Reprinted
February 28, 2014

ENGROSSED
SENATE BILL No. 173

DIGEST OF SB 173 (Updated February 27, 2014 2:27 pm - DI 104)

Citations Affected: IC 12-7; IC 12-10; IC 16-18; IC 16-28; IC 16-29.

Synopsis: CHOICE program; nursing facility moratorium. Beginning January 1, 2015, changes asset limitations within the community and home options to institutional care for the elderly and disabled program (program) from $500,000 to $250,000 and specifies certain exemptions. Beginning January 1, 2015, requires annual adjustment of the asset limitation using the federal Consumer Price Index. Beginning January 1, 2015, allows a participant who is unable to perform at least one activity to participate in the program under specified
(Continued next page)

Effective: Upon passage; June 30, 2014; July 1, 2014; January 1, 2015.

Miller Patricia, Leising, Skinner,
Mishler, Merritt
(HOUSE SPONSORS — BROWN T, CLERE, RIECKEN, BROWN C)

January 8, 2014, read first time and referred to Committee on Health and Provider Services.
January 16, 2014, amended, reported favorably — Do Pass.
January 21, 2014, read second time, amended, ordered engrossed.
January 22, 2014, engrossed.
January 23, 2014, read third time, passed. Yeas 33, nays 14.

HOUSE ACTION

February 11, 2014, read first time and referred to Committee on Public Health.
February 18, 2014, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 127.
February 24, 2014, amended, reported — Do Pass.
February 27, 2014, read second time, amended, ordered engrossed.

circumstances. Requires the division of aging (division) and the area agencies on aging to jointly establish specified procedures. Beginning January 1, 2015, allows the division to: (1) annually redetermine program eligibility; and (2) place a lien to recoup the cost of program services that exceed $20,000. Requires the division to exclude $20,000 of countable assets in determining cost participation for the program. Defines "under development" for purposes of the moratorium on nursing facility comprehensive care beds. Prohibits the state department of health from approving the licensure of comprehensive care health facilities or new or converted comprehensive care beds. Prohibits residential nursing care facility beds from being converted to comprehensive care beds. Adds exemptions for: (1) health facilities under development as of June 30, 2014; (2) certain replacement facilities; and (3) continuing care retirement communities. Specifies that the state department of health makes the final determination concerning whether an entity is under development. Postpones the expiration of the moratorium from June 30, 2014, to June 30, 2015.

Reprinted
February 28, 2014

Second Regular Session 118th General Assembly (2014)

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 2013 Regular Session and 2013 First Regular Technical Session of the General Assembly.

ENGROSSED
SENATE BILL No. 173

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 12-7-2-44.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 44.6. "Countable asset" **means the following:**

(1) For purposes of IC 12-10-10, in determining eligibility for the community and home options to institutional care for the elderly and disabled program, property that is included in determining assets in the same manner as determining an individual's eligibility for the Medicaid aged and disabled waiver.

(2) For purposes of IC 12-20, means noncash property that is not necessary for the health, safety, or decent living standard of a household that:

~~(1)~~ **(A)** is owned wholly or in part by the applicant or a member of the applicant's household;

~~(2)~~ **(B)** the applicant or the household member has the legal right to sell or liquidate; and

~~(3)~~ **(C)** includes:

~~(A)~~ **(i)** real property other than property that is used for the production of income or that is the primary residence of the household;

~~(B)~~ **(ii)** savings and checking accounts, certificates of deposit, bonds, stocks, and other intangibles that have a net cash value; and

~~(C)~~ **(iii)** boats, other vehicles, or any other personal property used solely for recreational or entertainment purposes.

SECTION 2. IC 12-7-2-49.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 49.5. "CPI", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-2.5.**

SECTION 3. IC 12-10-10-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 1. As used in this chapter, "case management" means an administrative function conducted locally by an area agency on aging that includes the following:

(1) Assessment of an individual to determine the individual's functional impairment level and corresponding need for services.

(2) Initial verification of an individual's income and assets.

~~(2)~~ **(3)** Development of a care plan ~~addressing~~ **that:**

(A) addresses an eligible individual's needs;

(B) takes into consideration the individual's family and community members who are willing to provide services to meet any of the individual's needs; and

(C) is consistent with a person centered approach to client care.

~~(3)~~ **(4)** Supervision of the implementation of appropriate and available services for an eligible individual.

~~(4)~~ **(5)** Advocacy on behalf of an eligible individual's interests.

