Second Regular Session of the 120th General Assembly (2018)

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 2017 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1317

AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 5-10-8-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 20. (a) As used in this section, "covered individual" means an individual entitled to coverage under a state employee plan.**

(b) As used in this section, "drug" means a prescription drug.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that has entered into an agreement with a state employee plan to provide drugs to individuals covered under a state employee plan.

(d) As used in this section, "state employee plan" refers to the following that provide coverage for drugs:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

The term includes a person that administers drug benefits on behalf of a state employee plan.

(e) A pharmacy or pharmacist shall have the right to provide a covered individual with information concerning the amount of the covered individual's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by a pharmacy

benefits manager from discussing this information or from selling to the covered individual a more affordable alternative if an affordable alternative is available.

(f) A pharmacy benefits manager that covers prescription drugs may not include a provision that requires a covered individual to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the contracted copayment amount; or

(2) the amount of total approved charges by the pharmacy benefits manager at the point of sale.

This subsection does not prohibit the adjudication of claims in accordance with the state employee plan administered by a pharmacy benefits manager. The covered individual is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.

SECTION 2. IC 12-10-1-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 6. (a) The area agencies on aging designated by the bureau in each planning and service region shall do the following:

(1) Determine the needs and resources of the aged in the area.

(2) Coordinate, in cooperation with other agencies or organizations in the area, region, district, or county, all programs and activities providing health, recreational, educational, or social services for the aged.

(3) Secure local matching money from public and private sources to provide, improve, or expand the sources available to meet the needs of the aged.

(4) Develop, in cooperation with the division and in accordance with the regulations of the commissioner of the federal Administration on Aging, an area plan for each planning and service area to provide for the following:

(A) A comprehensive and coordinated system for the delivery of services needed by the aged in the area.

(B) The collection and dissemination of information and referral sources.

(C) The effective and efficient use of all resources meeting the needs of the aged.

(D) The inauguration of new services and periodic evaluation of all programs and projects delivering services to the aged, with special emphasis on the low income and minority residents of the planning and service area.

(E) The establishment, publication, and maintenance of a toll

free telephone number to provide information, counseling, and referral services for the aged residents of the planning and service area.

(5) Conduct case management (as defined in IC 12-10-10-1).

(6) Perform any other functions required by regulations established under the Older Americans Act (42 U.S.C. 3001 et seq.).

(b) The division shall pay the costs associated with the toll free telephone number required under subsection (a).

(c) Changes may not be made to the designated coverage area of an area agency on aging until after the following:

(1) The office of the secretary holds a public hearing in each county where the existing area agency on aging is operating to discuss the proposed changes and receive public comment.

(2) One (1) year elapses from the date of the meeting held under subdivision (1).

SECTION 3. IC 12-10-10-2, AS AMENDED BY P.L.141-2006, SECTION 43, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 2. As used in this chapter, "community and home care services" means services provided within the limits of available funding to an eligible individual. The term includes the following:

(1) Homemaker services and attendant care, including personal care services.

(2) Respite care services and other support services for primary or family caregivers.

(3) Adult day care services.

(4) Home health services and supplies.

(5) Home delivered meals.

(6) Transportation.

(7) Attendant care services provided by a registered personal services attendant under IC 12-10-17.1 to persons described in IC 12-10-17.1-6.

(8) Other services necessary to prevent institutionalization of eligible individuals when feasible.

(9) Other services, not covered by Medicaid, including equipment and building modifications, necessary to:

(A) prevent individuals with intellectual or developmental disabilities from being institutionalized; and

(B) help an individual described in clause (A) to transition out of a health facility licensed under IC 16-28 or a group home (as defined by IC 31-9-2-48.5).

SECTION 4. IC 12-10-11-8, AS AMENDED BY P.L.143-2011,

SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 8. The board shall do the following:

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

(A) Individual independence, dignity, and privacy.

(B) Long term care services that are:

(i) integrated, accessible, and responsible; and

(ii) available in home and community settings.

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

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

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

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

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

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

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

(H) Services that:

(i) promote behavioral health; and

(ii) prevent and treat mental illness and addiction.

