117TH CONGRESS  
1ST SESSION  
H. R. _____

To amend title XIX of the Social Security Act to expand access to home and community-based services (HCBS) under Medicaid, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. DINGELL introduced the following bill; which was referred to the Committee on ______________________

A BILL

To amend title XIX of the Social Security Act to expand access to home and community-based services (HCBS) under Medicaid, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Better Care Better Jobs Act”.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
SEC. 2. DEFINITIONS.

In this Act:

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

(2) DIRECT CARE WORKER; DIRECT CARE WORKFORCE.—The terms “direct care worker” and “direct care workforce” mean—

(A) a direct support professional;

(B) a personal care attendant;

(C) a direct care worker;
(D) a home health aide; and

(E) any other relevant worker, as determined by the Secretary.

(3) ELIGIBLE INDIVIDUAL.—The term “eligible individual” means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

(4) HEALTH PLAN.—The term “health plan” means a group health plan or health insurance issuer (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)).

(5) HCBS PROGRAM IMPROVEMENT STATE.—The term “HCBS program improvement State” means a State with an HCBS infrastructure improvement plan approved by the Secretary under section 101(d).

(6) HOME AND COMMUNITY-BASED SERVICES.—The term “home and community-based services” means any of the following (whether provided on a fee-for-service, risk, or other basis):
(A) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

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

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

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

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

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

(G) Such other services specified by the Secretary.
(7) INSTITUTIONAL SETTING.—The term “institutional setting” means—

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

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

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

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

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

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

(G) any other relevant facility, as determined by the Secretary.
(8) MEDICAID PROGRAM.—The term “Medicaid program” means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

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

(10) STATE.—The term “State” has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

TITLE I—EXPANDING ACCESS TO MEDICAID HOME AND COMMUNITY-BASED SERVICES

SEC. 101. HCBS INFRASTRUCTURE IMPROVEMENT PLANNING GRANTS.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary shall award planning grants to States for the purpose of expanding access to home and community-based services and strengthening the direct care workforce that provides such services by developing HCBS infrastructure improvement plans that meet the requirements of subsections (b) and (c).
(b) CONTENT REQUIREMENTS.—In order to meet the requirements of this subsection, an HCBS infrastructure improvement plan shall include, with respect to a State, the following:

(1) EXISTING MEDICAID HCBS LANDSCAPE.—

(A) ELIGIBILITY AND BENEFITS.—A description of—

(i) the existing standards, pathways, and methodologies for eligibility for home and community-based services, including limits on assets and income;

(ii) the home and community-based services available under the State Medicaid program; and

(iii) utilization management standards for such services.

(B) ACCESS.—An assessment of the extent to which home and community-based services are available to eligible individuals in the State, including—

(i) estimates of the number of eligible individuals who are on a waitlist for such services;

(ii) estimates of the number of individuals who would be eligible individuals
but are not enrolled in the State Medicaid program or on a waitlist for such services;

(iii) a description of the home and community-based services not available under the State Medicaid program;

(iv) a description of the populations for which the State is unable to provide home and community-based services under the State Medicaid program that are provided under the Medicaid programs of other States; and

(v) a description of barriers to accessing home and community-based services identified by eligible individuals and families of such individuals.

(C) UTILIZATION.—An assessment of the utilization of home and community-based services in the State.

(D) SERVICE DELIVERY STRUCTURES.—A description of the service delivery structures for providing home and community-based services in the State, including with respect to the use and models of self-direction, the provision of services by agencies, the ownership of service provider agencies, the use of managed care
versus fee-for-service to provide such services, and the supports provided for family caregivers.

(E) WORKFORCE.—A description of the characteristics of the direct care workforce that provides home and community-based services, including the number of full- and part-time direct care workers, the average and range of direct care worker wages, the benefits provided to direct care workers, the turnover and vacancy rates of direct care worker positions, the membership of direct care workers in labor organizations or professional organizations, and the race, ethnicity, and gender of such workforce.

