HOUSE BILL No. 1493

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-10; IC 12-15; IC 16-18-2-317.7; IC 16-28.

Synopsis: Long term care matters. Requires a home and community based services program for individuals who are aged or disabled to include reimbursement for assisted living services. Requires the division of aging to report to the general assembly a plan to expand the scope and availability of home and community based services for individuals who are aged or disabled and requires the division to implement the plan. Prohibits the office of Medicaid policy and planning (office) from including individuals who receive nursing facility services in a risk based managed care program or a capitated managed care program. Requires the office to determine the amount of reimbursement payments that would have been reimbursed but for a reduction in reimbursement and use those dollars for the expansion of home and community based services. Establishes the home and community based expansion fund. Specifies circumstances in which a Medicaid reimbursement reduction must be suspended. Specifies the model to be used for Medicaid nursing facility service payments. Requires the office to do the following: (1) Provide public notice of at least one year before reducing nursing facility service reimbursements. (2) Obtain federal approval to operate a nursing facility closure incentive payment program and implement the program. (3) Review currently offered home health programs, develop additional programs, and report on the programs to the general assembly. Requires the state department of health to amend rules concerning residential care facilities to comply with federal law concerning the provision of home and community based services. Modifies the replacement facility exemption for purposes of the prohibition on the approval of licensure

(Continued next page)

Effective: Upon passage; July 1, 2017.

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January 18, 2017, read first time and referred to Committee on Public Health.

of comprehensive care health facilities and comprehensive care beds and extends the prohibition through June 30, 2023. Makes various changes concerning the collection of the health facility quality assessment fee and extends the collection of the assessment through June 30, 2023. Modifies the distribution of the quality assessment fee after state fiscal year 2017 and specifies circumstances in which the modification would be suspended by the office. Makes an appropriation.

Introduced

First Regular Session of the 120th General Assembly (2017)

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 2016 Regular Session of the General Assembly.

HOUSE BILL No. 1493

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

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

SECTION 1. IC 12-10-11.5-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 8. (a) To the extent permitted under federal law, any home and community based services program for individuals who are aged or disabled must include reimbursement for assisted living services.**

(b) If the division determines that a provider is out of compliance with state or federal home and community based setting requirements because of requirements of the provider's license, the division shall provide written guidance to the agency issuing the provider license in order to assist in the amendment of the licensure requirements to comply with federal and state home and community based setting requirements.

SECTION 2. IC 12-10-19 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2017]:

Chapter 19. Home and Community Based Services

Sec. 1. Before October 1, 2017, the division shall report to the general assembly in an electronic format under IC 5-14-6 a plan to expand the scope and availability of home and community based services for individuals who are aged and disabled. The report must include the following:

(1) Evaluation of the current system of services to determine which services provide the most appropriate use of resources.

(2) Study of the eligibility assessment process, including the function and financial assessment process, for home and community based services to determine how to streamline the process to allow access to services in a time frame similar to that of institutional care.

(3) Options for individuals to receive services and supports appropriate to meet the individual's needs in a cost effective and high quality manner that focuses on social and health outcomes.

(4) Evaluation of the adequacy of reimbursement rates to attract and retain a sufficient number of providers, including a plan to regularly and periodically increase reimbursement rates to address increased costs of providing services.

(5) Migration of individuals from the aged and disabled Medicaid waiver to amended Medicaid waivers, new Medicaid waivers, the state Medicaid plan, or other programs that offer home and community based services.

Sec. 2. The division shall, in consultation with the office, take any action necessary to implement the plan under section 1 of this chapter, including applying to the United States Department of Health and Human Services for approval to amend the aged and disabled Medicaid waiver, implement a new Medicaid waiver, or amend the state Medicaid plan.

Sec. 3. The division may adopt rules under IC 4-22-2 necessary to implement the plan and this chapter.

SECTION 3. IC 12-15-5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 17. (a) The office may not include a Medicaid recipient who is eligible to:**

(1) participate in the Medicare program (42 U.S.C. 1395 et seq.); and

(2) receive nursing facility services;

in a risk based managed care program or capitated managed care

program.

(b) This section expires June 30, 2022.

