

## COMMITTEE PRINT

### **Budget Reconciliation Legislative Recommendations Relating to the Medicaid Program under title XIX of the Social Security Act**

## 1                   **Subtitle G—Medicaid**

### 2           **PART 1—FEDERAL MEDICAID PROGRAM TO**

### 3                   **CLOSE THE COVERAGE GAP**

#### 4   **SEC. 30701. CLOSING THE MEDICAID COVERAGE GAP.**

5           (a) FEDERAL MEDICAID PROGRAM TO CLOSE COV-  
6 ERAGE GAP IN NONEXPANSION STATES.—Title XIX of  
7 the Social Security Act (42 U.S.C. 1396 et seq.) is amend-  
8 ed by adding at the end the following new section:

9   **“SEC. 1948. FEDERAL MEDICAID PROGRAM TO CLOSE COV-  
10                   ERAGE GAP IN NONEXPANSION STATES.**

11           “(a) ESTABLISHMENT.—In the case of a State that  
12 the Secretary determines (based on the State plan under  
13 this title, waiver of such plan, or other relevant informa-  
14 tion) is not expected to expend amounts under the State  
15 plan (or waiver of such plan) for all individuals described  
16 in section 1902(a)(10)(A)(i)(VIII) during a year (begin-  
17 ning with 2025), (in this section defined as ‘a coverage  
18 gap State’, with respect to such year), the Secretary shall  
19 (including through contract with eligible entities (as speci-  
20 fied by the Secretary), consistent with subsection (b)) pro-

1 vide for the offering to such individuals residing in such  
2 State of a health benefits plan (in this section referred  
3 to as the ‘Federal Medicaid program’ or the ‘Program’),  
4 for each quarter during the period beginning on January  
5 1 of such year, and ending with the last day of the first  
6 quarter during which the State provides medical assist-  
7 ance to all such individuals under the State plan (or waiv-  
8 er of such plan). Under the Federal Medicaid program,  
9 the Secretary—

10 “(1) may use the Federally Facilitated Market-  
11 place to facilitate eligibility determinations and en-  
12 rollments under the Federal Medicaid Program and  
13 shall establish a set of eligibility rules to be applied  
14 under the Program in a manner consistent with sec-  
15 tion 1902(e)(14);

16 “(2) shall establish benefits, beneficiary protec-  
17 tions, and access to care standards by, at a min-  
18 imum—

19 “(A) establishing a minimum set of bene-  
20 fits to be provided (and providing such benefits)  
21 under the Federal Medicaid program, which  
22 shall be in compliance with the requirements of  
23 section 1937 and shall consist of benchmark  
24 coverage described in section 1937(b)(1) or  
25 benchmark equivalent coverage described in sec-

1           tion 1937(b)(2) to the same extent as medical  
2           assistance provided to such an individual under  
3           this title (without application of this section) is  
4           required under section 1902(k)(1) to consist of  
5           such benchmark coverage or benchmark equiva-  
6           lent coverage;

7           “(B) applying the provisions of sections  
8           1902(a)(8), 1902(a)(34) (which may be applied  
9           in accordance with such phased-in implementa-  
10          tion as the Secretary deems necessary, but be-  
11          ginning as soon as practicable), and 1943 with  
12          respect to such an individual, benefits under the  
13          Federal Medicaid program, and making applica-  
14          tion for such benefits (which may be in accord-  
15          ance with a phased-in implementation as the  
16          Secretary deems necessary, but beginning as  
17          soon as practicable) in the same manner as  
18          such provisions would apply to such an indi-  
19          vidual, medical assistance under this title (other  
20          than pursuant to this section), and making ap-  
21          plication for such medical assistance under this  
22          title (other than pursuant to this section); and  
23          providing that redeterminations and appeals of  
24          eligibility and coverage determinations of serv-  
25          ices (including benefit reductions, terminations,

1 and suspension) shall be conducted under the  
2 Federal Medicaid program in accordance with a  
3 Federal fair hearing process established by the  
4 Secretary that is subject to the same require-  
5 ments as applied with respect to redetermina-  
6 tions and appeals of eligibility, and with respect  
7 to coverage of services (including benefit reduc-  
8 tions, terminations, and suspension), under a  
9 State plan under this title and that may provide  
10 for such fair hearings related to denials of eligi-  
11 bility (based on modified adjusted gross income  
12 eligibility determinations) to be conducted  
13 through the Federally Facilitated Marketplace  
14 for Exchanges;

15 “(C) applying, in accordance with sub-  
16 section (d), the provisions of section 1927  
17 (other than subparagraphs (B) and (C) of sub-  
18 section (b)(1) of such section) with respect to  
19 the Secretary and payment under the Federal  
20 Medicaid program for covered outpatient drugs  
21 with respect to a rebate period in the same  
22 manner and to the same extent as such provi-  
23 sions apply with respect to a State and payment  
24 under the State plan for covered outpatient  
25 drugs with respect to the rebate period; and

1           “(D) applying the provisions of sections  
2           1902(a)(14), 1902(a)(23), 1902(a)(47), and  
3           1920 through 1920C (as applicable) to the Fed-  
4           eral Medicaid program and such individuals en-  
5           rolled in such program in the same manner and  
6           to the same extent as such provisions apply to  
7           a State plan and such individuals eligible for  
8           medical assistance under the State plan, and  
9           applying the provisions of section  
10          1902(a)(30)(A) with respect to medical assist-  
11          ance available under the Federal Medicaid pro-  
12          gram in the same manner and to the same ex-  
13          tent as such provisions apply to medical assist-  
14          ance under a State plan under this title, except  
15          that—

16                   “(i) the Secretary shall provide that  
17                   no cost sharing shall be applied under the  
18                   Federal Medicaid program;

19                   “(ii) the Secretary may waive the pro-  
20                   visions of subparagraph (A) of section  
21                   1902(a)(23) to the extent deemed appro-  
22                   priate to facilitate the implementation of  
23                   managed care;

1 “(iii) in applying the provisions of sec-  
2 tion 1902(a)(47) and sections 1920  
3 through 1920C, the Secretary—

4 “(I) shall establish a single pre-  
5 sumptive eligibility process for individ-  
6 uals eligible under the Federal Med-  
7 icaid program, under which the Sec-  
8 retary may contract with entities to  
9 carry out such process; and

10 “(II) may apply such provisions  
11 and process in accordance with such  
12 phased-in implementation as the Sec-  
13 retary deems necessary, but beginning  
14 as soon as practicable).

15 “(b) ADMINISTRATION OF FEDERAL MEDICAID PRO-  
16 GRAM THROUGH CONTRACTS WITH MEDICAID MANAGED  
17 CARE ORGANIZATION AND THIRD PARTY PLAN ADMINIS-  
18 TRATOR REQUIREMENTS.—

19 “(1) IN GENERAL.—For the purpose of admin-  
20 istering the benefits under the Program (across all  
21 coverage gap geographic areas (as defined in para-  
22 graph (8)) to provide medical assistance to individ-  
23 uals described in section 1902(a)(10)(A)(i)(VIII) en-  
24 rolled under the Federal Medicaid program and re-  
25 siding in such areas, the Secretary shall solicit bids

1 described in paragraph (2) and enter into contracts  
2 with a total of at least 2 eligible entities (as speci-  
3 fied by the Secretary, which may be a medicaid  
4 managed care organization (in this section defined  
5 as including a managed care organization described  
6 in section 1932(a)(1)(B)(i), a prepaid inpatient  
7 health plan, and a prepaid ambulatory health plans  
8 (as defined in section 438.2 of title 42, Code of Fed-  
9 eral Regulations)), a third party plan administrator,  
10 or both). An eligible entity entering into a contract  
11 with the Secretary under this paragraph may admin-  
12 ister such benefits as a medicaid managed care orga-  
13 nization (as so defined), in which case such contract  
14 shall be in accordance with paragraph (3) with re-  
15 spect to such geographic area, or as a third-party  
16 administrator, in which case such contract shall be  
17 in accordance with paragraph (4) with respect to  
18 such geographic area. The Secretary may so con-  
19 tract with a Medicaid managed care organization or  
20 third party plan administrator in each coverage gap  
21 geographic area (and may specify which type of eli-  
22 gible entity may bid with respect to a coverage gap  
23 geographic area or areas) and may contract with  
24 more than one such eligible entity in the same cov-  
25 erage gap geographic area.

1           “(2) BIDS.—

2                   “(A) IN GENERAL.—To be eligible to enter  
3 into a contract under this subsection, for a  
4 year, an entity shall submit (at such time, in  
5 such manner, and containing such information  
6 as specified by the Secretary) one or more bids  
7 to administer the Program in one or more cov-  
8 erage gap geographic areas, which reflects the  
9 projected monthly cost to the entity of fur-  
10 nishing benefits under the Program to an indi-  
11 vidual enrolled under the Program in such a ge-  
12 ographic area (or areas) for such year.

13                   “(B) SELECTION.—In selecting from bids  
14 submitted under subparagraph (A) for purposes  
15 of entering into contracts with eligible entities  
16 under this subsection, with respect to a cov-  
17 erage gap geographic area, the Secretary shall  
18 take into account at least each of the following,  
19 with respect to each such bid:

20                           “(i) Network adequacy (as proposed  
21 in the submitted bid).

22                           “(ii) The amount, duration, and scope  
23 of benefits (such as value-added services  
24 offered in the submitted bid), as compared  
25 to the minimum set of benefits established



1 by the Secretary under subsection  
2 (a)(2)(A).

3 “(iii) The amount of the bid, taking  
4 into account the average per member cost  
5 of providing medical assistance under  
6 State plans under this title (or waivers of  
7 such plans) to individuals enrolled in such  
8 plans (or waivers) who are at least 18  
9 years of age and residing in the coverage  
10 gap geographic area, as well as the average  
11 cost of providing medical assistance under  
12 State plans under this title (and waivers of  
13 such plans) to individuals described in sec-  
14 tion 1902(a)(10)(A)(i)(VIII).

15 “(3) CONTRACT WITH MEDICAID MANAGED  
16 CARE ORGANIZATION.—In the case of a contract  
17 under paragraph (1) between the Secretary and an  
18 eligible entity administering benefits under the Pro-  
19 gram as a Medicaid managed care organization, with  
20 respect to one or more coverage gap geographic  
21 areas, the following shall apply:

22 “(A) The provisions of clauses (i) through  
23 (xi) of section 1903(m)(2)(A), clause (xii) of  
24 such section (to the extent such clause relates  
25 to subsections (b) and (f) of section 1932), and

1 clause (xiii) of such section 1903(m)(2)(A)  
2 shall, to the greatest extent practicable, apply  
3 to the contract, to the Secretary, and to the  
4 Medicaid managed care organization, with re-  
5 spect to providing medical assistance under the  
6 Federal Medicaid program with respect to such  
7 area, in the same manner and to the same ex-  
8 tent as such provisions apply to a contract  
9 under section 1903(m) between a State and an  
10 entity that is a medicaid managed care organi-  
11 zation (as defined in section 1903(m)(1)), to  
12 the State, and to the entity, with respect to  
13 providing medical assistance to individuals eligi-  
14 ble for benefits under this title.