(F) PAYMENT RATES.—A description of the payment rates for home and community-based services, including when such rates were last updated, an assessment of the extent to which authorized services are not delivered as a result of such rates being insufficient, and the extent to which payment rates are passed through to direct care worker wages.

(G) QUALITY.—A description of how the quality of home and community-based services is measured and monitored, including how the State uses beneficiary and family caregiver ex-
perience of care surveys to assess the quality of
home and community-based services provided
by the State.

(H) LONG-TERM SERVICES AND SUPPORTS
PROVIDED IN INSTITUTIONAL SETTINGS.—A de-
scription of—

(i) the extent to which eligible individ-
uals receive long-term services and sup-
ports in institutional settings in the State;

and

(ii) the populations provided such
services and supports.

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

(J) DEMOGRAPHIC DATA.—Each assess-
ment required under subparagraphs (B) and
(C), and the description required under sub-
paragraph (H)(ii) shall include, to the extent
available, data disaggregated by disability sta-
tus, age, income, gender, race, ethnicity, geog-
raphy, primary language, sexual orientation, gender identity, and type of service setting.

(2) Annual Measures and Reports.—A description of the State plan for—

(A) annually measuring and reporting on—

   (i) the availability and utilization of home and community-based services;

   (ii) the characteristics of the direct care workforce that provides home and community-based services and the race, ethnicity, and gender of such workforce;

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

   (iv) progress with respect to implementation of the activities, benchmarks, and improvement activities provided under subsection (jj) of section 1905 of the Social Security Act (as added under section 102); and

   (B) collecting and reporting disaggregated data by disability status, age, income, gender, race, ethnicity, geography, primary language, sexual orientation, gender identity, and type of
service setting for the information required by clause (i) of subparagraph (A).

(3) IMPLEMENTATION AND GOALS FOR HCBS IMPROVEMENTS.—A description of how the State will—

(A) conduct the activities, benchmarks, and improvement activities provided under subsection (jj) of section 1905 of the Social Security Act (as added under section 102), including how the State plans to meet the benchmarks described in paragraph (5) of such subsection and, if applicable, the additional HCBS improvement efforts described in paragraph (3) of such subsection;

(B) identify and reduce barriers to accessing home and community-based services, including for individuals in institutional settings, individuals experiencing homelessness or housing instability, and individuals in regions with low or no access to such services;

(C) identify and reduce disparities in access to, and utilization of, home and community-based services by disability status, age, income, gender, race, ethnicity, geography, pri-
mary language, sexual orientation, gender identity, and type of service setting;

(D) coordinate implementation of the HCBS infrastructure improvement plan among the State Medicaid agency, agencies serving individuals with disabilities, the elderly, and other relevant State and local agencies; and

(E) facilitate access to related supports by coordinating with State and local agencies and organizations that provide housing, transportation, employment, nutrition, and other services and supports.

(c) Development and Submission Requirements.—In order to meet the requirements of this subsection, an HCBS infrastructure improvement plan shall—

(1) be developed with input from stakeholders through a public notice and comment process that includes consultation with eligible individuals who are recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates;
(2) be submitted for approval by the Secretary not later than 24 months after the date on which the State was awarded the planning grant under this section; and

(3) be publicly available in the final version submitted to the Secretary on a State Internet website.

(d) APPROVAL; PUBLICATION.—

(1) IN GENERAL.—The Secretary shall approve an HCBS infrastructure improvement plan if the plan—

(A) is complete; and

(B) provides assurances to the satisfaction of the Secretary that the State will meet the requirements of the HCBS Infrastructure Improvement Program established under subsection (jj) of section 1905 of the Social Security Act (42 U.S.C. 1396d), as added by section 102, and achieve the benchmarks for improvement established by such program.