SECTION 4. IC 12-15-14-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 6. (a) Beginning July 1, 2017, the office shall do the following:**

(1) Determine quarterly the difference in the amount reimbursed to a nursing facility and the amount of money that would have been reimbursed to the nursing facility if not for the statewide nursing facility payment reductions set forth in 405 IAC 1-14.6-26 or any similar subsequent reduction.

(2) Deposit the amount calculated under subdivision (1) into the fund established by section 7 of this chapter.

(3) Use the money deposited under subdivision (2) for the purpose of expanding home and community based services under the Medicaid program for individuals who are aged or disabled.

(b) The office shall use the money described in subsection (a)(3) only to pay for additional home and community based services for the aged and disabled offered in the Medicaid program by any of the following:

(1) Adding beneficiary slots to existing Medicaid waivers.

(2) Adding new beneficiary services to existing Medicaid waivers.

(3) Adding new, or augmenting existing, administrative services to:

(A) streamline functionality and financial eligibility processes; or

(B) provide beneficiaries information about the home and community based services options.

(4) Increasing provider reimbursement rates.

(5) Establishing new Medicaid waiver programs for the aged and disabled.

(c) The office shall suspend any statewide reduction on nursing facility reimbursement payments upon the office's filing of a state plan amendment that reduces payments permitted by section 1 of this chapter. The office may not lift the suspension until the office does the following:

(1) Reviews the nursing facility payment methodology on a per facility and aggregate basis, comparing the costs for Medicaid nursing facility services deemed allowable by the office and the actual costs incurred by the nursing facility.

(2) Prepares and submits a written plan to the general assembly in an electronic format under IC 5-14-6 to address payments to nursing facilities based upon the review in subdivision (1).

SECTION 5. IC 12-15-14-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 7. (a) The home and community based expansion fund is created for the purpose of funding the expansion of home and community based services in Indiana as described in section 6 of this chapter. The fund shall be administered by the office.**

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

(c) The treasurer of state shall invest 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 investment shall be deposited in the fund.

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

(e) Money in the fund is continually appropriated for purposes of the fund.

SECTION 6. IC 12-15-14-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 8. (a) The office shall use the RUG-IV, 48-Group model for payment of nursing facility services.**

(b) Beginning July 1, 2018, the office may implement an end of therapy reclassification methodology in the RUG-IV, 48-Group model for payment of nursing facility services.

(c) Before the office changes a health facility service reimbursement that results in a reduction in reimbursement, the office shall provide public notice of at least one (1) year. The public notice under this subsection must include the fiscal impact of the proposed reimbursement change.

SECTION 7. IC 12-15-14-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 9. (a) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state Medicaid plan to implement a nursing facility closure incentive payment program, as set forth in this section.**

(b) Upon approval under subsection (a), the office shall:

(1) implement a nursing facility closure incentive payment program for the purpose of incentivizing closure of existing

Medicaid-certified nursing facilities; and

(2) collect the quality assessment fee authorized by IC 16-28-15-6(c).

(c) The office shall adopt rules under IC 4-22-2 to implement the nursing facility closure incentive payment program under this section. The rules must include the following concerning the program:

(1) The specific amount of an incentive payment.

(2) The timing for making an incentive payment.

(3) Any requirements for the acquiring entity to meet in order to qualify for an incentive payment, including the quality record of the acquiring entity as measured by the acquiring entity's total quality score or other indicators of quality, as determined by the office. Priority for an incentive payment must be given to entities with better quality records.

(d) This section expires June 30, 2023.

SECTION 8. IC 12-15-34-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 15. (a) Before January 1, 2018, the office shall review currently offered programs and develop additional funded programs for home health agencies participating in the Medicaid program. In developing a program under this section, the office shall focus on programs for home health agencies that do any of the following:**

(1) Provide incentives to home health agencies that meet established quality outcome and performance metrics.

(2) Ensure that there are a sufficient number of home health agencies to serve the population in need of home health services.

(b) Not later than January 1, 2018, the office shall report the office's review and development of programs under subsection (a) to the general assembly in electronic format under IC 5-14-6.

(c) If the office determines an additional funding program is feasible, the office shall implement the program.

