COMMITTEE PRINT

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

Subtitle G—Medicaid

PART 1—FEDERAL MEDICAID PROGRAM TO CLOSE THE COVERAGE GAP

SEC. 30701. CLOSING THE MEDICAID COVERAGE GAP.

(a) FEDERAL MEDICAID PROGRAM TO CLOSE COVERAGE GAP IN NONEXPANSION STATES.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

"SEC. 1948. FEDERAL MEDICAID PROGRAM TO CLOSE COVERAGE GAP IN NONEXPANSION STATES.

''(a) ESTABLISHMENT.—In the case of a State that the Secretary determines (based on the State plan under this title, waiver of such plan, or other relevant information) is not expected to expend amounts under the State plan (or waiver of such plan) for all individuals described in section 1902(a)(10)(A)(i)(VIII) during a year (beginning with 2025), (in this section defined as 'a coverage gap State', with respect to such year), the Secretary shall (including through contract with eligible entities (as specified by the Secretary), consistent with subsection (b)) pro-

vide for the offering to such individuals residing in such State of a health benefits plan (in this section referred to as the 'Federal Medicaid program' or the 'Program'), for each quarter during the period beginning on January 1 of such year, and ending with the last day of the first quarter during which the State provides medical assistance to all such individuals under the State plan (or waiver of such plan). Under the Federal Medicaid program, the Secretary—

''(1) may use the Federally Facilitated Marketplace to facilitate eligibility determinations and enrollments under the Federal Medicaid Program and shall establish a set of eligibility rules to be applied under the Program in a manner consistent with section 1902(e)(14);

''(2) shall establish benefits, beneficiary protections, and access to care standards by, at a minimum—

''(A) establishing a minimum set of benefits to be provided (and providing such benefits) under the Federal Medicaid program, which shall be in compliance with the requirements of section 1937 and shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in sec-

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

''(B) applying the provisions of sections 1902(a)(8), 1902(a)(34) (which may be applied in accordance with such phased-in implementation as the Secretary deems necessary, but beginning as soon as practicable), and 1943 with respect to such an individual, benefits under the Federal Medicaid program, and making application for such benefits (which may be in accordance with a phased-in implementation as the Secretary deems necessary, but beginning as soon as practicable) in the same manner as such provisions would apply to such an individual, medical assistance under this title (other than pursuant to this section), and making application for such medical assistance under this title (other than pursuant to this section); and providing that redeterminations and appeals of eligibility and coverage determinations of services (including benefit reductions, terminations,

and suspension) shall be conducted under the Federal Medicaid program in accordance with a Federal fair hearing process established by the Secretary that is subject to the same requirements as applied with respect to redeterminations and appeals of eligibility, and with respect to coverage of services (including benefit reductions, terminations, and suspension), under a State plan under this title and that may provide for such fair hearings related to denials of eligibility (based on modified adjusted gross income eligibility determinations) to be conducted through the Federally Facilitated Marketplace for Exchanges;

''(C) applying, in accordance with subsection (d), the provisions of section 1927 (other than subparagraphs (B) and (C) of subsection (b)(1) of such section) with respect to the Secretary and payment under the Federal Medicaid program for covered outpatient drugs with respect to a rebate period in the same manner and to the same extent as such provisions apply with respect to a State and payment under the State plan for covered outpatient drugs with respect to the rebate period; and

"(D) applying the provisions of sections 1902(a)(14), 1902(a)(23), 1902(a)(47), and 1920 through 1920C (as applicable) to the Federal Medicaid program and such individuals enrolled in such program in the same manner and to the same extent as such provisions apply to a State plan and such individuals eligible for medical assistance under the State plan, and applying the provisions of section 1902(a)(30)(A) with respect to medical assistance available under the Federal Medicaid program in the same manner and to the same extent as such provisions apply to medical assistance under a State plan under this title, except that—

"(i) the Secretary shall provide that no cost sharing shall be applied under the Federal Medicaid program;

"(ii) the Secretary may waive the provisions of subparagraph (A) of section 1902(a)(23) to the extent deemed appropriate to facilitate the implementation of managed care;

''(iii) in applying the provisions of section 1902(a)(47) and sections 1920 through 1920C, the Secretary—

''(I) shall establish a single presumptive eligibility process for individuals eligible under the Federal Medicaid program, under which the Secretary may contract with entities to carry out such process; and

''(II) may apply such provisions and process in accordance with such phased-in implementation as the Secretary deems necessary, but beginning as soon as practicable).

''(b) ADMINISTRATION OF FEDERAL MEDICAID PROGRAM THROUGH CONTRACTS WITH MEDICAID MANAGED CARE ORGANIZATION AND THIRD PARTY PLAN ADMINISTRATOR REQUIREMENTS.—

''(1) IN GENERAL.—For the purpose of administering the benefits under the Program (across all coverage gap geographic areas (as defined in paragraph (8)) to provide medical assistance to individuals described in section 1902(a)(10)(A)(i)(VIII) enrolled under the Federal Medicaid program and residing in such areas, the Secretary shall solicit bids

described in paragraph (2) and enter into contracts with a total of at least 2 eligible entities (as specified by the Secretary, which may be a medicaid managed care organization (in this section defined as including a managed care organization described in section 1932(a)(1)(B)(i), a prepaid inpatient health plan, and a prepaid ambulatory health plans (as defined in section 438.2 of title 42, Code of Federal Regulations)), a third party plan administrator, or both). An eligible entity entering into a contract with the Secretary under this paragraph may administer such benefits as a medicaid managed care organization (as so defined), in which case such contract shall be in accordance with paragraph (3) with respect to such geographic area, or as a third-party administrator, in which case such contract shall be in accordance with paragraph (4) with respect to such geographic area. The Secretary may so contract with a Medicaid managed care organization or third party plan administrator in each coverage gap geographic area (and may specify which type of eligible entity may bid with respect to a coverage gap geographic area or areas) and may contract with more than one such eligible entity in the same coverage gap geographic area.