15 “(B) The provisions of section 1932(h)  
16 shall apply to the contract, Secretary, and Med-  
17 icaid managed care organization.

18 “(C) The contract shall provide that the  
19 entity pay claims in a timely manner and in ac-  
20 cordance with the provisions of section  
21 1902(a)(37).

22 “(D) The contract shall provide that the  
23 Secretary shall make payments under this sec-  
24 tion to the entity, with respect to coverage of  
25 each individual enrolled under the Program in

1           such a coverage gap geographic area with re-  
2           spect to which the entity administers the Pro-  
3           gram in an amount specified in the contract,  
4           subject to subparagraph (D)(ii) and paragraph  
5           (6).

6           “(E) The contract shall require—

7                   “(i) the application of a minimum  
8                   medical loss ratio (as calculated under sub-  
9                   section (d) of section 438.8 of title 42,  
10                  Code of Federal Regulations (or any suc-  
11                  cessor regulation)) for payment for medical  
12                  assistance administered by the managed  
13                  care organization under the Program, with  
14                  respect to a year, that is equal to or great-  
15                  er than 85 percent (or such higher percent  
16                  as specified by the Secretary); and

17                   “(ii) in the case, with respect to a  
18                   year, the minimum medical loss ratio (as  
19                   so calculated) for payment for services  
20                   under the benefits so administered is less  
21                   than 85 percent (or such higher percent as  
22                   specified by the Secretary under clause  
23                   (i)), remittance by the organization to the  
24                   Secretary of any payments (or portions of  
25                   payments) made to the organization under

1           this section in an amount equal to the dif-  
2           ference in payments for medical assistance,  
3           with respect to the year, resulting from the  
4           organization's failure to meet such ratio  
5           for such year.

6           “(F) The contract shall require that the el-  
7           igible entity submit to the Secretary the num-  
8           ber of individuals enrolled in the Program with  
9           respect to each coverage gap geographic area  
10          and month with respect to which the contract  
11          applies and such additional information as spec-  
12          ified by the Secretary for purposes of payment,  
13          program integrity, oversight, quality measure-  
14          ment, or such other purpose specified by the  
15          Secretary.

16          “(G) The contract shall require that the el-  
17          igible entity perform any other activity identi-  
18          fied by the Secretary.

19          “(4) CONTRACT WITH A THIRD PARTY PLAN  
20          ADMINISTRATOR.—

21          “(A) IN GENERAL.—In the case of a con-  
22          tract under paragraph (1) between the Sec-  
23          retary and an eligible entity to administer the  
24          Program as a third party plan administrator,  
25          with respect to one or more coverage gap geo-

1 graphic areas, such contract shall provide that,  
2 with respect to medical assistance provided  
3 under the Federal Medicaid program to individ-  
4 uals who are enrolled in the Program with re-  
5 spect to such area (or areas)—

6 “(i) the third party plan administrator  
7 shall, consistent with such requirements as  
8 may be established by the Secretary—

9 “(I) establish provider networks,  
10 payment rates, and utilization man-  
11 agement, consistent with the provi-  
12 sions of section 1902(a)(30)(A), as  
13 applied by subsection (a)(4);

14 “(II) pay claims in a timely man-  
15 ner and in accordance with the provi-  
16 sions of section 1902(a)(37);

17 “(III) submit to the Secretary  
18 the number of individuals enrolled in  
19 the Program with respect to each cov-  
20 erage gap geographic area and month  
21 with respect to which the contract ap-  
22 plies and such additional information  
23 as specified by the Secretary for pur-  
24 poses of payment, program integrity,  
25 oversight, quality measurement, or

1           such other purpose specified by the  
2           Secretary; and

3                   “(IV) perform any other activity  
4           identified by the Secretary; and

5                   “(ii) the Secretary shall make pay-  
6           ments (for the claims submitted by the  
7           third party plan administrator and for an  
8           economic and efficient administrative fee)  
9           under this section to the third party plan  
10          administrator, with respect to coverage of  
11          each individual enrolled under the Program  
12          in a coverage gap geographic area with re-  
13          spect to which the third party plan admin-  
14          istrator administers the Program in an  
15          amount determined under the contract,  
16          subject to subclause (VI)(bb) and para-  
17          graph (7).

18                   “(B) THIRD PARTY PLAN ADMINISTRATOR  
19          DEFINED.—For purposes of this section, the  
20          term ‘third party plan administrator’ means an  
21          entity that satisfies such requirements as estab-  
22          lished by the Secretary, which shall include at  
23          least that such an entity administers health  
24          plan benefits, pays claims under the plan, es-

1           tablishes provider networks, sets payment rates,  
2           and are not risk-bearing entities.

3           “(5) ADMINISTRATIVE AUTHORITY.—The Sec-  
4           retary may take such actions as are necessary to ad-  
5           minister this subsection, including by setting pay-  
6           ment rates, setting network adequacy standards, es-  
7           tablishing quality requirements, establishing report-  
8           ing requirements, and specifying any other program  
9           requirements or standards necessary in contracting  
10          with specified entities under this subsection, and  
11          overseeing such entities, with respect to the adminis-  
12          tration of the Federal Medicaid program.

13          “(6) PREEMPTION.—In carrying out the duties  
14          under a contract entered into under paragraph (1)  
15          between the Secretary and a Medicaid managed care  
16          organization or a third party plan administrator,  
17          with respect to a coverage gap State—

18                 “(A) the Secretary may establish minimum  
19                 standards and licensure requirements for such a  
20                 Medicaid managed care organization or third  
21                 party plan administrator for purposes of car-  
22                 rying out such duties; and

23                 “(B) any provisions of law of that State  
24                 which relate to the licensing of the organization  
25                 or administrator and which prohibit the organi-

1           zation or administrator from providing coverage  
2           pursuant to a contract under this section shall  
3           be superseded.

4           “(7) PENALTIES.—In the case of an eligible en-  
5           tity with a contract under this section that fails to  
6           comply with the requirements of such entity pursu-  
7           ant to this section or such contract, the Secretary  
8           may withhold payment (or any portion of such pay-  
9           ment) to such entity under this section in accord-  
10          ance with a process specified by the Secretary, im-  
11          pose a corrective action plan on such entity, or im-  
12          pose a civil monetary penalty on such entity in an  
13          amount not to exceed \$10,000 for each such failure.  
14          In implementing this paragraph, the Secretary shall  
15          have the authorities provided the Secretary under  
16          section 1932(e) and subparts F and I of part 438  
17          of title 42, Code of Federal Regulations.

18          “(8) COVERAGE GAP GEOGRAPHIC AREA.—For  
19          purposes of this section, the term ‘coverage gap geo-  
20          graphic area’ means an area of one or more coverage  
21          gap States, as specified by the Secretary, or any  
22          area within such a State, as specified by the Sec-  
23          retary.

24          “(c) PERIODIC DATA MATCHING.—The Secretary  
25          shall, including through contract, periodically verify the



1 income of an individual enrolled in the Federal Medicaid  
2 program for a year, before the end of such year, to deter-  
3 mine if there has been any change in the individual's eligi-  
4 bility for benefits under the program. For purposes of the  
5 previous sentence, the Secretary may verify income of an  
6 individual based on the prospective income of the indi-  
7 vidual for such year or based on current monthly income  
8 of the individual, as specified by the Secretary. In the case  
9 that, pursuant to such verification, an individual is deter-  
10 mined to have had a change in income that results in such  
11 individual no longer be included as an individual described  
12 in section 1902(a)(10)(A)(i)(VIII), the Secretary shall  
13 apply the same processes and protections as States are  
14 required under this title to apply with respect to an indi-  
15 vidual who is determined to have had a change in income  
16 that results in such individual no longer being included  
17 as eligible for medical assistance under this title (other  
18 than pursuant to this section).

19 “(d) DRUG REBATES.—For purposes of subsection  
20 (a)(2)(B), in applying section 1927, the Secretary shall  
21 (either directly or through contracts)—

22 “(1) require an eligible entity with a contract  
23 under subsection (b) to report the data required to  
24 be reported under section 1927(b)(2) by a State  
25 agency and require such entity to submit to the Sec-

1       retary rebate data, utilization data, and any other  
2       information that would otherwise be required under  
3       section 1927 to be submitted to the Secretary by a  
4       State;

5           “(2) shall take such actions as are necessary  
6       and develop or adapt such processes and mecha-  
7       nisms as are necessary to report and collect data as  
8       is necessary and to bill and track rebates under sec-  
9       tion 1927, as applied pursuant to subsection  
10      (a)(2)(B) for drugs that are provided under the Fed-  
11      eral Medicaid program;

12           “(3) provide that the coverage requirements of  
13      prescription drugs under the Federal Medicaid pro-  
14      gram comply with the coverage requirements section  
15      1927; and

16           “(4) require that in order for payment to be  
17      available under the Federal Medicaid program or  
18      under section 1903(a) for covered outpatient drugs  
19      of a manufacturer, the manufacturer must have en-  
20      tered into and have in effect a rebate agreement to  
21      provide rebates under section 1927 to the Federal  
22      Medicaid program in the same form and manner as  
23      the manufacturer is required to provide rebates  
24      under an agreement described in section 1927(b) to  
25      a State Medicaid program under this title.

1 “(e) TRANSITIONS.—

2 “(1) FROM EXCHANGE PLANS ONTO FEDERAL  
3 MEDICAID PROGRAM.—The Secretary shall provide  
4 for a process under which, in the case of individuals  
5 described in section 1902(a)(10)(A)(i)(VIII) who are  
6 enrolled in qualified health plans through an Ex-  
7 change in a coverage gap State, the Secretary takes  
8 such steps as are necessary to transition such indi-  
9 viduals to coverage under the Federal Medicaid pro-  
10 gram. Such process shall apply procedures described  
11 in section 1943(b)(1)(C) to screen for eligibility and  
12 enrollment under the Federal Medicaid program in  
13 the same manner as such procedures screen for eligi-  
14 bility and enrollment under qualified health plans  
15 through an Exchange established under title I of the  
16 Patient Protection and Affordable Care Act.

17 “(2) IN CASE COVERAGE GAP STATE BEGINS  
18 PROVIDING COVERAGE UNDER STATE PLAN.—The  
19 Secretary shall provide for a process for, in the case  
20 of a coverage gap State in which the State begins  
21 to provide medical assistance to individuals described  
22 in section 1902(a)(10)(A)(i)(VIII) under the State  
23 plan (or waiver of such plan) and the Federal Med-  
24 icaid program ceases to be offered, transitioning in-  
25 dividuals from such program to the State plan (or

1 waiver), as eligible, including a process for  
2 transitioning all eligibility redeterminations.

