SENATE BILL No. 460

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15; IC 16-18-2; IC 16-28.

Synopsis: Quality assessment and moratorium. 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 certain Medicaid overpayments made to the provider. Extends: (1) the collection of a nursing facility quality assessment fee with changes to the amount collected and the amount and to whom the dollars are dispersed; and (2) a moratorium on the certification of new or converted comprehensive care beds for participation in the state Medicaid program; until June 30, 2014. Creates a moratorium on the construction and certification of health facilities until June 30, 2014.

Effective: July 1, 2011.

Miller

January 12, 2011, read first time and referred to Committee on Health and Provider Services.

Introduced

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.

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(a).**

SECTION 3. IC 12-15-13-3, AS AMENDED BY P.L.8-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 3. (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 16-29-42).

(b) If the office of the secretary believes that an overpayment to a

noninstitutional provider has occurred, the office of the secretary may do the following:

(1) Notify the **noninstitutional** provider in writing that the office of the secretary believes that an overpayment has occurred.

(2) ~~Request~~ **Demand** in the notice that the **noninstitutional** provider repay the amount of the alleged overpayment, including interest:

(A) due from the **noninstitutional** provider; and

(B) accruing from the date of overpayment.

~~(b)~~ **(c)** A **noninstitutional** provider who receives a notice and ~~request~~ **demand** for repayment under subsection ~~(a)~~ **(b)** may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office of the secretary, including interest:

(A) due from the **noninstitutional** provider; and

(B) accruing from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office of the secretary.

~~(3) Request a hearing not later than sixty (60) days after receiving notice from the office of the secretary and not repay the alleged overpayment, except as provided in subsection (d).~~

~~(c)~~ **(d)** If:

(1) a **noninstitutional** provider elects to proceed under subsection ~~(b)(2),~~ **(c)(2);** and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the **noninstitutional** provider does not owe the money that the office of the secretary believed the **noninstitutional** provider owed;

the office of the secretary 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.

~~(d) If:~~

~~(1) a provider elects to proceed under subsection (b)(3); and~~

~~(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;~~

~~the provider shall pay the amount of the overpayment, including interest due from the provider and accruing from the date of the overpayment.~~

(e) 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.

(f) 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.

(g) If interest on an overpayment to a **noninstitutional** provider is due from the **noninstitutional** provider, the secretary may, in the course of negotiations with the **noninstitutional** provider regarding an appeal filed under subsection (b), reduce the amount of interest due from the **noninstitutional** provider.

(h) 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 believes that an overpayment to an institutional provider has occurred, the office of the secretary 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 before the audit findings are finalized.

(2) Following consideration of an institutional provider's comments, notify the institutional provider in writing that the office of the secretary:

(A) believes that an overpayment has occurred; and

(B) is issuing a recalculated Medicaid rate.

(3) Upon the next payment cycle, retroactively implement the recalculated Medicaid rate.

(c) An institutional provider that receives a notice of overpayment and recalculated Medicaid rate under subsection (b)

may request administrative review of the recalculated Medicaid rate not later than forty-five (45) days after the issuance of the recalculated rate.

(d) If the institutional provider is dissatisfied with the office of the secretary's reconsideration response, the institutional provider may request a hearing.

(e) If an institutional provider requests a hearing under subsection (d) and the office determines after the hearing and any subsequent appeal that the institutional provider does not owe the money that the office of the secretary believed the institutional provider owed, the office of the secretary 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.

(f) 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.

(g) Interest on an overpayment to an institutional provider is not due from the institutional provider if the office of the secretary 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.

(h) If interest on an overpayment to an institutional provider is due from the institutional provider, the office of the secretary 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 16-18-2-67 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 67. **(a) "Comprehensive care bed", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-2.**

(b) "Comprehensive care bed", for purposes of IC 16-29-2, has the meaning set forth in IC 16-29-2-1.

SECTION 7. 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 8. 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 9. 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 10. 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 11. 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 12. 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 13. IC 16-18-2-316.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 316.5. "Replacement bed", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-3.**

SECTION 14. IC 16-18-2-331.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 331.9. "Small house health facility", for purposes of IC 16-28-16, has the meaning set forth in IC 16-28-16-2.**

SECTION 15. 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 as of July 1, 2011, 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%) as determined by the office.

(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%) as determined by the office.

(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 fails to pay the quality assessment fee under this chapter not later than one hundred twenty (120) days after 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 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 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 16. IC 16-28-16 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 16. Health Facility Moratorium

Sec. 1. This chapter does not apply to the following:

(1) For purposes of the construction of a health facility, an entity that:

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

(B) has complied with the moratorium in effect before July 1, 2011 in P.L.121-2008, SECTION 5;

(C) has physically begun significant construction of the health facility before May 15, 2011; and

(D) meets the licensure and survey requirements of this article.

(2) A new continuing care retirement community required to file a disclosure statement under IC 23-2-4 that has only Medicare certified beds or non-certified beds.

(3) A health facility that is licensed under IC 16-28-2 and does one (1) of the following:

(A) Transferring or relocating an existing health facility within the county of the existing health facility.

(B) Adding comprehensive care beds not certified under the Medicaid program to an existing campus under the same license.

(4) A small house health facility.

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

Sec. 2. As used in this chapter, "small house health facility" means a freestanding, self-contained 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. 3. The director may not approve a new health facility license under IC 16-28-2 and an entity may not add or construct a health facility licensed or to be licensed under this article.

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 bed 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; and

(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 health facility within twelve (12) months of the state department's approval of the application shall forfeit 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.

SECTION 17. IC 16-28-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 17. Moratorium on Medicaid Certification of Comprehensive Care Beds

Sec. 1. This chapter does not apply to the conversion of acute care beds to comprehensive care beds under IC 16-29-3.

Sec. 2. As used in this chapter, "comprehensive care bed" means a bed that:

(1) is licensed or is to be licensed under IC 16-28-2;

(2) functions as a bed licensed under IC 16-28-2; or

(3) is 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.

Sec. 3. As used in this chapter, "replacement bed" means a comprehensive care bed that is relocated to a 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.

Sec. 4. (a) Except as provided in subsection (b), the Indiana health facilities council may not recommend and the state department of health may not approve 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.

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

(1) A health facility that:

(A) seeks a replacement bed exception;

(B) 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 in the same facility; and

(C) applies to the division of aging in the manner:

(i) described in subsection (c); and

(ii) prescribed by the division; and

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

(2) A replacement facility if:

(A) the location of the replacement facility is within the same county of where the original facility was located;

(B) the replacement facility maintains the same ownership as the original facility; and

(C) the number of comprehensive care beds certified for participation in the Medicaid program does not exceed the number of comprehensive care beds certified for participation in the original facility.

(c) An application made under subsection (b) 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) Any other information requested by the division of aging that is necessary to evaluate the transaction.

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