Second Regular Session of the 123rd General Assembly (2024)

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 2023 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1067

AN ACT to amend the Indiana Code concerning human services.

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

SECTION 1. IC 12-7-2-48.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 48.7. "Covered population", for purposes of IC 12-15-13-1.8, has the meaning set forth in IC 12-15-13-1.8(a).**

SECTION 2. IC 12-9-4-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8. (a) As used in this section, "review team" refers to the special service review team established by subsection (c).**

(b) As used in this section, "waiver" refers to the community integration and habilitation waiver.

(c) The special service review team is established.

(d) The review team shall do the following:

(1) Subject to subsection (l)(2), review denied applications from the director for the waivers that were received after December 1, 2024, and before June 30, 2025, from Districts 1, 4, and 8 of the bureau of disabilities services districts, including a review of the waiver application and any other information submitted concerning the application.

(2) Subject to subsection (l)(2), review, at the director's discretion, waiver applications received after December 1, 2024, and before June 30, 2025, for which a determination has not been made by the director. The review team shall review

the waiver application and information submitted concerning the application.

(3) Maintain confidentiality of any protected health information and personally identifiable information collected during the review.

(4) Provide the following to the director:

(A) Concerning the review team's review of applications under subdivision (1), an evaluation of information that can be applied to the waiver at the systems level, including the criteria that can be used to approve and deny waiver applications.

(B) Concerning the review team's review of applications under subdivision (2), and not later than thirty (30) days from the review team's receipt of the application from the director, additional information submitted concerning an application.

(5) Issue a quarterly report to the council.

(e) The review team may, with consent of the applicant or applicant's legal guardian, collect additional information related to an application that was not submitted with the application. The collection of information under this subsection:

(1) may be used by the review team to provide information, referral, and resources to applicants concerning available services and supports;

(2) does not create a responsibility on the bureau to reconsider an application determination; and

(3) does not constitute a request to appeal an application determination.

(f) The director shall appoint the members of the review team and fill any vacancies on the review team. The review team must consist of the following five (5) members who are knowledgeable in the waiver requirements:

(1) A representative from The Arc of Indiana.

(2) A representative from a case management company that is approved by the bureau of disabilities services to provide waiver services.

(3) An individual who works as a behavior consultant that is approved by the bureau of disabilities services to provide waiver services.

(4) Two (2) individuals appointed by the director.

However, not more than one (1) member may be a state employee.

(g) The director shall appoint a member of the review team to

serve as the chairperson.

(h) The director shall:

(1) notify the chairperson; and

(2) provide the waiver application and accompanying information submitted with the application to the review team to begin to review of the application;

not later than five (5) business days after a waiver application has been denied. The director shall also notify the chairperson if the director would like additional consultation on an application described in subsection (d)(2).

(i) As used in this subsection, a "conflict of interest" has the meaning set forth in 460 IAC 6-3-15.2 and includes a direct or indirect financial interest with the applicant or a prior or current relationship with the applicant. If a member appointed to the review team under subsection (f)(1) through (f)(3) has a conflict of interest with the applicant of a waiver application under review by the review team, the member shall:

(1) inform the director of the conflict of interest; and

(2) recuse themself from review of the application for which the member has a conflict of interest.

The director may appoint a member to the review team to fill the vacancy of the recused member during the review of the application for which the member has been recused.

(j) Each member of the review team who is not a state employee is entitled to the following:

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties as provided under IC 4-13-1-4 and in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(k) A member of the review team who is a state employee is not entitled to any of the following:

(1) The minimum salary per diem provided by IC 4-10-11-2.1(b).

(2) Reimbursement for traveling expenses as provided under IC 4-13-1-4.

(3) Other expenses actually incurred in connection with the member's duties.

(l) The division shall do the following:

(1) Obtain consent from a waiver applicant or the applicant's

legal guardian to share the waiver application and additional information submitted with the waiver application with the review team. An applicant or applicant's legal guardian must voluntarily consent to sharing the application and information with the review team. If an applicant or applicant's legal guardian denies consent to share the application and submitted information with the review team, the division may not share the application and information with the review team and the denial of consent may not affect a determination on the applicant's waiver application.