3 “(f) COORDINATION WITH AND ENROLLMENT  
4 THROUGH EXCHANGES.—The Secretary shall take such  
5 actions as are necessary to provide, in the case of a cov-  
6 erage gap State in which the Federal Medicaid program  
7 is offered, for the availability of information on, deter-  
8 minations of eligibility for, and enrollment in such pro-  
9 gram through and coordinated with the Exchange estab-  
10 lished with respect to such State under title I of the Pa-  
11 tient Protection and Affordable Care Act.

12 “(g) THIRD PARTY LIABILITY.—The provisions of  
13 section 1902(a)(25) shall apply with respect to the Fed-  
14 eral Medicaid program, the Secretary, and the eligible en-  
15 tities with a contract under subsection (b) in the same  
16 manner as such provisions apply with respect to State  
17 plans under this title (or waiver of such plans) and the  
18 State or local agency administering such plan (or waiver).  
19 The Secretary may specify a timeline (which may include  
20 a phase-in) for implementing this subsection.

21 “(h) FRAUD AND ABUSE PROVISIONS.—Provisions of  
22 law (other than criminal law provisions) identified by the  
23 Secretary by regulation, in consultation (as appropriate)  
24 with the Inspector General of the Department of Health  
25 and Human Services, that impose sanctions with respect

1 to waste, fraud, and abuse under this title or title XI, such  
2 as the False Claims Act (31 U.S.C. 3729 et seq.), as well  
3 as provisions of law (other than criminal law provisions)  
4 identified by the Secretary that provide oversight author-  
5 ity, shall also apply to the Federal Medicaid program.

6 “(i) MAINTENANCE OF EFFORT.—

7 “(1) PAYMENT.—

8 “(A) IN GENERAL.—In the case of a State  
9 that, as of January 1, 2022, is expending  
10 amounts for all individuals described in section  
11 1902(a)(10)(A)(i)(VIII) under the State plan  
12 (or waiver of such plan) and that stops expend-  
13 ing amounts for all such individuals under the  
14 State plan (or waiver of such plan), such State  
15 shall for each quarter beginning after January  
16 1, 2022, during which such State does not ex-  
17 pend amounts for all such individuals provide  
18 for payment under this subsection to the Sec-  
19 retary of the product of—

20 “(i) 10 percent of, subject to subpara-  
21 graph (B), the average monthly per capita  
22 costs expended under the State plan (or  
23 waiver of such plan) for such individuals  
24 during the most recent previous quarter

1 with respect to which the State expended  
2 amounts for all such individuals; and

3 “(ii) the sum, for each month during  
4 such quarter, of the number of individuals  
5 enrolled under such program in such State.

6 “(B) ANNUAL INCREASE.—For purposes of  
7 subparagraph (A), in the case of a State with  
8 respect to which such subparagraph applies  
9 with respect to a period of consecutive quarters  
10 occurring during more than one calendar year,  
11 for such consecutive quarters occurring during  
12 the second of such calendar years or a subse-  
13 quent calendar year, the average monthly per  
14 capita costs for each such quarter for such  
15 State determined under subparagraph (A)(i), or  
16 this subparagraph, shall be annually increased  
17 by the Secretary by the percentage increase in  
18 Medicaid spending under this title during the  
19 preceding year (as determined based on the  
20 most recent National Health Expenditure data  
21 with respect to such year).

22 “(2) FORM AND MANNER OF PAYMENT.—Pay-  
23 ment under paragraph (1) shall be made in a form  
24 and manner specified by the Secretary.

1           “(3) COMPLIANCE.—If a State fails to pay to  
2           the Secretary an amount required under paragraph  
3           (1), interest shall accrue on such amount at the rate  
4           provided under section 1903(d)(5). The amount so  
5           owed and applicable interest shall be immediately  
6           offset against amounts otherwise payable to the  
7           State under section 1903(a), in accordance with the  
8           Federal Claims Collection Act of 1996 and applica-  
9           ble regulations.

10           “(4) DATA MATCH.—The Secretary shall per-  
11           form such periodic data matches as may be nec-  
12           essary to identify and compute the number of indi-  
13           viduals enrolled under the Federal Medicaid pro-  
14           gram under section 1948 in a coverage gap State (as  
15           referenced in subsection (a) of such section) for pur-  
16           poses of computing the amount under paragraph  
17           (1).

18           “(5) NOTICE.—The Secretary shall notify each  
19           State described in paragraph (1) not later than a  
20           date specified by the Secretary that is before the be-  
21           ginning of each quarter (beginning with 2022) of the  
22           amount computed under paragraph (1) for the State  
23           for that year.

24           “(i) APPROPRIATIONS.—There is appropriated, out of  
25           any funds in the Treasury not otherwise appropriated, for

1 each fiscal year such sums as are necessary to carry out  
2 subsections (a) through (i) of this section.”.

3 (b) DRUG REBATE CONFORMING AMENDMENT.—  
4 Section 1927(a)(1) of the Social Security Act (42 U.S.C.  
5 1396r–8(a)(1)) is amended in the first sentence—

6 (1) by striking “or under part B of title XVIII”  
7 and inserting “, under the Federal Medicaid pro-  
8 gram under section 1948, or under part B of title  
9 XVIII”; and

10 (2) by inserting “including as such subsection is  
11 applied pursuant to subsections (a)(2)(C) and (d) of  
12 section 1948 with respect to the Federal Medicaid  
13 program,” before “and must meet”.

14 **PART 2—EXPANDING ACCESS TO MEDICAID**

15 **HOME AND COMMUNITY-BASED SERVICES**

16 **SEC. 30711. DEFINITIONS.**

17 In this part:

18 (1) APPROPRIATE COMMITTEES OF CON-  
19 GRESS.—The term “appropriate committees of Con-  
20 gress” means the Committee on Energy and Com-  
21 merce of the House of Representatives, the Com-  
22 mittee on Finance of the Senate, the Committee on  
23 Health, Education, Labor and Pensions of the Sen-  
24 ate, and the Special Committee on Aging of the Sen-  
25 ate.



1           (2) DIRECT CARE WORKER.—The term “direct  
2           care worker” means, with respect to a State, any of  
3           the following individuals who by contract, by receipt  
4           of payment for care, or as a result of the operation  
5           of law, provides home and community-based services  
6           available under the State Medicaid program:

7                   (A) A registered nurse, licensed practical  
8                   nurse, nurse practitioner, or clinical nurse spe-  
9                   cialist who provides licensed nursing services, or  
10                  a licensed nursing assistant who provides such  
11                  services under the supervision of a registered  
12                  nurse, licensed practical nurse, nurse practi-  
13                  tioner, or clinical nurse specialist.

14                  (B) A direct support professional.

15                  (C) A personal care attendant.

16                  (D) A home health aide.

17                  (E) Any other paid health care profes-  
18                  sional or worker determined to be appropriate  
19                  by the State and approved by the Secretary.

20           (3) HCBS PROGRAM IMPROVEMENT STATE.—  
21           The term “HCBS program improvement State”  
22           means a State that is awarded a planning grant  
23           under section 1011(a) and has an HCBS improve-  
24           ment plan approved by the Secretary under section  
25           1011(d).

1           (4) HEALTH PLAN.—The term “health plan”  
2 means any of the following entities that provide or  
3 arrange for home and community-based services for  
4 Medicaid eligible individuals who are enrolled with  
5 the entities under a contract with a State:

6           (A) A medicaid managed care organiza-  
7 tion, as defined in section 1903(m)(1)(A) of the  
8 Social Security Act (42 U.S.C.  
9 1396b(m)(1)(A)).

10          (B) A prepaid inpatient health plan or pre-  
11 paid ambulatory health plan, as defined in sec-  
12 tion 438.2 of title 42, Code of Federal Regula-  
13 tions (or any successor regulation)).

14          (C) Any other entity determined to be ap-  
15 propriate by the State and approved by the Sec-  
16 retary.

17           (5) HOME AND COMMUNITY-BASED SERV-  
18 ICES.—The term “home and community-based serv-  
19 ices” means any of the following (whether provided  
20 on a fee-for-service, risk, or other basis):

21           (A) Home health care services authorized  
22 under paragraph (7) of section 1905(a) of the  
23 Social Security Act (42 U.S.C. 1396d(a)).

24           (B) Private duty nursing services author-  
25 ized under paragraph (8) of such section, when

1 such services are provided in a Medicaid eligible  
2 individual's home.

3 (C) Personal care services authorized  
4 under paragraph (24) of such section.

5 (D) PACE services authorized under para-  
6 graph (26) of such section.

7 (E) Home and community-based services  
8 authorized under subsections (b), (c), (i), (j),  
9 and (k) of section 1915 of such Act (42 U.S.C.  
10 1396n), such services authorized under a waiver  
11 under section 1115 of such Act (42 U.S.C.  
12 1315), and such services provided through cov-  
13 erage authorized under section 1937 of such  
14 Act (42 U.S.C. 1396u-7).

15 (F) Case management services authorized  
16 under section 1905(a)(19) of the Social Secu-  
17 rity Act (42 U.S.C. 1396d(a)(19)) and section  
18 1915(g) of such Act (42 U.S.C. 1396n(g)).

19 (G) Rehabilitative services, including those  
20 related to behavioral health, described in section  
21 1905(a)(13) of such Act (42 U.S.C.  
22 1396d(a)(13)).

23 (H) Self-directed personal assistance serv-  
24 ices authorized under section 1915(j) of the So-  
25 cial Security Act (42 U.S.C. 1396n(j)).

1 (I) School-based services when the school  
2 is the location for provision of services if the  
3 services are—

4 (i) authorized under section 1905(a)  
5 of such Act (42 U.S.C. 1396d(a)) (or  
6 under a waiver under section 1915(c) or  
7 demonstration under section 1115) ; and

8 (ii) described in another subparagraph  
9 of this paragraph.

10 (J) Such other services specified by the  
11 Secretary.

12 (6) INSTITUTIONAL SETTING.—The term “insti-  
13 tutional setting” means—

14 (A) a skilled nursing facility (as defined in  
15 section 1819(a) of the Social Security Act (42  
16 U.S.C. 1395i–3(a)));

17 (B) a nursing facility (as defined in section  
18 1919(a) of such Act (42 U.S.C. 1396r(a)));

19 (C) a long-term care hospital (as described  
20 in section 1886(d)(1)(B)(iv) of such Act (42  
21 U.S.C. 1395ww(d)(1)(B)(iv)));

22 (D) a facility (or distinct part thereof) de-  
23 scribed in section 1905(d) of such Act (42  
24 U.S.C. 1396d(d));

1 (E) an institution (or distinct part thereof)  
2 which is a psychiatric hospital (as defined in  
3 section 1861(f) of such Act (42 U.S.C.  
4 1395x(f))) or that provides inpatient psychiatric  
5 services in a residential setting specified by the  
6 Secretary;

7 (F) an institution (or distinct part thereof)  
8 described in section 1905(i) of such Act (42  
9 U.S.C. 1396d(i)); and

10 (G) any other relevant facility, as deter-  
11 mined by the Secretary.