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

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

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

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

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

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

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

(9) Develop policies that support the participation of families and

volunteers in meeting the long term care needs of individuals.
(10) Encourage the development of funding for a continuum of care from private resources, including insurance.
(11) Develop a cost of services basis and a program of cost reimbursement for those persons who can pay all or a part of the cost of the services rendered. The division shall use this cost of services basis and program of cost reimbursement in administering IC 12-10-10. The cost of services basis and program of cost reimbursement must include a client cost share formula that:
(A) imposes no charges for an eligible individual whose income does not exceed one hundred fifty percent (150%) of the federal income poverty level; and
(B) does not impose charges for the total cost of services provided to an individual under the community and home options to institutional care for the elderly and disabled program unless the eligible individual's income exceeds three hundred fifty percent (350%) of the federal income poverty level.
The calculation of income for an eligible individual must include the deduction of the individual's medical expenses and the medical expenses of the individual's spouse and dependent children who reside in the eligible individual's household.
(12) Establish long term goals for the provision of guardianship services for adults.
(13) Coordinate activities and programs with the activities of other boards and state agencies concerning the provision of guardianship services.
(14) Recommend statutory changes affecting the guardianship of indigent adults.
(15) Review a proposed rule concerning ~~home and community based services~~ **the community and home options to institutional care for the elderly and disabled program under IC 12-10-10** as required under section 9 of this chapter.

SECTION 5. IC 12-10-11-9, AS ADDED BY P.L.137-2005, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 9. (a) The board shall be given the opportunity to review **and recommend changes to** a proposed rule concerning ~~home and community based services~~ **the community and home options to institutional care for the elderly and disabled program under IC 12-10-10** for:
(1) elderly individuals; or

(2) individuals with disabilities;

~~at least three (3) months~~ before ~~a~~ **the** proposed rule may be published in the Indiana Register. **The proposed rule must be distributed to the board at least one (1) month before the board's next regularly scheduled meeting.**

(b) If the proposing agency fails to give the board the opportunity to review **and recommend changes to** a proposed rule described in subsection (a), the rule:

(1) is void; and

(2) must be withdrawn by the proposing agency.

~~(c) The board may determine that the proposed rule reviewed by the board under this section should be subject to a public comment period. If the board makes a determination that a public comment period is necessary, the board shall set the:~~

~~(1) date and time;~~

~~(2) location; and~~

~~(3) format;~~

~~of the public comment period for the proposed rule.~~

~~(d) After a public hearing, if the board determines that a proposed rule is substantially out of compliance with state law governing home and community based services, the board shall request that the agency proposing the rule modify or withdraw the proposed rule. If a proposed rule is modified under this subsection, the modified rule must be reviewed by the board.~~

SECTION 6. IC 12-12.7-2-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 21. (a) The office of the secretary of family and social services shall study service provider and systems point of entry reimbursement rates for recipients of early intervention services.**

(b) The office may contract with a vendor to conduct the rate study required under subsection (a).

(c) The rate study required under subsection (a) must include the following:

(1) A comprehensive review, evaluation, and analysis of the current revenue sources, payment methodology, and fund recovery systems for programs and services provided under this chapter. The requirements of this subdivision must include the following:

(A) The use of the following in gathering the required information:

(i) Data collection.

(ii) Surveys.
(iii) Focus groups.
(iv) Meetings.
(v) Interviews of state program personnel, contractors, state and local agency partners, and stakeholders that are relevant to the analysis.
(B) An analysis plan that at least identifies key personnel and information sources and develops an interview model and other tools.
(C) Analysis of early intervention rules, regulations, and fiscal policy, including a comprehensive review of Indiana's current policies, processes, revenue sources, and research on other states' systems and policies.
If the review, evaluation, and analysis under this subdivision are performed by a vendor, the vendor shall prepare a report with the vendor's findings and provide the report to the office of the secretary, the division of disability and rehabilitative services, and the council.
(2) The identification of potential revenue sources for programs and services provided under this chapter and the development of a plan for use of the identified sources and revenue to maximize funding for early intervention. The plan under this subdivision must include the following:
(A) A proposal for new reimbursement methodologies or modifications to current methodologies to address any concerns identified through the revenue, payment methodology, and fund recovery system analysis. Any proposal under this clause must comply with federal and state laws and regulations for any identified funding source.
(B) The integration of stakeholder input into any recommendations under this subdivision.
(C) Recommendations concerning the:
(i) administration;
(ii) service delivery; and
(iii) financing;
of programs and services provided under this chapter.
(3) A comprehensive rate and time study and the development of a detailed report containing responsible and sustainable recommendations for compensation of all early intervention services provided under this chapter, including system point of entry (SPOE), local planning and coordinating councils

(LPCC), intake and service coordination, and provider agencies and direct service providers. The study under this subdivision must include at least monthly meetings with the office of the secretary that discuss the progress of the study under this subdivision. The study must include the following:

(A) The examination of fiscal management and provider accountability for services rendered to a child and families under this chapter through the use of the following:

(i) Data collection.