(2) Provide members of the review team with the waiver application and submitted information required under subsection (d)(1) and (d)(2) for the applications where consent has been obtained under subdivision (1).

(3) Provide administrative support for the review team concerning the following:

(A) Contacting applicants who have provided consent under this section.

(B) Accessing the application and information submitted with the application.

(C) Receiving compensation as described in subsection (j).

The review team is responsible for any other administrative tasks not specified in this subdivision, including scheduling review team meetings and meeting the confidentiality requirements specified in subsection (d)(3).

(4) Pay the expenses of the review team.

(m) An employee of the division who provides records in accordance with subsection (l) in good faith is not subject to liability in:

(1) a civil;

(2) an administrative;

(3) a disciplinary; or

(4) a criminal;

action that might otherwise be imposed as a result of the disclosure of the records.

(n) This section expires December 31, 2026.

SECTION 3. IC 12-9-5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2025]: **Sec. 3.5. (a) The division shall provide to the division of disability and rehabilitative services advisory council established by IC 12-9-4-2 quarterly updates regarding the implementation of the recommendations made by the services for**

individuals with intellectual and other developmental disabilities task force under IC 12-11-15.5 (before its expiration).

(b) This section expires December 31, 2027.

SECTION 4. IC 12-10-2-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. (a) The commission consists of sixteen (16) members.

(b) Not more than eight (8) members may be from the same political party. The members must be Indiana residents who are interested in the problems of the aging and the aged.

(c) The governor shall appoint the members of the commission ~~using the following geographical distribution formula:~~

~~(1) One (1) member from each congressional district.~~

~~(2) The balance of the members appointed at large.~~ **to ensure that the commission includes members representing the area agencies on aging as follows:**

(1) Three (3) members from the region served by Area 1 through Area 5.

(2) Three (3) members from the region served by Area 6 through Area 9.

(3) Three (3) members from the region served by Area 10 through Area 16.

However, ~~Not~~ **not** more than two (2) residents of the same county may be appointed as members of the commission.

(d) Beginning July 1, 2024, the commission must contain:

(1) the executive director of the Indiana housing and community development authority or the executive director's designee;

(2) at least one (1) member who is a:

(A) direct provider of; or

(B) service worker employed to provide;

services provided through the division;

(3) at least one (1) member who is:

(A) a recipient; or

(B) the caregiver of a recipient;

of services provided through the division; and

(4) one (1) citizen nominated by one (1) or more organizations that:

(A) represent individuals with mental illness; and

(B) have statewide membership.

SECTION 5. IC 12-10-2-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) **Subject to subsection (c),** the term of a member of the commission is four (4)

years. The term of a member filling a vacancy is for the remainder of the unexpired term.

(b) The term of a member of the commission expires July 1, but a member continues in office until a successor is appointed.

(c) **A member of the commission serves at the will of the governor.** The governor may terminate the appointment of a member of the commission by notifying the member, the chairman of the commission, and the director.

SECTION 6. IC 12-10-11-2, AS AMENDED BY HEA 1026-2024, SECTION 80, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) The board consists of the following ~~fifteen (15)~~ **seventeen (17)** members:

(1) The director of the division of aging or the director's designee.

(2) The chairman of the Indiana state commission on aging or the chairman's designee.

(3) Three (3) citizens nominated by two (2) or more organizations that:

(A) represent senior citizens; and

(B) have statewide membership.

At least one (1) member appointed under this subdivision must be a recipient, or the caregiver of a recipient, of services provided under IC 12-10-10.

(4) One (1) citizen nominated by one (1) or more organizations that:

(A) represent individuals with disabilities, including individuals who are less than eighteen (18) years of age; and

(B) have statewide membership.

(5) One (1) citizen nominated by one (1) or more organizations that:

(A) represent individuals with mental illness; ~~including dementia;~~ and

(B) have statewide membership.

(6) One (1) provider who provides services under IC 12-10-10.

(7) One (1) licensed physician, physician assistant, or registered nurse who specializes either in the field of gerontology or in the field of disabilities.

