HOUSE BILL No. 1277

AM127705 has been incorporated into January 27, 2026 printing.

Synopsis: Long term care.

January 27, 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.

Merged

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 12-7-2-40.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 40.3. "Compensation", for purposes of IC 12-8-1.6-5.5, has the meaning set forth in IC 12-8-1.6-5.5(a).**

SECTION 2. IC 12-7-2-62.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 62.5. "Direct care staff", for purposes of IC 12-8-1.6-5.5, has the meaning set forth in IC 12-8-1.6-5.5(b).**

SECTION 3. 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 4. 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 5. IC 12-8-1.6-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 5.5. (a) As used in this section, "compensation" means any of the following:**

(1) Salaries and wages.

(2) Benefits, including the following:

(A) Paid time off.

(B) Health, dental, and vision insurance.

(C) Life and disability insurance.

(D) Worker's compensation.

(E) Qualifying pensions and other retirement benefits.

(F) Tuition reimbursement.

(G) The employer's share of payroll taxes.

(H) Travel reimbursement.

(I) Other remuneration under the federal Fair Labor Standards Act of 1938, as amended (29 U.S.C. 201-219).

The term does not include office administrative costs, supervision, or other program or overhead costs.

(b) As used in this section, "direct care staff" means an employee of a home and community based services waiver provider who provides direct, hands on care for a participant under the home and community based services waiver.

(c) A provider that provides attendant care services under a home and community based services waiver must use at least seventy percent (70%) of the state share of Medicaid per diem reimbursement for the services provided on compensation for the

provider's direct care staff providing attendant care services.

(d) A provider described in subsection (c) shall, not later than June 30 of each year, submit a direct care staff cost report to the office of the secretary documenting that the provider has complied with subsection (c). The report must meet at least the following requirements:

(1) Be based upon actual, documented expenditures.

(2) Be attested to by an authorized representative of the provider.

(3) Include the following information for the previous calendar year:

(A) The provider's total attendant care revenue under a home and community based services waiver.

(B) The total spent as compensation for direct care staff providing attendant care services, separated by each category described in subsection (a).

(C) The total dollars spent on supervision costs for direct care staff.

(D) The total dollars spent on administrative, overhead, and program support costs.

(4) Include any other information deemed relevant and required by the office to ensure compliance with this section.

SECTION 6. 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 7. 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 8. 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 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 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.

(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 9. 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. 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.**

SECTION 10. 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) 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.