HOUSE BILL No. 1385

DIGEST OF INTRODUCED BILL

Citations Affected: IC 16-21.

Synopsis: Various hospital matters. Requires (rather than allows) the development of programs designed to increase Medicaid reimbursement. Specifies that the reimbursement rates for a state directed payment program must be at least the Medicare reimbursement rates. Requires the office of the secretary of family and social services to perform a reconciliation of the capitation attributable to the incremental hospital fee. Prohibits money in the incremental hospital fee fund from being used to fund Medicaid. Amends the permissible use of funds collected under the hospital assessment fee. Removes language that allowed the hospital assessment fee to be used to fund a state directed payment program that depended upon the collection of the managed care assessment fee. Changes the definition of "prices" concerning the hospital statewide average rate study and pricing (study). Amends the requirements to conduct the study and the date by which the study must be completed.

Effective: Upon passage; July 1, 2026.

Barrett

January 8, 2026, read first time and referred to Committee on Public Health.

Introduced

Second Regular Session of the 124th General Assembly (2026)

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 2025 Regular Session of the General Assembly.

HOUSE BILL No. 1385

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

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

SECTION 1. IC 16-21-10-5.7, AS ADDED BY P.L.216-2025, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5.7. As used in this chapter, "state directed payment program" means a payment arrangement under section 8.5 of this chapter and authorized under 42 CFR 438.6(c) that ~~allows~~ **requires** the office to direct specific payments to a hospital by the managed care organizations that contract with the office to provide health coverage to Medicaid recipients.

SECTION 2. IC 16-21-10-8, AS AMENDED BY P.L.216-2025, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: 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 ~~may~~ **shall** develop the following programs designed to increase Medicaid reimbursement for inpatient and outpatient hospital services provided by a hospital to Medicaid recipients:

(1) A program concerning reimbursement for the Medicaid

fee-for-service program that, in the aggregate, will result in payments equivalent to the level of payment that would be paid under federal Medicare payment principles.

(2) A program concerning reimbursement for the Medicaid risk based managed care program that, in the aggregate, will result in payments equivalent to the level of payment that would be paid under federal Medicare payment principles, and up to any reimbursement approved under a state directed payment program set forth in section 8.5 of this chapter.

(b) The office shall not submit to the United States Department of Health and Human Services any Medicaid state plan amendments, waiver requests, or revisions to any Medicaid state plan amendments or waiver requests, to implement or continue the implementation of this chapter until the office has submitted a written report to the budget committee concerning the amendments, waivers, or revisions described in this subsection, including the following:

(1) The methodology to be used by the office in calculating the increased Medicaid reimbursement under the programs described in subsection (a).

(2) The methodology to be used by the office in calculating, imposing, or collecting the fee, or any other matter relating to the fee.

(3) The determination of Medicaid disproportionate share allotments under section 11 of this chapter (subject to section 11(d) and 11(e) of this chapter) that are to be funded by the fee, including the formula for distributing the Medicaid disproportionate share allotments.

(4) The distribution to private psychiatric institutions under section 13 of this chapter.

(c) This subsection applies to the programs described in subsection (a). The state share dollars for the programs must consist of the following:

(1) Fees paid under this chapter.

(2) The hospital care for the indigent funds allocated under section 10 of this chapter.

(3) Other sources of state share dollars available to the office. ~~excluding intergovernmental transfers of funds made by or on behalf of a hospital.~~

The money described in subdivisions (1) and (2) may be used only to fund the part of the payments that exceed the Medicaid reimbursement rates in effect on June 30, 2011.

(d) This subsection applies to the programs described in subsection

(a). If the state is unable to maintain the funding under subsection (c)(3) for the payments at Medicaid reimbursement levels in effect on June 30, 2011, because of budgetary constraints, the office shall reduce inpatient and outpatient hospital Medicaid reimbursement rates under subsection (a)(1) or (a)(2) or request approval from the United States Department of Health and Human Services to increase the fee to prevent a decrease in Medicaid reimbursement for hospital services. If the United States Department of Health and Human Services does not approve an increase in the fee, the office shall cease to collect the fee and the programs described in subsection (a) are terminated.

SECTION 3. IC 16-21-10-8.5, AS ADDED BY P.L.216-2025, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 8.5. (a) Subject to subsection (b), beginning July 1, 2025, or thereafter, the office may implement a state directed payment program in which payments are made for inpatient and outpatient hospital services as follows:

(1) Subject to available state share funding and federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act in effect on January 1, 2025, the reimbursement rates for inpatient and outpatient hospital services under the state directed payment program: ~~may be established at a rate greater than~~

(A) must be at a rate that is at least the Medicare ~~equivalent~~ reimbursement rates, **taking into account the amount of fees paid by the hospitals to receive Medicare reimbursement rates; and**

(B) ~~but~~ may not exceed the maximum reimbursement rates established by federal law.

(2) The office may implement the state directed payment program through the establishment of classes of hospitals with different rates of reimbursement among the classes, as set forth in subsection (c), and in a manner that is consistent with federal law.

(3) Before January 1, 2026, the office shall apply to the United States Department of Health and Human Services for the review and approval of a state directed payment program. The office may receive input from hospitals and other interested parties in the development of the documentation submitted with the application under this subdivision.

(4) The office may not implement the state directed payment program without the approval of the United States Department of Health and Human Services. To the extent allowed by the United

States Department of Health and Human Services, the office shall implement the state directed payment program on or after July 1, 2025.