~~(5)~~ **(6)** Monitoring the quality of community and home care services provided to an eligible individual.

~~(6)~~ **(7)** Reassessment of the care plan to determine:

(A) the continuing need and effectiveness of the community and home care services provided to an eligible individual under this chapter; **and**

(B) the annual reverification of a plan recipient's income and assets, as may be required by the division under section 4(e) of this chapter.

~~(7)~~ **(8)** Provision of information and referral services to individuals in need of community and home care services.

SECTION 4. IC 12-10-10-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 2.5. As used in this chapter, "CPI" refers to the United States Bureau of Labor Statistics Consumer Price Index, all items, all urban consumers, or its successor index.**

SECTION 5. IC 12-10-10-4, AS AMENDED BY P.L.99-2007, SECTION 64, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 4. (a) As used in this chapter, "eligible individual" means an individual who **meets the following criteria:**

(1) Is a resident of Indiana.

(2) Is:

(A) at least sixty (60) years of age; or

(B) an individual with a disability.

(3) Has assets **that meet the following criteria:**

(A) For an individual who participates in the program and whose date of application for the program is before January 1, 2015, assets that do not exceed five hundred thousand dollars ($500,000), as determined by the division. ~~and~~

(B) For an individual whose date of application for the program is after December 31, 2014, countable assets that do not exceed two hundred fifty thousand dollars ($250,000) adjusted by the CPI, as set forth in subsection (c). In determining assets under this clause, the division shall exclude an additional twenty thousand dollars ($20,000) in countable assets, as adjusted by the CPI as set forth in subsection (c).

(4) Qualifies under criteria developed by the board as having an impairment that places the individual at risk of losing the individual's independence, as described in subsection (b).

(b) For purposes of subsection (a), an individual is at risk of losing the individual's independence if the individual is unable to perform **any of the following:**

(1) Two (2) or more activities of daily living. The use by or on behalf of the individual of any of the following services or devices does not make the individual ineligible for services under this chapter:

~~(1)~~ **(A)** Skilled nursing assistance.

~~(2)~~ **(B)** Supervised community and home care services, including skilled nursing supervision.

~~(3)~~ **(C)** Adaptive medical equipment and devices.

~~(4)~~ **(D)** Adaptive nonmedical equipment and devices.

(2) One (1) activity of daily living if, using the needs based assessment established under section 13(1) of this chapter, the area agency on aging determines that addressing the single activity of daily living would significantly reduce the likelihood of the individual's loss of independence and the need for additional services.

(3) An activity if, using the needs based assessment established under section 13(1) of this chapter, the area agency on aging determines that targeted intervention or assistance with the activity would significantly reduce the likelihood of the individual's loss of independence and the need for additional services.

(c) Before June 1, 2015, and before June 1 of each subsequent year, the division shall determine an adjusted asset limit to be used for purposes of subsection (a)(3)(B), subsection (d)(4), and section 13 of this chapter in the following state fiscal year. The adjusted asset limit for the following state fiscal year shall be determined as follows:

STEP ONE: Determine the percentage change between:

(A) the CPI as last reported for the calendar year ending in the state fiscal year in which the determination is made; and

(B) the CPI as last reported for the calendar year that precedes the calendar year described in clause (A).

STEP TWO: Express the percentage change determined in STEP ONE as a two (2) digit decimal rounded to the nearest hundredth. A negative percentage change under this STEP must be treated as zero (0).

STEP THREE: Add one (1) to the STEP TWO result.

STEP FOUR: Multiply:

(A) the STEP THREE result; by

(B) the asset limit used for purposes of subsection (a)(3)(B) in the state fiscal year in which the determination is made.

Before June 15, 2015, and before June 15 of each subsequent year, the division shall publish in the Indiana Register the adjusted asset limit to be used for purposes of subsection (a)(3)(B) in the following state fiscal year.

(d) The division shall, in accordance with standards established under section 13(3) of this chapter, establish a cost participation schedule for a program recipient based on the program participant's income and countable assets. The cost participation

schedule must meet the following:

(1) Exclude from cost participation an eligible individual whose income and countable assets do not exceed one hundred fifty percent (150%) of the federal income poverty level.

(2) Exclude from cost participation for the total services provided to an individual under the program unless the eligible individual's income and countable assets exceed three hundred fifty percent (350%) of the federal income poverty level.

(3) In calculating income and countable assets for an eligible individual, deduct the medical expenses of the following:

(A) The individual.

(B) The spouse of the individual.