(2) PUBLICATION.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall make publicly available on an Internet website—
(A) the final version of each approved HCBS infrastructure improvement plan; and

(B) in the case of any HCBS infrastructure improvement plan submitted for approval that is not approved—

(i) the submitted plan;

(ii) the decision not approving such plan; and

(iii) information relating to why the plan was not approved.

(e) CONTINUATION OF AMERICAN RESCUE PLAN ACT INCREASED FMAP FOR HCBS FOR STATES AWARDED A PLANNING GRANT.—

(1) FMAP.—

(A) IN GENERAL.—Notwithstanding subsections (b) or (ff) of section 1905 of the Social Security Act (42 U.S.C. 1396d), subject to subparagraph (C), in the case of a State that is awarded a planning grant under this section and meets the maintenance of effort requirements under paragraph (2), the Federal medical assistance percentage determined for the State under such subsection (b) (or such subsection (ff), if applicable) and, if applicable, as increased under subsection (y), (z), (aa), or (ii)
of such section, section 1915(k) of such Act (42
U.S.C. 1396n(k)), or section 6008 of the Families First Coronavirus Response Act (Public
Law 116–127), shall be increased by 10 per-
centage points (but not to exceed 95 percent)
with respect to amounts expended by the State
Medicaid program for medical assistance for
home and community-based services that are
provided during HCBS planning period (as de-
dined in subparagraph (B)).

(B) HCBS PLANNING PERIOD.—In this
paragraph, the term “HCBS planning period”
means, with respect to a State, the period—

(i) beginning on the date on which the
State is awarded a planning grant under
this section; and

(ii) ending on the earlier of—

(I) the first day of the first fiscal
quarter for which the State is an
HCBS program improvement State;
and

(II) the date that is 3 years after
the date on which the State is award-
ed such a grant.
(C) Rule of Application in Case of Overlap with Period for American Rescue Plan Increase.—If the HCBS planning period for a State begins during the HCBS program improvement period (as defined under subsection (a)(2)(A) of section 9817 of the American Rescue Plan Act (Public Law 117–2)), and the State meets the HCBS program requirements under subsection (b) of such section, the increase in the Federal medical assistance percentage that would otherwise apply to the State under subparagraph (A) of this paragraph shall not apply during any portion of the HCBS program improvement period (as defined under subsection (a)(2)(A) of section 9817 of the American Rescue Plan Act (Public Law 117–2)) for which the State receives an increase in the Federal medical assistance percentage in accordance with that section.

(D) Nonapplication of Territorial Funding Caps.—Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percent-
age increase specified under subparagraph (A) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

(2) Maintenance of Effort Requirements.—For purposes of paragraph (1)(A), the requirements of this paragraph are, with respect to the period for which a State is awarded a planning grant under this section, the State shall not—

(A) lower the amount, duration, or scope of home and community-based services available under the State Medicaid program (relative to the services available under the program as of the date on which the State was awarded such grant); or

(B) adopt more restrictive standards, methodologies, or procedures for determining eligibility, benefits, or services for receipt of home and community-based services under the State Medicaid program, including with respect to utilization management or cost-sharing, than the standards, methodologies, or procedures applicable as of the date on which the State was awarded such grant.
(f) **FUNDING.**—

(1) **IN GENERAL.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for purposes of awarding planning grants under this section, $100,000,000 for fiscal year 2022, to remain available until expended.

(2) **TECHNICAL ASSISTANCE AND GUIDANCE.**—

The Secretary shall reserve $5,000,000 of the amount appropriated under paragraph (1) for purposes of issuing guidance and providing technical assistance to States seeking or awarded a planning grant under this section.

