Reprinted
February 24, 2026

ENGROSSED
HOUSE BILL No. 1277

DIGEST OF HB 1277 (Updated February 23, 2026 6:31 pm - DI 104)

Citations Affected: IC 12-8; IC 12-15.

Synopsis: Long term care. Amends the requirements for a Medicaid home and community based services waiver. Requires the office of the secretary of family and social services (office) to apply to the federal government for: (1) a new Medicaid waiver to provide assisted living services; and (2) an amendment to a specific Medicaid home and

(Continued next page)

Effective: July 1, 2025 (retroactive); July 1, 2026; March 1, 2027.

Barrett, Goss-Reaves, Porter, Slager

(SENATE SPONSORS — CRIDER, BROWN L, BUSCH, BECKER, CHARBONNEAU, RANDOLPH LONNIE M)

January 6, 2026, read first time and referred to Committee on Public Health.
January 13, 2026, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 126.3.
January 27, 2026, amended, reported — Do Pass.
January 29, 2026, read second time, ordered engrossed.
January 30, 2026, engrossed.
February 2, 2026, read third time, passed. Yeas 93, nays 0.

SENATE ACTION

February 5, 2026, read first time and referred to Committee on Health and Provider Services. Reassigned to Committee on Appropriations pursuant to Rule 68(b).
February 19, 2026, amended, reported favorably — Do Pass.
February 23, 2026, read second time, amended, ordered engrossed.

community based services waiver to establish an individual cost limit of not more than the institutional cost of nursing facility services. Specifies that provisions concerning reimbursement for assisted living services for individuals who are aged and disabled and receiving services under a Medicaid waiver apply to the new assisted living Medicaid waiver. Requires certain Medicaid recipients to choose the recipient's provider of integrated health care coordination. Provides that integrated health care coordination provided by a provider of assisted living services is not duplicative of certain other services. Specifies that an individual is no longer a member of the covered population upon receiving nursing facility services for 100 consecutive days. Provides that on the one hundredth day, the individual is not a member of the covered population and shall receive Medicaid services under a fee for service program. Requires, effective July 1, 2025, a managed care organization to pay interest on a Medicaid clean claim submitted by a nursing facility if the claim was not accurately and fully paid.

Reprinted
February 24, 2026

Second Regular Session of the 124th General Assembly (2026)

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 2025 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1277

A BILL FOR 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 12-8-1.6-2, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. (a) As used in this chapter, "home and community based services waiver" refers to a federal Medicaid waiver granted to the state under 42 U.S.C. 1396n(c) to provide home and community based long term care services and supports to individuals with disabilities **and the elderly.**

(b) The term does not include home and community services offered as part of the approved Medicaid state plan.

SECTION 2. IC 12-8-1.6-4, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The office of the secretary has all powers necessary and convenient to administer a home and community based services waiver.

(b) The office of the secretary shall do the following:

(1) Administer money appropriated or allocated to the office of the secretary by the state, including money appropriated or

allocated for a home and community based services waiver.

(2) Take any action necessary to implement a home and community based services waiver, including applying to the United States Department of Health and Human Services for approval to amend or renew the waiver, implement a new Medicaid waiver, or amend the Medicaid state plan.

(3) Ensure that a home and community based services waiver is subject to funding available to the office of the secretary.

(4) Ensure, in coordination with the budget agency, that the cost of a home and community based services waiver does not exceed the total amount of funding available by the budget agency, including state and federal funds, for the Medicaid programs established to provide services under a home and community based services waiver.

(5) Establish and administer a program for a home and community based services waiver, **including the assisted living waiver described in IC 12-15-1.3-26,** to provide an eligible individual with care that does not cost more than services provided to a similarly situated individual residing in an institution.

(6) Within the limits of available resources, provide service coordination services to individuals receiving services under a home and community based services waiver, including the development of an individual service plan that:

(A) addresses an individual's needs;

(B) identifies and considers family and community resources that are potentially available to meet the individual's needs; and

(C) is consistent with the person centered care approach for receiving services under a waiver.

(7) Monitor services provided by a provider that:

(A) provides services to an individual using funds provided by the office of the secretary or under the authority of the office of the secretary; or

(B) entered into one (1) or more provider agreements to provide services under a home and community based services waiver.

(8) Establish and administer a confidential complaint process for:

(A) an individual receiving; or

(B) a provider described in subdivision (7) providing;

services under a home and community based services waiver.

(c) The office of the secretary may do the following:

(1) At the office's discretion, delegate any of its authority under this chapter to any division or office within the office of the secretary.

(2) Issue administrative orders under IC 4-21.5-3-6 regarding the provision of a home and community based services waiver.

