Reprinted
April 21, 2011

ENGROSSED
SENATE BILL No. 460

DIGEST OF SB 460 (Updated April 20, 2011 3:41 pm - DI 92)

Citations Affected: IC 12-7; IC 12-15; IC 16-18; IC 16-28.

Synopsis: Long term care issues. Requires and sets forth the procedure for an institutional provider and a noninstitutional provider to reimburse the office of the secretary of family and social services for, or appeal a determination of, certain Medicaid overpayments made to the provider. Provides that a provider has to repay an overpayment within 300 days instead of 60 days. Extends the collection of a nursing facility quality assessment fee until June 30, 2014. Changes the amount collected and the distribution of the fee revenue.

Effective: July 1, 2011.

Miller, Lawson C, Breaux
(HOUSE SPONSORS — BROWN T, ESPICH, BROWN C, WELCH)

January 12, 2011, read first time and referred to Committee on Health and Provider Services.
January 27, 2011, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.
February 17, 2011, amended, reported favorably — Do Pass.
February 21, 2011, read second time, amended, ordered engrossed.
February 22, 2011, engrossed. Read third time, passed. Yeas 34, nays 15.

HOUSE ACTION

March 28, 2011, read first time and referred to Committee on Ways and Means.
April 13, 2011, amended, reported — Do Pass.
April 20, 2011, read second time, amended, ordered engrossed.

Reprinted
April 21, 2011

First Regular Session 117th General Assembly (2011)

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 2010 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 460

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 12-7-2-119.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 119.5. "Institutional provider", for purposes of IC 12-15-13-4, has the meaning set forth in IC 12-15-13-4(a).**

SECTION 2. IC 12-7-2-132.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 132.2. "Noninstitutional provider", for purposes of IC 12-15-13-3, has the meaning set forth in IC 12-15-13-3.5(a).**

SECTION 3. IC 12-15-13-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 3.5. (a) As used in this section, "noninstitutional provider" means any Medicaid provider other than the following:**

(1) A health facility licensed under IC 16-28.

(2) An ICF/MR (as defined in IC 16-29-4-2).

(b) If the office of the secretary or the office of the secretary's designee believes that an overpayment to a noninstitutional provider has occurred, the office of the secretary or the office of the secretary's designee may submit to the noninstitutional provider a preliminary review of the draft audit findings.

(c) A noninstitutional provider that receives a preliminary review of draft audit findings under subsection (b) may request administrative reconsideration of the preliminary review not later than forty-five (45) days after the issuance of the preliminary review. The noninstitutional provider may submit comments along with the request for administrative reconsideration. The noninstitutional provider must request administrative reconsideration before filing an appeal.

(d) Following administrative reconsideration of the preliminary review of draft audit findings and any comments submitted along with the noninstitutional provider's request for administrative consideration and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the noninstitutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final calculation of the overpayment.

(e) A noninstitutional provider who receives a notice under subsection (d) may elect to do one (1) of the following:

(1) Repay the amount of the final calculation not later than three hundred (300) days after the provider received the notice under subsection (d), including interest:

(A) due from the noninstitutional provider; and

(B) accruing from the date of overpayment.

(2) Request a hearing by filing an administrative appeal not later than sixty (60) days after receiving the notice under subsection (d) and repay the amount of the final calculation of the overpayment under subsection (d) not later than three hundred (300) days after receiving the notice under subsection (d).

(f) If:

(1) a noninstitutional provider elects to proceed under subsection (e)(2); and

(2) the office of the secretary or the office of the secretary's designee determines after the hearing and any subsequent appeal that the noninstitutional provider does not owe the

money that the office of the secretary or the office of the secretary's designee believed the noninstitutional provider owed;

the office of the secretary or the office of the secretary's designee shall return the amount of the alleged overpayment, and any interest paid by the noninstitutional provider, and pay the noninstitutional provider interest on the money from the date of the noninstitutional provider's repayment.

(g) Interest that is due under this section shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) as follows:

(1) Interest due from a noninstitutional provider to the state shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(2) Interest due from the state to a noninstitutional provider shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(h) Interest on an overpayment to a noninstitutional provider is not due from the noninstitutional provider if the overpayment is the result of an error of:

(1) the office; or

(2) a contractor of the office;

as determined by the office of the secretary or the office of the secretary's designee.

(i) If interest on an overpayment to a noninstitutional provider is due from the noninstitutional provider, the secretary or the secretary's designee may, in the course of negotiations with the noninstitutional provider regarding an appeal filed under subsection (e), reduce the amount of interest due from the noninstitutional provider.

(j) Proceedings under this section are subject to IC 4-21.5.

SECTION 4. IC 12-15-13-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 4. (a) As used in this section, "institutional provider" means the following:**

(1) A health facility that is licensed under IC 16-28.

