117TH CONGRESS
1ST SESSION

H. R. _____

To amend title XIX of the Social Security Act to require coverage of home and community-based services under the Medicaid program.

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 require coverage of home and community-based services under the Medicaid program.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) Short Title.—This Act may be cited as the
5 “HCBS Access Act of 2021”.

6 (b) Table of Contents.—The table of contents of

7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Purpose.
Sec. 2. PURPOSE.

It is the purpose of this Act to require coverage of home and community-based services (in this section referred to as “HCBS”) under a State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for the following reasons:

(1) In order to fulfill the purposes of Americans with Disabilities Act to ensure people with disabilities and older adults live in the most integrated setting.

(2) To eliminate waiting lists for HCBS, which delay access to necessary services and civil rights for people with disabilities and aging adults.

(3) To build on decades of progress in serving people with disabilities and aging adults via HCBS and not in institutions, nursing homes or other congregate settings.

(4) To fulfill the purposes of the Medicaid program to provide medical assistance for those whose income and resources are insufficient to meet the costs of necessary medical services, and to provide rehabilitation and other services to help such fami-
lies and individuals attain or retain capability for independence or self-care.

(5) To eliminate silos and ensure that people with all kinds of and with multiple disabilities, including intellectual disabilities, developmental disabilities, mental health disabilities, physical disabilities, and substance use disorders, and aging adults, receive the services they need to live in their communities.

(6) To streamline access to HCBS by eliminating the need for States to repeatedly apply for waivers.

(7) To continue to increase the capacity of community services to ensure people with disabilities and aging adults have safe and meaningful options in the community are not at risk of unnecessary institutionalization.

(8) Because decades of research and practice show that everyone, including people with the most severe disabilities, can live in the community with the right services and supports.

(9) To support over 65,000,000 unpaid family caregivers who are often providing complex services and supports to aging adults and people with disabilities because of a lack of affordable services,
workforce shortages, and other inefficiencies of the Medicaid system.

(10) To improve direct care work quality and address the decades long workforce barriers for nearly 4,600,000 direct care workers giving support to people with disabilities and aging adults in their homes and communities.

(11) To eliminate the race and gender disparities that exist in accessing information and HCBS and to prevent the unnecessary impoverishment and institutionalization of black and brown individuals with disabilities and aging adults.

SEC. 3. REQUIRING COVERAGE OF HOME AND COMMUNITY-BASED SERVICES UNDER THE MEDICAID PROGRAM.

(a) Definition of Home and Community-Based Services.—

(1) In general.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

“(hh) Home and Community-Based Services.—

“(1) In general.—For purposes of this title, the term ‘home and community-based services’ means those services specified in paragraph (2) furnished to an eligible individual (as defined in para-
graph (3)), based on an individualized assessment
(as described in paragraph (4)) of such individual,
in a setting that—

“(A) meets the qualities specified in para-
graph (1) of section 441.710(a) of title 42,
Code of Federal Regulations (or a successor
regulation);

“(B) is not described in paragraph (2) of
such section (or successor regulation); and

“(C) meets such other qualities as the Sec-
retary determines appropriate.

“(2) SERVICES SPECIFIED.—

“(A) IN GENERAL.—For purposes of para-
graph (1), the services specified in this para-
graph are services described in any of para-
graphs (7), (8), (13)(C), (19), (20), (24), and
(29) (as applied without regard to the reference
to ‘September 30, 2025’) of subsection (a) or in
any of subsections (c)(4)(B), (c)(5), (k)(1)(A),
(k)(1)(B), or (k)(1)(D) of section 1915, includ-
ing the following:

“(i) Supported employment and inte-
grated day services.

“(ii) Personal assistance, including
personal care attendants, direct support
professionals, home health aides, private
duty nursing, homemakers and chore as-
sistance, and companionship services.

“(iii) Services that enhance independ-
ence, inclusion, and full participation in
the broader community.

“(iv) Non-emergency, non-medical
transportation services to facilitate commu-

“(v) Respite services provided in the
individual’s home or broader community.

“(vi) Caregiver and family support
services.

“(vii) Case management, including in-
tensive case management, fiscal inter-
mediary, and support brokerage services.

“(viii) Services which support person-
centered planning and self-direction.

“(ix) Direct support services during
acute hospitalizations.

“(x) Necessary medical and nursing
services not otherwise covered which are
necessary in order for the individual to re-
main in their home and community, includ-
ing hospice services.
“(xi) Home and community-based intensive behavioral health and crisis intervention services.

“(xii) Peer support services.

“(xiii) Housing support and wrap-around services.

“(xiv) Necessary home modifications and assistive technology, including those which substitute for human assistance.

“(xv) Transition services to support an individual’s transition from an institutional setting to the community, including such transition services provided while the individual resides in an institution.