SECTION 3. IC 12-8-1.6-9, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 9. A home and community based services waiver, including the delivery and receipt of services provided under the home and community based services waiver, must meet the following requirements:

(1) Be provided under public supervision.

(2) Be individualized and designed to meet the needs of individuals eligible to receive services under the home and community based services waiver.

(3) Meet applicable state and federal standards.

(4) Be provided by qualified personnel.

(5) Be provided, to the extent appropriate, with services provided under the home and community based services waiver that are provided in a home and community based setting where nonwaiver individuals receive services.

(6) Be provided in accordance with an individual's:

(A) service plan; **and**

(B) choice of provider of waiver services.

SECTION 4. IC 12-8-1.6-10, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2026 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 10. (a) This section applies to **the following:**

(1) A home and community based services waiver that included assisted living services as an available service before July 1, 2025.

(2) An assisted living waiver described in IC 12-15-1.3-26.

(b) As used in this section, "office" includes the following:

(1) The office of the secretary of family and social services.

(2) A managed care organization that has contracted with the office of Medicaid policy and planning under IC 12-15.

(3) A person that has contracted with a managed care organization described in subdivision (2).

(c) Under a home and community based services waiver that provides services to an individual who is aged or disabled, the office shall reimburse for the following services provided to the individual by a provider of assisted living services, if included in the individual's

home and community based ~~service~~ **services** plan:

(1) Assisted living services.

(2) Integrated health care coordination.

(3) Transportation.

(d) If the office approves an increase in the level of services for a recipient of assisted living services, the office shall reimburse the provider of assisted living services for the level of services for the increase as of the date that the provider has documentation of providing the increase in the level of services.

(e) The office may reimburse for any home and community based services provided to a Medicaid recipient beginning on the date of the individual's Medicaid application.

(f) The office may not do any of the following concerning assisted living services provided in a home and community based services program:

(1) Require the installation of a sink in the kitchenette within any living unit of an entity that participated in the Medicaid home and community based services program before July 1, 2018.

(2) Require all living units within a setting that provides assisted living services to comply with physical plant requirements that are applicable to individual units occupied by a Medicaid recipient.

(3) Require a provider to offer only private rooms.

(4) Require a housing with services establishment provider to provide housing when:

(A) the provider is unable to meet the health needs of a resident without:

(i) undue financial or administrative burden; or

(ii) fundamentally altering the nature of the provider's operations; and

(B) the resident is unable to arrange for services to meet the resident's health needs.

(5) Require a housing with services establishment provider to separate an agreement for housing from an agreement for services.

(6) Prohibit a housing with services establishment provider from offering studio apartments with only a single sink in the unit.

(7) Preclude the use of a shared bathroom between adjoining or shared units if the participants consent to the use of a shared bathroom.

(8) Reduce the scope of services that may be provided by a provider of assisted living services under the aged and disabled

Medicaid waiver in effect on July 1, 2021.

(g) A Medicaid recipient who has a home and community based services plan that includes:

(1) assisted living services; and

(2) integrated health care coordination;

shall choose whether the provider of assisted living services or the office provides the integrated health care coordination to the recipient.

(h) Integrated health care coordination provided by a provider of assisted living services under this section is not duplicative of any services provided by the office.

~~(g)~~ **(i)** The office of the secretary may adopt rules under IC 4-22-2 that establish the right, and an appeals process, for a resident to appeal a provider's determination that the provider is unable to meet the health needs of the resident as described in subsection (f)(4). The process:

(1) must require an objective third party to review the provider's determination in a timely manner; and

(2) may not be required if the provider is licensed by the Indiana department of health and the licensure requirements include an appellate procedure for such a determination.

SECTION 5. IC 12-15-1.3-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 26. (a) Not later than September 1, 2026, the office of the secretary shall apply to the United States Department of Health and Human Services for a Medicaid waiver to provide assisted living services effective July 1, 2026, in a waiver separate from the Medicaid home and community based services waiver that included assisted living services to individuals who:**

(1) are at least sixty (60) years of age; and

(2) meet nursing facility level of care requirements;

as an available service before July 1, 2026.

(b) The office of the secretary shall state in the waiver application a plan to transfer waiver slots from the existing Medicaid home and community based services waivers that include assisted living services to individuals described in subsection (a) to the new assisted living Medicaid waiver application required under subsection (a) upon approval. If the new assisted living Medicaid waiver submitted under subsection (a) is approved, the office of the secretary shall transfer waiver slots currently used for individuals receiving assisted living services from the existing Medicaid home and community based services waivers that include assisted living services to individuals described in subsection (a) to the new

assisted living Medicaid waiver.