**SEC. 102. HCBS INFRASTRUCTURE IMPROVEMENT PROGRAM.**

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

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

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

“(jj) **ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HCBS PROGRAM IMPROVEMENT STATES.**—
“(1) IN GENERAL.—

“(A) INCREASED FEDERAL FINANCIAL PARTICIPATION.—Subject to paragraph (5), in the case of a State that is an HCBS program improvement State and meets the requirements described in paragraphs (2) and (4), for each fiscal year quarter that begins on or after the first date on which a State is an HCBS program improvement State—

“(i) notwithstanding subsection (b) or (ff), subject to subparagraph (B), with respect to amounts expended during the quarter by such State for medical assistance for home and community-based services, the Federal medical assistance percentage for such State and quarter (as determined for the State under subsection (b) and, if applicable, increased under subsection (y), (z), (aa), or (ii), or section 6008(a) of the Families First Coronavirus Response Act) shall be increased by 10 percentage points (but not to exceed 95 percent); and

“(ii) notwithstanding the per centum specified in section 1903(a)(7), with re-
spect to amounts expended during the quarter and before October 1, 2031, for administrative costs for expanding and enhancing home and community-based services, including for enhancing the Medicaid data and technology infrastructure, modifying rate setting processes, adopting, using, and reporting quality measures and beneficiary and family caregiver experience surveys, adopting or improving training programs for direct care workers and family caregivers, and adopting, carrying out, or enhancing programs that register qualified direct care workers or connect beneficiaries to qualified direct care workers, such per centum shall be increased to 80 percent.

“(B) ADDITIONAL HCBS IMPROVEMENT EFFORTS.—Subject to paragraph (5), in addition to the increase to the Federal medical assistance percentage under subparagraph (A)(i), with respect to amounts expended for medical assistance during the first 4 fiscal quarters throughout which an HCBS program improvement State has implemented a program to sup-
port self-directed care that meets the requirements of paragraph (3) (in addition to meeting the requirements described in paragraph (2)), the Federal medical assistance percentage for such State and each such quarter with respect to such amounts shall be further increased by 2 percentage points (but not to exceed 95 percent).

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

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

“(A) MAINTENANCE OF EFFORT.—
“(i) IN GENERAL.—Except as provided under clause (ii), the State does not—

“(I) lower the amount, duration, or scope of home and community-based services available under the State plan or waiver (relative to the home and community-based services available under the plan or waiver as of the date on which the State was awarded a planning grant under section 101 of the Better Care Better Jobs Act); or

“(II) adopt more restrictive standards, methodologies, or procedures for determining eligibility, benefits, or services for receipt of home and community-based services, including with respect to utilization management or cost-sharing and the amount, duration, and scope of available home and community-based services, than the standards, methodologies, or procedures applicable as of such date.
“(ii) EXCEPTION.—On or after October 1, 2028, a State may modify such standards, methodologies, or procedures if the State demonstrates that such modifications shall not result in—

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

“(II) fewer individuals (overall and within particular beneficiary populations) receiving home and community-based services; or

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

“(B) ACCESS TO SERVICES.—The State enhances, expands, or strengthens home and community-based services by doing all of the following:

“(i) Addressing access barriers and disparities in access or utilization identified in the State HCBS infrastructure improvement plan.
“(ii) Expanding financial eligibility criteria for home and community-based services up to Federal limits.

“(iii) Requiring coverage of personal care services for all eligible populations receiving home and community-based services in the State.

“(iv) Using ‘no wrong door’ programs, providing presumptive eligibility for home and community-based services, and improving home and community-based services counseling and education programs.

“(v) Expanding access to behavioral health services and coordination with employment, housing, and transportation supports.

“(vi) Providing supports to family caregivers, which shall include providing respite care, and may include providing such services as caregiver assessments, peer supports, or paid family caregiving.

“(vii) Adopting, expanding eligibility for, or improving coverage provided under a Medicaid buy-in program authorized
under subclause (XIII), (XV), or (XVI) of section 1902(a)(10)(A)(ii).

