

**CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1572**

Citations Affected: IC 2-5-23-8; IC 12-13-5-14; IC 23-2-4.

Synopsis: Medicaid matters. Requires the health policy advisory committee to submit an annual report to the health finance commission on the committee's findings and recommendations. Revises the definition of "continuing care agreement". Specifies when a person providing continuing care has to register the continuing care retirement community with the securities commissioner. Eliminates payments to the Indiana retirement home guaranty fund after June 30, 2009. Removes provisions limiting the health facilities subject to the quality assessment fee based on the health facility's Medicaid utilization rate and annual Medicaid revenue. Eliminates the exemption from the quality assessment fee for health facilities that only receive Medicare revenues. Provides an exemption for hospital based health facilities. Specifies conditions that a continuing care retirement community must meet in order to be exempt from the quality assessment fee. Eliminates the role of the department of state revenue in collecting quality assessment fees. Requires that certain contractors for: (1) the division of family resources; (2) the office of Medicaid policy and planning; and (3) the office of the secretary of family and social services; that process eligibility intake information for the federal supplemental nutrition assistance program (SNAP), the temporary assistance to needy families (TANF) program, and the Medicaid program review certain intake statistics and provide certain information to the select joint commission on Medicaid oversight. Establishes the Medicaid managed care quality strategy committee to study issues related to Medicaid managed care. Requires the office of the secretary of family and social services to report certain information to the select joint commission on Medicaid oversight and requires the commission to determine whether legislation is needed on the issues. **(This conference committee report: (1) removes a study by the health finance commission of the quality assessment fee; (2) adds additional reporting responsibilities for contractors of the office of the secretary; (3) changes the appointing authorities for the Medicaid managed care quality strategy committee and adds additional duties for the committee; (4) removes the extension of the expiration of the quality assessment fee and the specification of the distribution of the quality assessment fee for the enhanced federal match; and (5) adds additional topics for the office of the secretary of family and social services to report on to the select joint commission on Medicaid oversight and for the commission to study during the 2009 interim.)**

Effective: Upon passage; October 1, 2008 (retroactive); January 1, 2009 (retroactive); July 1,

2009.

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1572 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the House recede from its dissent from all Senate amendments and that the House now concur in all Senate amendments to the bill and that the bill be further amended as follows:

- 1 Delete everything after the enacting clause and insert the following:
2 SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE UPON PASSAGE]: Sec. 8. ~~Beginning May 1, 1997~~; (a)
4 The health policy advisory committee is established. At the request of
5 the chairman **of the commission**, the health policy advisory committee
6 shall provide information and otherwise assist the commission to
7 perform the duties of the commission under this chapter.
8 (b) The health policy advisory committee members are ex officio
9 and may not vote.
10 (c) The health policy advisory committee members shall be
11 appointed from the general public and must include one (1) individual
12 who represents each of the following:
13 (1) The interests of public hospitals.
14 (2) The interests of community mental health centers.
15 (3) The interests of community health centers.
16 (4) The interests of the long term care industry.
17 (5) The interests of health care professionals licensed under
18 IC 25, but not licensed under IC 25-22.5.
19 (6) The interests of rural hospitals. An individual appointed under
20 this subdivision must be licensed under IC 25-22.5.
21 (7) The interests of health maintenance organizations (as defined
22 in IC 27-13-1-19).

- 1 (8) The interests of for-profit health care facilities (as defined in
2 IC 27-8-10-1).
3 (9) A statewide consumer organization.
4 (10) A statewide senior citizen organization.
5 (11) A statewide organization representing people with
6 disabilities.
7 (12) Organized labor.
8 (13) The interests of businesses that purchase health insurance
9 policies.
10 (14) The interests of businesses that provide employee welfare
11 benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.
12 (15) A minority community.
13 (16) The uninsured. An individual appointed under this
14 subdivision must be and must have been chronically uninsured.
15 (17) An individual who is not associated with any organization,
16 business, or profession represented in this subsection other than
17 as a consumer.

18 **(d) The chairman of the commission shall annually select a**
19 **member of the health policy advisory committee to serve as**
20 **chairperson.**

21 **(e) The health policy advisory committee shall meet at the call**
22 **of the chairperson of the health policy advisory committee.**

23 **(f) The health policy advisory committee shall submit an annual**
24 **report not later than September 15 of each year to the commission**
25 **that summarizes the committee's actions and the committee's**
26 **findings and recommendations on any topic assigned to the**
27 **committee. The report must be in an electronic format under**
28 **IC 5-14-6.**

29 SECTION 2. IC 12-13-5-14 IS ADDED TO THE INDIANA CODE
30 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
31 1, 2009]: **Sec. 14. (a) As used in this section, "commission" refers**
32 **to the select joint commission on Medicaid oversight (IC 2-5-26-3).**

33 **(b) A contractor for the division, office, or secretary that has**
34 **responsibility for processing eligibility intake for the federal**
35 **Supplemental Nutrition Assistance program (SNAP), the**
36 **Temporary Assistance for Needy Families (TANF) program, and**
37 **the Medicaid program shall do the following:**