(2) An ICF/MR (as defined in IC 16-29-4-2).

(b) If the office of the secretary or the office of the secretary's designee believes that an overpayment to an institutional provider has occurred, the office of the secretary or the office of the secretary's designee may do the following:

(1) Submit to the institutional provider a draft of the audit

findings and accept comments from the institutional provider for consideration by the office of the secretary or the office of the secretary's designee before the audit findings are finalized.

(2) Finalize the audit findings and issue the preliminary recalculated Medicaid rate.

(c) An institutional provider that receives a preliminary recalculated Medicaid rate under subsection (b)(2) may request administrative reconsideration of the preliminary recalculated Medicaid rate not later than forty-five (45) days after the issuance of the preliminary recalculated rate. The institutional provider must request administrative reconsideration before filing an appeal.

(d) Following reconsideration of an institutional provider's comments, and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the institutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final recalculated Medicaid rate.

(e) Upon the next payment cycle, the office of the secretary or the office of the secretary's designee shall retroactively implement the final recalculated Medicaid rate.

(f) If the institutional provider is dissatisfied with the reconsideration response issued by the office of the secretary or the office of the secretary's designee, the institutional provider may request a hearing by filing an appeal with the office of the secretary not later than sixty (60) days after the issuance of the reconsideration response.

(g) If an institutional provider requests a hearing under subsection (f) and the office or the office's designee determines after the hearing and any subsequent appeal that the institutional provider does not owe the money that the office of the secretary or the office of the secretary's designee believed the institutional provider owed, the office of the secretary or the office of the secretary's designee shall repay the following to the institutional provider not later than thirty (30) days after the completion of the hearing:

(1) The amount of the alleged overpayment.

(2) Any interest paid by the institutional provider.

(3) Interest on the money described in subdivisions (1) and (2) from the date of the institutional provider's repayment.

(h) Interest due under this section by either the institutional provider or the office of the secretary shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(i) Interest on an overpayment to an institutional provider is not due from the institutional provider if the office of the secretary or the office of the secretary's designee determines that the overpayment is the result of an error by the following:

(1) The office of the secretary.

(2) A contractor of the office of the secretary.

(j) If interest on an overpayment to an institutional provider is due from the institutional provider, the office of the secretary or the office of the secretary's designee may, in the course of negotiations with the institutional provider concerning an appeal filed under subsection (c), reduce the amount of interest due from the institutional provider.

SECTION 5. IC 12-15-23-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 2. **(a)** If the **office of the secretary of family and social services or** administrator **of the office** determines that a provider has received payments the provider is not entitled to, the administrator may enter into an agreement with the provider stating that the amount of the overpayment shall be deducted from subsequent payments to the provider.

(b) If the office of the secretary of family and social services or the administrator of the office and the provider cannot come to an agreement within sixty (60) days after it is determined that a provider has received payments that the provider is not entitled to, the administrator may recoup the amount of overpayment to the provider claimed by the state from subsequent payments to the provider.

SECTION 6. IC 16-18-2-69.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 69.3. "Continuing care retirement community", for purposes of IC 16-28-15, has the meaning set forth in IC 16-28-15-2.**

SECTION 7. IC 16-18-2-167, AS AMENDED BY P.L.99-2007, SECTION 153, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 167. (a) "Health facility":

(1) except for purposes of IC 16-28-15, means a building, a structure, an institution, or other place for the reception,

accommodation, board, care, or treatment extending beyond a continuous twenty-four (24) hour period in a week of more than four (4) individuals who need or desire such services because of physical or mental illness, infirmity, or impairment; **and**

(2) for purposes of IC 16-28-15, has the meaning set forth in IC 16-28-15-3.

(b) The term does not include the premises used for the reception, accommodation, board, care, or treatment in a household or family, for compensation, of a person related by blood to the head of the household or family (or to the spouse of the head of the household or family) within the degree of consanguinity of first cousins.

(c) The term does not include any of the following:

(1) Hotels, motels, or mobile homes when used as such.

(2) Hospitals or mental hospitals, except for that part of a hospital that provides long term care services and functions as a health facility, in which case that part of the hospital is licensed under IC 16-21-2, but in all other respects is subject to IC 16-28.

(3) Hospices that furnish inpatient care and are licensed under IC 16-25-3.

(4) Institutions operated by the federal government.

(5) Foster family homes or day care centers.

(6) Schools for individuals who are deaf or blind.

(7) Day schools for individuals with mental retardation.

(8) Day care centers.

(9) Children's homes and child placement agencies.

(10) Offices of practitioners of the healing arts.

(11) Any institution in which health care services and private duty nursing services are provided that is listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

(12) Industrial clinics providing only emergency medical services or first aid for employees.