(C) The dependent children of the individual.

(4) Exclude twenty thousand dollars ($20,000) of a participant's countable assets, as adjusted by CPI, from consideration in determining a participant's cost participation.

The cost participation schedule established under this subsection may be applied only to an individual whose date of application for the program is after December 31, 2014.

(e) The division may require annual reverification for program participants whom the division determines are likely to experience a material increase in income or assets. An individual shall submit the information requested by the division to carry out the redetermination allowed by this subsection.

(f) The division may not require a family or other person to provide services as a condition of an individual's eligibility for or participation in the program.

SECTION 6. IC 12-10-10-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 7. (a) Except as provided in subsection (b), the case management under this chapter of an individual leading to participation in the program may not be conducted by any agency that delivers services under the program.

(b) If the division determines that there is no alternative agency capable of delivering services to the individual, the area agency on aging that performs the assessment under the program may also deliver the services.

(c) The division shall provide the necessary funding to provide case management services for the program, as determined under section 13(2) of this chapter.

SECTION 7. IC 12-10-10-9 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 9. (a) The division shall establish a program to train relatives of eligible individuals to provide homemaker and personal care services to those eligible individuals.

(b) Relatives of eligible individuals who complete the training program established under this section are eligible for reimbursement under this chapter or under the Medicaid program for the provision of homemaker and personal care services to those eligible individuals. Reimbursement under the Medicaid program is limited to those cases in which the provision of homemaker and personal care services to an eligible individual by a relative results in financial hardship to the relative.

(c) For services that an individual is eligible to receive under the program but receives from a relative or other individual without receiving compensation, the area agency on aging shall:

(1) determine, in accordance with section 13(4) of this chapter, the savings from not paying for these services; and

(2) allocate twenty percent (20%) of the savings calculated under subdivision (1) to offset the individual's cost share amount, if any, for participating in the program.

SECTION 8. IC 12-10-10-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13. The division and the area agencies on aging shall jointly develop policies that establish the following:**

(1) A needs based assessment to be used in determining a client's needs and care plan under section 1(3) of this chapter.

(2) The percentage of program dollars adequate to provide case management services.

(3) A cost participation schedule for program recipients as required by section 4(d) of this chapter.

(4) Procedures for determining cost savings as required by section 9(c) of this chapter.

(5) Program performance measures for the area agencies on aging.

SECTION 9. IC 12-10-10-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 14. (a) This section applies only to an individual whose date of application for the program is after December 31, 2014.**

(b) The division may obtain a lien on the program recipient's real property for the cost of services provided to the individual in

the program if the cost of the services exceeds twenty thousand dollars ($20,000), as adjusted by the CPI under section 4(c) of this chapter, in the same manner and with the same requirements as the office obtains a lien against a Medicaid recipient under IC 12-15-8.5, except that there may be no look back of the program recipient's property as required under the Medicaid program in IC 12-15-8.5-2.

(c) The division may adopt rules necessary under IC 4-22-2 to implement this section.

SECTION 10. IC 12-10-11-8, AS AMENDED BY P.L.143-2011, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 8. The board shall do the following:

(1) Establish long term goals of the state for the provision of a continuum of care for the elderly and individuals with a disability based on the following:

(A) Individual independence, dignity, and privacy.

(B) Long term care services that are:

(i) integrated, accessible, and responsible; and

(ii) available in home and community settings.

(C) Individual choice in planning and managing long term care.

(D) Access to an array of long term care services:

(i) for an individual to receive care that is appropriate for the individual's needs; and

(ii) to enable a case manager to have cost effective alternatives available in the construction of care plans and the delivery of services.

(E) Long term care services that include home care, community based services, assisted living, congregate care, adult foster care, and institutional care.

(F) Maintaining an individual's dignity and self-reliance to protect the fiscal interests of both taxpayers and the state.

(G) Long term care services that are fiscally sound.

(H) Services that:

(i) promote behavioral health; and

(ii) prevent and treat mental illness and addiction.

(2) Review state policies on community and home care services.

(3) Recommend the adoption of rules under IC 4-22-2.

(4) Recommend legislative changes affecting community and home care services.

(5) Recommend the coordination of the board's activities with the activities of other boards and state agencies concerned with

community and home care services.

(6) Evaluate cost effectiveness, quality, scope, and feasibility of a state administered system of community and home care services.

(7) Evaluate programs for financing services to those in need of a continuum of care.

(8) Evaluate state expenditures for community and home care services, taking into account efficiency, consumer choice, competition, and equal access to providers.