12 (7) MEDICAID ELIGIBLE INDIVIDUAL.—The  
13 term “Medicaid eligible individual” means an indi-  
14 vidual who is eligible for and receiving medical as-  
15 sistance under a State Medicaid plan or a waiver  
16 such plan. Such term includes an individual who  
17 would become eligible for medical assistance and en-  
18 rolled under a State Medicaid plan, or waiver of  
19 such plan, upon removal from a waiting list.

20 (8) STATE MEDICAID PROGRAM.—The term  
21 “State Medicaid program” means, with respect to a  
22 State, the State program under title XIX of the So-  
23 cial Security Act (42 U.S.C. 1396 et seq.) (including  
24 any waiver or demonstration under such title or

1 under section 1115 of such Act (42 U.S.C. 1315) re-  
2 lating to such title).

3 (9) SECRETARY.—The term “Secretary” means  
4 the Secretary of Health and Human Services.

5 (10) STATE.—The term “State” means each of  
6 the 50 States, the District of Columbia, Puerto Rico,  
7 the Virgin Islands, Guam, the Northern Mariana Is-  
8 lands, and American Samoa.

9 **SEC. 30712. HCBS IMPROVEMENT PLANNING GRANTS.**

10 (a) FUNDING.—

11 (1) IN GENERAL.—Out of any funds in the  
12 Treasury not otherwise appropriated, there is appro-  
13 priated to the Secretary for purposes of carrying out  
14 this section, \$130,000,000 for fiscal year 2022, to  
15 remain available until expended.

16 (2) TECHNICAL ASSISTANCE AND GUIDANCE.—  
17 The Secretary shall reserve \$5,000,000 of the  
18 amount appropriated under paragraph (1) for pur-  
19 poses of issuing guidance and providing technical as-  
20 sistance to States intending to apply for, or award-  
21 ed, a planning grant under this section, and for  
22 other administrative expenses related to awarding  
23 planning grants under this section.

24 (b) AWARD AND USE OF GRANTS.—

1           (1) DEADLINE FOR AWARD OF GRANTS.—From  
2 the amount appropriated under subsection (a)(1),  
3 the Secretary, not later than 12 months after the  
4 date of enactment of this Act, shall solicit State re-  
5 quests for HCBS improvement planning grants and  
6 award such grants to all States that meet such re-  
7 quirements as determined by the Secretary.

8           (2) CRITERIA FOR DETERMINING AMOUNT OF  
9 GRANTS.—The Secretary shall take into account the  
10 improvements a State would propose to make, con-  
11 sistent with the areas of focus of the HCBS im-  
12 provement plan requirements described under sub-  
13 section (c) in determining the amount of the plan-  
14 ning grant to be awarded to each State that requests  
15 such a grant.

16           (3) USE OF FUNDS.—A State awarded a plan-  
17 ning grant under this section shall use the grant to  
18 carry out planning activities for purposes of devel-  
19 oping and submitting to the Secretary an HCBS im-  
20 provement plan for the State that meets the require-  
21 ments of subsections (c) and (d) in order to expand  
22 access to home and community-based services and  
23 strengthen the direct care workforce that provides  
24 such services. A State may use planning grant funds  
25 to support activities related to the implementation of

1 the HCBS improvement plan for the State, collect  
2 and report information described in subsection (c),  
3 identify areas for improvement to the service deliv-  
4 ery systems for home and community-based services,  
5 carry out activities related to evaluating payment  
6 rates for home and community-based services and  
7 identifying improvements to update the rate setting  
8 process, and for such other purposes as the Sec-  
9 retary shall specify, including the following:

10 (A) Caregiver supports.

11 (B) Addressing social determinants of  
12 health (other than housing or homelessness).

13 (C) Promoting equity and addressing  
14 health disparities.

15 (D) Promoting community integration and  
16 compliance with the home and community-based  
17 settings rule published on January 16, 2014.

18 (E) Building partnerships.

19 (F) Infrastructure investments (such as  
20 case management or other information tech-  
21 nology systems).

22 (c) HCBS IMPROVEMENT PLAN REQUIREMENTS.—

23 In order to meet the requirements of this subsection, an  
24 HCBS improvement plan developed using funds awarded



1 to a State under this section shall include, with respect  
2 to the State and subject to subsection (d), the following:

3 (1) EXISTING MEDICAID HCBS LANDSCAPE.—

4 (A) ELIGIBILITY AND BENEFITS.—A de-  
5 scription of the existing standards, pathways,  
6 and methodologies for eligibility (which shall be  
7 delineated by the State based on eligibility  
8 group under the State plan or waiver of such  
9 plan) for home and community-based services,  
10 including limits on assets and income, the home  
11 and community-based services available under  
12 the State Medicaid program and the types of  
13 settings in which they may be provided, and  
14 utilization management standards for such  
15 services.

16 (B) ACCESS.—

17 (i) BARRIERS.—A description of the  
18 barriers to accessing home and community-  
19 based services in the State identified by  
20 Medicaid eligible individuals, the families  
21 of such individuals, and providers of such  
22 services, such as barriers for individuals  
23 who wish to leave institutional settings, in-  
24 dividuals experiencing homelessness or  
25 housing instability, and individuals in geo-

1 graphical areas of the State with low or no  
2 access to such services.

3 (ii) AVAILABILITY; UNMET NEED.—A  
4 summary, in accordance with guidance  
5 issued by the Secretary, of the extent to  
6 which home and community-based services  
7 are available to all individuals in the State  
8 who would be eligible for such services  
9 under the State Medicaid program (includ-  
10 ing individuals who are on a waitlist for  
11 such services).

12 (C) UTILIZATION.—An assessment of the  
13 utilization of home and community-based serv-  
14 ices in the State during such time period as the  
15 Secretary may specify.

16 (D) SERVICE DELIVERY STRUCTURES AND  
17 SUPPORTS.—A description of the service deliv-  
18 ery structures for providing home and commu-  
19 nity-based services in the State, including  
20 whether models of self-direction are used and to  
21 which Medicaid eligible individuals such models  
22 are available, the share of total services are ad-  
23 ministered by agencies, the use of managed care  
24 and fee-for-service to provide such services, and  
25 the supports provided for family caregivers.

1           (E) WORKFORCE.—A description of the di-  
2           rect care workforce that provides home and  
3           community-based services, including estimates  
4           (and a description of the methodology used to  
5           develop such estimates) of the number of full-  
6           and part-time direct care workers, the average  
7           and range of direct care worker wages, the ben-  
8           efits provided to direct care workers, the turn-  
9           over and vacancy rates of direct care worker po-  
10          sitions, the membership of direct care workers  
11          in labor organizations and, to the extent it the  
12          State has access to such data, demographic in-  
13          formation about such workforce, including in-  
14          formation on race, ethnicity, and gender.

15           (F) PAYMENT RATES.—

16           (i) IN GENERAL.—A description of the  
17           payment rates for home and community-  
18           based services, including, to the extent ap-  
19           plicable, how payments for such services  
20           are factored into the development of man-  
21           aged care capitation rates, and when the  
22           State last updated payment rates for home  
23           and community-based services, and the ex-  
24           tent to which payment rates are passed  
25           through to direct care worker wages.

1                   (ii) ASSESSMENT.—An assessment of  
2                   how current payment rates for such serv-  
3                   ices impact provider capacity and access to  
4                   care.

5                   (G) QUALITY.—A description of how the  
6                   quality of home and community-based services  
7                   is measured and monitored.

8                   (H) LONG-TERM SERVICES AND SUPPORTS  
9                   PROVIDED IN INSTITUTIONAL SETTINGS.—A de-  
10                  scription of the number of individuals enrolled  
11                  in the State Medicaid program who receive  
12                  items and services for greater than 30 days in  
13                  an institutional setting that is a nursing facil-  
14                  ity, intermediate care facility, or assistaed living  
15                  facility and the demographic information of  
16                  such individuals who are provided such items  
17                  and services in such settings.

18                  (I) HCBS SHARE OF OVERALL MEDICAID  
19                  LTSS SPENDING.—For the most recent State  
20                  fiscal year for which complete data is available,  
21                  the percentage of expenditures made by the  
22                  State under the State Medicaid program for  
23                  long-term services and supports that are for  
24                  home and community-based services.

1           (J) DEMOGRAPHIC DATA.—To the extent  
2 available and as applicable with respect to the  
3 information required under subparagraphs  
4 (B),(C), and (H), demographic data for such  
5 information, disaggregated by age groups, pri-  
6 mary disability, income brackets, gender, race,  
7 ethnicity, geography, primary language, and  
8 type of service setting.

9           (2) GOALS FOR HCBS IMPROVEMENTS.—A de-  
10 scription of how the State will do the following:

11           (A) Conduct the activities required under  
12 subsection (jj) of section 1905 of the Social Se-  
13 curity Act(as added under section 30713).

14           (B) Reduce barriers and disparities in ac-  
15 cess or utilization of home and community-  
16 based services in the State.

17           (C) Monitor and report (with supporting  
18 data to the extent available and applicable  
19 disaggregated by age groups, primary disability,  
20 income brackets, gender, race, ethnicity, geog-  
21 raphy, primary language, and type of service  
22 setting, on—

23           (i) access to home and community-  
24 based services under the State Medicaid  
25 program, disparities in access to such serv-

1                   ices, and the utilization of such services;  
2                   and

3                   (ii) the amount of State Medicaid ex-  
4                   penditures for home and community-based  
5                   services under the State Medicaid program  
6                   as a proportion of the total amount of  
7                   State expenditures under the State Med-  
8                   icaid program for long-term services and  
9                   supports.

10                  (D) Monitor and report on wages, benefits,  
11                  and vacancy and turnover rates for direct care  
12                  workers.

13                  (E) Assess and monitor the sufficiency of  
14                  payments under the State Medicaid program  
15                  for the specific types of home and community-  
16                  based services available under such program for  
17                  purposes of supporting direct care worker re-  
18                  cruitment and retention and ensuring the avail-  
19                  ability of home and community-based services.

20                  (F) Coordinate implementation of the  
21                  HCBS improvement plan among the State  
22                  Medicaid agency, agencies serving individuals  
23                  with disabilities, agencies serving the elderly,  
24                  and other relevant State and local agencies and  
25                  organizations that provide related supports,

1           such as those for housing, transportation, em-  
2           ployment, and other services and supports.

3           (d) DEVELOPMENT AND APPROVAL REQUIRE-  
4 MENTS.—

5           (1) DEVELOPMENT REQUIREMENTS.—In order  
6           to meet the requirements of this subsection, a State  
7           awarded a planning grant under this section shall  
8           develop an HCBS improvement plan for the State  
9           with input from stakeholders through a public notice  
10          and comment process that includes consultation with  
11          Medicaid eligible individuals who are recipients of  
12          home and community-based services, family care-  
13          givers of such recipients, providers, health plans, di-  
14          rect care workers, chosen representatives of direct  
15          care workers, and aging, disability, and workforce  
16          advocates.