(8) Two (2) home care services advocates or policy specialists nominated by two (2) or more:

(A) organizations;

(B) associations; or

(C) nongovernmental agencies;

that advocate on behalf of home care consumers, including an

organization listed in subdivision (3) that represents senior citizens or persons with disabilities.

(9) Two (2) members of the senate, who may not be members of the same political party, appointed by the president pro tempore of the senate with the advice of the minority leader of the senate.

(10) Two (2) members of the house of representatives, who may not be members of the same political party, appointed by the speaker of the house of representatives with the advice of the minority leader of the house of representatives.

(11) The executive director of the Indiana housing and community development authority or the executive director's designee.

(12) One (1) citizen nominated by one (1) or more organizations that:

(A) represent direct service workers; and

(B) have statewide membership.

The members of the board listed in subdivisions (9) and (10) are nonvoting members who serve two (2) year terms ending June 30 of each odd-numbered year. A legislative member serves at the pleasure of the appointing authority and may be reappointed to successive terms. A vacancy among the legislative members shall be filled by the appropriate appointing authority. An individual appointed to fill a vacancy serves for the unexpired term of the individual's predecessor.

(b) The members of the board designated by subsection (a)(3) through (a)(8) **and (a)(12)** shall be appointed by the governor for terms of four (4) years. **The initial term of the member appointed under subsection (a)(12) is three (3) years and the length of each successive term is four (4) years.** The term of a member of the board expires as follows:

(1) For a member appointed under subsection (a)(3) through (a)(5), June 30, 2025, and every fourth year thereafter.

(2) For a member appointed under subsection (a)(6) through (a)(8) **and (a)(12),** June 30, 2027, and every fourth year thereafter.

A member described in this subsection may be reappointed to successive terms. However, a member may continue to serve until a successor is appointed. In case of a vacancy, the governor shall appoint an individual to serve for the remainder of the unexpired term.

(c) The division shall establish notice and selection procedures to notify the public of the board's nomination process described in this chapter. Information must be distributed through:

(1) the area agencies on aging; and

(2) all organizations, associations, and nongovernmental agencies that work with the division on home care issues and programs.

SECTION 7. IC 12-11-15.5-4.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 4.8. (a) As used in this section, "buy-in program" refers to the Medicaid buy-in program for working individuals with disabilities established by IC 12-15-41-3.**

(b) Not later than May 1, 2024, the task force shall establish a subcommittee of task force members to make recommendations to the task force regarding the following:

(1) Modifications to the buy-in program to eliminate barriers to employment and independence for individuals with intellectual and developmental disabilities.

(2) Modifications to the buy-in program sliding scale of premiums to increase workforce participation for individuals participating in the buy-in program.

(3) How to reduce other public benefit related barriers to employment and independence for individuals with intellectual and developmental disabilities.

(c) Not later than October 1, 2024, the subcommittee shall prepare and submit recommendations made by the subcommittee to the task force.

SECTION 8. IC 12-11-15.5-6, AS ADDED BY P.L.262-2019, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. This chapter expires December 31, ~~2025.~~ **2024.**

SECTION 9. IC 12-15-1.3-15, AS AMENDED BY P.L.156-2020, SECTION 54, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 15. (a) As used in this section, "division" refers to the division of disability and rehabilitative services established by IC 12-9-1-1.

(b) As used in this section, "waiver" refers to any waiver administered by the office and the division under section 1915(c) of the federal Social Security Act.

(c) The office shall apply to the United States Department of Health and Human Services for approval to amend a waiver to set an emergency placement priority for individuals in the following situations:

(1) Death of a primary caregiver. ~~where alternative placement in a supervised group living setting:~~

~~(A) is not available; or~~

~~(B) is determined by the division to be an inappropriate option.~~

(2) ~~A situation in which:~~

~~(A)~~ The primary caregiver is at least eighty (80) years of age. ~~and~~

~~(B) alternate placement in a supervised group living setting is not available or is determined by the division to be an inappropriate option.~~

(3) There is evidence of abuse or neglect in the current institutional or home placement. ~~and alternate placement in a supervised group living setting is not available or is determined by the division to be an inappropriate option.~~

(4) There ~~are~~ **is evidence of** other health and safety risks, as determined by the division director, ~~and alternate placement in a supervised group living setting is not available or is determined by the division to be an inappropriate option.~~ **where other available services through:**

(A) the Medicaid program and other federal, state, and local public programs; and

(B) supports that families and communities provide;

are insufficient to address the other health and safety risks, as determined by the division director.