(d) This section expires December 31, 2018.

SECTION 9. IC 16-18-2-317.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 317.7. "Residential care facility", for purposes of IC 16-28-2, means a health care facility that provides residential assisted living care services, including the following services:**

(1) Identifying human responses to health conditions.

(2) Deriving a nursing diagnosis.

(3) Executing a minor regimen based on a nursing diagnosis or as prescribed by a health care provider.

(4) Administering, supervising, delegating, and evaluating outcomes of nursing activities.

SECTION 10. IC 16-28-2-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 11. The state department shall amend rules concerning the licensure of a residential care facility to comply with federal law and regulation concerning the provision of home and community based services in order for a residential care facility to qualify as a home and community based services provider.**

SECTION 11. IC 16-28-2.5-4, AS ADDED BY P.L.257-2015, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 4. As used in this chapter, "replacement facility" means a new comprehensive care health facility licensed under or subject to this article after July 1, 2015, that:

(1) is constructed to take the place of an existing comprehensive care health facility that is licensed before ~~July 2, 2015,~~ **July 1, 2017;**

(2) is constructed within the same county as the existing comprehensive care health facility licensed before ~~July 2, 2015,~~ **July 1, 2017;** and

(3) contains no more comprehensive care beds than the existing comprehensive care health facility licensed before July 2, 2015.

SECTION 12. IC 16-28-2.5-6, AS ADDED BY P.L.257-2015, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 6. (a) Except as provided in subsection (b), the state department may not approve the following:

(1) The licensure of:

(A) comprehensive care health facilities; or

(B) new or converted comprehensive care beds.

(2) The certification of new or converted comprehensive care beds for participation in the state Medicaid program unless the statewide comprehensive care bed occupancy rate is more than ninety-five percent (95%), as calculated annually on January 1 by the state department.

(3) Transfer between any comprehensive care facilities of licensed comprehensive care beds or comprehensive care bed certifications for participation in the state Medicaid program.

Beds in a health facility that provides residential nursing care under

IC 16-28 may not be converted to comprehensive care beds.

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

(1) A comprehensive care health facility that:

(A) is licensed under;

(B) is to be licensed under;

(C) is subject to; or

(D) will be subject to;

this article and that is under development as of July 1, 2015.

(2) A small house health facility approved under section 7 of this chapter.

(3) A ~~replacement facility, whether or not the replacement facility is under development before July 2, 2015. The existing comprehensive care health facility that is being replaced by the replacement facility:~~

~~(A) must no longer be licensed as a comprehensive care health facility sixty (60) days after the replacement facility obtains its license from the state department; and~~

~~(B) may transfer any of the comprehensive care beds to the replacement facility.~~ **comprehensive care health facility that meets the conditions set forth in section 6.5 of this chapter.**

(4) A continuing care retirement community that was registered under IC 23-2 before July 2, 2015, and that continuously maintains its registration under IC 23-2. If a continuing care retirement community fails to maintain registration under IC 23-2 after July 1, 2015, the comprehensive care beds, including beds certified for use in the state Medicaid program or the Medicare program, that the continuing care retirement community previously operated are not forfeited as long as the continuing care retirement community continues to comply with the licensure and certification requirements of this article.

(5) A comprehensive care health facility or a comprehensive care bed that is to be added or certified in the state Medicaid program in a county where the county's comprehensive care bed occupancy rate exceeds ninety percent (90%), as calculated by the state department on January 1 and July 1 of each year. The number of comprehensive care beds allowed under this subdivision may not exceed either:

(A) the number of beds that would cause the county occupancy rate to fall below the statewide average; or

(B) seventy (70) comprehensive care beds per applicant.

(6) A comprehensive care health facility that undergoes a change of ownership for purposes of:

(A) the granting of a license by the state department to operate the comprehensive care health facility; and

(B) the maintenance for any of the beds in the comprehensive care health facility, including Medicaid certified beds, by the entity granted a license by the state department.

However, after the change of ownership, the comprehensive care health facility is subject to subsection (a) unless the comprehensive care health facility meets the requirements under another subdivision under this subsection.