(ii) Surveys.

(iii) Focus groups.

(iv) Meetings.

(v) Interviews of state program personnel, contractors, state and local agency partners, and stakeholders that are relevant to the analysis.

(B) A market analysis, cost instrument, and time study tool design.

(C) Provider notification and training.

(D) Cost instrument and time study facilitation.

(E) Analysis and recommendations through the use of methods described in clause (B) concerning current rates, alternative rate structures, fiscal impact, and methodology to address increased costs and inflation.

(4) Consultation with the Indiana state department of health and the division of mental health and addiction to determine the projected number of children who will need early intervention services in the next five (5) years as a result of exposure to addictive substances.

(5) The identification of provider and systems point of entry service gaps throughout Indiana.

(6) The number of health care professionals needed to provide services in the next five (5) years to all children eligible for early intervention services.

(d) The office shall present the results of the fiscal analysis completed under this section to the state budget committee not later than October 31, 2018. The report to the state budget committee must include the following:

(1) An estimated number of all children in the next five (5) years who will need early intervention services, including children born with prenatal substance abuse exposure.

(2) The identified provider and system point of entry service gaps throughout Indiana.

(3) An estimated number of service providers needed to meet the needs of all children eligible for early intervention services in the next five (5) years.

(e) This section expires June 30, 2019.

SECTION 7. IC 12-14-29-5, AS AMENDED BY P.L.5-2015, SECTION 36, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) If referred by a court, an individual who meets the requirements of section 2 of this chapter may receive federal Supplemental Nutrition Assistance Program (SNAP) benefits. ~~for not more than twelve (12) months.~~

(b) If referred by a court, an individual who meets the requirements of section 3 of this chapter may receive TANF benefits for not more than twelve (12) months.

SECTION 8. IC 12-14-30-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: **Sec. 3. (a) Beginning January 1, 2020, and in accordance with 21 U.S.C. 862a(d)(1), the state elects to opt out of the application of 21 U.S.C. 862a(a) for individuals who have been convicted of an offense under IC 35-48 (controlled substances), or an offense in another jurisdiction that is substantially similar, for conduct occurring after August 22, 1996, if any of the following circumstances are met:**

(1) The individual has successfully completed probation, parole, community corrections, a reentry court program, or any other postconviction monitoring program ordered by a court.

(2) The individual is successfully complying with the individual's conditions of probation, parole, or community corrections, the terms of participation in a reentry court program, or the requirements of any other postconviction monitoring program ordered by a court.

(3) The individual is eligible for SNAP benefits under IC 12-14-29-2 as a participant in a program described in IC 12-14-29-2(4).

(b) If the individual violates any terms of the probation, parole, community corrections, or reentry court program described in subsection (a), the individual is not eligible for SNAP.

SECTION 9. IC 12-15-13-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8. (a) The office of family and social services shall study Medicaid reimbursement rates and the methodology for case management services for recipients of the**

Medicaid family support waiver and the Medicaid community integration and habilitation waiver.

(b) The office of family and social services may contract with a vendor to conduct the reimbursement rate and time and effort study in subsection (a).

(c) The results of the study in subsection (a) must include all activities of case management services specified in the Medicaid family support waiver and the Medicaid community integration and habilitation waiver, including the following:

(1) Case manager activities related to the transition of a participant from an institutional setting.

(2) Ensuring the ongoing facilitation of the person centered planning process.

(3) Developing, updating, and reviewing the person centered individualized support plan and related documents.

(4) Facilitating the integration of risk identification, planning, and mitigation in the person centered individualized support plan process.

(5) Convening team meetings.

(6) Monitoring of service delivery and utilization.

(7) Completing and processing the annual level of care determination.

(8) Completing case notes for all actions on behalf of the consumer.

(9) Convening and conducting all required and as needed face-to-face contacts.

(10) Completing and processing the monitoring checklist.

(11) Developing, submitting, and confirming initial, annual, reentry, and updated cost comparison budgets.

(12) Disseminating information, including all notices of action and forms to the participant, guardian, and the individualized support team.

(13) Developing and submitting budget modification requests, budget review questionnaires, and data entry worksheets, as needed.