''(2) BIDS.—

''(A) IN GENERAL.—To be eligible to enter into a contract under this subsection, for a year, an entity shall submit (at such time, in such manner, and containing such information as specified by the Secretary) one or more bids to administer the Program in one or more coverage gap geographic areas, which reflects the projected monthly cost to the entity of furnishing benefits under the Program to an individual enrolled under the Program in such a geographic area (or areas) for such year.

''(B) SELECTION.—In selecting from bids submitted under subparagraph (A) for purposes of entering into contracts with eligible entities under this subsection, with respect to a coverage gap geographic area, the Secretary shall take into account at least each of the following, with respect to each such bid:

''(i) Network adequacy (as proposed in the submitted bid).

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

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

''(iii) The amount of the bid, taking into account the average per member cost of providing medical assistance under State plans under this title (or waivers of such plans) to individuals enrolled in such plans (or waivers) who are at least 18 years of age and residing in the coverage gap geographic area, as well as the average cost of providing medical assistance under State plans under this title (and waivers of such plans) to individuals described in section 1902(a)(10)(A)(i)(VIII).

''(3) CONTRACT WITH MEDICAID MANAGED CARE ORGANIZATION.—In the case of a contract under paragraph (1) between the Secretary and an eligible entity administering benefits under the Program as a Medicaid managed care organization, with respect to one or more coverage gap geographic areas, the following shall apply:

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

clause (xiii) of such section 1903(m)(2)(A) shall, to the greatest extent practicable, apply to the contract, to the Secretary, and to the Medicaid managed care organization, with respect to providing medical assistance under the Federal Medicaid program with respect to such area, in the same manner and to the same extent as such provisions apply to a contract under section 1903(m) between a State and an entity that is a medicaid managed care organization (as defined in section 1903(m)(1)), to the State, and to the entity, with respect to providing medical assistance to individuals eligible for benefits under this title.

''(B) The provisions of section 1932(h) shall apply to the contract, Secretary, and Medicaid managed care organization.

''(C) The contract shall provide that the entity pay claims in a timely manner and in accordance with the provisions of section 1902(a)(37).

''(D) The contract shall provide that the Secretary shall make payments under this section to the entity, with respect to coverage of each individual enrolled under the Program in

such a coverage gap geographic area with respect to which the entity administers the Program in an amount specified in the contract, subject to subparagraph (D)(ii) and paragraph (6).

''(E) The contract shall require—

''(i) the application of a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation)) for payment for medical assistance administered by the managed care organization under the Program, with respect to a year, that is equal to or greater than 85 percent (or such higher percent as specified by the Secretary); and

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

this section in an amount equal to the difference in payments for medical assistance, with respect to the year, resulting from the organization's failure to meet such ratio for such year.

''(F) The contract shall require that the eligible entity submit to the Secretary the number of individuals enrolled in the Program with respect to each coverage gap geographic area and month with respect to which the contract applies and such additional information as specified by the Secretary for purposes of payment, program integrity, oversight, quality measurement, or such other purpose specified by the Secretary.

''(G) The contract shall require that the eligible entity perform any other activity identified by the Secretary.

''(4) CONTRACT WITH A THIRD PARTY PLAN ADMINISTRATOR.—

''(A) IN GENERAL.—In the case of a contract under paragraph (1) between the Secretary and an eligible entity to administer the Program as a third party plan administrator, with respect to one or more coverage gap geo-

graphic areas, such contract shall provide that, with respect to medical assistance provided under the Federal Medicaid program to individuals who are enrolled in the Program with respect to such area (or areas)—

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

''(I) establish provider networks, payment rates, and utilization management, consistent with the provisions of section 1902(a)(30)(A), as applied by subsection (a)(4);

''(II) pay claims in a timely manner and in accordance with the provisions of section 1902(a)(37);

''(III) submit to the Secretary the number of individuals enrolled in the Program with respect to each coverage gap geographic area and month with respect to which the contract applies and such additional information as specified by the Secretary for purposes of payment, program integrity, oversight, quality measurement, or

such other purpose specified by the Secretary; and

''(IV) perform any other activity identified by the Secretary; and

''(ii) the Secretary shall make payments (for the claims submitted by the third party plan administrator and for an economic and efficient administrative fee) under this section to the third party plan administrator, with respect to coverage of each individual enrolled under the Program in a coverage gap geographic area with respect to which the third party plan administrator administers the Program in an amount determined under the contract, subject to subclause (VI)(bb) and paragraph (7).

''(B) THIRD PARTY PLAN ADMINISTRATOR DEFINED.—For purposes of this section, the term 'third party plan administrator' means an entity that satisfies such requirements as established by the Secretary, which shall include at least that such an entity administers health plan benefits, pays claims under the plan, es-

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

''(5) ADMINISTRATIVE AUTHORITY.—The Secretary may take such actions as are necessary to administer this subsection, including by setting payment rates, setting network adequacy standards, establishing quality requirements, establishing reporting requirements, and specifying any other program requirements or standards necessary in contracting with specified entities under this subsection, and overseeing such entities, with respect to the administration of the Federal Medicaid program.

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

''(A) the Secretary may establish minimum standards and licensure requirements for such a Medicaid managed care organization or third party plan administrator for purposes of carrying out such duties; and

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

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

''(7) PENALTIES.—In the case of an eligible entity with a contract under this section that fails to comply with the requirements of such entity pursuant to this section or such contract, the Secretary may withhold payment (or any portion of such payment) to such entity under this section in accordance with a process specified by the Secretary, impose a corrective action plan on such entity, or impose a civil monetary penalty on such entity in an amount not to exceed $10,000 for each such failure. In implementing this paragraph, the Secretary shall have the authorities provided the Secretary under section 1932(e) and subparts F and I of part 438 of title 42, Code of Federal Regulations.

''(8) COVERAGE GAP GEOGRAPHIC AREA.—For purposes of this section, the term 'coverage gap geographic area' means an area of one or more coverage gap States, as specified by the Secretary, or any area within such a State, as specified by the Secretary.