(9) Develop policies that support the participation of families and volunteers in meeting the long term care needs of individuals.

(10) Encourage the development of funding for a continuum of care from private resources, including insurance.

~~(11) Develop a cost of services basis and a program of cost reimbursement for those persons who can pay all or a part of the cost of the services rendered. The division shall use this cost of services basis and program of cost reimbursement in administering IC 12-10-10. The cost of services basis and program of cost reimbursement must include a client cost share formula that:~~

~~(A) imposes no charges for an eligible individual whose income does not exceed one hundred fifty percent (150%) of the federal income poverty level; and~~

~~(B) does not impose charges for the total cost of services provided to an individual under the community and home options to institutional care for the elderly and disabled program unless the eligible individual's income exceeds three hundred fifty percent (350%) of the federal income poverty level.~~

~~The calculation of income for an eligible individual must include the deduction of the individual's medical expenses and the medical expenses of the individual's spouse and dependent children who reside in the eligible individual's household.~~

~~(12)~~ **(11)** Establish long term goals for the provision of guardianship services for adults.

~~(13)~~ **(12)** Coordinate activities and programs with the activities of other boards and state agencies concerning the provision of guardianship services.

~~(14)~~ **(13)** Recommend statutory changes affecting the guardianship of indigent adults.

~~(15)~~ **(14)** Review a proposed rule concerning home and community based services as required under section 9 of this

chapter.

SECTION 11. IC 16-18-2-67.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 67.1. "Comprehensive care health facility", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-2.5.**

SECTION 12. IC 16-18-2-316.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 316.6. "Replacement facility", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-3.2.**

SECTION 13. IC 16-28-16-2, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 2. As used in this chapter, "comprehensive care bed" means a bed that:

(1) is **within a comprehensive care health facility that is** licensed or is to be licensed under IC 16-28-2;

(2) functions as a bed **within a comprehensive care health facility** licensed under IC 16-28-2; or

(3) is **otherwise** subject to this article.

The term does not include a comprehensive care bed that will be used solely to provide specialized services and that is subject to IC 16-29.

SECTION 14. IC 16-28-16-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 2.5. As used in this chapter, "comprehensive care health facility" means a health facility that provides nursing care, room, food, laundry, administration of medications, special diets, and treatments and that may provide rehabilitative and restorative therapies under the order of an attending physician.**

SECTION 15. IC 16-28-16-3, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 3. As used in this chapter, "replacement bed" means a comprehensive care bed that is relocated **from one (1) comprehensive care health facility** to ~~a health facility~~ **another comprehensive care health facility** that is licensed or is to be licensed under this article. This term includes comprehensive care beds that are certified for participation in:

(1) the state Medicaid program; or

(2) both the state Medicaid program and federal Medicare program.

SECTION 16. IC 16-28-16-3.2 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 3.2. As used in this chapter, "replacement facility" means a new comprehensive care health facility licensed under or subject to this article after June 30, 2014, that:**

(1) is constructed to take the place of an existing comprehensive care health facility that is licensed before July 1, 2014;

(2) is constructed within the same county of the existing comprehensive care health facility licensed before July 1, 2014; and

(3) contains no more comprehensive care beds than the existing comprehensive care health facility licensed before July 1, 2014.

SECTION 17. IC 16-28-16-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 3.5. As used in this chapter, "under development" refers to an effort:**

(1) to add, construct, or convert comprehensive care beds in a comprehensive care health facility that is:

(A) licensed under;

(B) to be licensed under;

(C) subject to; or

(D) will be subject to;

this article; and

(2) that meets the following:

(A) Architectural plans have been completed.

(B) Funding to construct the comprehensive care health facility has been secured and is actively being drawn upon or otherwise used to further and complete construction.

(C) Zoning requirements have been met.

(D) Construction plans for the comprehensive care health facility have been submitted to the state department and the division of fire and building safety.

(E) Active and ongoing construction activities progressing to completion of the project are occurring at the project site.

SECTION 18. IC 16-28-16-4, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 4. (a) Except as provided in subsection (b), the state department may not approve **the following:**

(1) The licensure of comprehensive care health facilities or

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 of health.

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 is:

(A) licensed under;

(B) to be licensed under;

(C) subject to; or

(D) will be subject to;

IC 16-28 and that is under development as of June 30, 2014.

