

**AMENDMENT IN THE NATURE OF A SUBSTITUTE  
TO COMMITTEE PRINT FOR SUBTITLE G RE-  
LATING TO THE MEDICAID PROGRAM UNDER  
TITLE XIX OF THE SOCIAL SECURITY ACT  
OFFERED BY M\_\_ . \_\_\_\_\_**

In lieu of the proposed recommendations, insert the following:

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.—Not later than January 1,  
12 2025, the Secretary shall establish a program (in this sec-  
13 tion referred to as the ‘Federal Medicaid program’ or the  
14 ‘Program’ under which, in the case of a State that the  
15 Secretary determines (based on the State plan under this  
16 title, waiver of such plan, or other relevant information)

1 is not expected to expend amounts under the State plan  
2 (or waiver of such plan) for all individuals who would be  
3 entitled to medical assistance pursuant to section  
4 1902(a)(10)(A)(i)(VIII) during a year (beginning with  
5 2025), (in this section defined as ‘a coverage gap State’,  
6 with respect to such year), the Secretary shall (including  
7 through contract with eligible entities (as specified by the  
8 Secretary), consistent with subsection (b)) provide for the  
9 offering to such individuals residing in such State of  
10 health benefits. The Federal Medicaid program shall be  
11 offered in a coverage gap State for each quarter during  
12 the period beginning on January 1 of such year, and end-  
13 ing with the last day of the first quarter during which  
14 the State provides medical assistance to all such individ-  
15 uals under the State plan (or waiver of such plan). Under  
16 the Federal Medicaid program, the Secretary—

17           “(1) may use the Federally Facilitated Market-  
18           place to facilitate eligibility determinations and en-  
19           rollments under the Federal Medicaid Program and  
20           shall establish a set of eligibility rules to be applied  
21           under the Program in a manner consistent with sec-  
22           tion 1902(e)(14);

23           “(2) shall establish benefits, beneficiary protec-  
24           tions, and access to care standards by, at a min-  
25           imum—

1           “(A) establishing a minimum set of health  
2           benefits to be provided (and providing such ben-  
3           efits) under the Federal Medicaid program,  
4           which shall be in compliance with the require-  
5           ments of section 1937 and shall consist of  
6           benchmark coverage described in section  
7           1937(b)(1) or benchmark equivalent coverage  
8           described in section 1937(b)(2) to the same ex-  
9           tent as medical assistance provided to such an  
10          individual under this title (without application  
11          of this section) is required under section  
12          1902(k)(1) to consist of such benchmark cov-  
13          erage or benchmark equivalent coverage;

14          “(B) applying the provisions of sections  
15          1902(a)(8), 1902(a)(34), and 1943 with respect  
16          to such an individual, health benefits under the  
17          Federal Medicaid program, and making applica-  
18          tion for such benefits in the same manner as  
19          such provisions would apply to such an indi-  
20          vidual, medical assistance under this title (other  
21          than pursuant to this section), and making ap-  
22          plication for such medical assistance under this  
23          title (other than pursuant to this section); and  
24          providing that redeterminations and appeals of  
25          eligibility and coverage determinations of items

1 and services (including benefit reductions, ter-  
2 minations, and suspension) shall be conducted  
3 under the Federal Medicaid program in accord-  
4 ance with a Federal fair hearing process estab-  
5 lished by the Secretary that is subject to the  
6 same requirements as applied under section  
7 1902(a)(3) with respect to redeterminations  
8 and appeals of eligibility, and with respect to  
9 coverage of items and services (including benefit  
10 reductions, terminations, and suspension),  
11 under a State plan under this title and that  
12 may provide for such fair hearings related to  
13 denials of eligibility (based on modified adjusted  
14 gross income eligibility determinations) to be  
15 conducted through the Federally Facilitated  
16 Marketplace for Exchanges;

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

1 under the State plan for covered outpatient  
2 drugs with respect to the rebate period;

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

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

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

15 “(E) prohibiting payment from being avail-  
16 able under the Federal Medicaid program for  
17 any item or service subject to a payment exclu-  
18 sion under this title or title XI.

19 “(b) ADMINISTRATION OF FEDERAL MEDICAID PRO-  
20 GRAM THROUGH CONTRACTS WITH MEDICAID MANAGED  
21 CARE ORGANIZATION AND THIRD PARTY PLAN ADMINIS-  
22 TRATOR REQUIREMENTS.—

23 “(1) IN GENERAL.—For the purpose of pro-  
24 viding medical assistance to individuals described in  
25 section 1902(a)(10)(A)(i)(VIII) enrolled under the

1 Federal Medicaid program across all coverage gap  
2 geographic areas (as defined in paragraph (8)) in  
3 which such individuals reside, the Secretary shall so-  
4 licit bids described in paragraph (2) and enter into  
5 contracts with a total of at least 2 eligible entities  
6 (as specified by the Secretary, which may be a med-  
7 icaid managed care organization (in this section de-  
8 fined as a managed care organization described in  
9 section 1932(a)(1)(B)(i)), a third party plan admin-  
10 istrator, or both). An eligible entity entering into a  
11 contract with the Secretary under this paragraph  
12 may administer such benefits as a medicaid man-  
13 aged care organization (as so defined), in which case  
14 such contract shall be in accordance with paragraph  
15 (3) with respect to such geographic area, or as a  
16 third-party administrator, in which case such con-  
17 tract shall be in accordance with paragraph (4) with  
18 respect to such geographic area. The Secretary may  
19 so contract with a Medicaid managed care organiza-  
20 tion or third party plan administrator in each cov-  
21 erage gap geographic area (and may specify which  
22 type of eligible entity may bid with respect to a cov-  
23 erage gap geographic area or areas) and may con-  
24 tract with more than one such eligible entity in the  
25 same coverage 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 provide medical assistance under the Pro-  
8 gram in one or more coverage gap geographic  
9 areas, which are actuarially sound and reflect  
10 the projected monthly cost to the entity of pro-  
11 viding medical assistance under the Program to  
12 an individual enrolled under the Program in  
13 such a geographic area (or areas) for such year.

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

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

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



1 to the minimum set of benefits established  
2 by the Secretary under subsection  
3 (a)(2)(A).

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

16 “(iv) The organizational capacity of  
17 the entity, the experience of the entity with  
18 Medicaid managed care, the experience of  
19 the entity with Medicaid managed care for  
20 individuals described in section  
21 1902(a)(10)(A)(i)(VIII), the performance  
22 of the entity (if available) on the adult core  
23 set quality measures in States that are not  
24 coverage gap States.

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

8           “(A) The provisions of clauses (i) through  
9 (xi) of section 1903(m)(2)(A), clause (xii) of  
10 such section (to the extent such clause relates  
11 to subsections (b), (d), (f), and (i) of section  
12 1932), and clause (xiii) of such section  
13 1903(m)(2)(A) shall, to the greatest extent  
14 practicable, apply to the contract, to the Sec-  
15 retary, and to the Medicaid managed care orga-  
16 nization, with respect to providing medical as-  
17 sistance under the Federal Medicaid program  
18 with respect to such area (or areas), in the  
19 same manner and to the same extent as such  
20 provisions apply to a contract under section  
21 1903(m) between a State and an entity that is  
22 a medicaid managed care organization (as de-  
23 fined in section 1903(m)(1)), to the State, and  
24 to the entity, with respect to providing medical

1 assistance to individuals eligible for benefits  
2 under this title.