(c) The state department shall make the final determination concerning whether an entity has met or is meeting the requirements of this chapter concerning being under development.

SECTION 13. IC 16-28-2.5-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 6.5. A person may qualify for an exemption under section 6(b)(3) of this chapter and the state department may approve a construction permit, a new or amended license to operate, or Medicaid certification for a comprehensive care health facility if any of the following are met:**

(1) The applicant is a replacement facility and the comprehensive care health facility that is being replaced by the replacement facility:

(A) will no longer be licensed as a comprehensive care health facility sixty (60) days after the replacement facility obtains a license from the state department; and

(B) transfers any of the comprehensive care beds, including the certification status of the beds, to the replacement facility.

(2) The applicant is currently licensed to operate at least one (1) existing comprehensive care health facility and the applicant has identified at least one (1) comprehensive care health facility that has agreed to transfer any of the comprehensive care health facility's comprehensive care beds, including the certification status of the beds to the applicant. A comprehensive care health facility transferring the licensure and certification of any comprehensive care beds to the applicant under this subdivision will no longer be licensed as a comprehensive care health facility sixty (60) days after the applicant obtains a license from the state department for additional comprehensive care beds.

(3) The applicant will be constructing at least one (1) comprehensive care health facility and meets the following

criteria:

(A) The applicant has identified at least two (2) comprehensive care health facilities that have agreed to transfer any of the comprehensive care health facilities' beds, including the certification status of the comprehensive care beds, to the applicant's new comprehensive care health facility.

(B) The number of comprehensive care health facilities seeking to transfer comprehensive care beds to an applicant exceeds the number of new comprehensive care health facilities being constructed by the applicant.

(C) Unless granted an exception by both the state department and the office of Medicaid policy and planning, if a comprehensive care health facility seeking to transfer comprehensive care beds is located in a medically underserved area, as designated by the federal Health Resources & Services Administration, at least one (1) of the new comprehensive care health facilities must be constructed within five (5) minutes drive time or five (5) miles of the comprehensive care health facility that is located in the medically underserved area.

(D) The comprehensive care health facility transferring a comprehensive care bed, including the certified status of the comprehensive care bed, is no longer licensed as a comprehensive care health facility sixty (60) days after the applicant obtains a license from the state department.

SECTION 14. IC 16-28-2.5-8, AS ADDED BY P.L.257-2015, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 8. This chapter expires ~~June 30, 2018.~~ **June 30, 2023.**

SECTION 15. IC 16-28-15-6, AS ADDED BY P.L.229-2011, SECTION 162, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 6. (a) Effective July 1, 2011, the office shall collect a quality assessment fee from each health facility.

(b) The quality assessment fee must apply to all non-Medicare patient days of the health facility. The office shall determine the quality assessment rate per non-Medicare patient day in a manner that collects the maximum amount permitted by federal law as of July 1, 2011, and October 1, 2011, based on the latest nursing facility financial reports and nursing facility quality assessment data collection forms as of July 28, 2010.

(c) Except as provided in subsections (d) and (e), the office shall

collect the quality assessment fee as follows:

(1) Based on the latest nursing facility financial reports and nursing facility quality assessment data collection forms as of December 31, 2015, the office shall increase the quality assessment rate per non-Medicare patient day in a manner that collects an additional eight million five hundred thousand dollars ($8,500,000) more than the quality assessment collected from the health facilities under subsection (b).

(2) The quality assessment fee collection under subdivision (1) shall be used in the manner described in section 8(e) of this chapter.

(3) The quality assessment fee collection under subdivision (1) shall take place only for three (3) consecutive state fiscal years.

(d) Subsection (c) does not apply if the total assessment fee to be collected under this section exceeds the maximum amount allowable by federal law. If subsection (c) does not apply under this subsection, the office shall collect the quality assessment fee in the manner described in subsection (b).

(e) Subsection (c) is valid only if:

(1) the closure incentive program under IC 12-15-14-9 is approved by the federal Department of Health and Human Services and is implemented by the office; and

(2) the limitation on licensure and certification of comprehensive care beds under IC 16-28-2.5 or its successor is in effect.