~~(1)~~ **(2)** A comprehensive care health facility that:

(A) seeks a replacement bed exception;

(B) is licensed or is to be licensed under this article **or is under development as of June 30, 2014;**

(C) applies to the state department of health to certify a comprehensive care bed for participation in the Medicaid program if the comprehensive care bed for which the health facility is seeking certification is a replacement bed for an existing comprehensive care bed;

(D) applies to the division of aging **before July 1, 2014,** in the manner:

(i) described in subsection (c); and

(ii) prescribed by the division; and

(E) meets the licensure, survey, and certification requirements of this article.

~~(2)~~ **(3)** A small house health facility approved under section 6 of this chapter.

(4) A replacement facility, whether or not the replacement facility is under development before July 1, 2014. 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, and the replacement facility may accept, all of the comprehensive care beds from the existing comprehensive care health facility to the replacement

facility without seeking a replacement bed exception.

(5) A continuing care retirement community that was registered under IC 23-2 before July 1, 2014, and continuously maintains registration under IC 23-2. If a continuing care retirement community fails to maintain registration under IC 23-2 after June 30, 2014, the comprehensive care beds, including beds certified for Medicaid or Medicare, 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.

(c) An application made under subsection ~~(b)(1)~~ **(b)(2)** for a replacement bed exception must include the following:

(1) The total number and identification of the existing comprehensive care beds that the applicant requests be replaced by health facility location and by provider.

(2) If the replacement bed is being transferred to a different comprehensive care health facility with the same ownership, a provision that provides the division of aging written verification from the health facility holding the comprehensive care bed certification that the health facility has agreed to transfer the beds to the applicant health facility.

(3) If the replacement bed is being transferred to a different comprehensive care health facility under different ownership, a provision that provides the division of aging a copy of the complete agreement between the comprehensive care health facility transferring the beds and the applicant comprehensive care health facility.

(4) Any other information requested by the division of aging necessary to evaluate the transaction.

A replacement bed may be relocated after June 30, 2014, under this section only if the comprehensive care health facility applies to the division of aging before July 1, 2014, and complies with or will comply with section 5 of this chapter.

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

SECTION 19. IC 16-28-16-5, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 5. Except in the case of an emergency or a disaster, Medicaid certification of an existing

comprehensive care bed may not be transferred to ~~a new~~ **another** location until the ~~new~~ **receiving comprehensive care health** facility is seeking certification of the bed.

SECTION 20. IC 16-28-16-6, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 6. (a) A person planning to construct a small house health facility shall apply to the state department for a license under this article.

(b) An applicant under this section, including an entity related to the applicant through common ownership or control, may apply to the state department for Medicaid certification of not more than fifty (50) comprehensive care beds for small house health facilities per year.

(c) The state department may not approve **Medicaid** certification of more than one hundred (100) new comprehensive care beds designated for small house health facilities per year.

(d) The state department shall approve an application for Medicaid certification for a small house health facility:

(1) in the order of the completed application date; and

(2) if the applicant meets the definition of a small house health facility and the requirements of this section.

(e) A person that fails to complete construction and begin operation of a small house ~~comprehensive care~~ health facility within twelve (12) months after the state department's approval of the application forfeits the person's right to the Medicaid certified comprehensive care beds approved by the state department if:

(1) another person has applied to the state department for approval of certified comprehensive care beds for participation in the state Medicaid program **for** at least one (1) small house health facility; and

(2) the person's application was denied for the sole reason that the maximum number of Medicaid certified comprehensive care beds specified in subsection (c) had been approved for small house health facilities.

SECTION 21. IC 16-28-16-7, AS ADDED BY P.L.229-2011, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. This chapter expires ~~June 30, 2014.~~ **June 30, 2015.**

SECTION 22. IC 16-29-6 IS REPEALED [EFFECTIVE JUNE 30, 2014]. (Comprehensive Care Health Facilities and Medicaid Services).

SECTION 23. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 173, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, line 31, delete "operated by the" and insert "**licensed before July 1, 2014;**".

Page 2, delete lines 32 through 33.

Page 5, line 11, delete "7" and insert "**5**".

Page 6, after line 15, begin a new paragraph and insert:

"SECTION 13. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 173 as introduced.)

MILLER PATRICIA, Chairperson

Committee Vote: Yeas 8, Nays 4.

SENATE MOTION

Madam President: I move that Senate Bill 173 be amended to read as follows:

Page 2, line 29, after "licensed" insert "**under or subject to this article**".

Page 3, line 2, delete "licensed or to be licensed".