“(xvi) Any other service specified by the panel convened pursuant to subparagraph (B).

“(B) Specification of services.—

“(i) In general.—Not later than 6 months after the date of the enactment of this subparagraph, and not less frequently than once every 10 years thereafter, the Secretary shall convene an advisory panel (in this subparagraph referred to as the ‘panel’) for purposes of specifying services
which shall be included as home and community-based services under this paragraph.

“(ii) COMPOSITION.—

“(I) SELECTION.—The panel shall be composed of individuals selected by the Secretary from the following groups:

“(aa) Individuals with disabilities receiving home and community-based services under this title and individuals with disabilities in need of such services, including those with physical disabilities, behavioral health disabilities, or intellectual or developmental disabilities, and including elderly individuals.

“(bb) Representatives of beneficiary-led disability rights organizations, disability organizations representing families and providers, aging organizations, the Protection and Advocacy system, the Centers for Independent
Living, health care providers, the National Association of Medicaid Directors, the National Association of State Directors of Developmental Disabilities Services, the National Association of State Mental Health Program Directors, ADvancing States, the Centers for Medicare & Medicaid Services, the Administration for Community Living, and other relevant representatives from local, State, and Federal home and community-based service systems.

“(II) **REQUIREMENT FOR EQUAL REPRESENTATION.**—The Secretary shall select an equal number of individuals described in items (aa) and (bb) of subclause (I) in convening the panel.

“(iii) **DUTIES.**—Not later than 6 months after a panel is convened under clause (i), the panel shall submit to the Secretary and to Congress a report specifying services which shall be included as
home and community-based services under this paragraph. Such services shall be so specified with the goal of increasing community integration and self-determination for individuals with disabilities receiving such services.

“(iv) IMPLEMENTATION OF SPECIFIED SERVICES.—

“(I) IN GENERAL.—Services specified by the panel in a report submitted under clause (iii) shall be treated as services described in subparagraph (A)(xvi) for calendar quarters beginning on or after the date that is 1 year after the date of such submission.

“(II) NOTIFICATION.—Not later than 1 year after the first report is submitted under clause (iii), and not later than 1 year after the submission of each subsequent such report, the Secretary shall notify States of any additions or removals of home and community-based services based on services specified under such report
through State Medicaid Director letters.

“(3) ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—For purposes of paragraph (1), the term ‘eligible individual’ means—

“(i) an individual who is determined, on an annual basis or on a longer basis specified by the State, by a health care provider approved by the State under a process described in subparagraph (C) to have a functional impairment (as defined in subparagraph (B)) (not taking into account any items or services, or any other ameliorative measures, furnished to such individual to mitigate such impairment) that is expected to last at least 90 days; or

“(ii) an individual receiving or determined to be eligible for, as of the date of the enactment of this subsection, home and community-based services under this title under a waiver or State plan option in effect under section 1915 or 1115.

“(B) FUNCTIONAL IMPAIRMENT.—For purposes of subparagraph (A), the term ‘func-
national impairment’ means, with respect to an individual the inability of such individual to perform, without assistance, 2 or more activities of daily living (as described in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or 2 or more instrumental activities of daily living (as defined for purposes of section 1915(k)(1)(A)).

“(C) HEALTH CARE PROVIDER STATE APPROVAL.—For purposes of subparagraph (A)(i), a process described in this subparagraph is a process established by the State to approve health care providers to make determinations described in such subparagraph that meets such standards as the Secretary may prescribe.

“(4) INDIVIDUALIZED ASSESSMENT.—

“(A) IN GENERAL.—For purposes of paragraph (1), an individualized assessment described in this paragraph is an independent assessment, with respect to an eligible individual—

“(i) to determine a necessary level of services and supports to be provided, consistent with an individual’s functional impairments, to facilitate an individual’s
community integration, self-determination, and well-being;

“(ii) to prevent the provision of unnecessary or inappropriate care;

“(iii) to establish a person-centered care plan (as described in subparagraph (C)) for the individual;

“(iv) that includes each of the elements described in clauses (ii) through (v) of section 1915(i)(1)(F); and

“(v) that occurs not later than 30 days after such individual is determined to be an eligible individual.

“(B) PRESUMPTION.—The assessment described in subparagraph (A) shall be conducted with the presumption—

“(i) that each eligible individual, regardless of type or level of disability or service need, can be served in the individual’s own home and community; and

“(ii) at the option of the individual, that services may be self-directed (as defined in section 1915(i)(1)(G)(iii)(II)).

“(C) PERSON-CENTERED CARE PLAN.—For purposes of subparagraph (A)(iii), a per-
son-centered care plan described in this sub-
paragraph is a written plan with respect to an
individual that meets the requirements of sec-
tion 1915(i)(1)(G)(ii).