17          (2) AUTHORITY TO ADJUST CERTAIN PLAN  
18          CONTENT REQUIREMENTS.—The Secretary may  
19          modify the requirements for any of the information  
20          specified in subsection (c)(1) if a State requests a  
21          modification and demonstrates to the satisfaction of  
22          the Secretary that it is impracticable for the State  
23          to collect and submit the information.

24          (3) SUBMISSION AND APPROVAL.—Not later  
25          than 24 months after the date on which a State is

1 awarded a planning grant under this section, the  
2 State shall submit an HCBS improvement plan for  
3 approval by the Secretary, along with assurances by  
4 the State that the State will implement the plan in  
5 accordance with the requirements of the HCBS Im-  
6 provement Program established under subsection (jj)  
7 of section 1905 of the Social Security Act (42  
8 U.S.C. 1396d) (as added by section 30713). The  
9 Secretary shall approve and make publicly available  
10 the HCBS improvement plan for a State after the  
11 plan and such assurances are submitted to the Sec-  
12 retary for approval and the Secretary determines the  
13 plan meets the requirements of subsection (c). A  
14 State may amend its HCBS improvement plan, sub-  
15 ject to the approval of the Secretary that the plan  
16 as so amended meets the requirements of subsection  
17 (c). The Secretary may withhold or recoup funds  
18 provided under this section to a State or pursuant  
19 to section 1905(jj) of the Social Security Act, as  
20 added by section 30713, if the State fails to imple-  
21 ment the HCBS improvement plan of the State or  
22 meet applicable deadlines under this section.



1 **SEC. 30713. HCBS IMPROVEMENT PROGRAM.**

2 (a) INCREASED FMAP FOR HCBS PROGRAM IM-  
3 PROVEMENT STATES.—Section 1905 of the Social Secu-  
4 rity Act (42 U.S.C. 1396d) is amended—

5 (1) in subsection (b), by striking “and (ii)” and  
6 inserting “(ii), and (jj)”; and

7 (2) by adding at the end the following new sub-  
8 section:

9 “(jj) ADDITIONAL SUPPORT FOR HCBS PROGRAM  
10 IMPROVEMENT STATES.—

11 “(1) IN GENERAL.—

12 “(A) ADDITIONAL SUPPORT.—Subject to  
13 paragraph (5), in the case of a State that is an  
14 HCBS program improvement State, for each  
15 fiscal quarter that begins on or after the first  
16 date on which the State is an HCBS program  
17 improvement State—

18 “(i) and for which the State meets the  
19 requirements described in paragraphs (2)  
20 and (4), notwithstanding subsection (b) or  
21 (ff), subject to subparagraph (B), with re-  
22 spect to amounts expended during the  
23 quarter by such State for medical assist-  
24 ance for home and community-based serv-  
25 ices, the Federal medical assistance per-  
26 centage for such State and quarter (as de-

1           terminated for the State under subsection  
2           (b) and, if applicable, increased under sub-  
3           section (y), (z), (aa), or (ii), or section  
4           6008(a) of the Families First Coronavirus  
5           Response Act (but not taking into account  
6           any increase under section 1915(k)(2) if  
7           for such quarter an increase is made under  
8           section 1915(k)(2))) shall be increased by  
9           7 percentage points; and

10           “(ii) with respect to the State meeting  
11           the requirements described in paragraphs  
12           (2) and (4), notwithstanding section  
13           1903(a)(7), 1903(a)(3)(F), and 1903(t),  
14           with respect to amounts expended during  
15           the quarter and before October 1, 2031,  
16           for administrative costs for expanding and  
17           enhancing home and community-based  
18           services, including for enhancing Medicaid  
19           data and technology infrastructure, modi-  
20           fying rate setting processes, adopting or  
21           improving training programs for direct  
22           care workers and family caregivers, and  
23           adopting, carrying out, or enhancing pro-  
24           grams that register direct care workers or  
25           connect beneficiaries to direct care work-

1           ers, the per centum specified in such sec-  
2           tion shall be increased to 80 percent.

3           In no case may the application of clause (i) re-  
4           sult in the Federal medical assistance percent-  
5           age determined for a State being more than 95  
6           percent with respect to such expenditures. In no  
7           case shall the application of clause (ii) result in  
8           a reduction to the per centum otherwise speci-  
9           fied without application of such clause. Any in-  
10          crease pursuant to clause (ii) may be available  
11          to a State before the State meets the require-  
12          ments of paragraphs (2) and (4).

13           “(B) ADDITIONAL HCBS IMPROVEMENT  
14          EFFORTS.—Subject to paragraph (5), in addi-  
15          tion to the increase to the Federal medical as-  
16          sistance percentage under subparagraph (A)(i)  
17          for amounts expended during a quarter for  
18          medical assistance for home and community-  
19          based services by an HCBS program improve-  
20          ment State that meets the requirements of  
21          paragraphs (2) and (4) for the quarter, the  
22          Federal medical assistance percentage for  
23          amounts expended by the State during the  
24          quarter for medical assistance for home and  
25          community-based services shall be further in-

1           creased by 2 percentage points (but not to ex-  
2           ceed 95 percent) during the first 8 fiscal quar-  
3           ters throughout which the State has imple-  
4           mented and has in effect a program to support  
5           self-directed care that meets the requirements  
6           of paragraph (3).

7           “(C) NONAPPLICATION OF TERRITORIAL  
8           FUNDING CAPS.—Any payment made to Puerto  
9           Rico, the Virgin Islands, Guam, the Northern  
10          Mariana Islands, or American Samoa for ex-  
11          penditures that are subject to an increase in the  
12          Federal medical assistance percentage under  
13          subparagraph (A)(i) or (B), or an increase in  
14          an applicable Federal matching percentage  
15          under subparagraph (A)(ii), shall not be taken  
16          into account for purposes of applying payment  
17          limits under subsections (f) and (g) of section  
18          1108.

19          “(D) NONAPPLICATION TO CHIP EFMAP.—  
20          Any increase described in subparagraph (A) (or  
21          payment made for expenditures on medical as-  
22          sistance that are subject to such increase) shall  
23          not be taken into account in calculating the en-  
24          hanced FMAP of a State under section 2105.

1           “(2) REQUIREMENTS.—The requirements de-  
2           scribed in this paragraph, with respect to a State  
3           and a fiscal quarter, are the following:

4                   “(A) NONSUPPLANTATION.—The State  
5           uses the Federal funds attributable to the in-  
6           crease in the Federal medical assistance per-  
7           centage for amounts expended during a quarter  
8           for medical assistance for home and commu-  
9           nity-based services under subparagraphs (A)  
10          and, if applicable, (B) of paragraph (1) to sup-  
11          plement, and not supplant, the level of State  
12          funds expended for home and community-based  
13          services for eligible individuals through pro-  
14          grams in effect as of the date the State is  
15          awarded a planning grant under section 30712  
16          of the Act titled ‘An Act to provide for rec-  
17          onciliation pursuant to title II of S. Con. Res.  
18          14’.

19                   “(B) MAINTENANCE OF EFFORT.—

20                           “(i) IN GENERAL.—The State does  
21           not—

22                                   “(I) reduce the amount, dura-  
23                                   tion, or scope of home and commu-  
24                                   nity-based services available under the  
25                                   State plan or waiver (relative to the

1 home and community-based services  
2 available under the plan or waiver as  
3 of the date on which the State was  
4 awarded a planning grant under sec-  
5 tion 30712 of the Act titled ‘An Act  
6 to provide for reconciliation pursuant  
7 to title II of S. Con. Res. 14’;

8 “(II) reduce payment rates for  
9 home and community-based services  
10 lower than such rates that were in  
11 place on January 1, 2021, including,  
12 to the extent applicable, payment  
13 rates for such services that are in-  
14 cluded in managed care capitation  
15 rates; or

16 “(III) except to the extent per-  
17 mitted under clause (ii), adopt more  
18 restrictive standards, methodologies,  
19 or procedures for determining eligi-  
20 bility, benefits, or services for receipt  
21 of home and community-based serv-  
22 ices, including with respect to cost-  
23 sharing, than the standards, meth-  
24 odologies, or procedures applicable as  
25 of such date.

1                   “(ii) FLEXIBILITY TO SUPPORT INNO-  
2                   VATIVE MODELS.—A State may make  
3                   modifications that would otherwise violate  
4                   the maintenance of effort described in  
5                   clause (i) if the State demonstrates to the  
6                   satisfaction of the Secretary that such  
7                   modifications shall not result in—

8                   “(I) home and community-based  
9                   services that are less comprehensive  
10                  or lower in amount, duration, or  
11                  scope;

12                  “(II) fewer individuals (overall  
13                  and within particular eligibility groups  
14                  and categories) receiving home and  
15                  community-based services; or

16                  “(III) increased cost-sharing for  
17                  home and community-based services.

18                  “(C) ACCESS TO SERVICES.—Not later  
19                  than an implementation date as specified by the  
20                  Secretary after the first day of the first fiscal  
21                  quarter for which a State receives an increase  
22                  to the Federal medical assistance percentage or  
23                  other applicable Federal matching percentage  
24                  under paragraph (1), the State does all of the  
25                  following to improve access to services:

1           “(i) Reduce access barriers and dis-  
2           parities in access or utilization of home  
3           and community-based services, as de-  
4           scribed in the State HCBS improvement  
5           plan.

6           “(ii) Provides coverage of personal  
7           care services authorized under subsection  
8           (a)(24) for all individuals eligible for med-  
9           ical assistance in the State.

10          “(iii) Provides for navigation of home  
11          and community-based services through ‘no  
12          wrong door’ programs, provides expedited  
13          eligibility for home and community-based  
14          services, and improves home and commu-  
15          nity-based services counseling and edu-  
16          cation programs.

17          “(iv) Expands access to behavioral  
18          health services.

19          “(v) Improves coordination of home  
20          and community-based services with em-  
21          ployment, housing, and transportation sup-  
22          ports.

23          “(vi) Provides supports to family care-  
24          givers, such as respite care, caregiver as-



1            assessments, peer supports, or paid family  
2            caregiving.

3            “(vii) Adopts, expands eligibility for,  
4            or expands covered items and services pro-  
5            vided under 1 or more eligibility categories  
6            authorized under subclause (XIII), (XV),  
7            or (XVI) of section 1902(a)(10)(A)(ii).

8            “(D) STRENGTHENED AND EXPANDED  
9            WORKFORCE.—

10           “(i) IN GENERAL.—The State  
11           strengthens and expands the direct care  
12           workforce that provides home and commu-  
13           nity-based services by—

14           “(I) adopting processes to ensure  
15           that payments for home and commu-  
16           nity-based services are sufficient to  
17           ensure that care and services are  
18           available to the extent described in the  
19           State HCBS improvement plan; and

20           “(II) updating qualification  
21           standards (as appropriate), and devel-  
22           oping and adopting training opportu-  
23           nities, for the continuum of providers  
24           of home and community-based serv-  
25           ices, including programs for inde-

1                   pendent providers of such services and  
2                   agency direct care workers, as well as  
3                   unique programs and resources for  
4                   family caregivers.