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

6 “(C) The contract shall provide that the  
7 entity pay claims in a timely manner and in ac-  
8 cordance with the provisions of section  
9 1902(a)(37).

10 “(D) The contract shall provide that the  
11 Secretary shall make payments under this sec-  
12 tion to the entity, with respect to coverage of  
13 each individual enrolled under the Program in  
14 such a coverage gap geographic area with re-  
15 spect to which the entity administers the Pro-  
16 gram in an amount specified in the contract,  
17 subject to subparagraph (D)(ii) and paragraph  
18 (6).

19 “(E) The contract shall require—

20 “(i) the application of a minimum  
21 medical loss ratio (as calculated under sub-  
22 section (d) of section 438.8 of title 42,  
23 Code of Federal Regulations (or any suc-  
24 cesssor regulation)) for payment for medical  
25 assistance administered by the managed

1 care organization under the Program, with  
2 respect to a year, that is equal to or great-  
3 er than 85 percent (or such higher percent  
4 as specified by the Secretary); and

5 “(ii) in the case, with respect to a  
6 year, the minimum medical loss ratio (as  
7 so calculated) for payment for services  
8 under the benefits so administered is less  
9 than 85 percent (or such higher percent as  
10 specified by the Secretary under clause  
11 (i)), remittance by the organization to the  
12 Secretary of any payments (or portions of  
13 payments) made to the organization under  
14 this section in an amount equal to the dif-  
15 ference in payments for medical assistance,  
16 with respect to the year, resulting from the  
17 organization’s failure to meet such ratio  
18 for such year.

19 “(F) The contract shall require that the el-  
20 igible entity submit to the Secretary—

21 “(i) the number of individuals enrolled  
22 in the Program with respect to each cov-  
23 erage gap geographic area and month with  
24 respect to which the contract applies;

1           “(ii) encounter data (disaggregated by  
2           race, ethnicity, and age) with respect to  
3           each coverage gap geographic area and  
4           month with respect to which the contract  
5           applies; and

6           “(iii) such additional information as  
7           specified by the Secretary for purposes of  
8           payment, program integrity, oversight,  
9           quality measurement, or such other pur-  
10          pose specified by the Secretary.

11          “(G) The contract shall require that the el-  
12          igible entity perform any other activity identi-  
13          fied by the Secretary.

14          “(4) CONTRACT WITH A THIRD PARTY PLAN  
15          ADMINISTRATOR.—

16                 “(A) IN GENERAL.—In the case of a con-  
17          tract under paragraph (1) between the Sec-  
18          retary and an eligible entity to administer the  
19          Program as a third party plan administrator,  
20          with respect to one or more coverage gap geo-  
21          graphic areas, such contract shall provide that,  
22          with respect to medical assistance provided  
23          under the Federal Medicaid program to individ-  
24          uals who are enrolled in the Program with re-  
25          spect to such area (or areas)—

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

4 “(I) establish provider networks,  
5 payment rates, and utilization man-  
6 agement, consistent with the provi-  
7 sions of section 1902(a)(30)(A), as  
8 applied by subsection (a)(4) of this  
9 section;

10 “(II) pay claims in a timely man-  
11 ner and in accordance with the provi-  
12 sions of section 1902(a)(37);

13 “(III) submit to the Secretary—

14 “(aa) the number of individ-  
15 uals enrolled in the Program with  
16 respect to each coverage gap geo-  
17 graphic area and month with re-  
18 spect to which the contract ap-  
19 plies;

20 “(bb) encounter data  
21 (disaggregated by race, ethnicity,  
22 and age) with respect to each  
23 coverage gap geographic area and  
24 month with respect to which the  
25 contract applies; and

1                   “(cc) such additional infor-  
2                   mation as specified by the Sec-  
3                   retary for purposes of payment,  
4                   program integrity, oversight,  
5                   quality measurement, or such  
6                   other purpose specified by the  
7                   Secretary; and

8                   “(IV) perform any other activity  
9                   identified by the Secretary;

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

23                  “(iii) the provisions of clause (xii) of  
24                  section 1903(m)(2)(A) (to the extent such  
25                  clause relates to subsections (b), (d), (f),

1 and (i) of section 1932) shall, to the great-  
2 est extent practicable, apply to the con-  
3 tract, to the Secretary, and to the third  
4 party plan administrator, with respect to  
5 providing medical assistance under the  
6 Federal Medicaid program with respect to  
7 such area (or areas), in the same manner  
8 and to the same extent as such provisions  
9 apply to a contract under section 1903(m)  
10 between a State and an entity that is a  
11 Medicaid managed care organization (as  
12 defined in section 1903(m)(1)), to the  
13 State, and to the entity, with respect to  
14 providing medical assistance to individuals  
15 eligible for benefits under this title

16 “(B) THIRD PARTY PLAN ADMINISTRATOR  
17 DEFINED.—For purposes of this section, the  
18 term ‘third party plan administrator’ means an  
19 entity that satisfies such requirements as estab-  
20 lished by the Secretary, which shall include at  
21 least that such an entity administers health  
22 plan benefits, pays claims under the plan, es-  
23 tablishes provider networks, sets payment rates,  
24 and are not risk-bearing entities.



1           “(5) ADMINISTRATIVE AUTHORITY.—The Sec-  
2           retary may take such actions as are necessary to ad-  
3           minister this subsection, including by setting net-  
4           work adequacy standards, establishing quality re-  
5           quirements, establishing reporting requirements, lim-  
6           iting administrative costs, and specifying any other  
7           program requirements or standards necessary in  
8           contracting with specified entities under this sub-  
9           section, and overseeing such entities, with respect to  
10          the administration of the Federal Medicaid program.

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

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

21                 “(B) any provisions of law of that State  
22                 which relate to the licensing of the organization  
23                 or administrator and which prohibit the organi-  
24                 zation or administrator from providing coverage

1           pursuant to a contract under this section shall  
2           be superseded.

3           “(7) PENALTIES.—In the case of an eligible en-  
4           tity with a contract under this section that fails to  
5           comply with the requirements of such entity pursu-  
6           ant to this section or such contract, the Secretary  
7           may withhold payment (or any portion of such pay-  
8           ment) to such entity under this section in accord-  
9           ance with a process specified by the Secretary, im-  
10          pose a corrective action plan on such entity, termi-  
11          nate the contract, or impose a civil monetary penalty  
12          on such entity in an amount not to exceed \$10,000  
13          for each such failure. In implementing this para-  
14          graph, the Secretary shall have the authorities pro-  
15          vided the Secretary under section 1932(e) and sub-  
16          parts F and I of part 438 of title 42, Code of Fed-  
17          eral 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, in the case that, pursuant to such  
6 verification, an individual is determined to have had a  
7 change in income that results in such individual no longer  
8 be included as an individual described in section  
9 1902(a)(10)(A)(i)(VIII), the Secretary shall apply the  
10 same processes and protections as States are required  
11 under this title to apply with respect to an individual who  
12 is determined to have had a change in income that results  
13 in such individual no longer being included as eligible for  
14 medical assistance under this title (other than pursuant  
15 to this section).

