be deposited into the incremental hospital fee fund established by IC 16-21-10-13.5.

(d) The funds described in subsection (a)(4) shall be deposited into the fund established by section 15 of this chapter.

(e) If the fees collected for a state fiscal year are not sufficient to fulfill the funding levels specified in subsection (a)(1) through (a)(4), the fees must be applied in the following order of priority:

(1) First, to fund the amount described in subsection (a)(1).

(2) Second, to fund the amount specified in subsection (a)(3).

(3) Third, to fund the amount specified in subsection (a)(2).

(4) Fourth, to fund the amount specified in subsection (a)(4).

Sec. 17. (a) For fees due from a managed care organization under this chapter for the state fiscal year beginning July 1, 2024:

(1) the office shall, before December 21, 2024, notify each managed care organization of the fee amount owed by the managed care organization under this chapter; and

(2) each managed care organization shall remit the fee amount to the office before March 1, 2025.

(b) For fees due from a managed care organization beginning July 1, 2025, and thereafter:

(1) the office shall, before August 1 of each year, notify each managed care organization of the managed care organization's fee amount owed by the managed care organization under this chapter; and

(2) each managed care organization shall remit the fee

amount to the office before October 1 of the state fiscal year in which the fee is owed.

(c) The office may approve a monthly payment plan not to exceed twelve (12) months for a managed care organization for the fee amount owed by the managed care organization under this chapter if the managed care organization demonstrates extenuating circumstances in meeting the payment deadline described in this section.

(d) The office shall assess a managed care organization interest at the rate described in IC 12-15-21-3(6) for any fee that is at least eleven (11) calendar days past the payment date set forth in this section.

(e) The office shall report to the department each managed care organization that fails to pay the fee within one hundred twenty (120) calendar days after the payment date specified in this section. The department shall do the following concerning the managed care organization that has failed to make the payment:

(1) Notify the managed care organization that the managed care organization's authority to do business in Indiana will be revoked if the fee is not paid within thirty (30) calendar days from the date of the notice.

(2) Revoke or suspend the managed care organization's authority to do business in Indiana if the managed care organization fails to make the payment in the required time set forth in subdivision (1). IC 4-21.5-3-8 and IC 4-21.5-4 apply to this subdivision.

Sec. 18. (a) The office may adopt rules, including provisional rules under IC 4-22-2-37.1, necessary to implement this chapter.

(b) Rules adopted under this section may be retroactive to the effective date of any Medicaid state plan amendment or waiver necessary to implement this chapter.

Sec. 19. This chapter expires June 30, 2025.

SECTION 10. 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).~~ **IC 16-21-10-13.3(b)(1)(G).** 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) 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).~~ **IC 16-21-10-13.3(b)(1)(G).** 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 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), after considering the modification and the reduction in available funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance.

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

(2) The:

(A) methodology of calculating the incremental fee set forth in

IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) hospital assessment fee committee (IC 16-21-10), after considering the modification and reduction in available funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) 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 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 12-15-44.5-5, AS AMENDED BY P.L.201-2023, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) A managed care organization that contracts with the office to provide health coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall, **except as provided under subsection (c),** reimburse providers at a rate that is not less than the rate established by the secretary; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) A managed care organization that contracts with the office to provide health coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

(c) This subsection does not apply to the following:

(1) A hospital licensed under IC 16-21-2.

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

A managed care organization and a provider may agree to a different reimbursement rate from the rate specified in subsection (a)(2) as part of a value based services contract.

SECTION 13. IC 12-15-44.5-6, AS AMENDED BY P.L.108-2019, SECTION 198, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) For ~~a~~ **the** state fiscal year beginning ~~July 1, 2018,~~ **July 1, 2024,** ~~or thereafter,~~ 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.~~ **shall use the funds in the phase out trust fund established by section 7 of this chapter for a one (1) time pro rata reduction in overall incremental fees paid by hospitals under IC 16-21-10-13.3 for the state fiscal year.**

(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.

(d) This section expires June 30, 2025.

SECTION 14. IC 12-15-44.5-7, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. (a) The phase out trust fund is established. ~~for the purpose of holding the money needed during a phase out period of the plan.~~ Funds deposited under this section shall be used ~~only:~~

~~(1) to fund the state share of the expenses described in IC 16-21-10-13.3(b)(1)(A) through IC 16-21-10-13.3(b)(1)(F) incurred during a phase out period of the plan;~~

~~(2) after funds from the healthy Indiana trust fund (IC 12-15-44.2-17) are exhausted; and~~

~~(3) to refund hospitals in the manner described in subsection (h).~~ **as set forth in section 6 of this chapter.** The fund is separate from the state general fund.