Page 3, line 3, delete "under" and insert "**that is:**

(A) licensed under;

(B) to be licensed under;

(C) subject to; or

(D) will be subject to;".

Page 3, line 3, beginning with "this" begin a new line block indented.

Page 3, line 30, delete "is licensed or to".

Page 3, line 31, delete "be licensed under" and insert "**is:**

(A) licensed under;

(B) to be licensed under;

(C) subject to; or

(D) will be subject to;".

Page 3, line 31, beginning with "IC 16-28" begin a new line block indented.

Page 3, line 31, after "IC 16-28" insert "**and**".

Page 5, line 30, after "approve" insert "**Medicaid**".

(Reference is to SB 173 as printed January 17, 2014.)

MILLER PATRICIA

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 173, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

(Reference is to SB 173 as printed January 22, 2014.)

Committee Vote: Yeas 8, Nays 1

Representative Clere

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Engrossed Senate Bill 173, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 6, line 20, delete "2019." and insert "**2015.**".

and when so amended that said bill do pass.

(Reference is to ESB 173 as printed February 18, 2014.)

BROWN T, Chair

Committee Vote: yeas 12, nays 7.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 173 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-44.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 44.6. "Countable asset" **means the following:**

(1) For purposes of IC 12-10-10, in determining eligibility for the community and home options to institutional care for the elderly and disabled program, property that is included in determining assets in the same manner as determining an individual's eligibility for the Medicaid aged and disabled waiver.

(2) For purposes of IC 12-20, means noncash property that is not necessary for the health, safety, or decent living standard of a household that:

~~(1)~~ **(A)** is owned wholly or in part by the applicant or a member of the applicant's household;

~~(2)~~ **(B)** the applicant or the household member has the legal right to sell or liquidate; and

~~(3)~~ **(C)** includes:

~~(A)~~ **(i)** real property other than property that is used for the production of income or that is the primary residence of the household;

~~(B)~~ **(ii)** savings and checking accounts, certificates of deposit, bonds, stocks, and other intangibles that have a net cash value; and

~~(C)~~ **(iii)** boats, other vehicles, or any other personal property used solely for recreational or entertainment purposes.

SECTION 2. IC 12-7-2-49.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 49.5. "CPI", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-2.5.**

SECTION 3. IC 12-10-10-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 1. As used in this chapter, "case management" means an administrative function conducted locally by an area agency on aging that includes the following:

(1) Assessment of an individual to determine the individual's functional impairment level and corresponding need for services.

(2) Initial verification of an individual's income and assets.

~~(2)~~ **(3)** Development of a care plan ~~addressing~~ **that:**

(A) addresses an eligible individual's needs;

(B) takes into consideration the individual's family and community members who are willing to provide services to meet any of the individual's needs; and

(C) is consistent with a person centered approach to client care.

~~(3)~~ **(4)** Supervision of the implementation of appropriate and available services for an eligible individual.

~~(4)~~ **(5)** Advocacy on behalf of an eligible individual's interests.

~~(5)~~ **(6)** Monitoring the quality of community and home care services provided to an eligible individual.

~~(6)~~ **(7)** Reassessment of the care plan to determine:

(A) the continuing need and effectiveness of the community and home care services provided to an eligible individual under this chapter; **and**

(B) the annual reverification of a plan recipient's income and assets, as may be required by the division under section 4(e) of this chapter.

~~(7)~~ **(8)** Provision of information and referral services to individuals in need of community and home care services.

SECTION 4. IC 12-10-10-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 2.5. As used in this chapter, "CPI" refers to the United States Bureau of Labor Statistics Consumer Price Index, all items, all urban consumers, or its successor index.**

SECTION 5. IC 12-10-10-4, AS AMENDED BY P.L.99-2007, SECTION 64, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 4. (a) As used in this chapter, "eligible individual" means an individual who **meets the following criteria:**

(1) Is a resident of Indiana.

(2) Is:

(A) at least sixty (60) years of age; or

(B) an individual with a disability.

(3) Has assets **that meet the following criteria:**

(A) For an individual who participates in the program and whose date of application for the program is before January 1, 2015, assets that do not exceed five hundred thousand dollars ($500,000), as determined by the division. ~~and~~

(B) For an individual whose date of application for the program is after December 31, 2014, countable assets that do not exceed two hundred fifty thousand dollars ($250,000) adjusted by the CPI, as set forth in subsection (c). In determining assets under this clause, the division shall exclude an additional twenty thousand dollars ($20,000) in countable assets, as adjusted by the CPI as set forth in subsection (c).