16 “(d) DRUG REBATES.—For purposes of subsection  
17 (a)(2)(C), in applying section 1927, the Secretary shall  
18 (either directly or through contracts)—

19 “(1) require an eligible entity with a contract  
20 under subsection (b) to report the data required to  
21 be reported under section 1927(b)(2) by a State  
22 agency and require such entity to submit to the Sec-  
23 retary rebate data, utilization data, and any other  
24 information that would otherwise be required under

1 section 1927 to be submitted to the Secretary by a  
2 State;

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

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

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

24 “(5) require an eligible entity with a contract  
25 under subsection (b) to provide for a drug use re-

1 view program described in subsection (g) of section  
2 1927 in accordance with the requirements applicable  
3 to a State under such subsection (g) with respect to  
4 a drug use review program; and

5 “(6) adopt a mechanism to prevent the require-  
6 ments of section 1927 from applying to covered out-  
7 patient drugs under the Federal Medicaid program  
8 pursuant to this subsection and subsection (a)(2)(C)  
9 if such drugs are subject to discounts under section  
10 340B of the Public Health Service Act.

11 “(e) TRANSITIONS.—

12 “(1) FROM EXCHANGE PLANS ONTO FEDERAL  
13 MEDICAID PROGRAM.—The Secretary shall provide  
14 for a process under which, in the case of individuals  
15 entitled to medical assistance pursuant section  
16 1902(a)(10)(A)(i)(VIII) who are enrolled in qualified  
17 health plans through an Exchange in a coverage gap  
18 State, the Secretary takes such steps as are nec-  
19 essary to transition such individuals to coverage  
20 under the Federal Medicaid program. Such process  
21 shall apply procedures described in section  
22 1943(b)(1)(C) to screen for eligibility and enroll-  
23 ment under the Federal Medicaid program in the  
24 same manner as such procedures screen for eligi-  
25 bility and enrollment under qualified health plans

1 through an Exchange established under title I of the  
2 Patient Protection and Affordable Care Act.

3 “(2) IN CASE COVERAGE GAP STATE BEGINS  
4 PROVIDING COVERAGE UNDER STATE PLAN.—The  
5 Secretary shall provide for a process for, in the case  
6 of a coverage gap State in which the State begins  
7 to provide medical assistance to individuals described  
8 in section 1902(a)(10)(A)(i)(VIII) under the State  
9 plan (or waiver of such plan) and the Federal Med-  
10 icaid program ceases to be offered, transitioning in-  
11 dividuals from such program to the State plan (or  
12 waiver), as eligible, including a process for  
13 transitioning all eligibility redeterminations.

14 “(3) AUTHORITY FOR PHASE-IN.—The Sec-  
15 retary may apply section 1902(a)(34), pursuant to  
16 subsection (a)(2)(B) of this section, in accordance  
17 with such phased-in implementation as the Secretary  
18 deems necessary, but beginning as soon as prac-  
19 ticable.

20 “(f) COORDINATION WITH AND ENROLLMENT  
21 THROUGH EXCHANGES.—The Secretary shall take such  
22 actions as are necessary to provide, in the case of a cov-  
23 erage gap State in which the Federal Medicaid program  
24 is offered, for the availability of information on, deter-  
25 minations of eligibility for, and enrollment in such pro-

1 gram through and coordinated with the Exchange estab-  
2 lished with respect to such State under title I of the Pa-  
3 tient Protection and Affordable Care Act.

4 “(g) THIRD PARTY LIABILITY.—The provisions of  
5 section 1902(a)(25) shall apply with respect to the Fed-  
6 eral Medicaid program, the Secretary, and the eligible en-  
7 tities with a contract under subsection (b) in the same  
8 manner as such provisions apply with respect to State  
9 plans under this title (or waiver of such plans) and the  
10 State or local agency administering such plan (or waiver).  
11 The Secretary may specify a timeline (which may include  
12 a phase-in) for implementing this subsection.

13 “(h) FRAUD AND ABUSE PROVISIONS.—Provisions of  
14 law (other than criminal law provisions) identified by the  
15 Secretary, in consultation (as appropriate) with the In-  
16 spector General of the Department of Health and Human  
17 Services, that impose sanctions with respect to waste,  
18 fraud, and abuse under this title or title XI, such as the  
19 False Claims Act (31 U.S.C. 3729 et seq.), as well as pro-  
20 visions of law (other than criminal law provisions) identi-  
21 fied by the Secretary that provide oversight authority,  
22 shall also apply to the Federal Medicaid program.

23 “(i) MAINTENANCE OF EFFORT.—

24 “(1) PAYMENT.—

1           “(A) IN GENERAL.—In the case of a State  
2           that, as of January 1, 2022, is expending  
3           amounts for all individuals described in section  
4           1902(a)(10)(A)(i)(VIII) under the State plan  
5           (or waiver of such plan) and that stops expend-  
6           ing amounts for all such individuals under the  
7           State plan (or waiver of such plan), such State  
8           shall for each quarter beginning after January  
9           1, 2022, during which such State does not ex-  
10          pend amounts for all such individuals provide  
11          for payment under this subsection to the Sec-  
12          retary of the product of—

13                 “(i) 10 percent of, subject to subpara-  
14                 graph (B), the average monthly per capita  
15                 costs expended under the State plan (or  
16                 waiver of such plan) for such individuals  
17                 during the most recent previous quarter  
18                 with respect to which the State expended  
19                 amounts for all such individuals; and

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

23           “(B) ANNUAL INCREASE.—For purposes of  
24           subparagraph (A), in the case of a State with  
25           respect to which such subparagraph applies



1 with respect to a period of consecutive quarters  
2 occurring during more than one calendar year,  
3 for such consecutive quarters occurring during  
4 the second of such calendar years or a subse-  
5 quent calendar year, the average monthly per  
6 capita costs for each such quarter for such  
7 State determined under subparagraph (A)(i), or  
8 this subparagraph, shall be annually increased  
9 by the Secretary by the percentage increase in  
10 Medicaid spending under this title during the  
11 preceding year (as determined based on the  
12 most recent National Health Expenditure data  
13 with respect to such year).

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

17 “(3) COMPLIANCE.—If a State fails to pay to  
18 the Secretary an amount required under paragraph  
19 (1), interest shall accrue on such amount at the rate  
20 provided under section 1903(d)(5). The amount so  
21 owed and applicable interest shall be immediately  
22 offset against amounts otherwise payable to the  
23 State under section 1903(a), in accordance with the  
24 Federal Claims Collection Act of 1996 and applica-  
25 ble regulations.

1           “(4) DATA MATCH.—The Secretary shall per-  
2           form such periodic data matches as may be nec-  
3           essary to identify and compute the number of indi-  
4           viduals enrolled under the Federal Medicaid pro-  
5           gram under section 1948 in a coverage gap State (as  
6           referenced in subsection (a) of such section) for pur-  
7           poses of computing the amount under paragraph  
8           (1).