(d) The division shall report on a quarterly basis the following information to the division of disability and rehabilitative services advisory council established by IC 12-9-4-2 concerning each Medicaid waiver for which the office has been approved under this section to administer an emergency placement priority for individuals described in this section:

(1) The number of applications for emergency placement priority waivers.

(2) The number of individuals served on the waiver.

(3) The number of individuals on a wait list for the waiver.

(e) Before July 1, 2021, the division, in coordination with the task force established by IC 12-11-15.5-2, shall establish new priority categories for individuals served by a waiver.

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

SECTION 10. IC 12-15-13-1.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.8. (a) As used in this section, "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (b).**

(b) An individual is a member of the covered population if the individual:

(1) is eligible to participate in the federal Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services; or

(2) is:

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

(B) blind, aged, or disabled; and

(C) receiving services through one (1) of the following:

(i) The aged and disabled Medicaid waiver.

(ii) A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate in the federal Medicare program.

(iii) The state Medicaid plan.

(c) The office of the secretary may implement a risk based managed care program for the covered population.

(d) The office of Medicaid policy and planning and the managed care organizations that intend to participate in the risk based managed care program established under subsection (c) shall conduct a claims submission testing period before the risk based managed care program is implemented under subsection (c).

(e) The office of Medicaid policy and planning shall convene a workgroup for purposes of this section. The members of the workgroup shall consist of the fiscal officer of the office of Medicaid policy and planning, representatives of managed care organizations that intend to participate in the risk based managed care program established under subsection (c) who are appointed by the director, and provider representatives appointed by the director. The workgroup shall do the following:

(1) Develop a uniform billing format to be used by the managed care organizations participating in the risk based managed care program established under subsection (c).

(2) Seek and receive feedback on the claims submission testing period conducted under subsection (d).

(3) Advise the office of Medicaid policy and planning on claim submission education and training needs of providers participating in the risk based managed care program established under subsection (c).

(4) Develop a policy for defining "claims submitted appropriately" for the purposes of subsection (g)(1) and (g)(2).

(f) Subsections (g) through (k) apply during the first two hundred ten (210) days after the risk based managed care program for the covered population is implemented under subsection (c).

(g) The office of Medicaid policy and planning shall establish a temporary emergency financial assistance program for providers that experience financial emergencies due to claims payment issues while participating in the risk based managed care program established under subsection (c). For purposes of the program established under this subsection, a financial emergency exists:

(1) when the rate of denial of claims submitted in one (1) billing period by the provider to a managed care organization exceeds fifteen percent (15%) of claims submitted appropriately by the provider to the managed care organization under the risk based managed care program;

(2) when the provider, twenty-one (21) days after appropriately submitting claims to a managed care organization under the risk based managed care program, has not received payment for at least twenty-five thousand dollars ($25,000) in aggregate claims from the managed care organization;

(3) when, in the determination of the director, the claim submission system of a managed care organization with which the provider is contracted under the risk based managed care program experiences failure or overload; or

(4) upon the occurrence of other circumstances that, in the determination of the director, constitute a financial emergency for a provider.

(h) To be eligible for a payment of temporary emergency financial assistance under the program established under subsection (g), a provider:

(1) must have participated in the claims submission testing period conducted under subsection (d) for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c); and

(2) must submit to the office of Medicaid policy and planning a written request that includes all of the following:

(A) Documentation providing evidence of the provider's financial need for emergency assistance.

(B) Evidence that the provider's billing staff participated in claims submission education and training offered through the risk based managed care program established under subsection (c).

(C) Evidence that the provider participated in the claims submission testing period conducted under subsection (d)

for all managed care organizations with which the provider is contracted under the risk based managed care program established under subsection (c).

(D) Evidence of a consistent effort by the provider to submit claims in accordance with the uniform billing requirements developed under subsection (e)(1).