(13) A residential facility (as defined in IC 12-7-2-165).

(14) Maternity homes.

(15) Offices of Christian Science practitioners.

SECTION 8. IC 16-18-2-253.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 253.7. "Nursing facility", for purposes of IC 16-28-15, has the meaning set forth in IC 16-28-15-4.**

SECTION 9. IC 16-18-2-167, AS AMENDED BY P.L.99-2007, SECTION 153, IS AMENDED TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2011]: Sec. 167. (a) **Except for purposes of IC 16-28-15,** "health facility" means a building, a structure, an institution, or other place for the reception, accommodation, board, care, or treatment extending beyond a continuous twenty-four (24) hour period in a week of more than four (4) individuals who need or desire such services because of physical or mental illness, infirmity, or impairment.

(b) The term does not include the premises used for the reception, accommodation, board, care, or treatment in a household or family, for compensation, of a person related by blood to the head of the household or family (or to the spouse of the head of the household or family) within the degree of consanguinity of first cousins.

(c) The term does not include any of the following:

(1) Hotels, motels, or mobile homes when used as such.

(2) Hospitals or mental hospitals, except for that part of a hospital that provides long term care services and functions as a health facility, in which case that part of the hospital is licensed under IC 16-21-2, but in all other respects is subject to IC 16-28.

(3) Hospices that furnish inpatient care and are licensed under IC 16-25-3.

(4) Institutions operated by the federal government.

(5) Foster family homes or day care centers.

(6) Schools for individuals who are deaf or blind.

(7) Day schools for individuals with mental retardation.

(8) Day care centers.

(9) Children's homes and child placement agencies.

(10) Offices of practitioners of the healing arts.

(11) Any institution in which health care services and private duty nursing services are provided that is listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

(12) Industrial clinics providing only emergency medical services or first aid for employees.

(13) A residential facility (as defined in IC 12-7-2-165).

(14) Maternity homes.

(15) Offices of Christian Science practitioners.

(d) "Health facility", for purposes of IC 16-28-15, has the meaning set forth in IC 16-28-15-3.

SECTION 10. IC 16-18-2-253.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 253.7. "Nursing facility", for purposes of IC 16-28-15, has the meaning set forth in**

IC 16-28-15-4.

SECTION 11. IC 16-18-2-254.5, AS AMENDED BY P.L.38-2010, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 254.5. (a) "Office", for purposes of IC 16-19-13, refers to the office of women's health established by IC 16-19-13-2.

(b) "Office", for purposes of IC 16-19-14, refers to the office of minority health established by IC 16-19-14-4.

(c) "Office", for purposes of IC 16-28-15, has the meaning set forth in IC 16-28-15-5.

SECTION 12. IC 16-28-15 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 15. Health Facility Quality Assessment Fee

Sec. 1. The imposition of a quality assessment fee under this chapter occurs after July 31, 2011.

Sec. 2. As used in this chapter, "continuing care retirement community" means a health care facility that:

(1) provides independent living services and health facility services in a campus setting with common areas;

(2) holds continuing care agreements with at least twenty-five percent (25%) of its residents (as defined in IC 23-2-4-1);

(3) uses the money from the agreements described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.

Sec. 3. As used in this chapter, "health facility" refers to a health facility that is licensed under this article as a comprehensive care facility.

Sec. 4. As used in this chapter, "nursing facility" means a health facility that is certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

Sec. 5. As used in this chapter, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

Sec. 6. (a) Effective August 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, based on the latest nursing facility financial reports and nursing facility quality assessment data collection forms as of July 28, 2010.

(c) 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.

Sec. 7. The office shall implement the waiver approved by the United States Centers for Medicare and Medicaid Services under 42 CFR 433.68(e)(2), that provides for the following:

(1) Non-uniform quality assessment fee rates.

(2) An exemption from collection of a quality assessment fee from the following:

(A) A continuing care retirement community as follows:

(i) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on January 1, 2007, is not required to meet the definition of a continuing care retirement community in section 2 of this chapter.

(ii) A continuing care retirement community that, for the period January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).

(iii) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(iv) A continuing care retirement community that meets the definition set forth in section 2 of this chapter.

(B) A hospital based health facility.

(C) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this section is subject to and must comply with the provisions of this chapter.

Sec. 8. (a) The money collected from the quality assessment fee during the first year following the enactment may be used only as follows:

(1) Sixty-eight percent (68%) 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) One and four-tenths percent (1.4%) to pay the state's share of costs for Medicaid aged and disabled waiver services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Seventeen and six-tenths percent (17.6%) 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.).

(4) Four percent (4%) to be deposited in the office's Medicaid administration fund to pay the state's share of costs associated with the federal Patient Protection and Affordable Health Care Act.