9           “(5) NOTICE.—The Secretary shall notify each  
10          State described in paragraph (1) not later than a  
11          date specified by the Secretary that is before the be-  
12          ginning of each quarter (beginning with 2022) of the  
13          amount computed under paragraph (1) for the State  
14          for that year.

15          “(j) APPROPRIATIONS.—In addition to amounts oth-  
16          erwise available, there is appropriated, out of any funds  
17          in the Treasury not otherwise appropriated, for each fiscal  
18          year such sums as are necessary to carry out subsections  
19          (a) through (i) of this section.”.

20          (b) DRUG REBATE CONFORMING AMENDMENT.—  
21          Section 1927(a)(1) of the Social Security Act (42 U.S.C.  
22          1396r–8(a)(1)) is amended in the first sentence—

23                  (1) by striking “or under part B of title XVIII”  
24                  and inserting “, under the Federal Medicaid pro-

1       gram under section 1948, or under part B of title  
2       XVIII”; and

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

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

8       **HOME AND COMMUNITY-BASED SERVICES**

9       **SEC. 30711. DEFINITIONS.**

10       In this part:

11               (1) **APPROPRIATE COMMITTEES OF CON-**  
12       **GRESS.**—The term “appropriate committees of Con-  
13       gress” means the Committee on Energy and Com-  
14       merce of the House of Representatives, the Com-  
15       mittee on Finance of the Senate, the Committee on  
16       Health, Education, Labor and Pensions of the Sen-  
17       ate, and the Special Committee on Aging of the Sen-  
18       ate.

19               (2) **DIRECT CARE WORKER.**—The term “direct  
20       care worker” means, with respect to a State, any of  
21       the following individuals who by contract, by receipt  
22       of payment for care, or as a result of the operation  
23       of law, provides directly to Medicaid eligible individ-  
24       uals home and community-based services available  
25       under the State Medicaid program:

1 (A) A registered nurse, licensed practical  
2 nurse, nurse practitioner, or clinical nurse spe-  
3 cialist who provides licensed nursing services, or  
4 a licensed nursing assistant who provides such  
5 services under the supervision of a registered  
6 nurse, licensed practical nurse, nurse practi-  
7 tioner, or clinical nurse specialist.

8 (B) A direct support professional.

9 (C) A personal care attendant.

10 (D) A home health aide.

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

14 (3) HCBS PROGRAM IMPROVEMENT STATE.—  
15 The term “HCBS program improvement State”  
16 means a State that is awarded a planning grant  
17 under section 1011(a) and has an HCBS improve-  
18 ment plan approved by the Secretary under section  
19 1011(d).

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

1 (A) A medicaid managed care organiza-  
2 tion, as defined in section 1903(m)(1)(A) of the  
3 Social Security Act (42 U.S.C.  
4 1396b(m)(1)(A)).

5 (B) A prepaid inpatient health plan or pre-  
6 paid ambulatory health plan, as defined in sec-  
7 tion 438.2 of title 42, Code of Federal Regula-  
8 tions (or any successor regulation)).

9 (C) Any other entity determined to be ap-  
10 propriate by the State and approved by the Sec-  
11 retary.

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

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

19 (B) Private duty nursing services author-  
20 ized under paragraph (8) of such section, when  
21 such services are provided in a Medicaid eligible  
22 individual’s home.

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

1 (D) PACE services authorized under para-  
2 graph (26) of such section.

3 (E) Home and community-based services  
4 authorized under subsections (b), (c), (i), (j),  
5 and (k) of section 1915 of such Act (42 U.S.C.  
6 1396n), authorized under a waiver under sec-  
7 tion 1115 of such Act (42 U.S.C. 1315), or  
8 provided through coverage authorized under  
9 section 1937 of such Act (42 U.S.C. 1396u–7).

10 (F) Case management services authorized  
11 under section 1905(a)(19) of the Social Secu-  
12 rity Act (42 U.S.C. 1396d(a)(19)) and section  
13 1915(g) of such Act (42 U.S.C. 1396n(g)).

14 (G) Rehabilitative services, including those  
15 related to behavioral health, described in section  
16 1905(a)(13) of such Act (42 U.S.C.  
17 1396d(a)(13)).

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

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

24 (i) authorized under section 1905(a)  
25 of such Act (42 U.S.C. 1396d(a)) (or

1                   under a waiver under section 1915(c) or  
2                   demonstration under section 1115) ; and  
3                   (ii) described in another subparagraph  
4                   of this paragraph.

5                   (J) Such other services specified by the  
6                   Secretary.

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

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

12                  (B) a nursing facility (as defined in section  
13                  1919(a) of such Act (42 U.S.C. 1396r(a)));

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

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

20                  (E) an institution (or distinct part thereof)  
21                  which is a psychiatric hospital (as defined in  
22                  section 1861(f) of such Act (42 U.S.C.  
23                  1395x(f))) or that provides inpatient psychiatric  
24                  services in a residential setting specified by the  
25                  Secretary;

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

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

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

14 (8) STATE MEDICAID PROGRAM.—The term  
15 “State Medicaid program” means, with respect to a  
16 State, the State program under title XIX of the So-  
17 cial Security Act (42 U.S.C. 1396 et seq.) (including  
18 any waiver or demonstration under such title or  
19 under section 1115 of such Act (42 U.S.C. 1315) re-  
20 lating to such title).

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

23 (10) STATE.—The term “State” means each of  
24 the 50 States, the District of Columbia, Puerto Rico,



1 the Virgin Islands, Guam, the Northern Mariana Is-  
2 lands, and American Samoa.

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

4 (a) FUNDING.—

5 (1) IN GENERAL.—In addition to amounts oth-  
6 erwise available, there is appropriated to the Sec-  
7 retary for fiscal year 2022, out of any money in the  
8 Treasury not otherwise appropriated, \$130,000,000,  
9 to remain available until expended, for carrying out  
10 this section.

11 (2) TECHNICAL ASSISTANCE AND GUIDANCE.—

12 The Secretary shall reserve \$5,000,000 of the  
13 amount appropriated under paragraph (1) for pur-  
14 poses of issuing guidance and providing technical as-  
15 sistance to States intending to apply for, or award-  
16 ed, a planning grant under this section, and for  
17 other administrative expenses related to awarding  
18 planning grants under this section.

19 (b) AWARD AND USE OF GRANTS.—

20 (1) DEADLINE FOR AWARD OF GRANTS.—From  
21 the amount appropriated under subsection (a)(1),  
22 the Secretary, not later than 12 months after the  
23 date of enactment of this Act, shall solicit State re-  
24 quests for HCBS improvement planning grants and

1 award such grants to all States that meet such re-  
2 quirements as determined by the Secretary.