(c) The office of the secretary shall establish a work group of interested stakeholders to assist in the development and implementation of the waiver described in subsection (a). The governor shall appoint the members of the work group and include providers of assisted living services as members of the work group.

SECTION 6. IC 12-15-1.3-27 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 27. (a) Not later than September 1, 2026, the office of the secretary shall apply to the United States Department of Health and Human Services for an amendment to the Medicaid home and community based services waiver concerning the provision of services to individuals who are at least sixty (60) years of age and meet nursing facility level of care requirements to establish an individual cost limit of not more than the institutional cost of nursing facility services.**

(b) This section expires July 1, 2028.

SECTION 7. IC 12-15-5-17.5, AS AMENDED BY P.L.138-2022, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 17.5. (a) The office shall report on its progress on the development of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services to the interim study committee on public health, behavioral health, and human services before November 1, 2021.

(b) Not later than February 1, 2022, the office shall report the following information and analysis to the legislative council and budget committee (in an electronic format under IC 5-14-6) regarding the implementation of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services, as follows:

(1) The projected utilization of home and community based services and institutional services for the four (4) years following implementation, and including, but not limited to, information on:

(A) provider network adequacy;

(B) family caregiver programming; and

(C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.

(2) How administrative processes, including service approval and

billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.

(3) Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.

(4) The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality assessment fee and supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.

(c) A request for proposal for the procurement of a Medicaid program to enroll a Medicaid recipient who is eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services in a risk based managed care program or capitated managed care program:

(1) must comply with IC 12-15-13-1.9 and any other applicable statute; and

(2) may not be issued until the request for proposal has been reviewed by the budget committee.

~~(d) After the review of a request for proposal by the budget committee under subsection (c), the office may not enter into a final contract that would implement a program described in subsection (c) before January 31, 2023.~~

SECTION 8. IC 12-15-12.7-7, AS ADDED BY P.L.174-2025, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025 (RETROACTIVE)]: Sec. 7. (a) This section applies to claims submitted for payment under the program by a nursing facility participating in the program.

(b) The managed care organization shall pay, deny, or suspend each claim submitted by a nursing facility provider for payment under the program not later than:

(1) twenty-one (21) days after the claim was electronically filed;

or

(2) thirty (30) days after a claim has been filed on paper;

from receipt by the managed care organization.

(c) If the managed care organization:

(1) fails to **accurately and fully** pay a clean claim in the time required under this section; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the managed care organization shall pay the provider interest on the Medicaid allowable amount of the claim as set forth in this section.

(d) Interest paid under subsection (c):

(1) accrues beginning:

(A) twenty-two (22) days from the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days from the date the claim is filed under subsection (b)(2); and

(2) stops accruing on the date the managed care organization pays the claim.

(e) A managed care organization shall pay interest under subsection (c) to a provider at the rate established for Medicare overpayments and underpayments, as set forth in 42 CFR 405.378.

SECTION 9. IC 12-15-13-1.8, AS AMENDED BY P.L.213-2025, SECTION 112, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025 (RETROACTIVE)]: Sec. 1.8. (a) As used in this section **and section 1.9 of this chapter,** "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (b).

(b) **Except as provided in section 1.9 of this chapter,** 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) Any managed care organization that participates in the risk based managed care program under subsection (c) that fails to **accurately** pay a claim **in full that is** submitted by a nursing facility provider for payment under the program later than:

(1) twenty-one (21) days, if the claim was electronically filed; or

(2) thirty (30) days, if the claim was filed on paper;

from receipt by the managed care organization shall pay a penalty of five hundred dollars ($500) per calendar day per claim.

SECTION 10. IC 12-15-13-1.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2027]: **Sec. 1.9. Upon an individual receiving nursing facility services for a consecutive period of one hundred (100) days, the individual is no longer a member of the covered population. An individual who was part of the covered population is no longer part of the covered population on the one hundredth day and shall receive Medicaid services under a fee for service program.**

SECTION 11. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1277, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

(Reference is to HB 1277 as introduced.)

BARRETT

Committee Vote: Yeas 12, Nays 0

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1277, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 5, between lines 29 and 30, begin a new paragraph and insert:

"**(b) The office of the secretary shall state in the waiver application a plan to transfer waiver slots from the existing Medicaid home and community based services waivers that include assisted living services to the new assisted living Medicaid waiver application required under subsection (a) upon approval. If the new assisted living Medicaid waiver submitted under subsection (a) is approved, the office of the secretary shall transfer waiver slots currently used for individuals receiving assisted living services from the existing Medicaid home and community based services waivers that include assisted living services to the new assisted living Medicaid waiver.**".

Page 5, line 30, delete "(b)" and insert "**(c)**".