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

income of an individual enrolled in the Federal Medicaid program for a year, before the end of such year, to determine if there has been any change in the individual's eligibility for benefits under the program. For purposes of the previous sentence, the Secretary may verify income of an individual based on the prospective income of the individual for such year or based on current monthly income of the individual, as specified by the Secretary. In the case that, pursuant to such verification, an individual is determined to have had a change in income that results in such individual no longer be included as an individual described in section 1902(a)(10)(A)(i)(VIII), the Secretary shall apply the same processes and protections as States are required under this title to apply with respect to an individual who is determined to have had a change in income that results in such individual no longer being included as eligible for medical assistance under this title (other than pursuant to this section).

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

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

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

''(2) shall take such actions as are necessary and develop or adapt such processes and mechanisms as are necessary to report and collect data as is necessary and to bill and track rebates under section 1927, as applied pursuant to subsection (a)(2)(B) for drugs that are provided under the Federal Medicaid program;

''(3) provide that the coverage requirements of prescription drugs under the Federal Medicaid program comply with the coverage requirements section 1927; and

''(4) require that in order for payment to be available under the Federal Medicaid program or under section 1903(a) for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement to provide rebates under section 1927 to the Federal Medicaid program in the same form and manner as the manufacturer is required to provide rebates under an agreement described in section 1927(b) to a State Medicaid program under this title.

''(e) TRANSITIONS.—

''(1) FROM EXCHANGE PLANS ONTO FEDERAL MEDICAID PROGRAM.—The Secretary shall provide for a process under which, in the case of individuals described in section 1902(a)(10)(A)(i)(VIII) who are enrolled in qualified health plans through an Exchange in a coverage gap State, the Secretary takes such steps as are necessary to transition such individuals to coverage under the Federal Medicaid program. Such process shall apply procedures described in section 1943(b)(1)(C) to screen for eligibility and enrollment under the Federal Medicaid program in the same manner as such procedures screen for eligibility and enrollment under qualified health plans through an Exchange established under title I of the Patient Protection and Affordable Care Act.

''(2) IN CASE COVERAGE GAP STATE BEGINS PROVIDING COVERAGE UNDER STATE PLAN.—The Secretary shall provide for a process for, in the case of a coverage gap State in which the State begins to provide medical assistance to individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan (or waiver of such plan) and the Federal Medicaid program ceases to be offered, transitioning individuals from such program to the State plan (or

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

''(f) COORDINATION WITH AND ENROLLMENT THROUGH EXCHANGES.—The Secretary shall take such actions as are necessary to provide, in the case of a coverage gap State in which the Federal Medicaid program is offered, for the availability of information on, determinations of eligibility for, and enrollment in such program through and coordinated with the Exchange established with respect to such State under title I of the Patient Protection and Affordable Care Act.

''(g) THIRD PARTY LIABILITY.—The provisions of section 1902(a)(25) shall apply with respect to the Federal Medicaid program, the Secretary, and the eligible entities with a contract under subsection (b) in the same manner as such provisions apply with respect to State plans under this title (or waiver of such plans) and the State or local agency administering such plan (or waiver). The Secretary may specify a timeline (which may include a phase-in) for implementing this subsection.

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

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

''(i) MAINTENANCE OF EFFORT.—

''(1) PAYMENT.—

''(A) IN GENERAL.—In the case of a State that, as of January 1, 2022, is expending amounts for all individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan (or waiver of such plan) and that stops expending amounts for all such individuals under the State plan (or waiver of such plan), such State shall for each quarter beginning after January 1, 2022, during which such State does not expend amounts for all such individuals provide for payment under this subsection to the Secretary of the product of—

''(i) 10 percent of, subject to subparagraph (B), the average monthly per capita costs expended under the State plan (or waiver of such plan) for such individuals during the most recent previous quarter

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

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

''(B) ANNUAL INCREASE.—For purposes of subparagraph (A), in the case of a State with respect to which such subparagraph applies with respect to a period of consecutive quarters occurring during more than one calendar year, for such consecutive quarters occurring during the second of such calendar years or a subsequent calendar year, the average monthly per capita costs for each such quarter for such State determined under subparagraph (A)(i), or this subparagraph, shall be annually increased by the Secretary by the percentage increase in Medicaid spending under this title during the preceding year (as determined based on the most recent National Health Expenditure data with respect to such year).

''(2) FORM AND MANNER OF PAYMENT.—Payment under paragraph (1) shall be made in a form and manner specified by the Secretary.

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

''(4) DATA MATCH.—The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of individuals enrolled under the Federal Medicaid program under section 1948 in a coverage gap State (as referenced in subsection (a) of such section) for purposes of computing the amount under paragraph (1).

''(5) NOTICE.—The Secretary shall notify each State described in paragraph (1) not later than a date specified by the Secretary that is before the beginning of each quarter (beginning with 2022) of the amount computed under paragraph (1) for the State for that year.

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

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

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

(1) by striking ''or under part B of title XVIII'' and inserting '', under the Federal Medicaid program under section 1948, or under part B of title XVIII''; and

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

PART 2—EXPANDING ACCESS TO MEDICAID HOME AND COMMUNITY-BASED SERVICES

SEC. 30711. DEFINITIONS.

In this part:

(1) APPROPRIATE COMMITTEES OF CONGRESS.—The term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives, the Committee on Finance of the Senate, the Committee on Health, Education, Labor and Pensions of the Senate, and the Special Committee on Aging of the Senate.

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

(A) A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides licensed nursing services, or a licensed nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist.

(B) A direct support professional.

(C) A personal care attendant.

(D) A home health aide.

(E) Any other paid health care professional or worker determined to be appropriate by the State and approved by the Secretary.

(3) HCBS PROGRAM IMPROVEMENT STATE.—The term ''HCBS program improvement State'' means a State that is awarded a planning grant under section 1011(a) and has an HCBS improvement plan approved by the Secretary under section 1011(d).

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

(A) A medicaid managed care organization, as defined in section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. 1396b(m)(1)(A)).