“(C) STRENGTHENED AND EXPANDED WORKFORCE.—

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

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

“(II) updating, developing, and adopting qualification standards and training opportunities for the continuum of providers of home and community-based services, including programs for independent providers of such services and agency direct care workers, as well as unique programs and resources for family caregivers.
“(ii) PAYMENT RATES.—In carrying out clause (i)(I), the State shall—

“(I) address insufficient payment rates for delivery of home and community-based services, with an emphasis on supporting the recruitment and retention of the direct care workforce, as identified during the period in which the State HCBS infrastructure improvement plan was developed and during subsequent years;

“(II) update payment rates for home and community-based services at least every 2 years through a transparent process involving meaningful input from stakeholders, including recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates; and
“(III) ensure that increases in the payment rates for home and community-based services are—

“(aa) at a minimum, proportionately passed through to direct care workers and in a manner that is determined with input from the stakeholders described in subclause (II); and

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

“(3) HCBS IMPROVEMENT TO SUPPORT SELF-DIRECTED MODELS FOR THE DELIVERY OF SERVICES.—For purposes of paragraph (1)(B), the requirements of this paragraph, with respect to a
State and a fiscal year quarter, are that the State establishes directly or by contract with 1 or more non-profit entities, a program for the performance of all of the following functions:

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

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

“(C) Ensuring the safety of, and supporting the quality of, care provided to beneficiaries, such as by conducting background checks and addressing complaints reported by recipients of home and community-based services.

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

“(E) Supporting beneficiary hiring of independent providers of home and community-
based services through an agency with choice or similar model, including by processing applicable tax information, collecting and processing timesheets, submitting claims and processing payments to such providers.

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

“(G) Ensuring that program policies and procedures allow for cooperation with labor organizations that bargain on behalf of direct care workers in the case of a State in which the direct care workers in the State have elected to join, or form, such a labor organization, or, in the case of a State in which such workers have not joined or formed such a labor organization,
are neutral with regard to such workers joining
or forming such a labor organization.

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

“(A) The State adopts the core quality
measures for home and community-based serv-
ices developed by the Secretary under section
104 of the Better Care Better Jobs Act, or an
alternate set of quality measures approved by
the Secretary, and, at the option of the State,
expands the use of beneficiary and family care-
giver experience surveys.

“(B) The State designates an HCBS omb-
udsman office that—

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

“(ii) provides direct assistance to
beneficiaries and their families; and

“(iii) identifies and reports systemic
problems to State officials, the public, and
the Secretary.
“(C) Beginning with the 5th fiscal year quarter for which the State is an HCBS program improvement State, and annually thereafter, the State reports on the components of the existing home and community-based services landscape reported in the State HCBS infrastructure improvement plan, including with respect to—

“(i) the availability and utilization of home and community-based services, disaggregated by disability status, age, income, gender, race, ethnicity, geography, primary language, sexual orientation, gender identity, and type of service setting;

“(ii) the characteristics of the direct care workforce that provides home and community-based services workforce and the race, ethnicity, and gender of such workforce;

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

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

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

“(vi) the progress made with respect to meeting the benchmarks for demonstrating improvements required in paragraph (5).

“(5) BENCHMARKS FOR DEMONSTRATING IMPROVEMENTS.—An HCBS program improvement State shall cease to be eligible for an increase in the Federal medical assistance percentage under paragraph (1)(A)(i) or (1)(B) or an increase in an applicable Federal matching percentage under paragraph (1)(A)(ii) beginning with the 29th fiscal year quarter that begins on or after the first date on which a State is an HCBS program improvement State, unless, not later than 90 days before the first day of such fiscal year quarter, the State submits to the Secretary a report demonstrating the following improvements:

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

“(B) Increased utilization and availability of home and community-based services by populations with the lowest utilization and availability of such services (as reported in the State HCBS infrastructure improvement plan) relative to the utilization of such services by such populations as reported in such plan and adjusted for demographic changes in the State since the submission of such plan.

“(C) Evidence that a majority of direct care workers receive competitive wages and benefits.