5                   “(ii) PAYMENT RATES.—In carrying  
6                   out clause (i)(I), the State shall—

7                                 “(I) update and increase, as ap-  
8                                 propriate, payment rates for delivery  
9                                 of home and community-based serv-  
10                                ices to support the recruitment and  
11                                retention of the direct care workforce;

12                               “(II) review and, if necessary to  
13                                ensure sufficient access to care, in-  
14                                crease payment rates for home and  
15                                community-based services at least  
16                                every 3 years through a transparent  
17                                process involving meaningful input  
18                                from stakeholders, including recipients  
19                                of home and community-based serv-  
20                                ices, family caregivers of such recipi-  
21                                ents, providers, health plans, direct  
22                                care workers, chosen representatives  
23                                of direct care workers, and aging, dis-  
24                                ability, and workforce advocates; and

1                   “(III) ensure that increases in  
2                   the payment rates for home and com-  
3                   munity-based services are—

4                                 “(aa) at a minimum, results  
5                                 in a proportionate increase to  
6                                 payments for direct care workers  
7                                 and in a manner that is deter-  
8                                 mined with input from the stake-  
9                                 holders described in subclause  
10                                (II); and

11                               “(bb) incorporated into pro-  
12                               vider payment rates for home  
13                               and community-based services  
14                               provided under this title by a  
15                               managed care entity (as defined  
16                               in section 1932(a)(1)(B)) a pre-  
17                               paid inpatient health plan or pre-  
18                               paid ambulatory health plan, as  
19                               defined in section 438.2 of title  
20                               42, Code of Federal Regulations  
21                               (or any successor regulation)),  
22                               under a contract and paid  
23                               through capitation rates with the  
24                               State.

1           “(3) SELF-DIRECTED MODELS FOR THE DELIV-  
2           ERY OF SERVICES.—For purposes of paragraph  
3           (1)(B), the requirements of this paragraph, with re-  
4           spect to a State and a fiscal quarter, are that the  
5           State establishes directly or by contract with 1 or  
6           more non-profit entities, including an agency with  
7           choice or a similar service delivery model, a program  
8           for the performance of all of the following functions:

9                   “(A) Registering qualified direct care  
10                  workers and assisting beneficiaries in finding  
11                  direct care workers.

12                  “(B) Undertaking activities to recruit and  
13                  train independent providers to enable bene-  
14                  ficiaries to direct their own care, including by  
15                  providing or coordinating training for bene-  
16                  ficiaries on self-directed care.

17                  “(C) Ensuring the safety of, and sup-  
18                  porting the quality of, care provided to bene-  
19                  ficiaries, such as by conducting background  
20                  checks and addressing complaints reported by  
21                  recipients of home and community-based serv-  
22                  ices consistent with Fair Hearing requirements  
23                  and prior notice of service reductions, including  
24                  under subpart F of part 438 of title 42, Code

1 of Federal Regulations and section 438.71(d) of  
2 such title.

3 “(D) Facilitating coordination between  
4 State and local agencies and direct care workers  
5 for matters of public health, training opportuni-  
6 ties, changes in program requirements, work-  
7 place health and safety, or related matters.

8 “(E) Supporting beneficiary hiring, if se-  
9 lected by the beneficiary, of independent pro-  
10 viders of home and community-based services,  
11 including by processing applicable tax informa-  
12 tion, collecting and processing timesheets, sub-  
13 mitting claims and processing payments to such  
14 providers.

15 “(F) To the extent a State permits bene-  
16 ficiaries to hire a family member or individual  
17 with whom they have an existing relationship to  
18 provide home and community-based services,  
19 and notwithstanding subsection (a)(24), pro-  
20 viding support to beneficiaries who wish to hire  
21 a caregiver who is a family member or indi-  
22 vidual with whom they have an existing rela-  
23 tionship, such as by facilitating enrollment of  
24 such family member or individual as a provider

1 of home and community-based services under  
2 the State plan or a waiver of such plan.

3 “(G) Ensuring that programs and proce-  
4 dures do not discriminate against labor organi-  
5 zations or workers who may join or decline to  
6 join a labor organization.

7 “(4) REPORTING AND OVERSIGHT.—The re-  
8 quirements described in this paragraph, with respect  
9 to a State and a fiscal quarter, are the following:

10 “(A) The State designates (by a date spec-  
11 ified by the Secretary) an HCBS ombudsman  
12 office that—

13 “(i) operates independently from the  
14 State Medicaid agency and managed care  
15 entities;

16 “(ii) provides direct assistance to re-  
17 cipients of home and community-based  
18 services available under the State Medicaid  
19 program and their families; and

20 “(iii) identifies and reports systemic  
21 problems to State officials, the public, and  
22 the Secretary.

23 “(B) Beginning with the 5th fiscal quarter  
24 for which the State is an HCBS program im-  
25 provement State, and annually thereafter, the

1 State reports to the Secretary on the state (as  
2 of the last quarter before the report) of the  
3 components of the home and community-based  
4 services landscape described in the State HCBS  
5 improvement plan, including with respect to—

6 “(i) the availability and utilization of  
7 home and community-based services,  
8 disaggregated (to the extent available and  
9 as applicable) by age groups, primary dis-  
10 ability, income brackets, gender, race, eth-  
11 nicity, geography, primary language, and  
12 type of service setting;

13 “(ii) wages, benefits, turnover and va-  
14 cancy rates for the direct care workforce;

15 “(iii) changes in payment rates for  
16 home and community-based services;

17 “(iv) implementation of the activities  
18 to strengthen and expand access to home  
19 and community-based services and the di-  
20 rect care workforce that provides such  
21 services in accordance with the require-  
22 ments of subparagraphs (C) and (D) of  
23 paragraph (2);

24 “(v) if applicable, implementation of  
25 the activities described in paragraph (3);

1                   “(vi) State expenditures for home and  
2                   community-based services under the State  
3                   plan or a waiver of such plan as a propor-  
4                   tion of the total amount of State expendi-  
5                   tures under the plan or waiver of such plan  
6                   for long-term services and supports; and

7                   “(vii) the challenges in, and best prac-  
8                   tices for, expanding access to home and  
9                   community-based services, reducing dis-  
10                  parities, and supporting and expanding the  
11                  direct care workforce.

12                  “(5) BENCHMARKS FOR DEMONSTRATING IM-  
13                  PROVEMENTS.—An HCBS program improvement  
14                  State shall cease to be eligible for an increase in the  
15                  Federal medical assistance percentage under para-  
16                  graph (1)(A)(i) or (1)(B) or an increase in an appli-  
17                  cable Federal matching percentage under paragraph  
18                  (1)(A)(ii) at any time or beginning with the 29th fis-  
19                  cal quarter that begins on or after the first date on  
20                  which a State is an HCBS program improvement  
21                  State if the State is found to be out of compliance  
22                  with paragraph (2)(B) or any other requirement of  
23                  this subsection and, beginning with such 29th fiscal  
24                  quarter, unless, not later than 90 days before the  
25                  first day of such fiscal quarter, the State submits to



1 the Secretary a report demonstrating the following  
2 improvements:

3 “(A) Increased availability (above a mar-  
4 ginal increase) of home and community-based  
5 services in the State relative to such availability  
6 as reported in the State HCBS improvement  
7 plan and adjusted for demographic changes in  
8 the State since the submission of such plan.

9 “(B) Reduced disparities in the utilization  
10 and availability of home and community-based  
11 services relative to the availability and utiliza-  
12 tion of such services by such populations as re-  
13 ported in such plan according to age groups,  
14 primary disability, income brackets, gender,  
15 race, ethnicity, geography, primary language,  
16 and type of service setting, and adjusted for de-  
17 mographic changes in the State since the sub-  
18 mission of such plan.

19 “(C) Evidence that rates are sufficient to  
20 ensure access to items and services for individ-  
21 uals eligible for HCBS in such State.

22 “(D) With respect to the percentage of ex-  
23 penditures made by the State for long-term  
24 services and supports that are for home and  
25 community-based services, in the case of an

1 HCBS program improvement State for which  
2 such percentage (as reported in the State  
3 HCBS improvement plan) was—

4 “(i) less than 50 percent, the State  
5 demonstrates that the percentage of such  
6 expenditures has increased to at least 50  
7 percent since the plan was approved; and

8 “(ii) at least 50 percent, the State  
9 demonstrates that such percentage has not  
10 decreased since the plan was approved.

11 “(6) DEFINITIONS.—In this subsection, the  
12 terms ‘State Medicaid plan’, ‘direct care worker’,  
13 ‘HCBS program improvement State’, and ‘home and  
14 community-based services’ have the meaning given  
15 those terms in section 30711 of the Act titled ‘An  
16 Act to provide for reconciliation pursuant to title II  
17 of S. Con. Res. 14’.”.

18 **SEC. 30714. FUNDING FOR TECHNICAL ASSISTANCE AND**  
19 **OTHER ADMINISTRATIVE REQUIREMENTS**  
20 **RELATED TO MEDICAID HCBS.**

21 (a) IN GENERAL.—Out of any funds in the Treasury  
22 not otherwise appropriated, there is appropriated to the  
23 Secretary \$35,000,000 for fiscal year 2022, to remain  
24 available until expended, which the Secretary shall use to  
25 carry out the following activities:

1           (1) To prepare and submit to the appropriate  
2 committees of Congress—

3           (A) not later than 4 years after the date  
4 of enactment of this Act, a report that in-  
5 cludes—

6           (i) a description of the HCBS im-  
7 provement plans approved by the Secretary  
8 under section 30712(d);

9           (ii) a description (which may be a  
10 narrative report with examples or other-  
11 wise) of the landscape, at both the national  
12 and State levels, with respect to gaps in  
13 coverage of home and community-based  
14 services, disparities in access to, and utili-  
15 zation of, such services, and barriers to ac-  
16 cessing such services; and

17           (iii) a description of the national land-  
18 scape with respect to the direct care work-  
19 force that provides home and community-  
20 based services, including with respect to  
21 wages, benefits, and challenges to the  
22 availability of such workers; and

23           (B) not later than 7 years after the date  
24 of enactment of this Act, and every 3 years  
25 thereafter, a report that includes—

1 (i) the number of HCBS program im-  
2 provement States;

3 (ii) a summary of the progress being  
4 made by such States with respect to  
5 strengthening and expanding access to  
6 home and community-based services and  
7 the direct care workforce that provides  
8 such services and meeting the benchmarks  
9 for demonstrating improvements required  
10 under section 1905(jj)(5) of the Social Se-  
11 curity Act (as added by section 30713);

12 (iii) a summary of States' perform-  
13 ance measures as a part of the home and  
14 community-based services core quality  
15 measures and beneficiary and family care-  
16 giver surveys; and

17 (iv) a summary of the challenges and  
18 best practices reported by States in ex-  
19 panding access to home and community-  
20 based services and supporting and expand-  
21 ing the direct care workforce that provides  
22 such services.