(B) A prepaid inpatient health plan or prepaid ambulatory health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)).

(C) Any other entity determined to be appropriate by the State and approved by the Secretary.

(5) HOME AND COMMUNITY-BASED SERVICES.—The term ''home and community-based services'' means any of the following (whether provided on a fee-for-service, risk, or other basis):

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

(B) Private duty nursing services authorized under paragraph (8) of such section, when

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

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

(D) PACE services authorized under paragraph (26) of such section.

(E) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and such services provided through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u–7).

(F) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such Act (42 U.S.C. 1396n(g)).

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

(H) Self-directed personal assistance services authorized under section 1915(j) of the Social Security Act (42 U.S.C. 1396n(j)).

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

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

(ii) described in another subparagraph of this paragraph.

(J) Such other services specified by the Secretary.

(6) INSTITUTIONAL SETTING.—The term ''institutional setting'' means—

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

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

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

(D) a facility (or distinct part thereof) described in section 1905(d) of such Act (42 U.S.C. 1396d(d)));

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

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

(G) any other relevant facility, as determined by the Secretary.

(7) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for and receiving medical assistance under a State Medicaid plan or a waiver such plan. Such term includes an individual who would become eligible for medical assistance and enrolled under a State Medicaid plan, or waiver of such plan, upon removal from a waiting list.

(8) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or

under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(10) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

SEC. 30712. HCBS IMPROVEMENT PLANNING GRANTS.

(a) FUNDING.—

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

(2) TECHNICAL ASSISTANCE AND GUIDANCE.—The Secretary shall reserve $5,000,000 of the amount appropriated under paragraph (1) for purposes of issuing guidance and providing technical assistance to States intending to apply for, or awarded, a planning grant under this section, and for other administrative expenses related to awarding planning grants under this section.

(b) AWARD AND USE OF GRANTS.—

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

(2) CRITERIA FOR DETERMINING AMOUNT OF GRANTS.—The Secretary shall take into account the improvements a State would propose to make, consistent with the areas of focus of the HCBS improvement plan requirements described under subsection (c) in determining the amount of the planning grant to be awarded to each State that requests such a grant.

(3) USE OF FUNDS.—A State awarded a planning grant under this section shall use the grant to carry out planning activities for purposes of developing and submitting to the Secretary an HCBS improvement plan for the State that meets the requirements of subsections (c) and (d) in order to expand access to home and community-based services and strengthen the direct care workforce that provides such services. A State may use planning grant funds to support activities related to the implementation of

the HCBS improvement plan for the State, collect and report information described in subsection (c), identify areas for improvement to the service delivery systems for home and community-based services, carry out activities related to evaluating payment rates for home and community-based services and identifying improvements to update the rate setting process, and for such other purposes as the Secretary shall specify, including the following:

(A) Caregiver supports.

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

(C) Promoting equity and addressing health disparities.

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

(E) Building partnerships.

(F) Infrastructure investments (such as case management or other information technology systems).

(c) HCBS IMPROVEMENT PLAN REQUIREMENTS.—In order to meet the requirements of this subsection, an HCBS improvement plan developed using funds awarded

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

(1) EXISTING MEDICAID HCBS LANDSCAPE.—

(A) ELIGIBILITY AND BENEFITS.—A description of the existing standards, pathways, and methodologies for eligibility (which shall be delineated by the State based on eligibility group under the State plan or waiver of such plan) for home and community-based services, including limits on assets and income, the home and community-based services available under the State Medicaid program and the types of settings in which they may be provided, and utilization management standards for such services.

(B) ACCESS.—

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

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

(ii) AVAILABILITY; UNMET NEED.—A summary, in accordance with guidance issued by the Secretary, of the extent to which home and community-based services are available to all individuals in the State who would be eligible for such services under the State Medicaid program (including individuals who are on a waitlist for such services).

(C) UTILIZATION.—An assessment of the utilization of home and community-based services in the State during such time period as the Secretary may specify.

(D) SERVICE DELIVERY STRUCTURES AND SUPPORTS.—A description of the service delivery structures for providing home and community-based services in the State, including whether models of self-direction are used and to which Medicaid eligible individuals such models are available, the share of total services are administered by agencies, the use of managed care and fee-for-service to provide such services, and the supports provided for family caregivers.

(E) WORKFORCE.—A description of the direct care workforce that provides home and community-based services, including estimates (and a description of the methodology used to develop such estimates) of the number of full- and part-time direct care workers, the average and range of direct care worker wages, the benefits provided to direct care workers, the turnover and vacancy rates of direct care worker positions, the membership of direct care workers in labor organizations and, to the extent it the State has access to such data, demographic information about such workforce, including information on race, ethnicity, and gender.

(F) PAYMENT RATES.—

(i) IN GENERAL.—A description of the payment rates for home and community-based services, including, to the extent applicable, how payments for such services are factored into the development of managed care capitation rates, and when the State last updated payment rates for home and community-based services, and the extent to which payment rates are passed through to direct care worker wages.

(ii) ASSESSMENT.—An assessment of how current payment rates for such services impact provider capacity and access to care.

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

(H) LONG-TERM SERVICES AND SUPPORTS PROVIDED IN INSTITUTIONAL SETTINGS.—A description of the number of individuals enrolled in the State Medicaid program who receive items and services for greater than 30 days in an institutional setting that is a nursing facility, intermediate care facility, or assistaed living facility and the demographic information of such individuals who are provided such items and services in such settings.

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

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

(2) GOALS FOR HCBS IMPROVEMENTS.—A description of how the State will do the following:

(A) Conduct the activities required under subsection (jj) of section 1905 of the Social Security Act(as added under section 30713).

(B) Reduce barriers and disparities in access or utilization of home and community-based services in the State.

(C) Monitor and report (with supporting data to the extent available and applicable disaggregated by age groups, primary disability, income brackets, gender, race, ethnicity, geography, primary language, and type of service setting, on—

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

ices, and the utilization of such services; and

(ii) the amount of State Medicaid expenditures for home and community-based services under the State Medicaid program as a proportion of the total amount of State expenditures under the State Medicaid program for long-term services and supports.