“(D) With respect to the percentage of expenditures made by the State for long-term services and supports that are for home and community-based services, in the case of an HCBS program improvement State for which such percentage (as reported in the State HCBS infrastructure improvement plan) was—

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

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

“(6) DEFINITIONS.—In this subsection, the terms ‘direct care worker’, ‘direct care workforce’, ‘HCBS program improvement State’, and ‘home and community-based services’ have the meanings given those terms in section 2 of the Better Care Better Jobs Act.”.

SEC. 103. REPORTS; TECHNICAL ASSISTANCE; OTHER ADMINISTRATIVE REQUIREMENTS.

(a) REPORTS.—The Secretary shall submit to the appropriate committees of Congress the following reports relating to the HCBS Infrastructure Improvement Program established under this title:

(1) INITIAL REPORT.—Not later than 4 years after the date of enactment of this Act, a report that includes the following:

(A) A description of the HCBS infrastructure improvement plans approved by the Secretary under section 101(d).

(B) A description of the national landscape with respect to gaps in coverage of home and
community-based services, disparities in access to, and utilization of, such services, and barriers to accessing such services.

(C) A description of the national landscape with respect to the direct care workforce that provides home and community-based services, including with respect to compensation, benefits, and challenges to the availability of such workers.

(2) SUBSEQUENT REPORTS.—Not later than 7 years after the date of enactment of this Act, and every 3 years thereafter, a report that includes the following:

(A) The number of HCBS program improvement States.

(B) A summary of the progress being made by such States with respect to strengthening and expanding access to home and community-based services and the direct care workforce that provides such services and meeting the benchmarks for demonstrating improvements required under section 1905(jj)(5) of the Social Security Act (as added by section 102).

(C) A summary of outcomes related to home and community-based services core qual-
ity measures and beneficiary and family care-
giver surveys.

(D) A summary of the challenges and best
practices reported by States in expanding ac-
cess to home and community-based services and
supporting and expanding the direct care work-
force that provides such services.

(b) TECHNICAL ASSISTANCE; GUIDANCE; REGULA-
TIONS.—The Secretary shall provide HCBS program im-
provement States with technical assistance related to car-
rying out the HCBS infrastructure improvement plans ap-
proved by the Secretary under section 101(d) and meeting
the requirements and benchmarks for demonstrating im-
provements required under section 1905(jj) of the Social
Security Act (as added by section 102) and shall issue
such guidance or regulations as necessary to carry out this
title and the amendments made by this title, including
guidance specifying how States shall assess and track the
availability of home and community-based services over
time.

(c) RECOMMENDATIONS TO GUIDE INFRASTRUCTURE
IMPROVEMENT.—

(1) IN GENERAL.—Not later than 18 months
after the date of enactment of this Act, the Sec-
retary shall coordinate with the Secretary of Labor
and the Administrator of the Centers for Medicare & Medicaid Services for purposes of issuing recommendations for the Federal Government and for States to strengthen the direct care workforce that provides home and community-based services, including with respect to how the Federal Government should classify the direct care workforce, how such Administrator and State Medicaid programs can enforce and support the provision of competitive wages and benefits across the direct care workforce, including for workers with particular skills or expertise, and how State Medicaid programs can support training opportunities and other related efforts that support the provision of quality home and community-based services care.

(2) Stakeholder Consultation.—In developing the recommendations required under paragraph (1), the Secretary shall ensure that such recommendations are informed by consultation with recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates.
(d) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for purposes of carrying out this section, $10,000,000 for fiscal year 2022, to remain available until expended.

SEC. 104. QUALITY MEASUREMENT AND IMPROVEMENT.

(a) DEVELOPMENT AND PUBLICATION OF CORE AND SUPPLEMENTAL SETS OF HCBS QUALITY MEASURES.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall identify and publish for general comment a recommended core set and supplemental set of home and community-based services quality measures for use by State Medicaid programs, health plan and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) REGULAR REVIEWS AND UPDATES.—The Secretary shall review and update the recommended core set and supplemental set of home and community-based services quality measures published under paragraph (1) not less frequently than once every year.