“(D) STANDARDS.—An individualized as-
seSSment described in subparagraph (A) shall
be conducted in accordance with standards
specified by the Secretary, in consultation with
the Administration for Community Living,
that—

“(i) safeguard against conflicts of in-
terest;

“(ii) specify qualifications for who
may perform such assessments;

“(iii) ensure transparency in the fur-
nishing of such assessments, including en-
suring the provision of the results of such
assessments that includes information in
plain language necessary to interpret the
methodology and results of such assess-
ments;

“(iv) ensure that the methodologies
used in such assessments are sound and
evidence-based; and
“(v) require such methodologies to be
made available on the public website of the
State and tested for reliability and valid-
ity.”.

(2) INCLUSION AS MEDICAL ASSISTANCE.—Sec-
tion 1905(a) of the Social Security Act (42 U.S.C.
1396d(a)) is amended—

(A) in paragraph (30), by striking “; and”
and inserting a semicolon;

(B) by redesignating paragraph (31) as
paragraph (32); and

(C) by inserting after paragraph (30) the
following new paragraph:

“(31) home and community-based services (as
defined in subsection (hh)); and”.

(b) MANDATORY BENEFIT.—Section 1902(a)(10)(A)
of the Social Security Act (42 U.S.C. 1396a(a)(10)(A))
is amended by striking “and (30)” and inserting “, (30),
and (31)”.

(c) ENSURING COVERAGE OF HCBS FOR ALL MED-
ICAID-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(D)
of the Social Security Act (42 U.S.C. 1396a(a)(10)(A))
is amended—

(1) by inserting “(i)” after “(D)”;

(2) by adding “and” after the semicolon; and
(3) by adding at the end the following new clause:

“(ii) for the inclusion of home and community-based services (as defined in section 1905(hh)) for any individual who—

“(I) is eligible for medical assistance under the State plan (or waiver of such plan);

“(II) is an eligible individual (as defined in such section); and

“(III) elects to receive such services.”.

(d) FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HOME AND COMMUNITY-BASED SERVICES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by subsection (a), is further amended—

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

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

“(ii) SPECIFIED FMAP FOR HOME AND COMMUNITY-BASED SERVICES.—Notwithstanding any other provision of law, the Federal medical assistance percentage for amounts expended for medical assistance for home and community-based services (as defined in subsection (hh)), including any such services furnished under a waiver in
effect under section 1915, on or after the date of the enactment of this subsection shall be equal to 100 percent.”.

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

(1) in section 1902(a)(10)(A)(ii)(V), by inserting “or who are eligible individuals (as defined in section 1905(kk)(3))” after “such period”;

(2) in section 1905(a)(xvii), by striking “pursuant to a State plan amendment under such subsection” and inserting “(as defined in section 1905(hh))”; and

(3) in section 1915, by adding at the end the following new subsection:

“(m) SUNSET OF PROVISIONS RELATING TO HOME AND COMMUNITY-BASED SERVICES.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the preceding provisions of this section, insofar as such provisions relate to a waiver for home and community-based services, shall not apply beginning with the first calendar quarter beginning on or after the date that is 5 years after the date of the enactment of this subsection.

“(2) EXCEPTION.—The Secretary may waive the application of paragraph (1) for a calendar quarter and a State if the State requests such a waiver
and the Secretary determines that such a waiver is appropriate.”; and

(4) in section 1943(b)(5), by striking “the State” and all that follows through the period at the end and inserting “an annual determination be conducted in accordance with section 1905(gg) for purposes of providing home and community-based services under the State plan (or waiver of such plan).”.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section (other than the amendments made by subsection (d)) shall apply with respect to calendar quarters beginning on or after the date that is 5 years after the date of the enactment of this Act.

(2) EXCEPTION.—In the case of a State with an exception in effect under section 1915(m)(2) of the Social Security Act, the amendments described in paragraph (1) shall apply with respect to calendar quarters beginning on or after a date determined appropriate by the Secretary.

SEC. 4. MEDICAID ELIGIBILITY MODIFICATIONS.

Section 1902(a)(10)(C)(iii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iii)) is amended—
19

(1) by striking “and (II)” and inserting “(II)”;

and

(2) by inserting “, and (III) home and community-based services (as described in section 1905(hh))” after “delivery services”.

SEC. 5. HOME AND COMMUNITY-BASED SERVICES IMPLEMENTATION PLAN GRANT PROGRAM.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall award to each State a grant for purposes of enabling such State to implement the requirement to provide home and community-based services under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(b) USE OF FUNDS.—A grant awarded under subsection (a) shall be used by a State to develop an implementation plan described in subsection (c).

(c) IMPLEMENTATION PLAN.—An implementation plan described in this subsection is a plan developed by a State that includes the following:

(1) An explanation of how the State will operationalize the definition of an eligible individual under section 1905(hh) of the Social Security Act, including the process for determinations specified in paragraph (3)(A)(i) of such section.
(2) A description of the State’s plan to ensure a stable and high quality workforce and how the State plans to ensure a living wage for individuals furnishing home and community-based services and identify and address any additional workforce issues.