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

11 (3) USE OF FUNDS.—A State awarded a plan-  
12 ning grant under this section shall use the grant to  
13 carry out planning activities for purposes of devel-  
14 oping and submitting to the Secretary an HCBS im-  
15 provement plan for the State that meets the require-  
16 ments of subsections (c) and (d) in order to expand  
17 access to home and community-based services and  
18 strengthen the direct care workforce that provides  
19 such services. A State may use planning grant funds  
20 to support activities related to the implementation of  
21 the HCBS improvement plan for the State, collect  
22 and report information described in subsection (c),  
23 identify areas for improvement to the service deliv-  
24 ery systems for home and community-based services,  
25 carry out activities related to evaluating payment

1 rates for home and community-based services and  
2 identifying improvements to update the rate setting  
3 process, and for such other purposes as the Sec-  
4 retary shall specify, including the following:

5 (A) Caregiver supports.

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

8 (C) Promoting equity and addressing  
9 health disparities.

10 (D) Promoting community integration and  
11 compliance with the home and community-based  
12 settings rule published on January 16, 2014, or  
13 any successor regulation.

14 (E) Building partnerships.

15 (F) Infrastructure investments (such as  
16 case management or other information tech-  
17 nology systems).

18 (c) HCBS IMPROVEMENT PLAN REQUIREMENTS.—

19 In order to meet the requirements of this subsection, an  
20 HCBS improvement plan developed using funds awarded  
21 to a State under this section shall include, with respect  
22 to the State and subject to subsection (d), the following:

23 (1) EXISTING MEDICAID HCBS LANDSCAPE.—

24 (A) ELIGIBILITY AND BENEFITS.—A de-  
25 scription of the existing standards, pathways,

1 and methodologies for eligibility (which shall be  
2 delineated by the State based on eligibility  
3 group under the State plan or waiver of such  
4 plan) for home and community-based services,  
5 including limits on assets and income, the home  
6 and community-based services available under  
7 the State Medicaid program and the types of  
8 settings in which they may be provided, and  
9 utilization management standards for such  
10 services.

11 (B) ACCESS.—

12 (i) BARRIERS.—A description of the  
13 barriers to accessing home and community-  
14 based services in the State identified by  
15 Medicaid eligible individuals, the families  
16 of such individuals, and providers of such  
17 services, such as barriers for individuals  
18 who wish to leave institutional settings, in-  
19 dividuals experiencing homelessness or  
20 housing instability, and individuals in geo-  
21 graphical areas of the State with low or no  
22 access to such services.

23 (ii) AVAILABILITY; UNMET NEED.—A  
24 summary, in accordance with guidance  
25 issued by the Secretary, of the extent to

1           which home and community-based services  
2           are available to all individuals in the State  
3           who would be eligible for such services  
4           under the State Medicaid program (includ-  
5           ing individuals who are on a waitlist for  
6           such services).

7           (C) UTILIZATION.—An assessment of the  
8           utilization of home and community-based serv-  
9           ices in the State during such period specified by  
10          the Secretary.

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

21          (E) WORKFORCE.—A description of the di-  
22          rect care workforce that provides home and  
23          community-based services, including estimates  
24          (and a description of the methodology used to  
25          develop such estimates) of the number of full-

1 and part-time direct care workers, the average  
2 and range of direct care worker wages, the ben-  
3 efits provided to direct care workers, the turn-  
4 over and vacancy rates of direct care worker po-  
5 sitions, the membership of direct care workers  
6 in labor organizations and, to the extent the  
7 State has access to such data, demographic in-  
8 formation about such workforce, including in-  
9 formation on race, ethnicity, and gender.

10 (F) PAYMENT RATES.—

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

21 (ii) ASSESSMENT.—An assessment of  
22 the relationship between payment rates for  
23 such services and average beneficiary wait  
24 times for such services, provider-to-bene-  
25 ficiary ratios in the geographic region.

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

4 (H) LONG-TERM SERVICES AND SUPPORTS  
5 PROVIDED IN INSTITUTIONAL SETTINGS.—A de-  
6 scription of the number of individuals enrolled  
7 in the State Medicaid program who receive  
8 items and services for greater than 30 days in  
9 an institutional setting that is a nursing facility  
10 or intermediate care facility, and the demo-  
11 graphic information of such individuals who are  
12 provided such items and services in such set-  
13 tings.

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

21 (J) DEMOGRAPHIC DATA.—To the extent  
22 available and as applicable with respect to the  
23 information required under subparagraphs  
24 (B),(C), and (H), demographic data for such  
25 information, disaggregated by age groups, pri-

1           mary disability, income brackets, gender, race,  
2           ethnicity, geography, primary language, and  
3           type of service setting.

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

6                   (A) Conduct the activities required under  
7                   subsection (jj) of section 1905 of the Social Se-  
8                   curity Act(as added under section 30713).

9                   (B) Reduce barriers and disparities in ac-  
10                  cess or utilization of home and community-  
11                  based services in the State.

12                  (C) Monitor and report (with supporting  
13                  data to the extent available and applicable  
14                  disaggregated by age groups, primary disability,  
15                  income brackets, gender, race, ethnicity, geog-  
16                  raphy, primary language, and type of service  
17                  setting, on—

18                           (i) access to home and community-  
19                           based services under the State Medicaid  
20                           program, disparities in access to such serv-  
21                           ices, and the utilization of such services;  
22                           and

23                           (ii) the amount of State Medicaid ex-  
24                           penditures for home and community-based  
25                           services under the State Medicaid program



1 as a proportion of the total amount of  
2 State expenditures under the State Med-  
3 icaid program for long-term services and  
4 supports.

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

8 (E) Assess and monitor the sufficiency of  
9 payments under the State Medicaid program  
10 for the specific types of home and community-  
11 based services available under such program for  
12 purposes of supporting direct care worker re-  
13 ruitment and retention and ensuring the avail-  
14 ability of home and community-based services.

15 (F) Coordinate implementation of the  
16 HCBS improvement plan among the State  
17 Medicaid agency, agencies serving individuals  
18 with disabilities, agencies serving the elderly,  
19 and other relevant State and local agencies and  
20 organizations that provide related supports,  
21 such as those for housing, transportation, em-  
22 ployment, and other services and supports.

23 (d) DEVELOPMENT AND APPROVAL REQUIRE-  
24 MENTS.—

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

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

20          (3) SUBMISSION AND APPROVAL.—Not later  
21          than 24 months after the date on which a State is  
22          awarded a planning grant under this section, the  
23          State shall submit an HCBS improvement plan for  
24          approval by the Secretary, along with assurances by  
25          the State that the State will implement the plan in

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

19 **SEC. 30713. HCBS IMPROVEMENT PROGRAM.**

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

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

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

3           “(jj) ADDITIONAL SUPPORT FOR HCBS PROGRAM  
4 IMPROVEMENT STATES.—

5           “(1) IN GENERAL.—

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

12                 “(i) and for which the State meets the  
13                 requirements described in paragraphs (2)  
14                 and (4), notwithstanding subsection (b) or  
15                 (ff), subject to subparagraph (B), with re-  
16                 spect to amounts expended during the  
17                 quarter by such State for medical assist-  
18                 ance for home and community-based serv-  
19                 ices, the Federal medical assistance per-  
20                 centage for such State and quarter (as de-  
21                 termined for the State under subsection  
22                 (b) and, if applicable, increased under sub-  
23                 section (y), (z), (aa), or (ii), or section  
24                 6008(a) of the Families First Coronavirus

1 Response Act) shall be increased by 7 per-  
2 centage points; and

3 “(ii) with respect to the State meeting  
4 the requirements described in paragraphs  
5 (2) and (4), notwithstanding section  
6 1903(a)(7), 1903(a)(3)(F), and 1903(t),  
7 with respect to amounts expended during  
8 the quarter and before October 1, 2031,  
9 for administrative costs for expanding and  
10 enhancing home and community-based  
11 services, including for enhancing Medicaid  
12 data and technology infrastructure, modi-  
13 fying rate setting processes, adopting or  
14 improving training programs for direct  
15 care workers and family caregivers, and  
16 adopting, carrying out, or enhancing pro-  
17 grams that register direct care workers or  
18 connect beneficiaries to direct care work-  
19 ers, the per centum specified in such sec-  
20 tion shall be increased to 80 percent.