Page 6, delete lines 37 through 42.

Delete page 7.

and when so amended that said bill do pass.

(Reference is to HB 1277 as printed January 13, 2026.)

THOMPSON

Committee Vote: yeas 19, nays 0.

REPORT OF THE PRESIDENT
PRO TEMPORE

Mr. President: Pursuant to Senate Rule 68(b), I hereby report that House Bill 1277, currently assigned to the Committee on Health and Provider Services, be reassigned to the Committee on Appropriations.

BRAY

COMMITTEE REPORT

Mr. President: The Senate Committee on Appropriations, to which was referred Engrossed House Bill No. 1277, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Replace the effective date in SECTION 7 with "[EFFECTIVE JULY 1, 2027]".

Page 6, line 6, after "27." insert "**(a)**".

Page 6, between lines 13 and 14, begin a new paragraph and insert: "**(b) This section expires July 1, 2028.**".

and when so amended that said bill do pass.

(Reference is to HB 1277 as printed January 27, 2026.)

MISHLER, Chairperson

Committee Vote: Yeas 11, Nays 2.

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1277 be amended to read as follows:

Page 5, line 28, after "services" insert "**to individuals who:**

(1) are at least sixty (60) years of age; and

(2) meet nursing facility level of care requirements;".

Page 5, line 28, beginning with "as" begin a new line blocked left.

Page 5, line 33, after "services" insert "**to individuals described in subsection (a)**".

Page 5, line 39, after "services" insert "**to individuals described in subsection (a)**".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1277 as printed February 20, 2026.)

CRIDER

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1277 be amended to read as follows:

Replace the effective date in SECTION 7 with "[EFFECTIVE JULY 1, 2025 (RETROACTIVE)]".

Page 6, between lines 14 and 15, begin a new paragraph and insert:

"SECTION 10. IC 12-15-5-17.5, AS AMENDED BY P.L.138-2022, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 17.5. (a) The office shall report on its progress on the development of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services to the interim study committee on public health, behavioral health, and human services before November 1, 2021.

(b) Not later than February 1, 2022, the office shall report the following information and analysis to the legislative council and budget committee (in an electronic format under IC 5-14-6) regarding the implementation of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services, as follows:

(1) The projected utilization of home and community based services and institutional services for the four (4) years following implementation, and including, but not limited to, information on:

(A) provider network adequacy;

(B) family caregiver programming; and

(C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.

(2) How administrative processes, including service approval and billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific

discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.

(3) Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.

(4) The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality assessment fee and supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.

(c) A request for proposal for the procurement of a Medicaid program to enroll a Medicaid recipient who is eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services in a risk based managed care program or capitated managed care program:

(1) must comply with IC 12-15-13-1.9 and any other applicable statute; and

(2) may not be issued until the request for proposal has been reviewed by the budget committee.

~~(d) After the review of a request for proposal by the budget committee under subsection (c), the office may not enter into a final contract that would implement a program described in subsection (c) before January 31, 2023.~~

SECTION 7. IC 12-15-12.7-7, AS ADDED BY P.L.174-2025, SECTION 41, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025 (RETROACTIVE)]: Sec. 7. (a) This section applies to claims submitted for payment under the program by a nursing facility participating in the program.

(b) The managed care organization shall pay, deny, or suspend each claim submitted by a nursing facility provider for payment under the program not later than:

(1) twenty-one (21) days after the claim was electronically filed; or

(2) thirty (30) days after a claim has been filed on paper;

from receipt by the managed care organization.

(c) If the managed care organization:

(1) fails to **accurately and fully** pay a clean claim in the time required under this section; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the managed care organization shall pay the provider interest on the Medicaid allowable amount of the claim as set forth in this section.

(d) Interest paid under subsection (c):

(1) accrues beginning:

(A) twenty-two (22) days from the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days from the date the claim is filed under subsection (b)(2); and

(2) stops accruing on the date the managed care organization pays the claim.

(e) A managed care organization shall pay interest under subsection (c) to a provider at the rate established for Medicare overpayments and underpayments, as set forth in 42 CFR 405.378.".

Page 6, line 17, delete "section," and insert "section **and section 1.9 of this chapter,**".

Page 6, line 20, delete "subsection (e)," and insert "**section 1.9 of this chapter,**".

Page 6, line 36, after "to" insert "**accurately**".

Page 6, line 37, after "claim" insert "**in full that is**".

Page 7, line 1, delete "(e)" and insert "SECTION 9. IC 12-15-13-1.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2027]: **Sec. 1.9.**".

Page 7, after line 6, begin a new paragraph and insert:

"SECTION 11. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1277 as printed February 20, 2026.)

BROWN L