- 38 **(1) Review the eligibility intake process for:**
39 **(A) document management issues, including:**
40 **(i) unattached documents;**
41 **(ii) number of documents received by facsimile;**
42 **(iii) number of documents received by mail;**
43 **(iv) number of documents incorrectly classified;**
44 **(v) number of documents that are not indexed or not**
45 **correctly attached to cases;**
46 **(vi) number of complaints from clients regarding lost**
47 **documents; and**
48 **(vii) number of complaints from clients resolved**
49 **regarding lost documents;**
50 **(B) direct client assistance at county offices, including the:**
51 **(i) number of clients helped directly in completing**

- 1 eligibility application forms;
 2 (ii) wait times at local offices;
 3 (iii) amount of time an applicant is given as notice before
 4 a scheduled applicant appointment;
 5 (iv) amount of time an applicant waits for a scheduled
 6 appointment; and
 7 (v) timeliness of the tasks sent by the contractor to the
 8 state for further action, as specified through contracted
 9 performance standards; and
 10 (C) call wait times and abandonment rates.
 11 (2) Provide an update on employee training programs.
 12 (3) Provide a copy of the monthly key performance indicator
 13 report.
 14 (4) Provide information on error reports and contractor
 15 compliance with the contract.
 16 (5) Provide oral and written reports to the commission
 17 concerning matters described in subdivision (1):
 18 (A) in a manner and format to be agreed upon with the
 19 commission; and
 20 (B) whenever the commission requests.
 21 (6) Report on information concerning assistance provided by
 22 voluntary community assistance networks (V-CANs).
 23 (7) Report on the independent performance audit conducted
 24 on the contract.

25 (c) Solely referring an individual to a computer or telephone
 26 does not constitute the direct client assistance referred to in
 27 subsection (b)(1)(B).

28 SECTION 3. IC 23-2-4-1, AS AMENDED BY P.L.27-2007,
 29 SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 30 JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this
 31 chapter, the term:

32 "Application fee" means the fee charged an individual, in addition
 33 to the entrance fee or any other fee, to cover the provider's reasonable
 34 costs in processing the individual's application to become a resident.

35 "Commissioner" means the securities commissioner as provided in
 36 IC 23-19-6-1(a).

37 "Continuing care agreement" means **the following:**

38 (1) **For continuing care retirement communities registered**
 39 **before July 1, 2009**, an agreement by a provider to furnish to at
 40 ~~least one (1)~~ **an individual**, for the payment of an entrance fee **of**
 41 **at least twenty-five thousand dollars (\$25,000)** and periodic
 42 charges:

43 (A) accommodations in a living unit of a ~~home and:~~
 44 **continuing care retirement community;**

45 ~~(1)~~ (B) meals and related services;

46 ~~(2)~~ (C) nursing care services;

47 ~~(3)~~ (D) medical services;

48 ~~(4)~~ (E) other health related services; or

49 ~~(5)~~ (F) any combination of these services;

50 for the life of the individual or for more than one (1) month,
 51 **unless the agreement is canceled.**

1 **(2) For continuing care retirement communities registered**
 2 **after June 30, 2009, an agreement by a provider to furnish to**
 3 **an individual, for the payment of an entrance fee of at least**
 4 **twenty-five thousand dollars (\$25,000) and periodic charges:**

5 **(A) accommodations in a living unit of a continuing care**
 6 **retirement community;**

7 **(B) meals and related services;**

8 **(C) nursing care services;**

9 **(D) medical services;**

10 **(E) other health related services; or**

11 **(F) any combination of these services;**

12 **for the life of the individual, unless the agreement is**
 13 **terminated as specified under this chapter.**

14 **"Continuing care retirement community" includes both of the**
 15 **following:**

16 **(1) An independent living facility.**

17 **(2) A health facility licensed under IC 16-28.**

18 "Contracting party" means a person or persons who enter into a
 19 continuing care agreement with a provider.

20 "Entrance fee" means the sum of money or other property paid or
 21 transferred, or promised to be paid or transferred, to a provider in
 22 consideration for one (1) or more individuals becoming a resident of a
 23 **home continuing care retirement community** under a continuing care
 24 agreement.

25 "Home" means a facility where the provider undertakes, pursuant to
 26 a continuing care agreement, to provide continuing care to five (5) or
 27 more residents.

28 "Living unit" means a room, apartment, cottage, or other area within
 29 a **home continuing care retirement community** set aside for the use
 30 of one (1) or more identified residents.

31 "Long term financing" means financing for a period in excess of one
 32 (1) year.

33 "Omission of a material fact" means the failure to state a material
 34 fact required to be stated in any disclosure statement or registration in
 35 order to make the disclosure statement or registration, in light of the
 36 circumstances under which they were made, not misleading.

37 "Person" means an individual, a corporation, a partnership, an
 38 association, a limited liability company, or other legal entity.

39 "Provider" means a person that agrees to provide ~~continuing care to~~
 40 ~~an individual~~ under a continuing care agreement.