21 In no case may the application of clause (i) re-  
22 sult in the Federal medical assistance percent-  
23 age determined for a State being more than 95  
24 percent with respect to such expenditures. In no  
25 case shall the application of clause (ii) result in

1 a reduction to the per centum otherwise speci-  
2 fied without application of such clause. Any in-  
3 crease pursuant to clause (ii) shall be available  
4 to a State before the State meets the require-  
5 ments of paragraphs (2) and (4).

6 “(B) ADDITIONAL HCBS IMPROVEMENT  
7 EFFORTS.—Subject to paragraph (5), in addi-  
8 tion to the increase to the Federal medical as-  
9 sistance percentage under subparagraph (A)(i)  
10 for amounts expended during a quarter for  
11 medical assistance for home and community-  
12 based services by an HCBS program improve-  
13 ment State that meets the requirements of  
14 paragraphs (2) and (4) for the quarter, the  
15 Federal medical assistance percentage for  
16 amounts expended by the State during the  
17 quarter for medical assistance for home and  
18 community-based services shall be further in-  
19 creased by 2 percentage points (but not to ex-  
20 ceed 95 percent) during the first 8 fiscal quar-  
21 ters throughout which the State has imple-  
22 mented and has in effect a program to support  
23 self-directed care that meets the requirements  
24 of paragraph (3).

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

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

19           “(2) REQUIREMENTS.—As conditions for re-  
20 ceipt of the increase under paragraph (1) to the  
21 Federal medical assistance percentage determined  
22 for a State, with respect to a fiscal year quarter, the  
23 State shall meet each of the following requirements:

24           “(A) NONSUPPLANTATION.—The State  
25 uses the Federal funds attributable to the in-

1           crease in the Federal medical assistance per-  
2           centage for amounts expended during a quarter  
3           for medical assistance for home and commu-  
4           nity-based services under subparagraphs (A)  
5           and, if applicable, (B) of paragraph (1) to sup-  
6           plement, and not supplant, the level of State  
7           funds expended for home and community-based  
8           services for eligible individuals through pro-  
9           grams in effect as of the date the State is  
10          awarded a planning grant under section 30712  
11          of the Act titled ‘An Act to provide for rec-  
12          onciliation pursuant to title II of S. Con. Res.  
13          14’. In applying this subparagraph, the Sec-  
14          retary shall provide that a State shall have a 3-  
15          year period to spend any accumulated unspent  
16          State funds attributable to the increase de-  
17          scribed in clause (i) in the Federal medical as-  
18          sistance percentage.

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 as of the date described in sub-  
12 clause (I), including, to the extent ap-  
13 plicable, payment rates for such serv-  
14 ices that are included in managed  
15 care capitation 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 as defined in the State’s  
19          HCBS improvement plan.

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

24          “(vi) Provides supports to family care-  
25          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, not less  
16                                frequently than once every 3 years,  
17                                through a transparent process involv-  
18                                ing meaningful input from stake-  
19                                holders, including recipients of home  
20                                and community-based services, family  
21                                caregivers of such recipients, pro-  
22                                viders, health plans, direct care work-  
23                                ers, chosen representatives of direct  
24                                care workers, and aging, disability,  
25                                and workforce advocates; and

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

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) incorporate 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.—As conditions for receipt of the  
3           increase under paragraph (1)(B) to the Federal  
4           medical assistance percentage determined for a  
5           State, with respect to a fiscal year quarter, the State  
6           shall establish directly, or by contract with 1 or  
7           more non-profit entities, including an agency with  
8           choice or a similar service delivery model, a program  
9           for the performance of all of the following functions:

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

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

18                   “(C) Ensuring the safety of, and sup-  
19                   porting the quality of, care provided to bene-  
20                   ficiaries, such as by conducting background  
21                   checks and addressing complaints reported by  
22                   recipients of home and community-based serv-  
23                   ices consistent with Fair Hearing requirements  
24                   and prior notice of service reductions, including  
25                   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 service,  
19 providing support to beneficiaries who wish to  
20 hire a caregiver who is a family member or in-  
21 dividual with whom they have an existing rela-  
22 tionship, such as by facilitating enrollment of  
23 such family member or individual as a provider  
24 of home and community-based services under  
25 the State plan or a waiver of such plan.



1           “(G) Ensuring that such programs do not  
2           discriminate against labor organizations or  
3           workers who may join or decline to join a labor  
4           organization.

5           “(4) REPORTING AND OVERSIGHT.—As condi-  
6           tions for receipt of the increase under paragraph (1)  
7           to the Federal medical assistance percentage deter-  
8           mined for a State, with respect to a fiscal year quar-  
9           ter, the State shall meet each of the following re-  
10          quirements:

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

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

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

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

24           “(B) Beginning with the 5th fiscal quarter  
25           for which the State is an HCBS program im-

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

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

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

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

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

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

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

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

14 “(5) BENCHMARKS FOR DEMONSTRATING IM-  
15 PROVEMENTS.—An HCBS program improvement  
16 State shall cease to be eligible for an increase in the  
17 Federal medical assistance percentage under para-  
18 graph (1)(A)(i) or (1)(B) or an increase in an appli-  
19 cable Federal matching percentage under paragraph  
20 (1)(A)(ii) at any time or beginning with the 29th fis-  
21 cal quarter that begins on or after the first date on  
22 which a State is an HCBS program improvement  
23 State if the State is found to be out of compliance  
24 with paragraph (2)(B) or any other requirement of  
25 this subsection and, beginning with such 29th fiscal

1 quarter, unless, not later than 90 days before the  
2 first day of such fiscal quarter, the State submits to  
3 the Secretary a report demonstrating the following  
4 improvements:

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

11 “(B) Reduced disparities in the utilization  
12 and availability of home and community-based  
13 services relative to the availability and utiliza-  
14 tion of such services by such populations as re-  
15 ported in such plan according to age groups,  
16 primary disability, income brackets, gender,  
17 race, ethnicity, geography, primary language,  
18 and type of service setting (to the extent avail-  
19 able and applicable), and adjusted for demo-  
20 graphic changes in the State since the submis-  
21 sion of such plan.

