(c) If a person, firm, limited liability company, or corporation offers to the state or a political subdivision services, equipment, supplies, materials, or funds under gift, grant, or loan for purposes of emergency management:

(1) the state, acting through the governor; or

(2) the political subdivision, acting through its executive;

may accept the offer.

(d) Upon the acceptance in subsection (c), the governor or the executive of the political subdivision may authorize an officer of the state or of the political subdivision to receive the services, equipment, supplies, materials, or funds:

(1) on behalf of the state or the political subdivision; and

(2) subject to the terms of the offer.

(e) A person, firm, limited liability company, or corporation owning or controlling real estate or other premises that voluntarily and without compensation grants a license or privilege or otherwise permits the designation or use of the whole or any part of the real estate or premises to shelter persons during an actual or impending national security, natural, or manmade emergency or disaster or a drill for any of those situations, together with successors in interest, is not civilly liable by reason of:

(1) the condition of the real estate or premises; or

(2) the conduct of persons engaged in directing or seeking shelter;

for negligently causing the death of or injury to any person on or about the real estate or premises or for loss of or damage to the property of any person during the emergency or disaster or during a drill.

SECTION 137. IC 12-15-1.3-18, AS ADDED BY P.L.217-2017, SECTION 78, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 18. (a) The definitions set forth in 460 IAC 6-3 as of ~~January 1, 2017,~~ **January 1, 2021,** apply to the terms that are used in this section.

(b) As used in this section, "benefits" means allowances and services provided by employers to employees as compensation that is in addition to salary and wages, including but not limited to paid time off, health insurance, life insurance, worker's compensation, and qualifying pensions.

~~(b)~~ **(c)** The office of the secretary shall increase the reimbursement rate for services if the services are provided as follows:

(1) The services are provided to an individual who receives services under a Medicaid waiver under the federal home and community based services program.

(2) The individual is authorized under the Medicaid waiver described in subdivision (1) to receive any of the following services:

(A) Adult day services.

(B) Prevocational services.

(C) Residential habilitation and support.

(D) Respite.

(E) ~~Supported employment and~~ Extended services as defined in the family supports Medicaid waiver **and the community integration habilitation Medicaid waiver.**

(F) ~~Community habilitation and participation services.~~ **Day habilitation, as defined in the family supports Medicaid waiver and the community integration habilitation Medicaid waiver.**

(G) Workplace assistance, as defined in the family supports Medicaid waiver and the community integration habilitation Medicaid waiver.

~~(H) Facility habilitation.~~

~~(I)~~ **(H)** Residential habilitation and support (RHS daily).

~~(J)~~ **(I)** Transportation services.

~~(K)~~ **(J)** Participant assistance and care, as defined in the family supports Medicaid waiver.

~~(L)~~ **(K)** Facility based support, as defined in the family supports Medicaid waiver and the community integration habilitation Medicaid waiver.

(3) The services are delivered to the individual by a direct care staff.

~~(c)~~ **(d)** The amount of the increase in the reimbursement rate described in subsection ~~(b)~~ **(c)** for a state fiscal year beginning July 1, ~~2017,~~ **2021, or upon approval of CMS,** or thereafter is the reimbursement rate in effect as of June 30, ~~2017,~~ **2019,** for the services listed in subsection ~~(b)(2)~~ **(c)(2)** multiplied by ~~five percent (5%).~~ **fourteen percent (14%).**

~~(d)~~ **(e)** An authorized service provider shall use at least ~~seventy-five percent (75%)~~ **ninety-five percent (95%)** of the amount of the increase in the reimbursement rate to **pay payroll tax liabilities and to** increase the wages **and benefits** paid to direct care staff **in comparison to payroll tax liabilities, wages, and benefits paid to direct care staff as of the provider's most recent fiscal year ended on or before December 31, 2019,** who:

(1) are employed by the authorized service provider to provide services in Indiana; ~~and~~

(2) provide support services listed in subsection ~~(b)(2).~~ **(c)(2); and**

(3) are paid on an hourly basis.

~~(e)~~ **(f)** If a provider does not use at least ~~seventy-five percent (75%)~~ **ninety-five percent (95%)** of the increase to **pay payroll tax liabilities and to** increase wages **and benefits** paid to direct care staff, the office shall recoup part or all of the increase in the reimbursement rate that the provider receives as provided in subsection ~~(g).~~ **(h).**

~~(f)~~ **(g)** An authorized service provider providing services in Indiana shall provide written and electronic notification of its plan to **pay payroll tax liabilities and to** increase wages **and benefits** to:

(1) direct care staff **described in subsection (e) who are** employed by the provider; and

(2) the office of the secretary;

within thirty (30) days after the office implements an increase in reimbursement rates.

~~(g)~~ **(h)** The office may recoup the difference between ~~seventy-five percent (75%)~~ **ninety-five percent (95%)** of the amount received by a provider as a result of increased reimbursement rates and the amount of the increase that is actually used by the provider to **pay payroll tax liabilities and to** pay an increase in wages **and benefits** to direct care staff. The remaining ~~twenty-five percent (25%)~~ **five percent (5%)** may be retained by the provider to cover ~~the other employer related costs of providing direct care services, including payroll taxes, benefits, and paid time for nondirect services such as paid time off and training.~~ **administrative and overhead costs.**

~~(h)~~ **(i)** Providers shall maintain all books, documents, papers, accounting records, and other evidence required to support the reporting of payroll information for **payment of payroll tax liabilities and for** increased wages **and benefits** to direct care staff. Wages are defined as total compensation, **including paid time off and training,** less overtime and shift differential for direct care staff providing services to individuals receiving the services described in subsection ~~(b)(2)~~ **(c)(2)** as reported on the provider's payroll records. Providers shall make these materials available at their respective offices at all reasonable times and for three (3) years from the date of final payment for the services listed in subsection ~~(b)(2)~~ **(c)(2)** for inspection by the state or its authorized designees. Providers shall furnish copies at no cost to the state if requested.

~~(i)~~ **(j)** The office or its designee may recoup all or a part of the amount paid using the increased

reimbursement rates based upon an audit or review of the supporting documentation required to be maintained under subsection ~~(h)~~ **(i)** if the provider cannot provide adequate documentation to support the **payment of payroll tax liabilities and the payment of** increased wages **and benefits** to direct care staff.

~~(j)~~ **(k)** If required, the office shall file Medicaid waiver amendments for the family supports Medicaid waiver and the community integration and habilitation Medicaid waiver related to rate increases and Medicaid waiver caps only on or before ~~September 30, 2017,~~ **October 1, 2021,** with the earliest possible effective date allowed by the federal Centers for Medicare and Medicaid Services. If the federal Centers for Medicare and Medicaid Services ~~deny~~ **denies** the Medicaid waiver amendments, the office may modify the waiver amendment request. If a waiver amendment is not approved, rate increases may not be granted under this section.

~~(k)~~ **(l)** This section may not be construed as creating an employment relationship of any kind between office staff and direct care staff of an authorized service provider.

SECTION 138. IC 12-15-5-17.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **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