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

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

(d) The trust fund must consist of:

(1) the funds described in section 6 of this chapter; and

(2) any interest accrued under this section.

(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. Interest that accrues from these investments shall be deposited in the fund.

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

(g) 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 specifically authorized under this chapter.

(h) ~~At the end of the phase out period, any remaining funds and accrued interest shall be distributed to the hospitals on a pro rata basis based on the fees authorized by IC 16-21-10 that were paid by each hospital for the state fiscal year that ended immediately before the beginning of the phase out period.~~ **This section expires June 30, 2025.**

SECTION 15. 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;

(E) that is a physician owned hospital;

(F) that only provides respite care services to individuals who are:

(i) medically fragile; and

(ii) less than nineteen (19) years of age; or

(G) that is a freestanding psychiatric hospital with greater than ninety percent (90%) of admissions comprised of individuals who are at least fifty-five (55) years of age and have a primary diagnosis of:

(i) Alzheimer's disease;

(ii) early onset Alzheimer's disease;

(iii) dementia;

(iv) mood disorders;

(v) anxiety;

(vi) psychotic disorders;

(vii) other behavioral health illnesses or disorders; or

(viii) neurological disorders related to trauma or aging.

SECTION 16. IC 16-21-10-5.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5.1. As used in this chapter, "physician owned hospital" means a hospital licensed under IC 16-21-2 that provides acute care services and that has:**

(1) physician ownership; or

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

and the ownership of the hospital is of at least fifty-one percent (51%).

SECTION 17. IC 16-21-10-5.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5.2. As used in this chapter, "state directed payment program" means a payment arrangement under 42 CFR 438.6(c) that allows the office, through separate payment terms, to direct specific payments to a hospital by a managed care organization that contracts with the office to provide health coverage.**

SECTION 18. 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) 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 **(when in effect).**

(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)~~ **(2)** 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.~~ **to this chapter that are to go into effect on July 1, 2024, and are submitted by the office to the United States Department of Health and Human Services not later than May 1, 2024.**

~~(4)~~ **(3)** 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 **(when in effect)** 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.

SECTION 19. IC 16-21-10-7, AS AMENDED BY P.L.108-2019, SECTION 202, IS AMENDED TO READ AS FOLLOWS [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 **do the following:**

(1) 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.~~

(2) Review and approve the quality program described in section 8(a)(2) of this chapter, including:

(A) the initial development of the quality program before any Medicaid state plan amendment, waiver request, or any other request for approval of the program is submitted to the United States Department of Health and Human Services; and

(B) any subsequent revisions to the initially submitted quality program, including the acceptance by the office of the secretary of family and social services of the terms and conditions of the quality program proposed 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:

(A) 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; **and**

(B) be guided to ensure hospitals are reimbursed under the Medicaid program at a reimbursement rate that is:

(i) at least the level of reimbursement that would be paid under the federal Medicare payment principles; and

(ii) at the maximum reimbursement rate allowable under the federal Medicaid law.

(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 20. 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 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) **Beginning July 1, 2024, subject to approval of any Medicaid state plan amendment or Medicaid waiver by the committee and by the United States Department of Health and Human Services,** a **state directed payment** program concerning reimbursement for the Medicaid risk based managed care program that, in the aggregate, will result in **enhanced** payments ~~equivalent to the level of payment that would be paid under federal Medicare payment principles.~~ **for:**

(A) inpatient hospital services; and

(B) outpatient hospital services;

that are at least greater than what would be paid under federal Medicare principles, and at the maximum reimbursement rate allowable under federal Medicaid law. Subject to section 7(b) of this chapter, the program in this subdivision is subject to a quality program that is linked to the office's quality strategy approved by the committee. Any state plan amendment or waiver that the office submits to the United States Department of Health and Human Services must request that the fee be implemented on July 1, 2024, even if that requires the assessment to be implemented retroactively.

(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, **if in effect,** 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. **However, fees may not be used to fund the state share of the portion of capitation payments attributable to a managed care organization's payment of the managed care assessment fee under IC 12-15-29.5.**

(2) ~~The hospital care for the indigent funds allocated under section 10 of this chapter.~~ **The managed care assessment fee authorized under IC 12-15-29.5, subject to the requirements of IC 12-15-29.5-16.**

(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.

(e) If the state directed payment program described in

subsection (a)(2) is not approved by the committee or the United States Department of Health and Human Services, the state shall return to making payments equivalent to the level of payment that would be paid under federal Medicare payment principles.

