CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1277

Citations Affected: IC 12-8-1.6; IC 12-11-2.1-3; IC 12-15; IC 16-42-22.5-1; IC 29-1-14-1.

Synopsis: Health and human services matters. Amends the duties of the office of the secretary of family and social services (office) concerning Medicaid home and community based services waivers (waiver). Requires: (1) a provider of waiver services to provide certain documentation to a waiver recipient; (2) a waiver recipient to review the documentation and report errors or inconsistencies; and (3) the recipient's case manager to provide assistance to the recipient in reviewing the documentation and reporting any errors or inconsistencies. 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. Establishes a time frame in which the bureau of disabilities services must review and approve or deny requests for an increase in service units provided to certain individuals with a disability. Requires the 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 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. Provides that, beginning July 1, 2027, 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. Provides that a provision prohibiting the office from reducing reimbursement for home health services expires June 30, 2027. Requires the office to collaborate with certain entities to develop a new reimbursement methodology for home health services. Specifies that public notice of at least six months (rather than one year) must be provided before a health facility service reimbursement that results in a reduction in reimbursement may be changed. Amends the definition of "bulk drug substance" for provisions concerning drug compounding. Provides that a claim by the estate recovery unit of the office of Medicaid policy and planning (estate recovery unit) is forever barred unless the estate recovery unit files a claim in the court in which the decedent's estate is

being administered not later than nine months after the date of death of the decedent. **(This conference committee report does the following: (1) Relocates language in SECTION 10 and adjusts the applicability. (2) Modifies language concerning a Medicaid waiver amendment to establish an individual cost limit. (3) Removes language concerning claims submitted by nursing facilities. (4) Adds SECTIONS 1, 2 (with change), 3, 5, 7, 8, 9, and 11 from ESB 275). (5) Amends the definition of "bulk drug substance" for provisions concerning drug compounding in ESB 282. (6) Makes conforming changes.)**

Effective: Upon passage; July 1, 2026.

Adopted	Rejected

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1277 respectfully reports that said two committees have conferred and agreed as follows to wit:

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

Delete everything after the enacting clause and insert the following:

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.

(9) Establish a procedure for documenting compliance with subdivision (6) in the individual service plan of an individual receiving services under a home and community based services waiver, which must include provider attestation that services delivered to a recipient align with the recipient's individual service plan.

(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 12-8-1.6-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) An individual receiving services under a home and community based services waiver shall do the following:**

(1) Review any record or statement the individual receives under IC 12-15-11-11.

(2) Not later than forty-five (45) days after receiving a record or statement described in subdivision (1), report to the office of the secretary, the provider, or other appropriate entity any:

(A) error in the record or statement; or

(B) inconsistency between the record or statement and services received.

(b) Upon request, the case manager of a recipient described in subsection (a) shall do the following:

(1) Assist the recipient in reviewing the recipient's record or statement described in subsection (a)(1).

(2) Assist in reporting and resolving any error or inconsistency under subsection (a).

SECTION 5. 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 6. IC 12-11-2.1-3, AS AMENDED BY P.L.99-2007, SECTION 78, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. **(a)** All services provided to an individual must be provided under the individual service plan of the individual with a disability. To the extent that services described in IC 12-11-1.1-1(e) are available and meet the individual's needs, services provided to an individual shall be provided in the least restrictive environment possible.

(b) Pursuant to the applicable home and community based services waiver, a request to increase service units on an individual's approved service plan must be submitted to the bureau for review and approval or denial not later than forty-five (45) calendar days from the first day of the qualifying event, as prescribed by the bureau.

SECTION 7. 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 8. 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:**

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

(2) meet nursing facility level of care requirements; and

(3) are not transferring to the waiver from another home and community based services waiver;

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 9. 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 12-15-13-1.8(e) 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 10. IC 12-15-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 11. A provider of services under a home and community based services waiver (as defined in IC 12-8-1.6-2) shall do the following:**

(1) Upon request by an individual receiving services under the waiver or the individual's legal guardian, but not more than once per calendar quarter, provide to the individual or the individual's legal guardian the provider's accounting records of service delivery for the recipient.

(2) Upon request, but not more than twice per calendar year, provide to an individual receiving services under the waiver an itemized statement of the services billed by the provider for the recipient. The statement must be in plain language.

SECTION 11. IC 12-15-13-1.8, AS AMENDED BY P.L.213-2025, SECTION 112, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: 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) **Except as provided in subsection (e),** 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 pay a claim 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.