(5) Nine percent (9%) to pay prior year state nursing facility expenditures.

(b) The money collected from the quality assessment fee during the second year following enactment may be used only as follows:

(1) Sixty-eight percent (68%) 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) One and four-tenths percent (1.4%) to pay the state's share of costs for Medicaid aged and disabled waiver services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Twenty percent (20%) 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.).

(4) Six and four-tenths percent (6.4%) to be deposited in the office's Medicaid administration fund to pay the state's share of costs associated with the federal Patient Protection and Affordable Health Care Act.

(5) Four and two-tenths percent (4.2%) to pay prior year state nursing facility expenditures.

(c) The money collected from the quality assessment fee after the second year following enactment may be used only as follows:

(1) Seventy-two and two-tenths percent (72.2%) 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) One and four-tenths percent (1.4%) to pay the state's share of costs for Medicaid aged and disabled waiver services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(3) Twenty percent (20%) 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.).

(4) Six and four-tenths percent (6.4%) to be deposited in the office's Medicaid administration fund to pay the state's share of costs associated with the federal Patient Protection and Affordable Health Care Act.

(d) Any increase in reimbursement for Medicaid nursing facility services resulting from maximizing the quality assessment under section 6(b) of this chapter shall be directed exclusively to initiatives determined by the office to promote and enhance improvements in quality of care to nursing facility residents.

(e) 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.

Sec. 9. If federal financial participation becomes unavailable to match money collected from the quality assessment fees for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall cease collection of the quality assessment fee under this chapter.

Sec. 10. The office shall adopt rules under IC 4-22-2 necessary to implement this chapter.

Sec. 11. (a) If a health facility fails to pay the quality assessment under this chapter not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(b) The office shall report to the state department each nursing facility and each health facility that either fails to submit patient day information requested by the office to calculate the quality assessment fee or fails to pay the quality assessment fee under this chapter not later than one hundred twenty (120) days after the patient day information or payment of the quality assessment fee is due.

Sec. 12. (a) The state department shall do the following:

(1) Notify each nursing facility and each health facility reported under section 11 of this chapter that the nursing facility's license or health facility's license under IC 16-28 will be revoked if the patient day information is not submitted, or the quality assessment fee is not paid.

(2) Revoke the nursing facility's license or health facility's

license under IC 16-28 if the nursing facility or the health facility fails to submit the patient day information or fails to pay the quality assessment fee.

(b) An action taken under subsection (a)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

Sec. 13. The select joint commission on Medicaid oversight established by IC 2-5-26-3 shall review the implementation of this chapter.

Sec. 14. This chapter expires June 30, 2014.

SECTION 13. IC 12-15-13-3 IS REPEALED [EFFECTIVE JULY 1, 2011].

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 460, 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 1, line 17, after "secretary" insert "**or the office of the secretary's designee**".

Page 2, line 1, after "secretary" insert "**or the office of the secretary's designee**".

Page 2, line 4, after "secretary" insert "**or the office of the secretary's designee**".

Page 2, line 13, strike "sixty (60)" and insert "**three hundred (300)**".

Page 2, line 14, delete "secretary," and insert "secretary **or the office of the secretary's designee,**".

Page 2, line 19, strike "sixty (60)" and insert "**three hundred (300)**".

Page 2, line 20, delete "." and insert "**or the office of the secretary's designee.**".

Page 2, line 27, after "secretary" insert "**or the office of the secretary's designee**".

Page 2, line 29, after "secretary" insert "**or the office of the secretary's designee**".

Page 2, line 31, after "secretary" insert "**or the office of the secretary's designee**".

Page 3, line 14, delete "secretary." and insert "secretary **or the office of the secretary's designee.**".

Page 3, line 16, after "secretary" insert "**or the secretary's designee**".

Page 3, line 27, after "secretary" insert "**or the office of the secretary's designee**".

Page 3, line 28, after "secretary" insert "**or the office of the secretary's designee**".

Page 3, line 32, after "secretary" insert "**or the office of the secretary's designee**".

Page 3, line 34, delete "Following consideration of an institutional provider's" and insert "**Finalize the audit findings and issue the preliminary recalculated Medicaid rate.**

(c) An institutional provider that receives a preliminary recalculated Medicaid rate under subsection (b)(2) may request

administrative reconsideration of the preliminary recalculated Medicaid rate not later than forty-five (45) days after the issuance of the preliminary recalculated rate. The institutional provider must request administrative reconsideration before filing an appeal.

(d) Following reconsideration of an institutional provider's comments, the office of the secretary or the office of the secretary's designee shall notify the institutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final recalculated Medicaid rate.