(4) Qualifies under criteria developed by the board as having an impairment that places the individual at risk of losing the individual's independence, as described in subsection (b).

(b) For purposes of subsection (a), an individual is at risk of losing the individual's independence if the individual is unable to perform **any of the following:**

(1) Two (2) or more activities of daily living. The use by or on behalf of the individual of any of the following services or devices does not make the individual ineligible for services under this chapter:

~~(1)~~ **(A)** Skilled nursing assistance.

~~(2)~~ **(B)** Supervised community and home care services, including skilled nursing supervision.

~~(3)~~ **(C)** Adaptive medical equipment and devices.

~~(4)~~ **(D)** Adaptive nonmedical equipment and devices.

(2) One (1) activity of daily living if, using the needs based assessment established under section 13(1) of this chapter, the area agency on aging determines that addressing the single activity of daily living would significantly reduce the likelihood of the individual's loss of independence and the need for additional services.

(3) An activity if, using the needs based assessment established under section 13(1) of this chapter, the area agency on aging determines that targeted intervention or assistance with the activity would significantly reduce the likelihood of the individual's loss of independence and the need for additional services.

(c) Before June 1, 2015, and before June 1 of each subsequent year, the division shall determine an adjusted asset limit to be used for purposes of subsection (a)(3)(B), subsection (d)(4), and section 13 of this chapter in the following state fiscal year. The adjusted asset limit for the following state fiscal year shall be determined as follows:

STEP ONE: Determine the percentage change between:

(A) the CPI as last reported for the calendar year ending in the state fiscal year in which the determination is made; and

(B) the CPI as last reported for the calendar year that precedes the calendar year described in clause (A).

STEP TWO: Express the percentage change determined in STEP ONE as a two (2) digit decimal rounded to the nearest hundredth. A negative percentage change under this STEP must be treated as zero (0).

STEP THREE: Add one (1) to the STEP TWO result.

STEP FOUR: Multiply:

(A) the STEP THREE result; by

(B) the asset limit used for purposes of subsection (a)(3)(B) in the state fiscal year in which the determination is made.

Before June 15, 2015, and before June 15 of each subsequent year, the division shall publish in the Indiana Register the adjusted asset limit to be used for purposes of subsection (a)(3)(B) in the following state fiscal year.

(d) The division shall, in accordance with standards established under section 13(3) of this chapter, establish a cost participation schedule for a program recipient based on the program participant's income and countable assets. The cost participation schedule must meet the following:

(1) Exclude from cost participation an eligible individual whose income and countable assets do not exceed one hundred fifty percent (150%) of the federal income poverty level.

(2) Exclude from cost participation for the total services provided to an individual under the program unless the eligible individual's income and countable assets exceed three hundred fifty percent (350%) of the federal income poverty level.

(3) In calculating income and countable assets for an eligible individual, deduct the medical expenses of the following:

(A) The individual.

(B) The spouse of the individual.

(C) The dependent children of the individual.

(4) Exclude twenty thousand dollars ($20,000) of a participant's countable assets, as adjusted by CPI, from consideration in determining a participant's cost participation.

The cost participation schedule established under this subsection may be applied only to an individual whose date of application for

the program is after December 31, 2014.

(e) The division may require annual reverification for program participants whom the division determines are likely to experience a material increase in income or assets. An individual shall submit the information requested by the division to carry out the redetermination allowed by this subsection.

(f) The division may not require a family or other person to provide services as a condition of an individual's eligibility for or participation in the program.

SECTION 6. IC 12-10-10-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 7. (a) Except as provided in subsection (b), the case management under this chapter of an individual leading to participation in the program may not be conducted by any agency that delivers services under the program.

(b) If the division determines that there is no alternative agency capable of delivering services to the individual, the area agency on aging that performs the assessment under the program may also deliver the services.

(c) The division shall provide the necessary funding to provide case management services for the program, as determined under section 13(2) of this chapter.

SECTION 7. IC 12-10-10-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 9. (a) The division shall establish a program to train relatives of eligible individuals to provide homemaker and personal care services to those eligible individuals.

(b) Relatives of eligible individuals who complete the training program established under this section are eligible for reimbursement under this chapter or under the Medicaid program for the provision of homemaker and personal care services to those eligible individuals. Reimbursement under the Medicaid program is limited to those cases in which the provision of homemaker and personal care services to an eligible individual by a relative results in financial hardship to the relative.