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

(E) Assess and monitor the sufficiency of payments under the State Medicaid program for the specific types of home and community-based services available under such program for purposes of supporting direct care worker recruitment and retention and ensuring the availability of home and community-based services.

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

such as those for housing, transportation, employment, and other services and supports.

(d) DEVELOPMENT AND APPROVAL REQUIREMENTS.—

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

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

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

awarded a planning grant under this section, the State shall submit an HCBS improvement plan for approval by the Secretary, along with assurances by the State that the State will implement the plan in accordance with the requirements of the HCBS Improvement Program established under subsection (jj) of section 1905 of the Social Security Act (42 U.S.C. 1396d) (as added by section 30713). The Secretary shall approve and make publicly available the HCBS improvement plan for a State after the plan and such assurances are submitted to the Secretary for approval and the Secretary determines the plan meets the requirements of subsection (c). A State may amend its HCBS improvement plan, subject to the approval of the Secretary that the plan as so amended meets the requirements of subsection (c). The Secretary may withhold or recoup funds provided under this section to a State or pursuant to section 1905(jj) of the Social Security Act, as added by section 30713, if the State fails to implement the HCBS improvement plan of the State or meet applicable deadlines under this section.

SEC. 30713. HCBS IMPROVEMENT PROGRAM.

(a) INCREASED FMAP FOR HCBS PROGRAM IMPROVEMENT STATES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (b), by striking ''and (ii)'' and inserting ''(ii), and (jj)''; and

(2) by adding at the end the following new subsection:

''(jj) ADDITIONAL SUPPORT FOR HCBS PROGRAM IMPROVEMENT STATES.—

''(1) IN GENERAL.—

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

''(i) and for which the State meets the requirements described in paragraphs (2) and (4), notwithstanding subsection (b) or (ff), subject to subparagraph (B), with respect to amounts expended during the quarter by such State for medical assistance for home and community-based services, the Federal medical assistance percentage for such State and quarter (as de-

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

''(ii) with respect to the State meeting the requirements described in paragraphs (2) and (4), notwithstanding section 1903(a)(7), 1903(a)(3)(F), and 1903(t), with respect to amounts expended during the quarter and before October 1, 2031, for administrative costs for expanding and enhancing home and community-based services, including for enhancing Medicaid data and technology infrastructure, modifying rate setting processes, adopting or improving training programs for direct care workers and family caregivers, and adopting, carrying out, or enhancing programs that register direct care workers or connect beneficiaries to direct care work-

ers, the per centum specified in such section shall be increased to 80 percent.

In no case may the application of clause (i) result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. In no case shall the application of clause (ii) result in a reduction to the per centum otherwise specified without application of such clause. Any increase pursuant to clause (ii) may be available to a State before the State meets the requirements of paragraphs (2) and (4).

''(B) ADDITIONAL HCBS IMPROVEMENT EFFORTS.—Subject to paragraph (5), in addition to the increase to the Federal medical assistance percentage under subparagraph (A)(i) for amounts expended during a quarter for medical assistance for home and community-based services by an HCBS program improvement State that meets the requirements of paragraphs (2) and (4) for the quarter, the Federal medical assistance percentage for amounts expended by the State during the quarter for medical assistance for home and community-based services shall be further in-

creased by 2 percentage points (but not to exceed 95 percent) during the first 8 fiscal quarters throughout which the State has implemented and has in effect a program to support self-directed care that meets the requirements of paragraph (3).

''(C) NONAPPLICATION OF TERRITORIAL FUNDING CAPS.—Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures that are subject to an increase in the Federal medical assistance percentage under subparagraph (A)(i) or (B), or an increase in an applicable Federal matching percentage under subparagraph (A)(ii), shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108.

''(D) NONAPPLICATION TO CHIP EFMAP.—Any increase described in subparagraph (A) (or payment made for expenditures on medical assistance that are subject to such increase) shall not be taken into account in calculating the enhanced FMAP of a State under section 2105.

''(2) REQUIREMENTS.—The requirements described in this paragraph, with respect to a State and a fiscal quarter, are the following:

''(A) NONSUPPLANTATION.—The State uses the Federal funds attributable to the increase in the Federal medical assistance percentage for amounts expended during a quarter for medical assistance for home and community-based services under subparagraphs (A) and, if applicable, (B) of paragraph (1) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of the date the State is awarded a planning grant under section 30712 of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14'.

''(B) MAINTENANCE OF EFFORT.—

''(i) IN GENERAL.—The State does not—

''(I) reduce the amount, duration, or scope of home and community-based services available under the State plan or waiver (relative to the

home and community-based services available under the plan or waiver as of the date on which the State was awarded a planning grant under section 30712 of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14';

''(II) reduce payment rates for home and community-based services lower than such rates that were in place on January 1, 2021, including, to the extent applicable, payment rates for such services that are included in managed care capitation rates; or

''(III) except to the extent permitted under clause (ii), adopt more restrictive standards, methodologies, or procedures for determining eligibility, benefits, or services for receipt of home and community-based services, including with respect to cost-sharing, than the standards, methodologies, or procedures applicable as of such date.

''(ii) FLEXIBILITY TO SUPPORT INNOVATIVE MODELS.—A State may make modifications that would otherwise violate the maintenance of effort described in clause (i) if the State demonstrates to the satisfaction of the Secretary that such modifications shall not result in—

''(I) home and community-based services that are less comprehensive or lower in amount, duration, or scope;

''(II) fewer individuals (overall and within particular eligibility groups and categories) receiving home and community-based services; or

''(III) increased cost-sharing for home and community-based services.

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

''(i) Reduce access barriers and disparities in access or utilization of home and community-based services, as described in the State HCBS improvement plan.

''(ii) Provides coverage of personal care services authorized under subsection (a)(24) for all individuals eligible for medical assistance in the State.