(14) Developing and submitting the request for authorization, as outlined in the division of disability and rehabilitative services waiver manual, verifying the service is provided and the equipment is received.

(15) Completing, submitting, and following up on nonsentinel incident reports.

(16) Completing all required processes and procedures as

outlined in the bureau of quality improvement services sentinel event protocol.

(17) Completing all required processes and procedures as outlined in the bureau of quality improvement services mortality review protocol, as requested.

(18) Monitoring participants' health, safety, and welfare.

(19) Monitoring participants' satisfaction and service outcomes.

(20) Monitoring claims reimbursed through the approved Medicaid management information system and pertaining to waiver funded services.

(21) Maintaining files according to state standards.

(22) Cultivating and strengthening informal and natural supports for each participant.

(23) Identifying resources and negotiating the best solutions to meet identified needs.

(24) Completing the onboarding process for referrals.

(25) Completing the intake requirements and process for all referrals new to a waiver.

(26) Costs associated with initial and ongoing training for case managers.

(27) Costs associated with the on call system.

(28) Costs associated with the requirement to employ or contract with a registered nurse.

(29) Costs associated with the requirement to be accredited.

(30) Costs associated with maintaining the required quality assurance systems.

(31) Costs associated with providing supervision and support of case managers.

(32) Specific case manager requirements related to persons assessed to be at the Algo 6 level assessment level.

(d) The results of the study must include the following:

(1) An analysis and comparison of service rates and rate structures for similar services in comparable states and the number of hours of service per person per month provided for each rate.

(2) An analysis and comparison of competitive market rates and rate structures for similar services in Indiana and the number of hours of service per person per month provided for each market rate.

(3) Recommendations for Medicaid rates for case management services for recipients of the Medicaid family

support waiver and the Medicaid community integration and habilitation waiver.

(4) The methodology for arriving at the recommended rates and number of hours or units for each rate.

(5) The amount of state dollars needed to adequately fund the service for all potentially and currently eligible recipients under the recommended Medicaid rates.

(6) The number of all potential and current persons eligible to receive case management services.

(e) Any new rates as a result of a study under this section:

(1) may not:

(A) take effect until at least January 1, 2019; and

(B) be applied retroactively to any claim or approved service before the effective date of the new rate; and

(2) must be approved by the federal Department of Health and Human Services through a Medicaid waiver amendment applied for by the office of the secretary.

(f) The office of family and social services shall present the results of the study to the budget committee before January 1, 2019.

(g) This section expires July 1, 2019.

SECTION 10. IC 25-26-13-29, AS AMENDED BY P.L.158-2013, SECTION 285, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 29. (a) It is unlawful:

(1) For any person to display or permit to be displayed, a pharmacy permit in any facility or place of business other than that for which it was issued.

(2) For any person to accept a prescription for filling or compounding at any place or facility for which there is not a valid pharmacy permit.

(3) For any person to operate a pharmacy or to take, assume, exhibit, display, or advertise by any medium, the title "drugs", "prescriptions", "medicine", "drug store", "pharmacy", or "apothecary shop", or any combination of such titles or any other title, symbol, term, or description of like import intended to cause the public to believe that it is a pharmacy unless the person holds a valid pharmacy permit.

(4) For any person to engage or offer to engage in the practice of pharmacy or to hold himself or herself out as a pharmacist without a valid pharmacist's license that is classified as active by the board.

(b) A person who violates a provision of subsection (a) commits a

Level 6 felony.

(c) Nothing in this chapter shall apply to, nor in any manner interfere with the business of a general merchant in selling and distributing nonnarcotic, nonprescription medicines or drugs which are prepackaged, fully prepared by the manufacturer for use by the consumer, and labeled in accordance with the requirements of the state and federal food and drug acts.

(d) This chapter does not apply to, or in any manner interfere with, the business of a manufacturer in selling and delivering a dialysate drug or a device that is necessary for home peritoneal renal dialysis for a patient who has end stage renal disease if all of the following apply:

(1) The dialysate drug or device is approved by the federal Food and Drug Administration under federal law.

(2) The dialysate drug or device is held by the manufacturer, a third party logistics provider, or a wholesale drug distributor in accordance with the requirements of IC 25-26-14.

(3) The dialysate drug or device is delivered in the manufacturer's original, sealed packaging.