(e) Upon the next payment cycle, the office of the secretary or the office of the secretary's designee shall retroactively implement the final recalculated Medicaid rate.".

Page 3, delete lines 35 through 42.

Page 4, delete lines 1 through 3.

Page 4, line 4, delete "(d)" and insert "**(f)**".

Page 4, line 4, delete "office of".

Page 4, line 5, delete "the secretary's".

Page 4, line 5, delete "response," and insert "**response issued by the office of the secretary or the office of the secretary's designee,**".

Page 4, line 6, delete "hearing." and insert "**hearing by filing an appeal with the office of the secretary not later than sixty (60) days after the issuance of the reconsideration response.**".

Page 4, line 7, delete "(e)" and insert "**(g)**".

Page 4, line 8, delete "(d)" and insert "**(f)**".

Page 4, line 8, after "office" insert "**or the office's designee**".

Page 4, line 10, after "secretary" insert "**or the office of the secretary's designee**".

Page 4, line 11, after "secretary" insert "**or the office of the secretary's designee**".

Page 4, line 18, delete "(f)" and insert "**(h)**".

Page 4, line 24, delete "(g)" and insert "**(i)**".

Page 4, line 25, after "secretary" insert "**or the office of the secretary's designee**".

Page 4, line 30, delete "(h)" and insert "**(j)**".

Page 4, line 31, after "secretary" insert "**or the office of the secretary's designee**".

Page 11, line 42, after "16." insert "**Comprehensive Care**".

Page 12, line 1, after "1." insert "**(a)**".

Page 12, line 2, delete "health facility," and insert "**comprehensive care health facility,**".

Page 12, delete lines 5 through 6.

Page 12, line 7, delete "(C) has" and insert "**(B) either:**

(i) has".

Page 12, line 8, delete "and" and insert "**or**

(ii) is seeking only to license a bed that has been obtained through purchase or agreement from an existing licensed comprehensive care health facility; and".

Page 12, line 9, delete "(D)" and insert "**(C)**".

Page 12, delete lines 11 through 13.

Page 12, line 14, delete "(3)" and insert "**(2)**".

Page 12, line 14, after "A" insert "**comprehensive care**".

Page 12, line 14, delete "does" and insert "**is transferring or relocating an existing comprehensive care health facility.**".

Page 12, delete lines 15 through 20.

Page 12, line 21, delete "(4)" and insert "**(3)**".

Page 12, line 24, after "a" insert "**comprehensive care**".

Page 12, line 24, delete "(1)(C)." and insert "**(1)(B).**".

Page 12, between lines 24 and 25, begin a new paragraph and insert:

"**(b) If a replacement bed license is being transferred as described in subsection (a) to a different comprehensive care health facility with the same ownership, the comprehensive care health facility holding the comprehensive care bed license shall provide the state department with written verification that the health facility has agreed to transfer the beds to the applicant health facility.**

(c) If a replacement bed license is being transferred as described in subsection (a) to a different comprehensive care health facility under different ownership, the comprehensive care health facility transferring the bed license shall provide the state department with a copy of the complete agreement between the comprehensive care health facility transferring the beds and the applicant comprehensive care health facility.

(d) Except in the case of an emergency or a disaster, licensure of an existing comprehensive care bed may not be transferred to a new location until the new facility is seeking licensure of the bed.".

Page 12, line 26, after "self-contained" insert "**comprehensive care**".

Page 13, line 6, after "new" insert "**comprehensive care**".

Page 13, line 8, before "health" insert "**comprehensive care**".

Page 14, line 3, after "house" insert "**comprehensive care**".

Page 15, line 3, delete "the following:" and insert "**a comprehensive care health facility that:**

(1) seeks a replacement bed exception;

(2) is licensed or is to be licensed under this article;

(3)".

Page 15, delete lines 4 through 5.

Page 15, line 6, delete "(B)".

Page 15, run in lines 3 through 6.

Page 15, line 10, delete "bed in the same facility;" and insert "**bed;**".

Page 15, line 12, delete "(C)", begin a new line block indented and insert:

"**(4)**".

Page 15, delete lines 13 through 25, begin a new line double block indented and insert:

"**(A) described in subsection (c); and**

(B) prescribed by the division; and

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

Page 15, line 31, after "(2)" insert "**If the replacement bed is being transferred to a different comprehensive care health facility with the same ownership, provide the division of aging with 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, provide the division of aging with a copy of the complete agreement between the comprehensive care health facility transferring the beds and the applicant comprehensive care health facility.

(4)".

Page 15, line 33, after "5." insert "**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 location until the new facility is seeking certification of the bed.**

Sec. 6.".

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 460 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 7, Nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 460, 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 1, line 13, delete "section," and insert "**section and section 3.5 of this chapter,**".