23 (2) To provide HCBS program improvement  
24 States with technical assistance related to carrying  
25 out the HCBS improvement plans approved by the

1 Secretary under section 30712(d) and meeting the  
2 requirements and benchmarks for demonstrating im-  
3 provements required under section 1905(jj) of the  
4 Social Security Act (as added by section 30713),  
5 and to issue such guidance or regulations as nec-  
6 essary to carry out this subtitle and the amendments  
7 made by this subtitle, including guidance specifying  
8 how States shall assess and track access to home  
9 and community-based services over time.

10 **SEC. 30715. FUNDING FOR HCBS QUALITY MEASUREMENT**  
11 **AND IMPROVEMENT.**

12 (a) IN GENERAL.—Title XI of the Social Security Act  
13 (42 U.S.C. 1301 et seq.) is amended—

14 (1) in section 1139A—

15 (A) in subsection (a)(4)(B)—

16 (i) by striking “Beginning with the  
17 annual State report on fiscal year 2024”  
18 and inserting the following:

19 “(i) IN GENERAL.—Subject to clause  
20 (ii), beginning with the annual State report  
21 on fiscal year 2024”; and

22 (ii) by adding at the end the following  
23 new clause:

24 “(ii) REPORTING HCBS QUALITY  
25 MEASURES.—With respect to reporting on

1 information regarding the quality of home  
2 and community-based services provided to  
3 children under title XIX, beginning with  
4 the annual State report for the first fiscal  
5 year that begins on or after the date that  
6 is 2 years after the date that the Secretary  
7 publishes the home and community-based  
8 services quality measures developed under  
9 subsection (b)(5)(B) the Secretary shall re-  
10 quire States to report such information  
11 using the standardized format for report-  
12 ing information and procedures developed  
13 under subparagraph (A) and using ei-  
14 ther—

15 “(I) such home and community-  
16 based quality measures developed  
17 under subsection (b)(5) (including any  
18 updates or changes to such measures);  
19 or

20 “(II) an equivalent alternative set  
21 of home and community-based quality  
22 measures approved by the Secretary.”;  
23 and

24 (B) in subsection (b)(5)—

1 (i) by striking “Beginning no later  
2 than January 1, 2013” and inserting the  
3 following:

4 “(A) IN GENERAL.—Beginning no later  
5 than January 1, 2013”; and

6 (ii) by adding at the end the following  
7 new subparagraph:

8 “(B) HCBS QUALITY MEASURES.—Begin-  
9 ning with the first year that begins on the date  
10 that is 2 years after the date of enactment of  
11 this subparagraph, the core measures described  
12 in subsection (a) (and any updates or changes  
13 to such measures) shall include home and com-  
14 munity-based services quality measures devel-  
15 oped by the Secretary in the manner described  
16 in section 1139B(b)(5)(D). The Secretary may  
17 determine which measures are to be included in  
18 the core set under this section and which in the  
19 core set under section 1139B, based on the dif-  
20 ferences in health care needs for the relevant  
21 populations.”; and

22 (2) in section 1139B—

23 (A) in subsection (b)—

24 (i) in paragraph (3), by adding at the  
25 end the following new subparagraph:

1           “(C) MANDATORY REPORTING WITH RE-  
2           SPECT TO HCBS QUALITY MEASURES.—Begin-  
3           ning with the State report required under sub-  
4           section (d)(1) for the first year that begins on  
5           or after the date that is 2 years after the date  
6           that the Secretary publishes the home and com-  
7           munity-based quality measures developed under  
8           paragraph (5)(D), the Secretary shall require  
9           States to report information, using the stand-  
10          ardized format for reporting information and  
11          procedures developed under subparagraph (A),  
12          regarding the quality of home and community-  
13          based services for Medicaid eligible adults using  
14          either—

15                 “(i) the home and community-based  
16                 services quality measures included in the  
17                 core set of adult health quality measures  
18                 under subparagraph (D), and any updates  
19                 or changes to such measures; or

20                 “(ii) an equivalent alternative set of  
21                 home and community-based services qual-  
22                 ity measures approved by the Secretary.”;  
23                 and

24                 (ii) in paragraph (5), by adding at the  
25                 end the following new subparagraph:



1 “(D) HCBS QUALITY MEASURES.—

2 “(i) IN GENERAL.—Beginning with  
3 respect to State reports required under  
4 subsection (d)(1) for the first year that be-  
5 gins on or after the date that is 2 years  
6 after the date of enactment of this sub-  
7 paragraph, the core set of adult health  
8 quality measures maintained under this  
9 paragraph (and any updates or changes to  
10 such measures) shall include home and  
11 community-based services quality measures  
12 developed in accordance with this subpara-  
13 graph.

14 “(ii) REQUIREMENTS.—

15 “(I) INTERAGENCY COLLABORA-  
16 TION; STAKEHOLDER INPUT.—In de-  
17 veloping (and subsequently reviewing  
18 and updating) the home and commu-  
19 nity-based services quality measures  
20 included in the core set of adult  
21 health quality measures maintained  
22 under this paragraph, the Secretary  
23 shall—

24 “(aa) collaborate with the  
25 Administrator of the Centers for

1 Medicare & Medicaid Services,  
2 the Administrator of the Admin-  
3 istration for Community Living,  
4 the Director of the Agency for  
5 Healthcare Research and Qual-  
6 ity, and the Assistance Secretary  
7 for Mental Health and Substance  
8 Use; and

9 “(bb) ensure that such home  
10 and community-based services  
11 quality measures are informed by  
12 input from stakeholders, includ-  
13 ing recipients of home and com-  
14 munity-based services, family  
15 caregivers of such recipients, pro-  
16 viders, health plans, direct care  
17 workers, chosen representatives  
18 of direct care workers, and aging,  
19 disability, and workforce advo-  
20 cates.

21 “(II) REFLECTIVE OF FULL  
22 ARRAY OF SERVICES.—Such home and  
23 community-based services quality  
24 measures shall—

1           “(aa) reflect the full array  
2 of home and community-based  
3 services and recipients of such  
4 services, including adults and  
5 children; and

6           “(bb) include—

7           “(AA) outcomes-based  
8 measures;

9           “(BB) measures of  
10 availability of services;

11           “(CC) measures of pro-  
12 vider capacity and avail-  
13 ability;

14           “(DD) measures re-  
15 lated to person-centered  
16 care;

17           “(EE) measures spe-  
18 cific to self-directed care;

19           “(FF) measures related  
20 to transitions to and from  
21 institutional care; and

22           “(GG) beneficiary and  
23 family caregiver surveys.

24           “(III) DEMOGRAPHICS.—Such  
25 home and community-based services

1 quality measures shall allow for the  
2 collection, to the extent available, of  
3 data that is disaggregated by age  
4 groups, primary disability, income  
5 brackets, gender, race, ethnicity, geog-  
6 raphy, primary language, and type of  
7 service setting.

8 “(IV) DEFINITIONS.—For pur-  
9 poses of this section and section  
10 1139A, the terms ‘home and commu-  
11 nity-based services’, ‘*health plan*’, and  
12 ‘direct care worker’ have the mean-  
13 ings given those terms in section  
14 30711 of the Act titled ‘An Act to  
15 provide for reconciliation pursuant to  
16 title II of S. Con. Res. 14’.

17 “(iii) FUNDING.—Out of any funds in  
18 the Treasury not otherwise appropriated,  
19 there is appropriated to the Secretary for  
20 purposes of carrying out this subpara-  
21 graph, \$5,000,000 for fiscal year 2022, to  
22 remain available until expended.”; and

23 (B) in subsection (d)(1)(A), by striking “;  
24 and” and inserting “and, beginning with the re-  
25 port for the first year that begins after the date

1           that is 2 years after the Secretary publishes the  
2           home and community-based quality measures  
3           developed under subsection (b)(5)(D), home  
4           and community-based services quality measures  
5           included in the core set of adult health quality  
6           measures maintained under subsection (b)(5)  
7           and any updates or changes to such measures  
8           or an equivalent alternative set of home and  
9           community-based services quality measures ap-  
10          proved by the Secretary; and”.

11          (b) INCREASED FEDERAL MATCHING RATE FOR  
12          ADOPTION AND REPORTING.—Section 1903(a)(3) of the  
13          Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

14                 (1) in subparagraph (F)(ii), by striking “plus”  
15                 after the semicolon and inserting “and”; and

16                 (2) by inserting after subparagraph (F), the fol-  
17          lowing:

18                         “(G) 80 percent of so much of the sums  
19                         expended during such quarter as are attrib-  
20                         utable to the reporting of information regarding  
21                         the quality of home and community-based serv-  
22                         ices in accordance with sections  
23                         1139A(a)(4)(B)(ii) and 1139B(b)(3)(C); and”.

1                                   **PART 3—OTHER MEDICAID**  
2   **SEC. 30721. PERMANENT EXTENSION OF MEDICAID PRO-**  
3                                   **TECTIONS AGAINST SPOUSAL IMPOVERISH-**  
4                                   **MENT FOR RECIPIENTS OF HOME AND COM-**  
5                                   **MUNITY-BASED SERVICES.**

6           (a) IN GENERAL.—Section 1924(h)(1)(A) of the So-  
7   cial Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amend-  
8   ed by striking “(at the option of the State) is described  
9   in section 1902(a)(10)(A)(ii)(VI)” and inserting the fol-  
10   lowing: “is eligible for medical assistance for home and  
11   community-based services provided under subsection (c),  
12   (d), or (i) of section 1915 or under a waiver approved  
13   under section 1115, or who is eligible for such medical  
14   assistance by reason of being determined eligible under  
15   section 1902(a)(10)(C) or by reason of section 1902(f) or  
16   otherwise on the basis of a reduction of income based on  
17   costs incurred for medical or other remedial care, or who  
18   is eligible for medical assistance for home and community-  
19   based attendant services and supports under section  
20   1915(k)”.

21           (b) CONFORMING AMENDMENT.—Section 2404 of the  
22   Patient Protection and Affordable Care Act (42 U.S.C.  
23   1396r–5 note) is amended by striking “September 30,  
24   2023” and inserting “the date of enactment of the Act  
25   titled ‘An Act to provide for reconciliation pursuant to title  
26   II of S. Con. Res. 14’ ”.