''(iii) Provides for navigation of home and community-based services through 'no wrong door' programs, provides expedited eligibility for home and community-based services, and improves home and community-based services counseling and education programs.

''(iv) Expands access to behavioral health services.

''(v) Improves coordination of home and community-based services with employment, housing, and transportation supports.

''(vi) Provides supports to family caregivers, such as respite care, caregiver as-

sessments, peer supports, or paid family caregiving.

''(vii) Adopts, expands eligibility for, or expands covered items and services provided under 1 or more eligibility categories authorized under subclause (XIII), (XV), or (XVI) of section 1902(a)(10)(A)(ii).

''(D) STRENGTHENED AND EXPANDED WORKFORCE.—

''(i) IN GENERAL.—The State strengthens and expands the direct care workforce that provides home and community-based services by—

''(I) adopting processes to ensure that payments for home and community-based services are sufficient to ensure that care and services are available to the extent described in the State HCBS improvement plan; and

''(II) updating qualification standards (as appropriate), and developing and adopting training opportunities, for the continuum of providers of home and community-based services, including programs for inde-

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

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

''(I) update and increase, as appropriate, payment rates for delivery of home and community-based services to support the recruitment and retention of the direct care workforce;

''(II) review and, if necessary to ensure sufficient access to care, increase payment rates for home and community-based services at least every 3 years through a transparent process involving meaningful input from stakeholders, including recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates; and

"(III) ensure that increases in the payment rates for home and community-based services are—

"(aa) at a minimum, results in a proportionate increase to payments for direct care workers and in a manner that is determined with input from the stakeholders described in subclause (II); and

"(bb) incorporated into provider payment rates for home and community-based services provided under this title by a managed care entity (as defined in section 1932(a)(1)(B)) a prepaid inpatient health plan or prepaid ambulatory health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)), under a contract and paid through capitation rates with the State.

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

''(A) Registering qualified direct care workers and assisting beneficiaries in finding direct care workers.

''(B) Undertaking activities to recruit and train independent providers to enable beneficiaries to direct their own care, including by providing or coordinating training for beneficiaries on self-directed care.

''(C) Ensuring the safety of, and supporting the quality of, care provided to beneficiaries, such as by conducting background checks and addressing complaints reported by recipients of home and community-based services consistent with Fair Hearing requirements and prior notice of service reductions, including under subpart F of part 438 of title 42, Code

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

''(D) Facilitating coordination between State and local agencies and direct care workers for matters of public health, training opportunities, changes in program requirements, workplace health and safety, or related matters.

''(E) Supporting beneficiary hiring, if selected by the beneficiary, of independent providers of home and community-based services, including by processing applicable tax information, collecting and processing timesheets, submitting claims and processing payments to such providers.

''(F) To the extent a State permits beneficiaries to hire a family member or individual with whom they have an existing relationship to provide home and community-based services, and notwithstanding subsection (a)(24), providing support to beneficiaries who wish to hire a caregiver who is a family member or individual with whom they have an existing relationship, such as by facilitating enrollment of such family member or individual as a provider

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

''(G) Ensuring that programs and procedures do not discriminate against labor organizations or workers who may join or decline to join a labor organization.

''(4) REPORTING AND OVERSIGHT.—The requirements described in this paragraph, with respect to a State and a fiscal quarter, are the following:

''(A) The State designates (by a date specified by the Secretary) an HCBS ombudsman office that—

''(i) operates independently from the State Medicaid agency and managed care entities;

''(ii) provides direct assistance to recipients of home and community-based services available under the State Medicaid program and their families; and

''(iii) identifies and reports systemic problems to State officials, the public, and the Secretary.

''(B) Beginning with the 5th fiscal quarter for which the State is an HCBS program improvement State, and annually thereafter, the

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

''(i) the availability and utilization of home and community-based services, disaggregated (to the extent available and as applicable) by age groups, primary disability, income brackets, gender, race, ethnicity, geography, primary language, and type of service setting;

''(ii) wages, benefits, turnover and vacancy rates for the direct care workforce;

''(iii) changes in payment rates for home and community-based services;

''(iv) implementation of the activities to strengthen and expand access to home and community-based services and the direct care workforce that provides such services in accordance with the requirements of subparagraphs (C) and (D) of paragraph (2);

''(v) if applicable, implementation of the activities described in paragraph (3);

''(vi) State expenditures for home and community-based services under the State plan or a waiver of such plan as a proportion of the total amount of State expenditures under the plan or waiver of such plan for long-term services and supports; and

''(vii) the challenges in, and best practices for, expanding access to home and community-based services, reducing disparities, and supporting and expanding the direct care workforce.

''(5) BENCHMARKS FOR DEMONSTRATING IMPROVEMENTS.—An HCBS program improvement State shall cease to be eligible for an increase in the Federal medical assistance percentage under paragraph (1)(A)(i) or (1)(B) or an increase in an applicable Federal matching percentage under paragraph (1)(A)(ii) at any time or beginning with the 29th fiscal quarter that begins on or after the first date on which a State is an HCBS program improvement State if the State is found to be out of compliance with paragraph (2)(B) or any other requirement of this subsection and, beginning with such 29th fiscal quarter, unless, not later than 90 days before the first day of such fiscal quarter, the State submits to

the Secretary a report demonstrating the following improvements:

"(A) Increased availability (above a marginal increase) of home and community-based services in the State relative to such availability as reported in the State HCBS improvement plan and adjusted for demographic changes in the State since the submission of such plan.

"(B) Reduced disparities in the utilization and availability of home and community-based services relative to the availability and utilization of such services by such populations as reported in such plan according to age groups, primary disability, income brackets, gender, race, ethnicity, geography, primary language, and type of service setting, and adjusted for demographic changes in the State since the submission of such plan.

"(C) Evidence that rates are sufficient to ensure access to items and services for individuals eligible for HCBS in such State.

"(D) With respect to the percentage of expenditures made by the State for long-term services and supports that are for home and community-based services, in the case of an

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

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

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

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

SEC. 30714. FUNDING FOR TECHNICAL ASSISTANCE AND OTHER ADMINISTRATIVE REQUIREMENTS RELATED TO MEDICAID HCBS.