If subsection (c) becomes invalid under this subsection, the office shall collect the quality assessment fee in the manner set forth in subsection (b).

~~(c)~~ **(f)** The office shall offset the collection of the assessment fee for a health facility:

(1) against a Medicaid payment to the health facility;

(2) against a Medicaid payment to another health facility that is related to the health facility through common ownership or control; or

(3) in another manner determined by the office.

SECTION 16. IC 16-28-15-8, AS AMENDED BY P.L.205-2013, SECTION 215, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 8. (a) The money collected from the quality assessment fee during state fiscal year 2012 may be used only as follows:

(1) Sixty-seven and one-tenth percent (67.1%) to pay the state's

share of costs for Medicaid nursing facility services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(2) Twenty-three and eight-tenths percent (23.8%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Nine and one-tenth percent (9.1%) to pay prior year state nursing facility expenditures.

(b) The money collected from the quality assessment fee during state fiscal year 2013 may be used only as follows:

(1) Sixty-six and five-tenths percent (66.5%) to pay the state's share of costs for Medicaid nursing facility services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(2) Twenty-nine and four-tenths percent (29.4%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Four and one-tenth percent (4.1%) to pay prior year state nursing facility expenditures.

(c) The money collected from the quality assessment fee after state fiscal year 2013 **through state fiscal year 2017** may be used only as follows:

(1) Seventy and six-tenths percent (70.6%) to pay the state's share of the costs for Medicaid nursing facility services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(2) Twenty-nine and four-tenths percent (29.4%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) The office may decrease the percentage specified in subdivision (1) to pay state fiscal year 2011 and prior year state nursing facility expenditures only if the amounts collected in subsections (a)(3) and (b)(3) are insufficient to pay the expenditures. Once the expenditures described in this subdivision have been collected, the percentage specified in subdivision (1) shall be restored.

(d) The money collected from the quality assessment fee after state fiscal year 2017 may be used only as provided in subsection (e) and as follows:

(1) Seventy and six-tenths percent (70.6%) to pay the state's share of the costs for Medicaid nursing facility services

provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(2) Nineteen and four-tenths percent (19.4%) to pay the state's share of costs for other Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Ten percent (10%) to pay the state's share of costs for expanding home and community based services provided to aged and disabled individuals under a waiver or state Medicaid plan option under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(e) The money collected from the quality assessment fee under section 6(c) of this chapter shall be used to implement the nursing facility closure incentive program under IC 12-15-14-9. If money collected from the quality assessment fee under section 6(c) of this chapter is not spent within a three (3) year period of the collection, the office shall distribute the remaining quality assessment fee collected in accordance with subsection (d)(3). If section 6(c) of this chapter is no longer in effect, the office shall distribute the additional fee collected under section 6(c) of this chapter in the manner set forth in subsection (d)(3).

(f) The office shall immediately suspend expenditures under subsection (d)(3) upon the office's filing of a Medicaid state plan amendment that reduces nursing facility payments established by IC 12-15-14-1(b) and IC 12-15-14-1(c). The office may not lift the suspension until:

(1) a review of nursing facility payment methodology that compares, on a per facility and aggregate basis, costs deemed allowable by the office to actual costs incurred by nursing facilities in providing Medicaid services; and

(2) a plan to address any shortage in payment to nursing facilities based on the review under subdivision (1). The office shall submit the plan in electronic format under IC 5-14-6 to the general assembly.

~~(d)~~ **(g)** ~~Any~~ **The money from the** increase in ~~reimbursement for Medicaid nursing facility services resulting from maximizing~~ the quality assessment rate **during state fiscal year 2012** under section 6(b) of this chapter **and subsections (a) through (d)** shall be directed exclusively to initiatives determined by the office to promote and enhance improvements in quality of care to nursing facility residents.

~~(e)~~ **(h)** The office may establish a method to allow a health facility to enter into an agreement to pay the quality assessment fee collected

under this chapter under an installment plan.

SECTION 17. IC 16-28-15-14, AS AMENDED BY P.L.205-2013, SECTION 217, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 14. This chapter expires ~~June 30, 2017.~~ **June 30, 2023.**

SECTION 18. **An emergency is declared for this act.**