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

1           “(D) With respect to the percentage of ex-  
2           penditures made by the State for long-term  
3           services and supports that are for home and  
4           community-based services, in the case of an  
5           HCBS program improvement State for which  
6           such percentage (as reported in the State  
7           HCBS improvement plan) was—

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

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

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

1 **SEC. 30714. FUNDING FOR TECHNICAL ASSISTANCE AND**  
2 **OTHER ADMINISTRATIVE REQUIREMENTS**  
3 **RELATED TO MEDICAID HCBS.**

4 (a) IN GENERAL.—In addition to amounts otherwise  
5 available, there is appropriated to the Secretary for fiscal  
6 year 2022, out of any money in the Treasury not otherwise  
7 appropriated, \$35,000,000, to remain available until ex-  
8 pended, to carry out the following activities:

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

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

14 (i) a description of the HCBS im-  
15 provement plans approved by the Secretary  
16 under section 30712(d);

17 (ii) a description (which may be a  
18 narrative report with examples or other-  
19 wise) of the landscape, at both the national  
20 and State levels, with respect to gaps in  
21 coverage of home and community-based  
22 services, disparities in access to, and utili-  
23 zation of, such services, and barriers to ac-  
24 cessing such services; and

25 (iii) a description of the national land-  
26 scape with respect to the direct care work-

1 force that provides home and community-  
2 based services, including with respect to  
3 wages, benefits, and challenges to the  
4 availability of such workers; and

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

8 (i) the number of HCBS program im-  
9 provement States;

10 (ii) a summary of the progress being  
11 made by such States with respect to  
12 strengthening and expanding access to  
13 home and community-based services and  
14 the direct care workforce that provides  
15 such services and meeting the benchmarks  
16 for demonstrating improvements required  
17 under section 1905(jj)(5) of the Social Se-  
18 curity Act (as added by section 30713);

19 (iii) a summary of States' perform-  
20 ance measures as a part of the home and  
21 community-based services core quality  
22 measures and beneficiary and family care-  
23 giver surveys; and

24 (iv) a summary of the challenges and  
25 best practices reported by States in ex-

1           panding access to home and community-  
2           based services and supporting and expand-  
3           ing the direct care workforce that provides  
4           such services.

5           (2) To provide HCBS program improvement  
6           States with technical assistance related to carrying  
7           out the HCBS improvement plans approved by the  
8           Secretary under section 30712(d) and meeting the  
9           requirements and benchmarks for demonstrating im-  
10          provements required under section 1905(jj) of the  
11          Social Security Act (as added by section 30713),  
12          and to issue such guidance or regulations as nec-  
13          essary to carry out this subtitle and the amendments  
14          made by this subtitle, including guidance specifying  
15          how States shall assess and track access to home  
16          and community-based services over time.

17 **SEC. 30715. FUNDING FOR HCBS QUALITY MEASUREMENT**  
18 **AND IMPROVEMENT.**

19          (a) IN GENERAL.—Title XI of the Social Security Act  
20 (42 U.S.C. 1301 et seq.) is amended—

21           (1) in section 1139A—

22           (A) in subsection (a)(4)(B)—

23           (i) by striking “Beginning with the  
24           annual State report on fiscal year 2024”  
25           and inserting the following:



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

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

6                   “(ii) REPORTING HCBS QUALITY  
7                   MEASURES.—With respect to reporting on  
8                   information regarding the quality of home  
9                   and community-based services provided to  
10                  children under title XIX, beginning with  
11                  the annual State report for the first fiscal  
12                  year that begins on or after the date that  
13                  is 2 years after the date that the Secretary  
14                  publishes the home and community-based  
15                  services quality measures developed under  
16                  subsection (b)(5)(B) the Secretary shall re-  
17                  quire States to report such information  
18                  using the standardized format for report-  
19                  ing information and procedures developed  
20                  under subparagraph (A) and using such  
21                  home and community-based quality meas-  
22                  ures developed under subsection (b)(5) (in-  
23                  cluding any updates or changes to such  
24                  measures).”;

25                  (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 Assistant 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; and

5                   “(bb) include—

6                   “(AA) outcomes-based  
7 measures;

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

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

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

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

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

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

23                   “(III) DEMOGRAPHICS.—Such  
24 home and community-based services  
25 quality measures shall allow for the

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

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

16 “(iii) FUNDING.—In addition to  
17 amounts otherwise available, there is ap-  
18 propriated to the Secretary for fiscal year  
19 2022, out of any money in the Treasury  
20 not otherwise appropriated, \$5,000,000, to  
21 remain available until expended, for car-  
22 rying out this subparagraph.”; 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.—

13               (1) IN GENERAL.—Section 1903(a)(3) of the  
14          Social Security Act (42 U.S.C. 1396b(a)(3)) is  
15          amended—

16                   (A) in subparagraph (F)(ii), by striking  
17                   “plus” after the semicolon and inserting “and”;  
18                   and

19                   (B) by inserting after subparagraph (F),  
20                   the following:

21                           “(G) 80 percent of so much of the sums  
22                           expended during such quarter as are attrib-  
23                           utable to the reporting of information regarding  
24                           the quality of home and community-based serv-



1           ices     in     accordance     with     sections  
2           1139A(a)(4)(B)(ii) and 1139B(b)(3)(C); and”.

3           (2) EXEMPTION FROM TERRITORIES’ PAYMENT  
4     LIMITS.—Section 1108(g)(4) of the Social Security  
5     Act is amended by adding at the end the following  
6     new subparagraph:

7                   “(C) ADDITIONAL EXEMPTION RELATING  
8                   TO HCBS QUALITY REPORTING.—Payments  
9                   under section 1903(a)(3)(G) shall not be taken  
10                   into account in applying payment limits under  
11                   subsection (f) and this subsection.”.

12                   **PART 3—OTHER MEDICAID**

13     **SEC. 30721. PERMANENT EXTENSION OF MEDICAID PRO-**  
14                   **TECTIONS AGAINST SPOUSAL IMPOVERISH-**  
15                   **MENT FOR RECIPIENTS OF HOME AND COM-**  
16                   **MUNITY-BASED SERVICES.**

17           Section 1924(h)(1)(A) of the Social Security Act (42  
18     U.S.C. 1396r–5(h)(1)(A)) is amended by striking “(at the  
19     option of the State) is described in section  
20     1902(a)(10)(A)(ii)(VI)” and inserting the following: “is  
21     eligible for medical assistance for home and community-  
22     based services provided under subsection (c), (d), or (i)  
23     of section 1915 or under a waiver approved under section  
24     1115, or who is eligible for such medical assistance by rea-  
25     son of being determined eligible under section

1 1902(a)(10)(C) or by reason of section 1902(f) or other-  
2 wise on the basis of a reduction of income based on costs  
3 incurred for medical or other remedial care, or who is eligi-  
4 ble for medical assistance for home and community-based  
5 attendant services and supports under section 1915(k)”.  
6

6 **SEC. 30722. PERMANENT EXTENSION OF MONEY FOLLOWS**  
7 **THE PERSON REBALANCING DEMONSTRA-**  
8 **TION.**

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

12 (1) in paragraph (1)—

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

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

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

19 (C) by striking subparagraph (K);