(4) The dialysate drug or device is delivered only upon:

(A) receipt of a physician's prescription by a pharmacy that holds a pharmacy permit under this chapter; and

(B) the transmittal of an order from the pharmacy described in clause (A) to the manufacturer, third party logistics provider, or wholesale drug distributor.

(5) The manufacturer, third party logistics provider, or wholesale drug distributor delivers the dialysate drug or device directly to:

(A) the patient or the patient's designee for self-administration of the dialysis therapy; or

(B) a health care provider for administration of the dialysis therapy to the patient.

SECTION 11. IC 25-26-13.5-18, AS ADDED BY P.L.202-2017, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18. **(a)** The board may adopt rules under IC 4-22-2 necessary to implement this chapter.

(b) The Indiana board of pharmacy shall, not later than July 1, 2018, adopt rules under IC 4-22-2, including emergency rules in the manner provided under IC 4-22-2-37.1, to implement this chapter with respect to telepharmacy. This subsection expires July 1, 2019.

SECTION 12. IC 27-8-11-12 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 12. (a) As used in this section, "drug" means a prescription drug.**

(b) As used in this section, "insurer" refers to an insurer that provides coverage for drugs. The term includes a person that administers drug benefits on behalf of an insurer.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that has entered into an agreement with an insurer under section 3 of this chapter.

(d) A pharmacy or pharmacist shall have the right to provide an insured with information concerning the amount of the insured's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by an insurer from discussing this information or from selling to the insured a more affordable alternative if an affordable alternative is available.

(e) An insurer that covers prescription drugs may not include a provision that requires an insured to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the contracted copayment amount; or

(2) the amount of total approved charges by the insurer at the point of sale.

This subsection does not prohibit the adjudication of claims in accordance with an accident and sickness insurance policy issued or administered by an insurer. The insured is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.

SECTION 13. IC 27-13-15-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 6. (a) As used in this section, "drug" means a prescription drug.**

(b) As used in this section, "health maintenance organization" refers to a health maintenance organization that provides coverage for drugs. The term includes the following:

(1) A limited service health maintenance organization.

(2) A person that administers drug benefits on behalf of a health maintenance organization or a limited service health maintenance organization.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that is a participating provider.

(d) A pharmacy or pharmacist shall have the right to provide an enrollee with information concerning the amount of the enrollee's

cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by a health maintenance organization from discussing this information or from selling to the enrollee a more affordable alternative if an affordable alternative is available.

(e) A health maintenance organization that covers prescription drugs may not include a provision that requires an enrollee to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the contracted copayment amount; or

(2) the amount of total approved charges by the health maintenance organization at the point of sale.

This subsection does not prohibit the adjudication of claims in accordance with an individual contract or group contract issued or administered by a health maintenance organization. The enrollee is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.

SECTION 14. IC 32-21-6-3, AS AMENDED BY P.L.25-2016, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 3. As used in this chapter, "psychologically affected property" includes real estate or a dwelling that is for sale, rent, or lease and to which one (1) or more of the following facts or a reasonable suspicion of facts apply:

~~(1) That an occupant of the property was afflicted with or died from a disease related to the human immunodeficiency virus (HIV).~~

~~(2)~~ **(1)** That an individual died on the property.

~~(3)~~ **(2)** That the property was the site of:

(A) a felony under IC 35;

(B) criminal organization (as defined in IC 35-45-9-1) activity;

(C) the discharge of a firearm involving a law enforcement officer while engaged in the officer's official duties; or

(D) the illegal manufacture or distribution of a controlled substance.

SECTION 15. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "nurse licensure compact" refers to a multistate compact entered into by states with the interstate commission of nurse licensure compact administrators.**

(b) The legislative council is urged to assign to an appropriate interim study committee the task of studying the impact that joining the nurse licensure compact would have on the delivery of nursing services to residents of Indiana. An interim study

committee assigned a study under this SECTION shall consider the following:

(1) Recent changes made to the nurse licensure compact, including benefits other states have realized from joining the nurse licensure compact.

(2) The likely changes to access to nursing services in Indiana as a result of adopting the nurse licensure compact, including access to nurses in border areas of the state and in underserved areas.

(3) Increased employment opportunities that may be gained by Indiana nurses if Indiana enters into the nurse licensure compact.

(4) Issues concerning the oversight and enforcement of standards of practice of nurses by the Indiana state board of nursing and the interstate commission of nurse licensure compact administrators.

(c) This SECTION expires January 1, 2019.

SECTION 16. **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: ______________