41 "Refurbishment fee" means the fee charged an individual, in
 42 addition to the entrance fee or any other fee, to cover the provider's
 43 reasonable costs in refurbishing a previously occupied living unit
 44 specifically designated for occupancy by that individual.

45 "Resident" means an individual who is entitled to receive benefits
 46 under a continuing care agreement.

47 "Solicit" means any action of a provider in seeking to have an
 48 individual residing in Indiana pay an application fee and enter into a
 49 continuing care agreement, including:

50 (1) personal, telephone, or mail communication or any other
 51 communication directed to and received by any individual in

1 Indiana; and
 2 (2) advertising in any media distributed or communicated by any
 3 means to individuals residing in Indiana.

4 **"Termination" refers to the cancellation of a continuing care**
 5 **agreement under this chapter.**

6 SECTION 4. IC 23-2-4-2 IS AMENDED TO READ AS FOLLOWS
 7 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 2. This
 8 chapter applies to any person who:

- 9 (1) enters into a continuing care agreement in Indiana to provide
 10 care at a ~~home~~ **continuing care retirement community** located
 11 either inside Indiana or outside Indiana;
 12 (2) enters into a continuing care agreement outside Indiana to
 13 provide care at a ~~home~~ **continuing care retirement community**
 14 located in Indiana;
 15 (3) extends the term of an existing continuing care agreement in
 16 Indiana to provide care at a ~~home~~ **continuing care retirement**
 17 **community** located either inside Indiana or outside Indiana;
 18 (4) extends the term of an existing continuing care agreement
 19 outside Indiana to provide care at a ~~home~~ **continuing care**
 20 **retirement community** located in Indiana; or
 21 (5) solicits the execution of a continuing care agreement by
 22 persons in Indiana.

23 SECTION 5. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS
 24 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A
 25 provider shall register each ~~home~~ **continuing care retirement**
 26 **community** with the commissioner if:

- 27 **(1) before opening the continuing care retirement community,**
 28 **the provider:**
 29 **(A) enters into;**
 30 **(B) extends; or**
 31 **(C) solicits;**
 32 **a continuing care agreement; or**
 33 **(2) while operating the continuing care retirement**
 34 **community, the provider has entered into a continuing care**
 35 **agreement with at least twenty-five percent (25%) of the**
 36 **individuals living in the continuing care retirement**
 37 **community.**

38 **(b) If a provider fails to register a ~~home~~, continuing care**
 39 **retirement community, the provider may not:**

- 40 (1) enter into, or extend the term of, a continuing care agreement
 41 to provide continuing care to any person at that ~~home~~; **continuing**
 42 **care retirement community;**
 43 (2) provide services at that ~~home~~ **continuing care retirement**
 44 **community** under a continuing care agreement; or
 45 (3) solicit the execution, by persons residing within Indiana, of a
 46 continuing care agreement to provide continuing care at that
 47 ~~home~~; **continuing care retirement community.**

48 ~~(b)~~ **(c) The provider's application for registration must be filed with**
 49 **the commissioner by the provider on forms prescribed by the**
 50 **commissioner, and must be accompanied by an application fee of two**
 51 **hundred fifty dollars (\$250). The application must contain the**

1 following information:

- 2 (1) an initial disclosure statement, as described in section 4 of this
 3 chapter; and
 4 (2) any other information required by the commissioner under
 5 rules adopted under this chapter.

6 ~~(c)~~ (d) The commissioner may accept, in lieu of the information
 7 required by subsection ~~(b)~~; (c), any other registration, disclosure
 8 statement, or other document filed by the provider in Indiana, in any
 9 other state, or with the federal government if the commissioner
 10 determines that such document substantially complies with the
 11 requirements of this chapter.

12 ~~(d)~~ (e) Upon receipt of the application for registration, the
 13 commissioner shall mark the application filed. Within sixty (60) days
 14 of the filing of the application, the commissioner shall enter an order
 15 registering the provider or rejecting the registration. If no order of
 16 rejection is entered within that sixty (60) day period, the provider shall
 17 be considered registered unless the provider has consented in writing
 18 to an extension of time; if no order of rejection is entered within the
 19 time period as extended by consent, the provider shall be considered
 20 registered.

21 ~~(e)~~ (f) If the commissioner determines that the application for
 22 registration complies with all of the requirements of this chapter, the
 23 commissioner shall enter an order registering the provider. If the
 24 commissioner determines that such requirements have not been met,
 25 the commissioner shall notify the provider of the deficiencies and shall
 26 inform the provider that it has sixty (60) days to correct them. If the
 27 deficiencies are not corrected within sixty (60) days, the commissioner
 28 shall enter an order rejecting the registration. The order rejecting the
 29 registration shall include the findings of fact upon which the order is
 30 based. The provider may petition for reconsideration, and is entitled to
 31 a hearing upon that petition.