(3) REQUIREMENTS.—
(A) INTERAGENCY COLLABORATION;

STAKEHOLDER INPUT.—In developing the recommended core set and supplemental set of home and community-based services quality measures under paragraph (1), and subsequently reviewing and updating such core and supplemental sets, the Secretary shall—

(i) collaborate with the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Administration for Community Living, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Substance Abuse and Mental Health Services Administration; and

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

(B) REFLECTIVE OF FULL ARRAY OF SERVICES.—Such recommended core set and
supplemental set of home and community-based services quality measures shall—

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

(ii) include—

(I) outcomes-based measures;

(II) measures of availability of services;

(III) measures of provider capacity and availability;

(IV) measures related to person-centered care;

(V) measures specific to self-directed care;

(VI) measures related to transitions to and from institutional care; and

(VII) beneficiary and family caregiver surveys.

(C) DEMOGRAPHICS.—Such recommended core set and supplemental set of home and community-based services quality measures shall allow for the collection of data that is
disaggregated by disability status, age, income, gender, race, ethnicity, geography, primary language, sexual orientation, gender identity, and type of service setting.

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

(b) STATE ADOPTION AND REPORTS.—

(1) IN GENERAL.—Not later than 2 years after the date on which the Secretary publishes the recommended core set and supplemental set of home and community-based services quality measures under subsection (a)(1), and annually thereafter, each State Medicaid program shall use such core and supplemental sets (or an alternative set of quality measures approved by the Secretary) to report information to the Secretary regarding the quality of home and community-based services provided under such program.

(2) PROCESS.—The information required under paragraph (1) shall be reported using a standardized format and procedures established by the Secretary. Such procedures shall allow a State Medicaid pro-
gram to report such information separately or as part of the annual reports required under sections 1139A(c) and 1139B(d) of the Social Security Act (42 U.S.C. 1320b–9a, 1320b–9b).

(3) **Publication of Quality Measures.**—Each State Medicaid program shall periodically make the information reported to the Secretary under paragraph (1) available to the public.

(4) **Increased Federal Matching Rate for Adoption and Reporting.**—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

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

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

“(G) 80 percent of so much of the sums expended during such quarter as are attributable to the reporting of information regarding the quality of home and community-based services in accordance with section 104(b) of the Better Care Better Jobs Act; and”.
TITLE II—OTHER PROVISIONS

SEC. 201. MACPAC STUDY AND REPORT ON APPENDIX K EMERGENCY HOME AND COMMUNITY-BASED SERVICES (HCBS) 1915(C) WAIVERS.

(a) IN GENERAL.—The Medicaid and CHIP Payment and Access Commission (referred to in this section as “MACPAC”) shall conduct a study and submit to Congress a report on the accelerated changes and emergency amendments to home and community-based services waivers under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) approved for States during the COVID–19 pandemic using the Appendix K template issued by the Centers for Medicare & Medicaid Services on March 22, 2020.

(b) REPORT.—The report submitted under subsection (a) shall—

(1) describe the specific types of flexibilities or other program changes adopted by States using the Appendix K template;

(2) evaluate the efficiency, management, and success and failures of such flexibilities and program changes; and

(3) include recommendations for legislative and administrative actions to continue specific flexibilities, program changes, and innovative service deliv-
ery models that increase access to care in home and community settings.

SEC. 202. MAKING PERMANENT THE STATE OPTION TO EXTEND PROTECTION UNDER MEDICAID FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

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

(b) Conforming Amendment.—Section 2404 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396r–5 note) is amended by striking “September 30,
2023” and inserting “the date of enactment of the Better Care Better Jobs Act”.

SEC. 203. PERMANENT EXTENSION OF MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

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

(1) in paragraph (1)—

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

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

“(G) $450,000,000 for each fiscal year after fiscal year 2021.”; and

(C) by striking subparagraph (K); and

(2) in paragraph (2), by striking “September 30, 2023” and inserting “September 30 of such fiscal year”.

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