(e) Beginning July 1, 2027, 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 12. IC 12-15-14-8, AS AMENDED BY P.L.241-2023, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) The office may implement an end of therapy reclassification methodology in the RUG-IV, 48-Group model or its successor for payment of nursing facility services.

(b) Before the office changes a health facility service reimbursement that results in a reduction in reimbursement, the office shall provide public notice of at least ~~one (1) year.~~ **six (6) months.** The public notice under this subsection:

(1) is not a rulemaking action or part of the administrative rulemaking process under IC 4-22; and

(2) must include the fiscal impact of the proposed reimbursement change.

SECTION 13. IC 12-15-34-14.5, AS ADDED BY P.L.217-2017, SECTION 79, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14.5. (a) This section is effective beginning July 1, 2017.

(b) The office of the secretary may not reduce reimbursement for home health services.

(c) 405 IAC 1-4.2-4(l) and any successor rule concerning reducing home health services reimbursement are void and may not be renewed or otherwise implemented.

(d) This section expires June 30, 2027.

SECTION 14. IC 12-15-34-14.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 14.6. (a) The office of the secretary shall, in partnership and collaboration with a home health services association and providers of home health services, develop a new reimbursement methodology for home health services and, not later than November 30, 2026, submit the new reimbursement methodology for home health services to the legislative council in an electronic format under IC 5-14-6.**

(b) This section expires December 31, 2027.

SECTION 15. IC 16-42-22.5-1, AS ADDED BY SEA 282-2026, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) As used in this chapter, "bulk drug substance" means a substance that is intended:

(1) for incorporation into a finished drug product; and

(2) to furnish pharmacological activity or other direct effect;

in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body.

~~(b) The term includes an amino acid.~~

~~(c)~~ **(b)** The term does not include the following:

(1) A vitamin, mineral, herb, essential oil, extract, or other non-pharmaceutical ingredient not described in subsection (a).

(2) Intermediates used in the synthesis of a substance.

SECTION 16. IC 29-1-14-1, AS AMENDED BY P.L.99-2024, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) Except as provided in IC 29-1-7-7, all claims against a decedent's estate, other than expenses of administration and claims of the United States, the state, or a subdivision of the state, whether due or to become due, absolute or contingent, liquidated or unliquidated, founded on contract or otherwise, shall be forever barred against the estate, the personal representative, the heirs, devisees, and legatees of the decedent, unless filed with the court in which such estate is being administered within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(b) No claim shall be allowed which was barred by any statute of limitations at the time of decedent's death.

(c) No claim shall be barred by the statute of limitations which was not barred at the time of the decedent's death, if the claim shall be filed within:

(1) three (3) months after the date of the first published notice to creditors; or

(2) three (3) months after the court has revoked probate of a will, in accordance with IC 29-1-7-21, if the claimant was named as a beneficiary in that revoked will;

whichever is later.

(d) All claims barrable under subsection (a) shall be barred if not

filed within nine (9) months after the death of the decedent.

(e) Nothing in this section shall affect or prevent any action or proceeding to enforce any mortgage, pledge, or other lien upon property of the estate.

(f) Nothing in this section shall affect or prevent the enforcement of a claim for injury to person or damage to property arising out of negligence against the estate of a deceased tort feasor within the period of the statute of limitations provided for the tort action. A tort claim against the estate of the tort feasor may be opened or reopened and suit filed against the special representative of the estate within the period of the statute of limitations of the tort. Any recovery against the tort feasor's estate shall not affect any interest in the assets of the estate unless the suit was filed within the time allowed for filing claims against the estate. The rules of pleading and procedure in such cases shall be the same as apply in ordinary civil actions.

(g) A claim by the unit against a decedent's estate is forever barred unless:

(1) the unit files a claim in the court in which the decedent's estate is being administered; or

(2) the unit opens an estate for the decedent and files a claim against the decedent in the estate;

not later than ~~one hundred twenty (120) days~~ **nine (9) months** after the date of death of the decedent.

SECTION 17. **An emergency is declared for this act.**

(Reference is to EHB 1277 as reprinted February 24, 2026.)

Conference Committee Report
on
Engrossed House Bill 1277

Signed by:

Representative Barrett Chairperson	Senator Crider
Representative Shackleford	Senator Jackson L
House Conferees	**Senate Conferees**