32 SECTION 6. IC 23-2-4-4 IS AMENDED TO READ AS FOLLOWS
 33 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 4. The
 34 initial disclosure statement shall contain the following information:

- 35 (1) The name and business address of the provider.
 36 (2) If the provider is a partnership, corporation, limited liability
 37 company, or association, the names and duties of its officers,
 38 directors, trustees, partners, members, or managers.
 39 (3) The name and business address of any person having a five
 40 percent (5%) or greater ownership interest in the provider or
 41 manager of the ~~home~~: **continuing care retirement community**.
 42 (4) A description of the business experience of the provider and
 43 its officers, directors, trustees, partners, or managers.
 44 (5) A statement as to whether the provider or any of its officers,
 45 directors, trustees, partners, or managers, within ten (10) years
 46 prior to the date of the initial disclosure statement:
 47 (A) was convicted of a crime;
 48 (B) was a party to any civil action for fraud, embezzlement,
 49 fraudulent conversion, or misappropriation of property that
 50 resulted in a judgment against ~~him~~; **the provider or**
 51 **individual;**

- 1 (C) had a prior discharge in bankruptcy or was found insolvent
 2 in any court action; or
 3 (D) had any state or federal licenses or permits suspended or
 4 revoked in connection with any health care or continuing care
 5 activities, or related business activities.
- 6 (6) The identity of any other ~~home~~ **continuing care retirement**
 7 **community** currently or previously operated by the provider or
 8 manager of the ~~home~~; **continuing care retirement community**.
- 9 (7) The location and description of other properties, both existing
 10 and proposed, of the provider in which the provider owns a
 11 twenty-five percent (25%) ownership interest, and on which
 12 ~~homes~~ **continuing care retirement communities** are or are
 13 intended to be located.
- 14 (8) A statement as to whether the provider is, or is affiliated with,
 15 a religious, charitable, or other nonprofit association, and the
 16 extent to which the affiliate organization is responsible for the
 17 financial and contractual obligations of the provider.
- 18 (9) A description of all services to be provided by the provider
 19 under its continuing care agreements with contracting parties, and
 20 a description of all fees for those services, including conditions
 21 under which the fees may be adjusted.
- 22 (10) A description of the terms and conditions under which the
 23 continuing care agreement can be cancelled, or fees refunded.
- 24 (11) Financial statements of the provider prepared in accordance
 25 with generally accepted accounting principles applied on a
 26 consistent basis and certified by an independent certified or
 27 public accountant, including a balance sheet as of the end of the
 28 provider's last fiscal year and income statements for the last three
 29 (3) fiscal years, or such shorter period of time as the provider has
 30 been in operation.
- 31 (12) If the operation of the ~~home~~ **continuing care retirement**
 32 **community** has not begun, a statement of the anticipated source
 33 and application of funds to be used in the purchase or
 34 construction of the ~~home~~; **continuing care retirement**
 35 **community**, and an estimate of the funds, if any, which are
 36 anticipated to be necessary to pay for start-up losses.
- 37 (13) A copy of the forms of agreement for continuing care used by
 38 the provider.
- 39 (14) Any other information that the commissioner may require by
 40 rule or order.
- 41 SECTION 7. IC 23-2-4-5 IS AMENDED TO READ AS FOLLOWS
 42 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 5. (a) Each
 43 year after the initial year in which a ~~home~~ **continuing care retirement**
 44 **community** is registered under section 3 of this chapter, the provider
 45 shall file with the commissioner within four (4) months after the end of
 46 the provider's fiscal year, unless otherwise extended by the written
 47 consent of the commissioner, an annual disclosure statement which
 48 shall consist of the financial information set forth in section 4(11) of
 49 this chapter.
- 50 (b) The annual disclosure statement required to be filed with the

1 commissioner under this section shall be accompanied by an annual
2 filing fee of one hundred dollars (\$100).

3 SECTION 8. IC 23-2-4-6 IS AMENDED TO READ AS FOLLOWS
4 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 6. (a) A
5 provider shall amend its initial or annual disclosure statement filed
6 with the commissioner under section 3 and section 5 of this chapter at
7 any time if necessary to prevent the initial or annual disclosure
8 statement from containing any material misstatement of fact or
9 omission of a material fact.

10 (b) Upon the sale of a ~~home~~ **continuing care retirement**
11 **community** to a new provider, the new provider shall amend the
12 currently filed disclosure statement to reflect the fact of sale and any
13 other fact that would be required to be disclosed under section 4 of this
14 chapter if the new provider were filing an initial disclosure statement.

15 SECTION 9. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE
16 AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE
17 JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. (a) This section**
18 **does not apply to a continuing care retirement community**
19 **registered before July 1, 2009.**

20 (b) **A continuing care agreement may be terminated for any of**
21 **the following reasons:**

22 (1) **The provider has determined that the resident is**
23 **inappropriate for living in the care setting.**

24 (2) **The resident is unable to fully pay the periodic charges**
25 **because the resident inappropriately divested the assets and**
26 **income the resident identified at the time of admission to meet**
27 **the ordinary and customary living expenses for the resident.**

28 (3) **Providing assistance to the resident would jeopardize the**
29 **financial solvency of the provider and the other residents**
30 **being served by the provider.**

31 (4) **The resident has requested a termination of the agreement**
32 **as allowed under the agreement.**

33 SECTION 10. IC 23-2-4-10 IS AMENDED TO READ AS
34 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:
35 Sec. 10. (a) Except as provided by section 11 of this chapter, the
36 commissioner shall require, as a condition of registration, that:

37 (1) the provider establish an interest-bearing escrow account with
38 a bank, trust company, or other escrow agent approved by the
39 commissioner; and

40 (2) any entrance fees received by the provider prior to the date the
41 resident is permitted to occupy the living unit in the ~~home~~
42 **continuing care retirement community** be placed in the escrow
43 account, subject to release as provided by subsection (b).