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

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

(A) not later than 4 years after the date of enactment of this Act, a report that includes—

(i) a description of the HCBS improvement plans approved by the Secretary under section 30712(d);

(ii) a description (which may be a narrative report with examples or otherwise) of the landscape, at both the national and State levels, with respect to gaps in coverage of home and community-based services, disparities in access to, and utilization of, such services, and barriers to accessing such services; and

(iii) a description of the national landscape with respect to the direct care workforce that provides home and community-based services, including with respect to wages, benefits, and challenges to the availability of such workers; and

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

(i) the number of HCBS program improvement States;

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

(iii) a summary of States' performance measures as a part of the home and community-based services core quality measures and beneficiary and family caregiver surveys; and

(iv) a summary of the challenges and best practices reported by States in expanding access to home and community-based services and supporting and expanding the direct care workforce that provides such services.

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

Secretary under section 30712(d) and meeting the requirements and benchmarks for demonstrating improvements required under section 1905(jj) of the Social Security Act (as added by section 30713), and to issue such guidance or regulations as necessary to carry out this subtitle and the amendments made by this subtitle, including guidance specifying how States shall assess and track access to home and community-based services over time.

SEC. 30715. FUNDING FOR HCBS QUALITY MEASUREMENT AND IMPROVEMENT.

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

(1) in section 1139A—

(A) in subsection (a)(4)(B)—

(i) by striking ''Beginning with the annual State report on fiscal year 2024'' and inserting the following:

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

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

''(ii) REPORTING HCBS QUALITY MEASURES.—With respect to reporting on

information regarding the quality of home and community-based services provided to children under title XIX, beginning with the annual State report for the first fiscal year that begins on or after the date that is 2 years after the date that the Secretary publishes the home and community-based services quality measures developed under subsection (b)(5)(B) the Secretary shall require States to report such information using the standardized format for reporting information and procedures developed under subparagraph (A) and using either—

''(I) such home and community-based quality measures developed under subsection (b)(5) (including any updates or changes to such measures); or

''(II) an equivalent alternative set of home and community-based quality measures approved by the Secretary.''; and

(B) in subsection (b)(5)—

(i) by striking ''Beginning no later than January 1, 2013'' and inserting the following:

''(A) IN GENERAL.—Beginning no later than January 1, 2013''; and

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

''(B) HCBS QUALITY MEASURES.—Beginning with the first year that begins on the date that is 2 years after the date of enactment of this subparagraph, the core measures described in subsection (a) (and any updates or changes to such measures) shall include home and community-based services quality measures developed by the Secretary in the manner described in section 1139B(b)(5)(D). The Secretary may determine which measures are to be included in the core set under this section and which in the core set under section 1139B, based on the differences in health care needs for the relevant populations.''; and

(2) in section 1139B—

(A) in subsection (b)—

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

''(C) MANDATORY REPORTING WITH RESPECT TO HCBS QUALITY MEASURES.—Beginning with the State report required under subsection (d)(1) for the first year that begins on or after the date that is 2 years after the date that the Secretary publishes the home and community-based quality measures developed under paragraph (5)(D), the Secretary shall require States to report information, using the standardized format for reporting information and procedures developed under subparagraph (A), regarding the quality of home and community-based services for Medicaid eligible adults using either—

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

''(ii) an equivalent alternative set of home and community-based services quality measures approved by the Secretary.''; and

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

''(D) HCBS QUALITY MEASURES.—

''(i) IN GENERAL.—Beginning with respect to State reports required under subsection (d)(1) for the first year that begins on or after the date that is 2 years after the date of enactment of this subparagraph, the core set of adult health quality measures maintained under this paragraph (and any updates or changes to such measures) shall include home and community-based services quality measures developed in accordance with this subparagraph.

''(ii) REQUIREMENTS.—

''(I) INTERAGENCY COLLABORATION; STAKEHOLDER INPUT.—In developing (and subsequently reviewing and updating) the home and community-based services quality measures included in the core set of adult health quality measures maintained under this paragraph, the Secretary shall—

''(aa) collaborate with the Administrator of the Centers for

Medicare & Medicaid Services, the Administrator of the Administration for Community Living, the Director of the Agency for Healthcare Research and Quality, and the Assistance Secretary for Mental Health and Substance Use; and

''(bb) ensure that such home and community-based services quality measures are informed by input from stakeholders, including recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates.

''(II) REFLECTIVE OF FULL ARRAY OF SERVICES.—Such home and community-based services quality measures shall—

‘‘(aa) reflect the full array of home and community-based services and recipients of such services, including adults and children; and

‘‘(bb) include—

‘‘(AA) outcomes-based measures;

‘‘(BB) measures of availability of services;

‘‘(CC) measures of provider capacity and availability;

‘‘(DD) measures related to person-centered care;

‘‘(EE) measures specific to self-directed care;

‘‘(FF) measures related to transitions to and from institutional care; and

‘‘(GG) beneficiary and family caregiver surveys.

‘‘(III) DEMOGRAPHICS.—Such home and community-based services

quality measures shall allow for the collection, to the extent available, of data that is disaggregated by age groups, primary disability, income brackets, gender, race, ethnicity, geography, primary language, and type of service setting.

''(IV) DEFINITIONS.—For purposes of this section and section 1139A, the terms 'home and community-based services', '*health plan*', and 'direct care worker' have the meanings given those terms in section 30711 of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14'.

''(iii) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for purposes of carrying out this subparagraph, $5,000,000 for fiscal year 2022, to remain available until expended.''; and

(B) in subsection (d)(1)(A), by striking ''; and'' and inserting ''and, beginning with the report for the first year that begins after the date

that is 2 years after the Secretary publishes the home and community-based quality measures developed under subsection (b)(5)(D), home and community-based services quality measures included in the core set of adult health quality measures maintained under subsection (b)(5) and any updates or changes to such measures or an equivalent alternative set of home and community-based services quality measures approved by the Secretary; and''.