(c) For services that an individual is eligible to receive under the program but receives from a relative or other individual without receiving compensation, the area agency on aging shall:

(1) determine, in accordance with section 13(4) of this chapter, the savings from not paying for these services; and

(2) allocate twenty percent (20%) of the savings calculated under subdivision (1) to offset the individual's cost share amount, if any, for participating in the program.

SECTION 8. IC 12-10-10-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 13. The division and the area agencies on aging shall jointly develop policies that establish the following:**

(1) A needs based assessment to be used in determining a client's needs and care plan under section 1(3) of this chapter.

(2) The percentage of program dollars adequate to provide case management services.

(3) A cost participation schedule for program recipients as required by section 4(d) of this chapter.

(4) Procedures for determining cost savings as required by section 9(c) of this chapter.

(5) Program performance measures for the area agencies on aging.

SECTION 9. IC 12-10-10-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: **Sec. 14. (a) This section applies only to an individual whose date of application for the program is after December 31, 2014.**

(b) The division may obtain a lien on the program recipient's real property for the cost of services provided to the individual in the program if the cost of the services exceeds twenty thousand dollars ($20,000), as adjusted by the CPI under section 4(c) of this chapter, in the same manner and with the same requirements as the office obtains a lien against a Medicaid recipient under IC 12-15-8.5, except that there may be no look back of the program recipient's property as required under the Medicaid program in IC 12-15-8.5-2.

(c) The division may adopt rules necessary under IC 4-22-2 to implement this section.

SECTION 10. IC 12-10-11-8, AS AMENDED BY P.L.143-2011, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2015]: Sec. 8. The board shall do the following:

(1) Establish long term goals of the state for the provision of a continuum of care for the elderly and individuals with a disability based on the following:

(A) Individual independence, dignity, and privacy.

(B) Long term care services that are:

(i) integrated, accessible, and responsible; and

(ii) available in home and community settings.

(C) Individual choice in planning and managing long term

care.

(D) Access to an array of long term care services:

(i) for an individual to receive care that is appropriate for the individual's needs; and

(ii) to enable a case manager to have cost effective alternatives available in the construction of care plans and the delivery of services.

(E) Long term care services that include home care, community based services, assisted living, congregate care, adult foster care, and institutional care.

(F) Maintaining an individual's dignity and self-reliance to protect the fiscal interests of both taxpayers and the state.

(G) Long term care services that are fiscally sound.

(H) Services that:

(i) promote behavioral health; and

(ii) prevent and treat mental illness and addiction.

(2) Review state policies on community and home care services.

(3) Recommend the adoption of rules under IC 4-22-2.

(4) Recommend legislative changes affecting community and home care services.

(5) Recommend the coordination of the board's activities with the activities of other boards and state agencies concerned with community and home care services.

(6) Evaluate cost effectiveness, quality, scope, and feasibility of a state administered system of community and home care services.

(7) Evaluate programs for financing services to those in need of a continuum of care.

(8) Evaluate state expenditures for community and home care services, taking into account efficiency, consumer choice, competition, and equal access to providers.

(9) Develop policies that support the participation of families and volunteers in meeting the long term care needs of individuals.

(10) Encourage the development of funding for a continuum of care from private resources, including insurance.

~~(11) Develop a cost of services basis and a program of cost reimbursement for those persons who can pay all or a part of the cost of the services rendered. The division shall use this cost of services basis and program of cost reimbursement in administering IC 12-10-10. The cost of services basis and program of cost reimbursement must include a client cost share formula that:~~

~~(A) imposes no charges for an eligible individual whose income does not exceed one hundred fifty percent (150%) of the federal income poverty level; and~~

~~(B) does not impose charges for the total cost of services provided to an individual under the community and home options to institutional care for the elderly and disabled program unless the eligible individual's income exceeds three hundred fifty percent (350%) of the federal income poverty level.~~

~~The calculation of income for an eligible individual must include the deduction of the individual's medical expenses and the medical expenses of the individual's spouse and dependent children who reside in the eligible individual's household.~~

~~(12)~~ **(11)** Establish long term goals for the provision of guardianship services for adults.

~~(13)~~ **(12)** Coordinate activities and programs with the activities of other boards and state agencies concerning the provision of guardianship services.

~~(14)~~ **(13)** Recommend statutory changes affecting the guardianship of indigent adults.

~~(15)~~ **(14)** Review a proposed rule concerning home and community based services as required under section 9 of this chapter.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 173 as printed February 24, 2014.)

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