44 (b) If the entrance fee gives the resident the right to occupy a living
45 unit that has been previously occupied, the entrance fee and any
46 income earned thereon shall be released to the provider when the living
47 unit is first occupied by the new resident. If the entrance fee applies to
48 a living unit that has not been previously occupied by any resident, the
49 entrance fee and any income earned thereon shall be released to the
50 provider when the commissioner is satisfied that:

51 (1) aggregate entrance fees received or receivable by the provider

1 pursuant to executed continuing care agreements, plus:

- 2 (A) anticipated proceeds of any first mortgage loan or other
 3 long term financing commitment; and
 4 (B) funds from other sources in the actual possession of the
 5 provider;

6 are equal to at least fifty percent (50%) of the aggregate cost of
 7 constructing, purchasing, equipping, and furnishing the ~~home~~
 8 **continuing care retirement community** and equal to at least
 9 fifty percent (50%) of the estimate of funds necessary to fund
 10 startup losses of the ~~home~~; **continuing care retirement**
 11 **community**, as reported under section 4(12) of this chapter; and
 12 (2) a commitment has been received by the provider for any
 13 permanent mortgage loan or other long term financing described
 14 in the statement of anticipated source and application of funds to
 15 be used in the purchase or construction of the ~~home~~ **continuing**
 16 **care retirement community** under section 4(12) of this chapter,
 17 and any conditions of the commitment prior to disbursement of
 18 funds thereunder, other than completion of the construction or
 19 closing of the purchase of the ~~home~~; **continuing care retirement**
 20 **community**, have been substantially satisfied.

21 (c) If the funds in an escrow account under this section and any
 22 interest earned thereon are not released within the time provided by this
 23 section or by rules adopted by the commissioner, then the funds shall
 24 be returned by the escrow agent to the persons who made the payment
 25 to the provider.

26 (d) An entrance fee held in escrow shall be returned by the escrow
 27 agent to the person who paid the fee in the following instances:

- 28 (1) At the election of the person who paid the fee, at any time
 29 before the fee is released to the provider under subsection (b).
 30 (2) Upon receipt by the escrow agent of notice from the provider
 31 that the person is entitled to a refund of the entrance fee.

32 (e) This section does not require a provider to place a nonrefundable
 33 application fee charged to prospective residents in escrow.

34 (f) A provider is not required to place a refurbishment fee of a
 35 prospective resident in escrow if a continuing care agreement provides
 36 that the prospective resident:

- 37 (1) will occupy the living unit within sixty (60) days after the
 38 refurbishment fee is paid; and
 39 (2) will receive a refund of any portion of the refurbishment fee
 40 not expended for refurbishment if the continuing care agreement
 41 is cancelled before occupancy.

42 SECTION 11. IC 23-2-4-12 IS AMENDED TO READ AS
 43 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:
 44 Sec. 12. Any money or property received by a provider as an entrance
 45 fee to a ~~home~~ **continuing care retirement community** constructed or
 46 purchased after August 31, 1982, or any income earned thereon, may
 47 be used by the provider only for purposes directly related to the
 48 construction, maintenance, or operation of that particular ~~home~~:
 49 **continuing care retirement community**. A ~~home~~ **continuing care**
 50 **retirement community** in operation on September 1, 1982, may not

1 use the entrance fees or income earned thereon after August 31, 1982,
2 for the construction, operation, or maintenance of another ~~home~~
3 **continuing care retirement community** constructed or purchased
4 after August 31, 1982.

5 SECTION 12. IC 23-2-4-13, AS AMENDED BY P.L.2-2006,
6 SECTION 180, IS AMENDED TO READ AS FOLLOWS
7 [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the
8 Indiana retirement home guaranty fund. The purpose of the fund is to
9 provide a mechanism for protecting the financial interests of residents
10 and contracting parties in the event of the bankruptcy of the provider.

11 (b) To create the fund, a guaranty association fund fee of one
12 hundred dollars (\$100) shall be levied on each contracting party who
13 enters into a continuing care agreement after August 31, 1982, **and**
14 **before July 1, 2009**. The fee shall be collected by the provider and
15 forwarded to the commissioner within thirty (30) days after occupancy
16 by the resident. Failure of the provider to collect and forward such fee
17 to the commissioner within that thirty (30) day period shall result in the
18 imposition by the commissioner of a twenty-five dollar (\$25) penalty
19 against the provider. In addition, interest payable by the provider shall
20 accrue on the unpaid fee at the rate of two percent (2%) a month.