Page 1, line 16, delete "IC 16-29-42)." and insert "**IC 16-29-4-2).**".

Page 2, between lines 11 and 12, begin a new line block indented and insert:

"**(3) Follow the procedure set forth in section 3.5 of this chapter.**".

Page 3, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 4. IC 12-15-13-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 3.5. (a) If the office of the secretary or the office of the secretary's designee believes that an overpayment to a noninstitutional provider has occurred, the office of the secretary or the office of the secretary's designee may do the following:**

(1) Submit to the noninstitutional provider a draft of the audit findings and accept comments from the noninstitutional provider for consideration by the office of the secretary or the office of the secretary's designee before the audit findings are finalized.

(2) Finalize the audit findings and issue the preliminary calculation of the overpayment.

(b) A noninstitutional provider that receives a preliminary calculation of the overpayment under subsection (a)(2) may request administrative reconsideration of the preliminary calculation of the overpayment not later than forty-five (45) days after the issuance of the preliminary calculation of the overpayment. The noninstitutional provider must request administrative reconsideration before filing an appeal.

(c) Following reconsideration of a noninstitutional provider's comments and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the noninstitutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final calculation of the overpayment.

(d) If the noninstitutional provider is dissatisfied with the reconsideration response issued by the office of the secretary or the office of the secretary's designee, the noninstitutional provider may request a hearing by filing an appeal with the office of the secretary not later than sixty (60) days after the issuance of the reconsideration response.".

Page 8, line 19, delete "IC 16-28-16," and insert "**IC 16-29-6,**".

Page 8, line 20, delete "IC 16-28-16-2." and insert "**IC 16-29-6-1.**".

Page 10, line 25, delete "as determined by the office." and insert "**to pay prior year unreimbursed state nursing facility expenditures.**".

Page 10, line 42, delete "as determined by the" and insert "**to pay prior year unreimbursed state nursing facility expenditures.**".

Page 11, delete line 1.

Page 12, delete lines 18 through 42.

Delete pages 13 through 14.

Page 15, delete lines 1 through 6.

Page 16, after line 32, begin a new paragraph and insert:

"SECTION 17. IC 16-29-6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 6. Comprehensive Care Health Facilities

Sec. 1. As used in this chapter, "small house health facility" means a freestanding, self-contained comprehensive care health facility that has the following characteristics:

(1) Has at least ten (10) and not more than twelve (12) private resident rooms in one (1) structure that has the appearance of a residential dwelling that is not more than eight thousand (8,000) square feet and includes the following:

(A) A fully accessible private bathroom for each resident room that includes a toilet, sink, and roll in shower with a seat.

(B) A common area living room seating area.

(C) An open full-sized kitchen where one hundred percent (100%) of the resident's meals are prepared.

(D) A dining room that has one (1) table large enough to seat each resident of the dwelling and at least two (2) staff members.

(E) Access to natural light in each habitable space.

(2) Does not include the following characteristics of an institutional setting:

(A) A nurse's station.

(B) Room numbering or other signs that would not be

found in a residential setting.

(3) Provides self-directed care.

Sec. 2. (a) This chapter does not apply to the following:

(1) An entity that:

(A) is licensed or to be licensed under this article;

(B) either:

(i) has physically begun significant construction of the health facility before December 31, 2011; or

(ii) is seeking only to license a bed that has been obtained through purchase or agreement from an existing licensed comprehensive care health facility; and

(C) meets the licensure and survey requirements of IC 16-28.

(2) A comprehensive care health facility that is licensed under IC 16-28-2 and is transferring or relocating an existing comprehensive care health facility to a county in which the occupancy rate is at least ninety percent (90%).

(3) A comprehensive care health facility that is licensed under IC 16-28-2 and is replacing existing licensed beds within the same county.

(4) A small house health facility.

The state department shall make the final determination on whether an entity has physically begun significant construction of a comprehensive care health facility for purposes of subdivision (1)(B).

(b) If a replacement bed license is being transferred as described in subsection (a) to a different comprehensive care health facility with the same ownership, the comprehensive care health facility holding the comprehensive care bed license shall provide the state department with written verification that the health facility has agreed to transfer the beds to the applicant health facility.

(c) If a replacement bed license is being transferred as described in subsection (a) to a different comprehensive care health facility under different ownership, the comprehensive care health facility transferring the bed license shall provide the state department with a copy of the complete agreement between the comprehensive care health facility transferring the beds and the applicant comprehensive care health facility.

(d) Except in the case of an emergency or a disaster, licensure of an existing comprehensive care bed may not be transferred to a new location until the new facility is seeking licensure of the bed.