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

(1) in subparagraph (F)(ii), by striking ''plus'' after the semicolon and inserting ''and''; and

(2) by inserting after subparagraph (F), the following:

''(G) 80 percent of so much of the sums expended during such quarter as are attributable to the reporting of information regarding the quality of home and community-based services in accordance with sections 1139A(a)(4)(B)(ii) and 1139B(b)(3)(C); and''.

PART 3—OTHER MEDICAID

SEC. 30721. PERMANENT EXTENSION OF MEDICAID PROTECTIONS AGAINST SPOUSAL IMPOVERISHMENT FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting the following: ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915 or under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)''.

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

SEC. 30722. PERMANENT EXTENSION OF MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

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

(1) in paragraph (1)—

(A) in subparagraph (I), by inserting ''and'' after the semicolon;

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

''(J) $450,000,000 for each fiscal year after fiscal year 2021.''; and

(C) by striking subparagraph (K);

(2) in paragraph (2), by striking ''September 30, 2023'' and inserting ''September 30 of the subsequent fiscal year''; and

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

''(3) TECHNICAL ASSISTANCE.—Out of the amounts made available under paragraph (1), for the 3-year period beginning with fiscal year 2022 and for each subsequent 3-year period, $5,000,000 shall be made available for carrying out subsection (f) and (i).''.

(b) REDISTRIBUTION OF UNEXPENDED GRANT AWARDS.—Subsection (e)(2) of section 6071 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended by adding at the end the following new sentence: ''Any portion of a State grant award for a fiscal year under this section that is unexpended by the State at the end of the fourth succeeding fiscal year shall be rescinded by the Secretary and added to the appropriation for the fifth succeeding fiscal year.''.

SEC. 30723. EXTENDING CONTINUOUS MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.

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

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

(A) by striking ''(5) A woman who'' and inserting ''(5)(A) For any fiscal year quarter with respect to which the amendments made by section 30723(a)(1)(B) of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14' do not apply (beginning with the first fiscal year quarter beginning one year

after the date of the enactment of such Act), a woman who''; and

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

''(B) For any fiscal year quarter (beginning with the first fiscal year quarter beginning one year after the date of the enactment of this subparagraph), any individual who, while pregnant, is eligible for and received medical assistance under the State plan or a waiver of such plan (including during a period of retroactive eligibility under subsection (a)(34)), shall remain eligible, notwithstanding section 1916(c)(3) or any other limitation under this title, for medical assistance through the end of the month in which the 12-month period (beginning on the last day of pregnancy of the individual) ends, regardless of the basis for the individual's eligibility for medical assistance and such medical assistance shall be in accordance with clauses (i) and (ii) of paragraph (16)(B).''.

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

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

the medical assistance'' and all that follows through '', (VIII)'' and inserting ''(VIII)'';

(B) in section 1902(e)(6), by striking ''In the case of'' and inserting ''For any fiscal year quarter with respect to which the amendments made by section 30723(a)(1)(B) of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14' do not apply (beginning with the first fiscal year quarter beginning one year after the date of the enactment of such Act), in the case of'';

(C) in section 1902(l)(1)(A), by striking ''60-day period'' and inserting ''12-month period'';

(D) in section 1903(v)(4)(A)—

(i) in clause (i), by striking ''60-day period'' and inserting ''12-month period (or, for any fiscal year quarter with respect to which the amendments made by section 30723(a)(1)(B) of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14' do not apply (beginning with the first fiscal year quarter beginning one year after the date of the

enactment of such Act), 60-day period)''; and

(ii) in clause (ii), by inserting ''and including an individual to whom section 1902(e)(5)(B) applies, in accordance with such section, through the end of the month in which the 12-month period (beginning on the last day of pregnancy of the individual) ends'' before the period at the end; and

(E) in section 1905(a), in the 4th sentence in the matter following paragraph (31), by striking ''60-day period'' and inserting ''12-month period (or, for any fiscal year quarter with respect to which the amendments made by section 30723(a)(1)(B) of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14' do not apply (beginning with the first fiscal year quarter beginning one year after the date of the enactment of such Act), 60-day period)''.

(b) TRANSITION FROM STATE OPTION.—Section 1902(e)(16)(A) of the Social Security Act (42 U.S.C. 1396a(e)(16)(A)) is amended by striking ''At the option of the State'' and inserting ''For any fiscal year quarter

with respect to which the amendments made by section 30723(a)(1)(B) of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14' do not apply (beginning with the first fiscal year quarter beginning one year after the date of the enactment of such Act), at the option of the State''.

(c) EFFECTIVE DATE.—

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

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

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

SEC. 30724. PROVIDING FOR 1 YEAR OF CONTINUOUS ELIGIBILITY FOR CHILDREN UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended—

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

(2) by adding at the end following new paragraph:

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

''(A) the end of the 12-month period beginning on the date of such determination;

"(B) the time that such individual attains the age of 19; or

"(C) the date that such individual ceases to be a resident of such State.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a)(2) shall apply with respect to eligibility determinations or redeterminations made on or after the date of the enactment of this Act.

(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet any requirement imposed by amendments made under subsection (a)(2), the plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such a requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year

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

SEC. 30725. ALLOWING FOR MEDICAL ASSISTANCE UNDER MEDICAID FOR INMATES DURING 30-DAY PERIOD PRECEDING RELEASE.

The subdivision (A) following paragraph (31) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''and, beginning on the first day of the first fiscal year quarter that begins at least one year after the date of the enactment of the Act titled 'An Act to provide for reconciliation pursuant to title II of S. Con. Res. 14', except during the 30-day period preceding the date of release of such individual from such public institution'' after ''medical institution''.

SEC. 30726. EXTENSION OF CERTAIN PROVISIONS.

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

(c) CONFORMING AMENDMENTS FOR ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—

(1) in the paragraph heading, by striking ''THROUGH SEPTEMBER 30, 2027''; and

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