21 (c) Any money received by the commissioner under subsection (b)
22 shall be forwarded to the treasurer of state. The fund, and any income
23 from it, shall be held in trust, deposited in a segregated account,
24 invested and reinvested by the treasurer of state in the same manner as
25 provided in IC 20-49-3-10 for investment of the common school fund.

26 (d) All reasonable expenses of collecting and administering the fund
27 shall be paid from the fund.

28 (e) Money in the fund at the end of the state's fiscal year shall
29 remain in the fund and shall not revert to the general fund.

30 SECTION 13. IC 23-2-4-16 IS AMENDED TO READ AS
31 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:
32 Sec. 16. (a) If a ~~home~~ **continuing care retirement community** is
33 bankrupt and the operation of the ~~home~~ **continuing care retirement**
34 **community** is terminated, the board of directors shall, subject to the
35 approval of the commissioner, distribute from the guaranty association
36 fund established in section 13 to the living residents of the ~~home~~
37 **continuing care retirement community** an aggregate amount not to
38 exceed one-half (1/2) of the amount in the fund at the time of
39 disbursement. The amount each living resident is entitled to receive
40 shall be prorated, based on the total amount paid on behalf of the
41 resident by the contracting party under the continuing care agreement.
42 In no event may the amount paid to an individual resident under this
43 section exceed the total amount paid on behalf of that resident under
44 the continuing care agreement, less the total value of services received
45 under the agreement.

46 (b) Any living resident of the ~~home~~ **continuing care retirement**
47 **community** shall be eligible to receive distributions under subsection
48 (a), regardless of whether any contribution to the guaranty association
49 fund has been made on behalf of the resident.

50 (c) A resident compensated under this section assigns ~~his~~ **the**

1 **resident's** rights under the continuing care agreement, to the extent of
 2 compensation received under this section, to the board of directors on
 3 behalf of the fund. The board of directors may require an assignment
 4 of those rights by a resident to the board, on behalf of the fund, as a
 5 condition precedent to the receipt of compensation under this section.
 6 The board of directors, on behalf of the fund, is subrogated to these
 7 rights against the assets of a bankrupt or dissolved provider. Any
 8 monies or property collected by the board of directors under this
 9 subsection shall be deposited in the fund.

10 (d) The subrogation rights of the board of directors, on behalf of the
 11 fund, have the same priority against the assets of the bankrupt or
 12 dissolved provider as those possessed by the resident under the
 13 continuing care agreement.

14 SECTION 14. IC 23-2-4-21 IS AMENDED TO READ AS
 15 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:
 16 Sec. 21. If the commissioner has reason to believe that a ~~home~~
 17 **continuing care retirement community** is insolvent, the
 18 commissioner may petition the superior or circuit court of the county
 19 in which the ~~home continuing care retirement community~~ is located,
 20 or the superior or circuit court of Marion County, for the appointment
 21 of a receiver to assume the management and possession of the ~~home~~
 22 **continuing care retirement community** and its assets.

23 SECTION 15. P.L.3-2007, SECTION 1, IS AMENDED TO READ
 24 AS FOLLOWS [EFFECTIVE OCTOBER 1, 2008 (RETROACTIVE)]:
 25 SECTION 1. (a) As used in this SECTION, "continuing care
 26 retirement community" means a health care facility that:

- 27 (1) provides independent living services and health facility
- 28 services in a campus setting with common areas;
- 29 (2) holds continuing care agreements with at least twenty-five
- 30 percent (25%) of its residents (as defined in IC 23-2-4-1);
- 31 (3) uses the money described in subdivision (2) to provide
- 32 services to the resident before the resident may be eligible for
- 33 Medicaid under IC 12-15; and
- 34 (4) meets the requirements of IC 23-2-4.

35 (b) As used in this SECTION, "health facility" refers to a health
 36 facility that is licensed under IC 16-28 as a comprehensive care facility.

37 ~~(b)~~ (c) As used in this SECTION, "nursing facility" means a health
 38 facility that is certified for participation in the federal Medicaid
 39 program under Title XIX of the federal Social Security Act (42 U.S.C.
 40 1396 et seq.).

41 ~~(c)~~ (d) As used in this SECTION, "office" refers to the office of
 42 Medicaid policy and planning established by IC 12-8-6-1.

43 ~~(d)~~ As used in this SECTION, "total annual revenue" does not
 44 include revenue from Medicare services provided under Title XVIII of
 45 the federal Social Security Act (42 U.S.C. 1395 et seq.):

46 (e) Effective August 1, ~~2003~~, **2009**, the office shall collect a quality
 47 assessment from each nursing **health** facility. that has:

- 48 ~~(1)~~ a Medicaid utilization rate of at least twenty-five percent
- 49 ~~(25%); and~~
- 50 ~~(2)~~ at least seven hundred thousand dollars (\$700,000) in annual
- 51 Medicaid revenue, adjusted annually by the average annual

percentage increase in Medicaid rates.

The office shall offset the collection of the assessment for a health facility:

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

(2) in another manner determined by the office.

(f) If The office shall implement the waiver approved by the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (f) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). The revised state plan amendment and waiver request must provide that provides for the following:

(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.