(3) A list of any home and community-based services provided under the State Medicaid plan (including any waiver of such plan) [as of the date of enactment of this Act], including a breakdown of use of such services by different disability populations and by gender, race, ethnicity, geography, and other demographics, compared to such services that are required under the amendments made by section 3, and a description of numerical goals to increase access to such services that have barriers to access for populations in need of such services.

(4) A description of how the State will incorporate existing State disability agencies into the new unified provision of home and community-based services and how such State will ensure that such services address all functional impairments.

(5) An explanation of how the State will ensure access to such services.

(6) A plan for carrying out outreach and education activities with respect to the availability of
such services through Aging and Disability Resource
Centers and other similar entities (such as entities
receiving funds from the Administration for Community Living or the Substance Abuse and Mental Health Services Administration), including a program that ensures that an individual is not denied such services based on the fact that the individual contacts the wrong entity (commonly referred to as a “No Wrong Door Program”).

(7) A plan for how such services will be coordinated with other relevant State agencies, such as housing, transportation, child welfare, food and income security, and employment agencies.

(8) A description of how the State will build capacity prior to the implementation of the requirement described in subsection (a) to ensure that such services are available to every eligible individual under the Medicaid program and how the State will ensure that such services are provided in a setting that meets the requirements specified in paragraph (1) of section 1905(hh).

(9) In the case of a State that utilizes an alternative benefit plan, a description of how the State will ensure that all individuals who are eligible individuals (as defined in such section) are appropriately
identified as medically frail and exempted from such plan.

(10) How the State will coordinate eligibility for such services with other disability eligibility programs, such as disability buy-in programs.

(11) Data and milestone requirements to ensure community integration, including such requirements with respect to utilization of such services by gender, race, ethnicity, geography, and other demographics.

(d) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (86), by striking “and” at the end;

(2) in paragraph (87), by striking the period at the end and inserting “; and”;

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

“(88) provide for the submission to the Secretary of an implementation plan described in section 5(c) of the HCBS Access Act of 2021 prior to the beginning of the first calendar quarter beginning on or after the date that is 5 years after the date of the enactment of this paragraph.”.

(e) DEFINITIONS.—In subsections (a) through (e):
(1) **HOME AND COMMUNITY-BASED SERVICES.**—The term “home and community-based services” has the meaning given such term in section 1905(hh) of the Social Security Act.

(2) **STATE.**—The term “State” has the meaning given that term in section 1101(1) of the Social Security Act (42 U.S.C. 1301(1)) for purposes of title XIX of such Act (42 U.S.C. 1396 et seq.).

**SEC. 6. QUALITY OF SERVICES.**

(a) **IN GENERAL.**—

(1) **DEVELOPMENT OF METRICS.**—Not later than 1 year after the date of enactment of this Act, the Director of the Agency for Healthcare Research and Quality, in consultation with State Medicaid Directors, shall develop standardized, State-level metrics of access to, and satisfaction with, providers, including primary care and specialist providers, with respect to individuals who are enrolled in State Medicaid plans under title XIX of the Social Security Act, broken down by gender, race, ethnicity, geography, and other demographics. Such metrics shall include metrics on the total number of individuals enrolled in the State plan or under a waiver of the plan during a fiscal year that required the level of care provided in a nursing facility, intermediate care...
facility for individuals with intellectual disabilities, institution for mental disease, or other similarly re-
strictive or institutional setting, disaggregated by the type of facility or setting, race, ethnicity, pri-
mary language, disability status, age, sex, sexual ori-
entation, and gender identity.

(2) PROCESS.—The Director of the Agency for Healthcare Research and Quality shall develop the metrics described in paragraph (1) through a public process, which shall provide opportunities for stake-
holders to participate.

(b) UPDATING METRICS.—The Director of the Agen-
cy for Healthcare Research and Quality, in consultation with the Deputy Administrator for the Center for Med-
icaid and CHIP Services and State Medicaid Directors, shall update the metrics developed under subsection (a) not less than once every 3 years.

(c) STATE IMPLEMENTATION FUNDING.—The Direc-
tor of the Agency for Healthcare Research and Quality may award funds, from the amount appropriated under subsection (d), to States for the purpose of implementing the metrics developed under this section.

(d) APPROPRIATION.—There is appropriated to the Director of the Agency for Healthcare Research and Quali-
ity, out of any funds in the Treasury not otherwise appro-
appropriated, $200,000,000 for fiscal year 2021, to remain available until expended, for the purpose of carrying out this section.

SEC. 7. WORKFORCE DEVELOPMENT.

[To be supplied.]