20 (2) in paragraph (2), by striking “September  
21 30, 2023” and inserting “September 30 of the sub-  
22 sequent fiscal year”; and

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

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

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

16       **SEC. 30723. EXTENDING CONTINUOUS MEDICAID COV-**  
17                               **ERAGE FOR PREGNANT AND POSTPARTUM**  
18                               **WOMEN.**

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

22           (1) IN GENERAL.—Paragraph (5) of section  
23           1902(e) of the Social Security Act (42 U.S.C.  
24           1396a(e)) is amended—

1 (A) by striking “(5) A woman who” and  
2 inserting “(5)(A) For any fiscal year quarter  
3 with respect to which the amendments made by  
4 section 30723(a)(1)(B) of the Act titled ‘An  
5 Act to provide for reconciliation pursuant to  
6 title II of S. Con. Res. 14’ do not apply (begin-  
7 ning with the first fiscal year quarter beginning  
8 one year after the date of the enactment of  
9 such Act), a woman who”; and

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

12 “(B) For any fiscal year quarter (beginning  
13 with the first fiscal year quarter beginning one year  
14 after the date of the enactment of this subpara-  
15 graph), any individual who, while pregnant, is eligi-  
16 ble for and received medical assistance under the  
17 State plan or a waiver of such plan (regardless of  
18 the basis for the individual’s eligibility for medical  
19 assistance and including during a period of retro-  
20 active eligibility under subsection (a)(34)), shall re-  
21 main eligible, notwithstanding section 1916(c)(3) or  
22 any other limitation under this title, for medical as-  
23 sistance through the end of the month in which the  
24 12-month period (beginning on the last day of preg-  
25 nancy of the individual) ends, and such medical as-

1           sistance shall be in accordance with clauses (i) and  
2           (ii) of paragraph (16)(B).”.

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

6                   (A) in section 1902(a)(10), in the matter  
7                   following subparagraph (G), by striking “(VII)  
8                   the medical assistance” and all that follows  
9                   through “, (VIII)” and inserting “(VIII)”;

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

19                   (C) in section 1902(l)(1)(A), by striking  
20                   “60-day period” and inserting “12-month pe-  
21                   riod”;

22                   (D) in section 1903(v)(4)(A)—

23                           (i) in clause (i), by striking “60-day  
24                           period” and inserting “12-month period  
25                           (or, for any fiscal year quarter with respect

1 to which the amendments made by section  
2 30723(a)(1)(B) of the Act titled ‘An Act  
3 to provide for reconciliation pursuant to  
4 title II of S. Con. Res. 14’ do not apply  
5 (beginning with the first fiscal year quar-  
6 ter beginning one year after the date of the  
7 enactment of such Act), 60-day period’’;  
8 and

9 (ii) in clause (ii), by inserting “and  
10 including an individual to whom section  
11 1902(e)(5)(B) applies, in accordance with  
12 such section, through the end of the month  
13 in which the 12-month period (beginning  
14 on the last day of pregnancy of the indi-  
15 vidual) ends” before the period at the end;  
16 and

17 (E) in section 1905(a), in the 4th sentence  
18 in the matter following paragraph (31), by  
19 striking “60-day period” and inserting “12-  
20 month period (or, for any fiscal year quarter  
21 with respect to which the amendments made by  
22 section 30723(a)(1)(B) of the Act titled ‘An  
23 Act to provide for reconciliation pursuant to  
24 title II of S. Con. Res. 14’ do not apply (begin-  
25 ning with the first fiscal year quarter beginning

1           one year after the date of the enactment of  
2           such Act), 60-day period)”.  
3

3           (b) TRANSITION FROM STATE OPTION.—Section  
4 1902(e)(16)(A) of the Social Security Act (42 U.S.C.  
5 1396a(e)(16)(A)) is amended by striking “At the option  
6 of the State” and inserting “For any fiscal year quarter  
7 with respect to which the amendments made by section  
8 30723(a)(1)(B) of the Act titled ‘An Act to provide for  
9 reconciliation pursuant to title II of S. Con. Res. 14’ do  
10 not apply (beginning with the first fiscal year quarter be-  
11 ginning one year after the date of the enactment of such  
12 Act), at the option of the State”.

13           (c) EFFECTIVE DATE.—

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

20           (2) EXCEPTION FOR STATE LEGISLATION.—In  
21           the case of a State plan under title XIX of the So-  
22           cial Security Act (42 U.S.C. 1396 et seq.) that the  
23           Secretary of Health and Human Services determines  
24           requires State legislation in order for the plan to  
25           meet any requirement imposed by amendments made

1 by this section, the plan shall not be regarded as  
2 failing to comply with the requirements of such title  
3 solely on the basis of its failure to meet such a re-  
4 quirement before the first day of the first calendar  
5 quarter beginning after the close of the first regular  
6 session of the State legislature that begins after the  
7 date of the enactment of this Act. For purposes of  
8 the previous sentence, in the case of a State that has  
9 a 2-year legislative session, each year of the session  
10 shall be considered to be a separate regular session  
11 of the State legislature.

12 **SEC. 30724. PROVIDING FOR 1 YEAR OF CONTINUOUS ELIGI-**  
13 **BILITY FOR CHILDREN UNDER THE MED-**  
14 **ICAID PROGRAM.**

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

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

20 (2) by adding at the end following new para-  
21 graph:

22 “(17) 1 YEAR OF CONTINUOUS ELIGIBILITY FOR  
23 CHILDREN.—The State plan (or waiver of such  
24 State plan) shall provide that an individual who is  
25 under the age of 19 and who is determined to be eli-



1       gible for benefits under a State plan approved under  
2       subsection (a)(10)(A) shall remain eligible for such  
3       benefits until the earlier of—

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

6               “(B) the time that such individual attains  
7               the age of 19; or

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

10       (b) EFFECTIVE DATE.—

11               (1) IN GENERAL.—Subject to paragraph (2),  
12       the amendments made by subsection (a)(2) shall  
13       apply with respect to eligibility determinations or re-  
14       determinations made on or after the date of the en-  
15       actment of this Act.

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

1 calendar quarter beginning after the close of the  
2 first regular session of the State legislature that be-  
3 gins after the date of the enactment of this Act. For  
4 purposes of the previous sentence, in the case of a  
5 State that has a 2-year legislative session, each year  
6 of the session shall be considered to be a separate  
7 regular session of the State legislature.

8 **SEC. 30725. ALLOWING FOR MEDICAL ASSISTANCE UNDER**  
9 **MEDICAID FOR INMATES DURING 30-DAY PE-**  
10 **RIOD PRECEDING RELEASE.**

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

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

21 (b) **EXPRESS LANE ELIGIBILITY OPTION.**—Section  
22 1902(e)(13) of the Social Security Act (42 U.S.C.  
23 1396a(e)(13)) is amended by striking subparagraph (I).

24 (c) **CONFORMING AMENDMENTS FOR ASSURANCE OF**  
25 **AFFORDABILITY STANDARD FOR CHILDREN AND FAMI-**

1 LIES.—Section 1902(gg)(2) of the Social Security Act (42  
2 U.S.C. 1396a(gg)(2)) is amended—

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

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