(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.

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

(A)

(1) A continuing care retirement community as follows:

(A) 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 subsection (a).

(B) A continuing care retirement community that, for the period January 1, 2007, through June 30, 2009, operates 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).

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

(D) A continuing care retirement community that meets the definition set forth in subsection (a).

(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.

(C)

(2) A hospital based health facility that has less than seven hundred fifty thousand dollars (\$750,000) in total annual revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(D)

(3) The Indiana Veterans' Home.

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

1 (g) If the United States Centers for Medicare and Medicaid Services
 2 determines not to approve payments under this SECTION using the
 3 methodology described in subsections (d) and (e), ~~and (f)~~; the office
 4 shall revise the state plan amendment and waiver request submitted
 5 under ~~subsection (f)~~ **this SECTION** as soon as possible to demonstrate
 6 compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection
 7 of a quality assessment from health facilities effective August 1, ~~2003~~
 8 **2009**. ~~In amending the state plan amendment and waiver request under~~
 9 ~~this subsection, the office may modify the parameters described in~~
 10 ~~subsection (f)(3). However, if the office determines a need to modify~~
 11 ~~the parameters described in subsection (f)(3), the office shall modify~~
 12 ~~the parameters in order to achieve a methodology and result as similar~~
 13 ~~as possible to the methodology and result described in subsection (f).~~
 14 ~~Any revision of the state plan amendment and waiver request under~~
 15 ~~this subsection is subject to and must comply with the provisions of~~
 16 ~~this SECTION.~~

17 (h) The money collected from the quality assessment may be used
 18 only to pay the state's share of the costs for Medicaid services provided
 19 under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et
 20 seq.) as follows:

- 21 (1) Twenty percent (20%) as determined by the office.
- 22 (2) Eighty percent (80%) to nursing facilities.

23 (i) After:

- 24 (1) the amendment to the state plan and waiver request submitted
 25 under this SECTION is approved by the United States Centers for
 26 Medicare and Medicaid Services; and
- 27 (2) the office calculates and begins paying enhanced
 28 reimbursement rates set forth in this SECTION;

29 the office ~~and the department of state revenue~~ shall begin the collection
 30 of the quality assessment set under this SECTION. The office ~~and the~~
 31 ~~department of state revenue shall may~~ establish a method to allow a
 32 facility to enter into an agreement to pay the quality assessment
 33 collected under this SECTION subject to an installment plan.

34 (j) If federal financial participation becomes unavailable to match
 35 money collected from the quality assessments for the purpose of
 36 enhancing reimbursement to nursing facilities for Medicaid services
 37 provided under Title XIX of the federal Social Security Act (42 U.S.C.
 38 1396 et seq.), the office ~~and department of state revenue~~ shall cease
 39 collection of the quality assessment under this SECTION.

40 (k) To implement this SECTION, the

- 41 ~~(1)~~ office shall adopt rules under IC 4-22-2. ~~and~~
- 42 ~~(2)~~ office ~~and department of state revenue~~ shall adopt joint rules
 43 ~~under IC 4-22-2.~~

44 (l) Not later than ~~July 1, 2003~~; **August 1, 2009**, the office shall do
 45 the following:

- 46 (1) Request the United States Department of Health and Human
 47 Services under 42 CFR 433.72 to approve waivers of 42 CFR
 48 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance
 49 with 42 CFR 433.68(e)(2)(ii).
- 50 (2) Submit any state Medicaid plan amendments to the United
 51 States Department of Health and Human Services that are

1 necessary to implement this SECTION.

2 (m) After approval of the waivers and state Medicaid plan
3 amendment applied for under ~~subsection (f)~~; **this SECTION**, the office
4 **and the department of state revenue** shall implement this SECTION
5 effective ~~July 1, 2003~~; **August 1, 2009**.

6 (n) The select joint commission on Medicaid oversight, established
7 by IC 2-5-26-3, shall review the implementation of this SECTION. The
8 office may not make any change to the reimbursement for nursing
9 facilities unless the select joint commission on Medicaid oversight
10 recommends the reimbursement change.

11 (o) A nursing facility or a health facility may not charge the facility's
12 residents for the amount of the quality assessment that the facility pays
13 under this SECTION.

14 (p) The office may withdraw a state plan amendment **submitted**
15 under ~~subsection (e)~~; ~~(f)~~; or ~~(g)~~ **this SECTION** only if the office
16 determines that failure to withdraw the state plan amendment will
17 result in the expenditure of state funds not funded by the quality
18 assessment.

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

23 (r) ~~The following shall be provided to the state department of health:~~
24 ~~(1) The~~ office shall report **to the state department of health** each
25 nursing **facility and each health** facility that fails to pay the
26 quality assessment under this SECTION not later than one
27 hundred twenty (120) days after payment of the quality
28 assessment is due.

29 ~~(2) The department of state revenue shall report each health~~
30 ~~facility that is not a nursing facility that fails to pay the quality~~
31 ~~assessment under this SECTION not later than one hundred~~
32 ~~twenty (120) days after payment of the quality assessment is due.~~

33 (s) The state department of health shall do the following:

34 (1) Notify each nursing facility and each health facility reported
35 under subsection (r) that the nursing facility's or health facility's
36 license under IC 16-28 will be revoked if the quality assessment
37 is not paid.