(5) The office may not implement a fee under the state directed payment program without the approval of the fee by the United States Department of Health and Human Services, including any waiver related to the fee, to fund the state share of the payments under the state directed payment program. To the extent allowed by the United States Department of Health and Human Services, the office shall use the fee to fund the state directed payment program on or after July 1, 2025.

(6) The office shall make payments under the state directed payment program to managed care organizations that contract with the office to provide medical assistance to Medicaid recipients as follows:

(A) Except as provided in clause (B), capitation payments at levels necessary to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates established under subdivision (1). The fee must be used to pay the state share of the part of the capitation payments that fund the portion of the reimbursement rates that exceed the reimbursement rates in effect on June 30, 2011. However, the fees collected under this section and sections 8 and 13.3 of this chapter may not fund the state share of the capitation payments of the managed care assessment fee under IC 27-1-50.3.

(B) For plan enrollees described in section 13.3(b)(1)(A) of this chapter, capitation payments at a level sufficient to pay inpatient and outpatient hospital services at reimbursement rates equal to the reimbursement rates established by subdivision (1). The incremental fee shall fund the entire state share of these capitation payments. However, the fees collected under this section and sections 8 and 13.3 of this chapter may not fund the state share of the capitation payments of the managed care assessment fee under IC 27-1-50.3.

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

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

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

(2) Class 2 hospitals consist of a hospital licensed under

IC 16-21-2 that is not described in subdivision (1) and that is:

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

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

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

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

SECTION 4. IC 16-21-10-13.3, AS AMENDED BY P.L.216-2025, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: 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 office establishes a fee formula to be used to fund the state share of ~~the Medicaid program or~~ the following expenses described in this subdivision:

(A) The state share of the capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees other than plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act, including portions of the capitation attributed to a state directed payment program under section 8.5 of this chapter.

(B) The state share of capitated payments described in clause (A) for plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act that are limited to the difference between:

(i) the capitation rates effective September 1, 2014, developed using Medicaid reimbursement rates; and

(ii) the capitation rates applicable for the plan developed using the plan's Medicare reimbursement rates described in IC 12-15-44.5-5(a)(2), or higher reimbursement amounts for any state fiscal year for which the state directed payment program established under section 8.5 of this chapter is in

effect.

(C) The state share of the state's contributions to plan enrollee accounts.

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

(E) The state share of the costs of increasing reimbursement rates for physician services provided to individuals enrolled in Medicaid programs other than the plan, but not to exceed the difference between the Medicaid fee schedule for a physician service that was in effect before the implementation of the plan and the amount equal to seventy-five percent (75%) of the previous year federal Medicare reimbursement rate for a physician service. The incremental fee may not be used for the amount that exceeds seventy-five percent (75%) of the federal Medicare reimbursement rate for a physician service.

(F) The state share of the state's administrative costs that, for purposes of this clause, may not exceed one hundred seventy dollars ($170) per person per plan enrollee per year, and adjusted annually by the Consumer Price Index.

(2) The office approves a process to be used for reconciling:

(A) the state share of the costs of the plan;

(B) the amounts used to fund the state share of the costs of the plan; and

(C) the amount of fees assessed for funding the state share of the costs of the plan.

For purposes of this subdivision, "costs of the plan" includes the costs of the expenses listed in subdivision (1)(A) through (1)(F). The fees collected for the purposes of subdivision (1)(A) through (1)(F) shall be deposited into the incremental hospital fee fund established by section 13.5 of this chapter.

(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 termination of the plan.

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

(f) The office of the secretary shall do the following:

(1) Perform a reconciliation at the end of each state fiscal year to ensure that portions of the capitation rates attributable to the payment of the incremental fee under this section were appropriately and accurately calculated.

(2) Not later than November 1 of each year, submit a report to the budget committee with the results of the reconciliation described in subdivision (1) for the preceding state fiscal year.

SECTION 5. IC 16-21-10-13.5, AS AMENDED BY P.L.216-2025, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: 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 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 the termination of the healthy Indiana plan.

~~(3) To fund the Medicaid program.~~

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

(f) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

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

SECTION 6. IC 16-21-10-14, AS AMENDED BY P.L.216-2025, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14. (a) This section does not apply to the use of the incremental fee described in section 13.3 of this chapter.

(b) The fees collected under section 8 **and the fees collected and utilized under section 8.5** of this chapter ~~may~~ **must** 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~~ **to** be used by the office for Medicaid expenses.

(2) Seventy-one and five-tenths percent (71.5%) to hospitals **to leverage federal funds to increase Medicaid reimbursement for hospitals.**

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

SECTION 7. IC 16-21-18-3, AS ADDED BY P.L.216-2025, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. As used in this chapter, "prices" means the amounts that are paid **to and collected by a hospital** for patient care services, **including the final amounts reimbursed by a health insurance plan and paid by a patient.**

SECTION 8. IC 16-21-18-4, AS ADDED BY P.L.216-2025, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The office of management and budget shall develop a methodology to conduct the study of commercial:

(1) inpatient hospital prices; and

(2) outpatient hospital prices;

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

(b) The methodology developed under subsection (a):

(1) must utilize at least eighty-five percent (85%) of paid claims data from hospitals for the 2024 calendar year; and

(2) may not utilize the price transparency files required under 45 CFR 180 or 45 CFR 147.212.

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

SECTION 9. IC 16-21-18-5, AS ADDED BY P.L.216-2025,

SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) Before ~~June~~ **September** 30, 2026, the office of management and budget shall conduct the study described in section 4 of this chapter, using the methodology that was reviewed by the budget committee.

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

SECTION 10. **An emergency is declared for this act.**