SECTION 21. 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) of this chapter shall be used for the payments described in ~~sections~~ **section** 8(a) and **section** 11 **(if in effect)** of this chapter. Any money not required for the payments described in ~~sections~~ **section** 8(a) and **section** 11 **(if in effect)** 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.

SECTION 22. IC 16-21-10-10 IS REPEALED [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) 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 23. 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 if the state directed payment program under section 8(a)(2) of this chapter is in effect; and

~~(1)~~ **(2)** does not apply to the incremental fee described in section 13.3 of this chapter **at any time.**

~~(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 **(before its repeal).**

(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.

SECTION 24. IC 16-21-10-13.3, AS AMENDED BY P.L.201-2023, SECTION 147, 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 establishes a fee formula to be used to fund the

state share of the following expenses described in this subdivision:

(A) **Subject to clause (C),** 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) **Subject to clause (C),** 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) Beginning July 1, 2024, and subject to approval of any Medicaid state plan amendment or Medicaid waiver by the committee and by the United States Department of Health and Human Services, the state share of capitated payments and state directed payment programs for inpatient and outpatient hospital services are to be determined as follows:

(i) The state share of capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees shall provide Medicaid reimbursement for inpatient and outpatient hospital services at a rate that is equal to the base Medicaid reimbursement rate in effect on September 1, 2014. However, fees under this section may not be used to fund the state share of the portion of capitation payments attributable to a managed care organization's (as defined in IC 12-15-29.5-6) payment of the managed care assessment fee.

(ii) The state share of payments made under a state directed payment program described in section 8 of this chapter for inpatient and outpatient hospital services provided to plan enrollees at a rate above the rate calculated in item (i) and at the maximum rate allowable under federal Medicaid law.

~~(C)~~ **(D)** The state share of the state's contributions to plan

enrollee accounts.

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

~~(E)~~ **(F)** 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)~~ **(G)** 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)~~ **(1)(G)** 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)~~ **(1)(G)** 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 **the following:**

(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).

(3) The managed care assessment fee authorized under IC 12-15-29.5, subject to IC 12-15-29.5-16.

(4) The amount of funds in the phase out trust fund set forth in IC 12-15-44.5-6, before its expiration.

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

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

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

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

SECTION 25. IC 16-21-10-14 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~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.~~

SECTION 26. IC 16-21-10-15, AS ADDED BY P.L.205-2013, SECTION 214, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 15. **(a)** This chapter may not be construed to authorize any county, municipality, district, or authority to impose a fee, tax, or assessment on a hospital.

(b) This chapter may not be construed to prohibit a hospital licensed under IC 16-21-2 that is established and operated under IC 16-22-2 or IC 16-23 from making an intergovernmental transfer as the state match for disproportionate share payments under IC 12-15-16-6.

SECTION 27. 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 **(if in effect)** 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.

SECTION 28. IC 27-1-3-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. The commissioner shall have power:

(1) to revoke or suspend the authority to do business in this state of:

(A) any company which refuses to permit an examination under IC 27-1-3.1; **or**

(B) any managed care organization (as defined in IC 12-15-29.5-6) that fails to pay the managed care organization's fee assessed under IC 12-15-29.5; and

(2) to revoke or suspend any certificate of authority when any condition prescribed by law for granting it no longer exists.

SECTION 29. [EFFECTIVE UPON PASSAGE] **(a) The office of the secretary of family and social services may continue to collect unpaid managed care assessment fees owed by a managed care organization under IC 12-15-29.5, as added by this act, including after the expiration of IC 12-15-29.5, as added by this act.**

(b) This SECTION expires December 31, 2026.

SECTION 30. [EFFECTIVE UPON PASSAGE] **(a) Any balance resulting from interest payments in the phase out trust fund established by IC 12-15-44.5-7 after distribution of payments required by IC 12-15-44.5-6, as amended by this act, and upon expiration of the phase out trust fund on June 30, 2025, shall be transferred to the state general fund.**

(b) This SECTION expires December 31, 2025.

SECTION 31. [EFFECTIVE UPON PASSAGE] **(a) 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 or Medicaid waiver:**

(1) approved by the hospital assessment fee committee under IC 16-21-10-7, as amended by this act;

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

(3) 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 in the manner set forth in IC 4-22-2-37.1.

(b) The administrative rules amended under subsection (a) 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 (a).

(c) If the office of the secretary adopts the changes to the administrative rules as required in subsection (a) through a provisional rule, the provisional rule expires on the date on which a rule that supersedes the provisional rule is adopted by the office of the secretary under IC 4-22-2-19.7 through IC 4-22-2-36.

(d) This SECTION expires December 31, 2025.

SECTION 32. **An emergency is declared for this act.**