38 (2) Revoke the nursing facility's or health facility's license under
39 IC 16-28 if the nursing facility or the health facility fails to pay
40 the quality assessment.

41 (t) An action taken under subsection (s)(2) is governed by:

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

43 (2) IC 4-21.5-4.

44 (u) The office shall report the following information to the select
45 joint commission on Medicaid oversight established by IC 2-5-26-3 at
46 every meeting of the commission:

47 (1) Before the quality assessment is approved by the United States
48 Centers for Medicare and Medicaid Services:

49 (A) an update on the progress in receiving approval for the
50 quality assessment; and

51 (B) a summary of any discussions with the United States

- 1 Centers for Medicare and Medicaid Services.
- 2 (2) After the quality assessment has been approved by the United
- 3 States Centers for Medicare and Medicaid Services:
- 4 (A) an update on the collection of the quality assessment;
- 5 (B) a summary of the quality assessment payments owed by a
- 6 nursing facility or a health facility; and
- 7 (C) any other relevant information related to the
- 8 implementation of the quality assessment.
- 9 (v) This SECTION expires August 1, 2009.
- 10 SECTION 16. [EFFECTIVE UPON PASSAGE] (a) **As used in this**
- 11 **SECTION, "committee" refers to the Medicaid managed care**
- 12 **quality strategy committee created by this SECTION.**
- 13 (b) **The Medicaid managed care quality strategy committee is**
- 14 **created to provide information on policy issues concerning**
- 15 **Medicaid. The committee shall study issues related to the**
- 16 **following:**
- 17 (1) **Emergency room utilization.**
- 18 (2) **Prior authorization.**
- 19 (3) **Standardization of procedures, forms, and service**
- 20 **descriptions.**
- 21 (4) **Effectiveness and quality of care.**
- 22 (5) **The number of denials by a managed care organization,**
- 23 **the reasons for the denials, and the number of appeals and**
- 24 **overturning of denials by a managed care organization.**
- 25 (6) **How reimbursement rates are determined by a managed**
- 26 **care organization, including reimbursement rates for**
- 27 **emergency room care and neonatal intensive care.**
- 28 (c) **The committee consists of seven (7) members as follows:**
- 29 (1) **Two (2) individuals representing Medicaid providers.**
- 30 (2) **One (1) individual representing public hospitals.**
- 31 (3) **Two (2) individuals representing Medicaid managed care**
- 32 **organizations.**
- 33 (4) **One (1) individual representing mental health professions.**
- 34 (5) **One (1) individual from the office of Medicaid policy and**
- 35 **planning, who shall act as chairperson of the committee.**
- 36 (d) **The president pro tempore of the senate shall appoint three**
- 37 **(3) members under subsection (c) as follows:**
- 38 (1) **One (1) member described in subsection (c)(1).**
- 39 (2) **One (1) member described in subsection (c)(3).**
- 40 (3) **One (1) member described in subsection (c)(5).**
- 41 (e) **The speaker of the house of representatives shall appoint**
- 42 **three (3) members under subsection (c) as follows:**
- 43 (1) **One (1) member described in subsection (c)(1).**
- 44 (2) **One (1) member described in subsection (c)(2).**
- 45 (3) **One (1) member described in subsection (c)(3).**
- 46 (f) **The chairperson of the legislative council shall appoint one**
- 47 **(1) member described in subsection (c)(4).**
- 48 (g) **The office of the secretary of family and social services shall**
- 49 **staff the committee.**
- 50 (h) **The affirmative votes of a majority of the members are**
- 51 **required for the committee to make recommendations.**

1 **(i) Before October 1, 2009, and October 1, 2010, the committee**
2 **shall report to the select joint commission on Medicaid oversight**
3 **established by IC 2-5-26-3 concerning the committee's**
4 **recommendations.**

5 **(j) This SECTION expires December 31, 2010.**

6 SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) As used in this**
7 **SECTION, "commission" refers to the select joint commission on**
8 **Medicaid oversight established by IC 2-5-26-3.**

9 **(b) Before October 1, 2009, the office of the secretary of family**
10 **and social services shall provide the commission with information**
11 **concerning the following:**

12 **(1) An update on the medical review team and whether the**
13 **medical review team has a backlog of cases in need of review.**

14 **(2) Coordination of benefits.**

15 **(3) The extension of the office of the secretary of family and**
16 **social services.**

17 **(c) During the 2009 interim, the commission shall study the**
18 **issues and information provided in subsection (b) and determine**
19 **whether any legislation action is necessary for the 2010 session.**

20 **(d) This SECTION expires December 31, 2009.**

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

(Reference is to EHB 1572 as reprinted April 15, 2009.)

Conference Committee Report
on
Engrossed House Bill 1572

Signed by:

Representative Welch
Chairperson

Senator Lawson C

Representative Turner

Senator Errington

House Conferees

Senate Conferees