Sec. 3. The state department may not approve a new

comprehensive care health facility license under IC 16-28-2 and an entity may not add or construct a comprehensive care health facility licensed or to be licensed under IC 16-28 unless the state department determines that there is a need for the health facility in the county by determining that the occupancy rate in health facilities for the county in which the health facility is located or is to be located is at a rate of at least ninety percent (90%).

Sec. 4. (a) A person planning to construct a small house health facility shall apply to the Indiana health facility council for approval.

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

(c) The Indiana health facilities council may not recommend, and the state department may not approve, 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 a small house health facility:

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

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

(3) after the Indiana health facilities council has recommended the application for approval.

(e) The health facilities council may not recommend, and the state department may not approve, an application for construction and operation of a small house health facility if the person meets any of the following:

(1) Has a record of operation of less than a full license.

(2) Has owned or operated a health facility that has had the health facility's license revoked, suspended, or denied.

(3) Has received a survey finding of substandard quality of care, immediate jeopardy, or actual harm.

(4) Has filed for bankruptcy, reorganization, or receivership.

(5) Was the subject of any of the following:

(A) License decertification.

(B) License termination.

(C) A finding of patient:

(i) abuse;

(ii) mistreatment; or

(iii) neglect.

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

(1) another person has applied to the Indiana health facilities council for approval of at least (1) small house health facility; and

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

Sec. 5. This chapter expires June 30, 2014.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 460 as introduced.)

KENLEY, Chairperson

Committee Vote: Yeas 12, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 460 be amended to read as follows:

Page 11, line 21, delete "unreimbursed".

Page 11, line 40, delete "unreimbursed".

Page 13, line 15, delete "IC 16-28-17" and insert "IC 16-28-16".

Page 13, line 18, delete "17." and insert "**16.**".

Page 13, line 37, delete "the Indiana".

Page 13, line 38, delete "health facilities council may not recommend and".

Page 16, between lines 2 and 3, begin a new line block indented and insert:

"**(5) A continuing care retirement community (as defined in IC 16-28-15-2) that seeks to add licensed beds to an existing licensed facility.**".

Page 16, line 32, delete "Indiana health facility council" and insert "**state department**".

Page 16, line 38, delete "Indiana health facilities council may not recommend,".

Page 16, line 39, delete "and the".

Page 16, line 39, delete "approve," and insert "**approve**".

Page 17, line 2, after "date;" insert "**and**".

Page 17, line 4, delete "section; and" and insert "**section.**".

Page 17, delete lines 5 through 6.

Page 17, line 7, delete "health facilities council may not recommend, and the".

Page 17, line 8, delete "approve," and insert "**approve**".

Page 17, line 29, delete "Indiana health facilities" and insert "**state department**".

Page 17, line 30, delete "council".

Page 17, line 36, after "5." insert "**The state department may adopt rules under IC 4-22-2 to implement this chapter.**

Sec. 6.".

(Reference is to SB 460 as printed February 18, 2011.)

MILLER

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Senate Bill 460, 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 9, delete lines 12 through 16, begin a new paragraph and insert:

"SECTION 15. IC 16-18-2-331.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 331.7. "Small house health facility", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-4.**".

Page 10, line 5, delete "law as of" and insert "**law,**".

Page 10, line 6, delete "July 1, 2011,".

Page 13, between lines 36 and 37, begin a new paragraph and insert:

"**Sec. 4. As used in this chapter, "small house health facility" means a freestanding, self-contained comprehensive care health facility that has the following characteristics:**

(1) Has at least ten (10) and not more than twelve (12) private resident rooms in one (1) structure that has the appearance of a residential dwelling that is not more than eight thousand

(8,000) square feet and includes the following:

(A) A fully accessible private bathroom for each resident room that includes a toilet, sink, and roll in shower with a seat.

(B) A common area living room seating area.

(C) An open full-sized kitchen where one hundred percent (100%) of the resident's meals are prepared.

(D) A dining room that has one (1) table large enough to seat each resident of the dwelling and at least two (2) staff members.

(E) Access to natural light in each habitable space.

(2) Does not include the following characteristics of an institutional setting:

(A) A nurse's station.

(B) Room numbering or other signs that would not be found in a residential setting.

(3) Provides self-directed care.

Sec. 5. Section 6 of this chapter does not apply to a small house health facility approved under section 8 of this chapter.".

Page 13, line 37, delete "4." and insert "**6.**".

Page 13, line 37, after "in" insert "**section 5 of this chapter and**".

Page 14, line 35, delete "5." and insert "**7.**".

Page 14, between lines 38 and 39, begin a new paragraph and insert:

"**Sec. 8. (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 office of Medicaid policy and planning for certification for not more than fifty (50) comprehensive care beds for small house health facilities per year.