1 **SEC. 30722. PERMANENT EXTENSION OF MONEY FOLLOWS**  
2 **THE PERSON REBALANCING DEMONSTRATION.**  
3 **TION.**

4 (a) IN GENERAL.—Subsection (h) of section 6071 of  
5 the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note)  
6 is amended—

7 (1) in paragraph (1)—

8 (A) in subparagraph (I), by inserting  
9 “and” after the semicolon;

10 (B) by amending subparagraph (J) to read  
11 as follows:

12 “(J) \$450,000,000 for each fiscal year  
13 after fiscal year 2021.”; and

14 (C) by striking subparagraph (K);

15 (2) in paragraph (2), by striking “September  
16 30, 2023” and inserting “September 30 of the sub-  
17 sequent fiscal year”; and

18 (3) by adding at the end the following new  
19 paragraph:

20 “(3) TECHNICAL ASSISTANCE.—Out of the  
21 amounts made available under paragraph (1), for  
22 the 3-year period beginning with fiscal year 2022  
23 and for each subsequent 3-year period, \$5,000,000  
24 shall be made available for carrying out subsection  
25 (f) and (i).”.

1 (b) REDISTRIBUTION OF UNEXPENDED GRANT  
2 AWARDS.—Subsection (e)(2) of section 6071 of the Deficit  
3 Reduction Act of 2005 (42 U.S.C. 1396a note) is amended  
4 by adding at the end the following new sentence: “Any  
5 portion of a State grant award for a fiscal year under this  
6 section that is unexpended by the State at the end of the  
7 fourth succeeding fiscal year shall be rescinded by the Sec-  
8 retary and added to the appropriation for the fifth suc-  
9 ceeding fiscal year.”.

10 **SEC. 30723. EXTENDING CONTINUOUS MEDICAID COV-**  
11 **ERAGE FOR PREGNANT AND POSTPARTUM**  
12 **WOMEN.**

13 (a) REQUIRING FULL BENEFITS FOR PREGNANT  
14 AND POSTPARTUM WOMEN FOR 12-MONTH PERIOD POST  
15 PREGNANCY.—

16 (1) IN GENERAL.—Paragraph (5) of section  
17 1902(e) of the Social Security Act (42 U.S.C.  
18 1396a(e)) is amended—

19 (A) by striking “(5) A woman who” and in-  
20 serting “(5)(A) For any fiscal year quarter with  
21 respect to which the amendments made by sec-  
22 tion 30723(a)(1)(B) of the Act titled ‘An Act to  
23 provide for reconciliation pursuant to title II of  
24 S. Con. Res. 14’ do not apply (beginning with  
25 the first fiscal year quarter beginning one year



1 after the date of the enactment of such Act), a  
2 woman who”; and

3 (B) by adding at the end the following new  
4 subparagraph:

5 “(B) For any fiscal year quarter (beginning  
6 with the first fiscal year quarter beginning one year  
7 after the date of the enactment of this subpara-  
8 graph), any individual who, while pregnant, is eligi-  
9 ble for and received medical assistance under the  
10 State plan or a waiver of such plan (including dur-  
11 ing a period of retroactive eligibility under sub-  
12 section (a)(34)), shall remain eligible, notwith-  
13 standing section 1916(e)(3) or any other limitation  
14 under this title, for medical assistance through the  
15 end of the month in which the 12-month period (be-  
16 ginning on the last day of pregnancy of the indi-  
17 vidual) ends, regardless of the basis for the individ-  
18 ual’s eligibility for medical assistance and such med-  
19 ical assistance shall be in accordance with clauses (i)  
20 and (ii) of paragraph (16)(B).”.

21 (2) CONFORMING AMENDMENTS.—Title XIX of  
22 the Social Security Act (42 U.S.C. 1396 et seq.) is  
23 amended—

24 (A) in section 1902(a)(10), in the matter  
25 following subparagraph (G), by striking “(VII)

1 the medical assistance” and all that follows  
2 through “, (VIII)” and inserting “(VIII)”;

3 (B) in section 1902(e)(6), by striking “In  
4 the case of” and inserting “For any fiscal year  
5 quarter with respect to which the amendments  
6 made by section 30723(a)(1)(B) of the Act ti-  
7 tled ‘An Act to provide for reconciliation pursu-  
8 ant to title II of S. Con. Res. 14’ do not apply  
9 (beginning with the first fiscal year quarter be-  
10 ginning one year after the date of the enact-  
11 ment of such Act), in the case of”;

12 (C) in section 1902(l)(1)(A), by striking  
13 “60-day period” and inserting “12-month pe-  
14 riod”;

15 (D) in section 1903(v)(4)(A)—

16 (i) in clause (i), by striking “60-day  
17 period” and inserting “12-month period  
18 (or, for any fiscal year quarter with respect  
19 to which the amendments made by section  
20 30723(a)(1)(B) of the Act titled ‘An Act  
21 to provide for reconciliation pursuant to  
22 title II of S. Con. Res. 14’ do not apply  
23 (beginning with the first fiscal year quar-  
24 ter beginning one year after the date of the

1 enactment of such Act), 60-day period)”;

2 and

3 (ii) in clause (ii), by inserting “and

4 including an individual to whom section

5 1902(e)(5)(B) applies, in accordance with

6 such section, through the end of the month

7 in which the 12-month period (beginning

8 on the last day of pregnancy of the indi-

9 vidual) ends” before the period at the end;

10 and

11 (E) in section 1905(a), in the 4th sentence

12 in the matter following paragraph (31), by

13 striking “60-day period” and inserting “12-

14 month period (or, for any fiscal year quarter

15 with respect to which the amendments made by

16 section 30723(a)(1)(B) of the Act titled ‘An

17 Act to provide for reconciliation pursuant to

18 title II of S. Con. Res. 14’ do not apply (begin-

19 ning with the first fiscal year quarter beginning

20 one year after the date of the enactment of

21 such Act), 60-day period)”.

22 (b) TRANSITION FROM STATE OPTION.—Section

23 1902(e)(16)(A) of the Social Security Act (42 U.S.C.

24 1396a(e)(16)(A)) is amended by striking “At the option

25 of the State” and inserting “For any fiscal year quarter

1 with respect to which the amendments made by section  
2 30723(a)(1)(B) of the Act titled ‘An Act to provide for  
3 reconciliation pursuant to title II of S. Con. Res. 14’ do  
4 not apply (beginning with the first fiscal year quarter be-  
5 ginning one year after the date of the enactment of such  
6 Act), at the option of the State”.

7 (c) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Subject to paragraph (2),  
9 the amendments made by this section shall take ef-  
10 fect on the 1st day of the 1st fiscal year quarter  
11 that begins one year after the date of the enactment  
12 of this Act and shall apply with respect to medical  
13 assistance provided on or after such date.

14 (2) EXCEPTION FOR STATE LEGISLATION.—In  
15 the case of a State plan under title XIX of the So-  
16 cial Security Act (42 U.S.C. 1396 et seq.) that the  
17 Secretary of Health and Human Services determines  
18 requires State legislation in order for the plan to  
19 meet any requirement imposed by amendments made  
20 by this section, the plan shall not be regarded as  
21 failing to comply with the requirements of such title  
22 solely on the basis of its failure to meet such a re-  
23 quirement before the first day of the first calendar  
24 quarter beginning after the close of the first regular  
25 session of the State legislature that begins after the

1 date of the enactment of this Act. For purposes of  
2 the previous sentence, in the case of a State that has  
3 a 2-year legislative session, each year of the session  
4 shall be considered to be a separate regular session  
5 of the State legislature.

6 **SEC. 30724. PROVIDING FOR 1 YEAR OF CONTINUOUS ELIGI-**  
7 **BILITY FOR CHILDREN UNDER THE MED-**  
8 **ICAID PROGRAM.**

9 (a) IN GENERAL.—Section 1902(e) of the Social Se-  
10 curity Act (42 U.S.C. 1396a(e)) is amended—

11 (1) in paragraph (12), by inserting “before the  
12 date of the enactment of paragraph (17)” after  
13 “subsection (a)(10)(A)”.

14 (2) by adding at the end following new para-  
15 graph:

16 “(17) 1 YEAR OF CONTINUOUS ELIGIBILITY FOR  
17 CHILDREN.—The State plan (or waiver of such  
18 State plan) shall provide that an individual who is  
19 under the age of 19 and who is determined to be eli-  
20 gible for benefits under a State plan approved under  
21 subsection (a)(10)(A) shall remain eligible for such  
22 benefits until the earlier of—

23 “(A) the end of the 12-month period begin-  
24 ning on the date of such determination;

1           “(B) the time that such individual attains  
2           the age of 19; or

3           “(C) the date that such individual ceases  
4           to be a resident of such State.”.

5           (b) EFFECTIVE DATE.—

6           (1) IN GENERAL.—Subject to paragraph (2),  
7           the amendments made by subsection (a)(2) shall  
8           apply with respect to eligibility determinations or re-  
9           determinations made on or after the date of the en-  
10          actment of this Act.

11          (2) EXCEPTION FOR STATE LEGISLATION.—In  
12          the case of a State plan under title XIX of the So-  
13          cial Security Act (42 U.S.C. 1396 et seq.) that the  
14          Secretary of Health and Human Services determines  
15          requires State legislation in order for the plan to  
16          meet any requirement imposed by amendments made  
17          under subsection (a)(2), the plan shall not be re-  
18          garded as failing to comply with the requirements of  
19          such title solely on the basis of its failure to meet  
20          such a requirement before the first day of the first  
21          calendar quarter beginning after the close of the  
22          first regular session of the State legislature that be-  
23          gins after the date of the enactment of this Act. For  
24          purposes of the previous sentence, in the case of a  
25          State that has a 2-year legislative session, each year

1 of the session shall be considered to be a separate  
2 regular session of the State legislature.

3 **SEC. 30725. ALLOWING FOR MEDICAL ASSISTANCE UNDER**  
4 **MEDICAID FOR INMATES DURING 30-DAY PE-**  
5 **RIOD PRECEDING RELEASE.**

6 The subdivision (A) following paragraph (31) of sec-  
7 tion 1905(a) of the Social Security Act (42 U.S.C.  
8 1396d(a)) is amended by inserting “and, beginning on the  
9 first day of the first fiscal year quarter that begins at least  
10 one year after the date of the enactment of the Act titled  
11 ‘An Act to provide for reconciliation pursuant to title II  
12 of S. Con. Res. 14’, except during the 30-day period pre-  
13 ceding the date of release of such individual from such  
14 public institution” after “medical institution”.

15 **SEC. 30726. EXTENSION OF CERTAIN PROVISIONS.**

16 (b) EXPRESS LANE ELIGIBILITY OPTION.—Section  
17 1902(e)(13) of the Social Security Act (42 U.S.C.  
18 1396a(e)(13)) is amended by striking subparagraph (I).

19 (c) CONFORMING AMENDMENTS FOR ASSURANCE OF  
20 AFFORDABILITY STANDARD FOR CHILDREN AND FAMI-  
21 LIES.—Section 1902(gg)(2) of the Social Security Act (42  
22 U.S.C. 1396a(gg)(2)) is amended—

23 (1) in the paragraph heading, by striking  
24 “THROUGH SEPTEMBER 30, 2027”; and

1           (2) by striking “through September 30” and all  
2           that follows through “ends on September 30, 2027”  
3           and inserting “(but beginning on October 1, 2019,”.