(i) The office of Medicaid policy and planning:

(1) shall determine whether a provider is experiencing a financial emergency based upon the provider's submission of a written request that meets the requirements of subsection (h)(2); and

(2) shall make a determination whether a provider is experiencing a financial emergency not more than seven (7) calendar days after it receives a written request submitted by a provider under subsection (h)(2).

(j) If the office of Medicaid policy and planning determines that a provider is experiencing a financial emergency for purposes of the program established under subsection (g), it shall direct each managed care organization with which the provider is contracted under the risk based managed care program established under subsection (c) to provide a temporary emergency assistance payment to the provider. A managed care organization directed to provide a temporary emergency assistance payment to a provider under this subsection shall provide the payment in not more than seven (7) calendar days after the office directs the managed care organization to provide the payment. The amount of the temporary emergency assistance payment that a managed care organization shall make to a provider under this subsection is equal to seventy-five percent (75%) of the monthly average of the provider's long-term services and supports Medicaid claims for the six (6) month period immediately preceding the implementation of the risk based managed care program under subsection (c), adjusted in proportion to the ratio of the managed care organization's covered population membership to the total covered population membership of the risk based managed care program established under subsection (c).

(k) Upon issuing any payment of a temporary emergency assistance to a provider under subsection (j), a managed care organization shall set up a receivable to reconcile the temporary emergency assistance funds with actual claims payment amounts. A managed care organization shall reconcile the temporary emergency assistance payment funds with actual claims payment

amounts on the first day of the month that is more than thirty-one (31) days after the managed care organization issues the temporary emergency assistance funds to the provider. If a temporary emergency assistance payment is issued to a provider, managed care organizations are still required to meet contract obligations for reviewing and paying claims, specifically claims that total a payment in excess of the temporary emergency assistance payment reconciliation. However, if a managed care organization fails to comply with a directive of the office of Medicaid policy and planning under subsection (j) to provide a temporary emergency assistance payment to a provider, the failure of the managed care organization:

(1) is a violation of the claim processing requirements of the managed care organization's contract; and

(2) makes the managed care organization subject to the penalties set forth in the contract, including payment of interest on the amount of the unpaid temporary emergency assistance at the rate set forth in IC 12-15-21-3(7)(A).

SECTION 11. IC 12-21-2-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3.5. (a) This subsection applies if the federal government selects the state of Indiana to participate in the community mental health services demonstration program described in IC 12-15-1.3-25(f). The office of the secretary and the division shall include each community mental health center that is able to meet all federal and state requirements concerning programming and data reporting:**

(1) before July 1, 2027, as a part of the community mental health services demonstration program; or

(2) beginning July 1, 2027, as part of a state plan amendment requiring Medicaid reimbursement for Medicaid eligible certified community behavioral health clinic services upon the completion of the demonstration program described in subdivision (1).

(b) This subsection applies if the federal government does not select the state of Indiana to participate in the community mental health services demonstration program described in IC 12-15-1.3-25(f). The office of the secretary and the division may apply for a Medicaid state plan amendment or a Medicaid waiver requiring Medicaid reimbursement for Medicaid eligible certified community behavioral health clinic services provided by a Medicaid behavioral health professional, including each

community mental health center and a behavioral health professional authorized to provide Medicaid services and employed by a community mental health center or a certified community behavioral health clinic.

SECTION 12. IC 34-30-2.1-129.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 129.5. IC 12-9-4-8 (Concerning providing information to the special service review team).**

SECTION 13. [EFFECTIVE UPON PASSAGE] **(a) Before May 1, 2024, the governor shall make the appointments to the Indiana state commission on aging in accordance with IC 12-10-2-3(c), as amended by this act.**

(b) A member of the Indiana state commission on aging appointed by the governor before March 1, 2024, under IC 12-10-2-3(c) but who no longer meets the requirements for appointment under IC 12-10-2-3(c), as amended by this act, shall remain as a member of the commission until the earlier of the following:

(1) The governor appoints a successor that meets the new qualifications.

(2) April 30, 2024.

(c) This SECTION expires June 30, 2024.

SECTION 14. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____