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

(d) The office of Medicaid policy and planning 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 office of Medicaid policy and planning's approval of the application forfeits the person's right to the Medicaid certified comprehensive care beds approved by the office of Medicaid policy and planning if:

(1) another person has applied to the office of Medicaid policy and planning for approval of certified comprehensive care beds for participation in the state Medicaid program at least (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.".

Page 14, line 39, delete "6." and insert "**9.**".

Page 14, delete lines 40 through 42.

Delete pages 15 through 17.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 460 as reprinted February 22, 2011.)

ESPICH, Chair

Committee Vote: yeas 21, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 460 be amended to read as follows:

Page 1, line 10, delete "IC 12-15-13-3(a)." and insert "**IC 12-15-13-3.5(a).**".

Page 1, delete lines 11 through 17.

Delete pages 2 through 3.

Page 4, delete lines 1 through 24, begin a new paragraph and insert:

"SECTION 3. IC 12-15-13-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 3.5. (a) As used in this section, "noninstitutional provider" means any Medicaid provider other than the following:**

(1) A health facility licensed under IC 16-28.

(2) An ICF/MR (as defined in IC 16-29-4-2).

(b) If the office of the secretary or the office of the secretary's designee believes that an overpayment to a noninstitutional

provider has occurred, the office of the secretary or the office of the secretary's designee may submit to the noninstitutional provider a preliminary review of the draft audit findings.

(c) A noninstitutional provider that receives a preliminary review of draft audit findings under subsection (b) may request administrative reconsideration of the preliminary review not later than forty-five (45) days after the issuance of the preliminary review. The noninstitutional provider may submit comments along with the request for administrative reconsideration. The noninstitutional provider must request administrative reconsideration before filing an appeal.

(d) Following administrative reconsideration of the preliminary review of draft audit findings and any comments submitted along with the noninstitutional provider's request for administrative consideration and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the noninstitutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final calculation of the overpayment.

(e) A noninstitutional provider who receives a notice under subsection (d) may elect to do one (1) of the following:

(1) Repay the amount of the final calculation not later than three hundred (300) days after the provider received the notice under subsection (d), including interest:

(A) due from the noninstitutional provider; and

(B) accruing from the date of overpayment.

(2) Request a hearing by filing an administrative appeal not later than sixty (60) days after receiving the notice under subsection (d) and repay the amount of the final calculation of the overpayment under subsection (d) not later than three hundred (300) days after receiving the notice under subsection (d).

(f) If:

(1) a noninstitutional provider elects to proceed under subsection (e)(2); and

(2) the office of the secretary or the office of the secretary's designee determines after the hearing and any subsequent appeal that the noninstitutional provider does not owe the money that the office of the secretary or the office of the secretary's designee believed the noninstitutional provider

owed;

the office of the secretary or the office of the secretary's designee shall return the amount of the alleged overpayment, and any interest paid by the noninstitutional provider, and pay the noninstitutional provider interest on the money from the date of the noninstitutional provider's repayment.

(g) Interest that is due under this section shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) as follows:

(1) Interest due from a noninstitutional provider to the state shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(2) Interest due from the state to a noninstitutional provider shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(h) Interest on an overpayment to a noninstitutional provider is not due from the noninstitutional provider if the overpayment is the result of an error of:

(1) the office; or

(2) a contractor of the office;

as determined by the office of the secretary or the office of the secretary's designee.

(i) If interest on an overpayment to a noninstitutional provider is due from the noninstitutional provider, the secretary or the secretary's designee may, in the course of negotiations with the noninstitutional provider regarding an appeal filed under subsection (e), reduce the amount of interest due from the noninstitutional provider.

(j) Proceedings under this section are subject to IC 4-21.5.".

Page 5, line 7, after "comments," insert "**and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred,**".

Page 12, line 37, after "that" insert "**either**".

Page 12, line 37, after "fails" insert "**to submit patient day information requested by the office to calculate the quality assessment fee or fails**".

Page 12, line 39, after "after" insert "**the patient day information or**".

Page 13, line 3, after "the" insert "**patient day information is not submitted, or the**".

Page 13, line 6, after "to" insert "**submit the patient day information or fails to**".

Page 16, after line 10, begin a new paragraph and insert:

"SECTION 19. IC 12-15-13-3 IS REPEALED [EFFECTIVE JULY 1, 2011].".

Renumber all SECTIONS consecutively.

(Reference is to ESB 460 as printed April 13, 2011.)

BROWN T

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 460 be amended to read as follows:

Page 6, delete lines 24 through 29.

Page 9, delete lines 7 through 16.

Page 13, delete lines 14 through 42.

Delete pages 14 through 16.

Renumber all SECTIONS consecutively.

(Reference is to ESB 460 as printed April 13, 2011.)

CULVER