

MEDICAID PROVISIONS INCLUDED IN THE HOUSE BUILD BACK BETTER ACT

EXECUTIVE SUMMARY

Over the last several months, Democrats have been working to clinch a reconciliation package that reflects a host of policy priorities outlined in their \$3.5 trillion budget resolution passed in August. While House Democrats were ultimately able to clear the first procedural vote [221-213] on the Build Back Better Act (BBBA) on November 5, the path forward is still uncertain absent a full cost estimate from the Congressional Budget Office (CBO).

Recently, House Democrats have released finalized [text](#) of their BBBA, which has been whittled down to \$1.75 trillion to appease centrist Democratic concerns about the size and scope of the package. As reported, the BBBA includes several major health policy proposals aimed at expanding access to health care for low-income Americans, with several prescription drug pricing reforms included in the package expected to help pay for the large spending bill. However, these policies could be subject to further changes in the Senate depending on the favorability of CBO's cost estimate.

Along with Medicare expansion and drug pricing, the BBBA includes several key Medicaid provisions to expand access to care. Such provisions would: (1) increase access to home- and community-based services (HCBS); (2) expand access to maternal health; (3) address the Medicaid fiscal cliff for U.S. territories; (4) phase-out certain policies to assist state Medicaid programs in responding to the COVID-19 public health emergency, and; (5) permanently expand the Children's Health Insurance Program (CHIP). The House BBBA also includes several Medicaid provisions that seek to increase access to behavioral health services and coverage for vaccines.

PROVISIONS TO INCREASE ACCESS TO HOME- AND COMMUNITY BASED SERVICES (HCBS)

As currently drafted, the House version of the BBBA would strengthen and expand access to Medicaid HCBS by: (1) facilitating statewide planning to develop HCBS infrastructure plans through grants; (2) increasing Medicaid funding for HCBS by providing states with a permanent increase in federal match if they take certain actions to expand access and strengthen the HCBS workforce; (3) incentivizing HCBS workforce growth through innovative models; (4) supporting quality and accountability of state HCBS programs, and; (5) permanently extending the spousal impoverishment protections and the Money Follows the Person (MFP) demonstration to assist individuals transitioning from institutions to HCBS settings.

HCBS Infrastructure Improvement Planning Grants and Improvement Program

Part 1 of Subtitle F of the Energy and Commerce provisions included in Title III of the House BBBA would provide the Secretary of the Department of Health and Human Services (HHS) with \$130,000,000 for fiscal year (FY) 2022 (until expended) to issue planning grants to states to assess their current HCBS programs. Recipient states would be required to submit “HCBS infrastructure improvement plans” to HHS describing future state efforts to expand access to HCBS and to strengthen the direct care workforce that provide HCBS services in the state. As part of these plans, states would be required to submit reports to the Secretary on the current Medicaid HCBS landscape in the state and include information on:

- existing HCBS eligibility standards, services (including private duty nursing services) and settings available in the state;
- barriers to access to HCBS services for eligible individuals;
- HCBS service utilization;
- structure of HCBS service delivery;
- the direct care workforce;
- payment rates for HCBS services and when such rates were last updated;
- how quality of HCBS services is measured and monitored;
- the extent to which long-term services and supports are provided in institutional settings;
- the HCBS share of overall Medicaid spending in the state, and;
- demographic data of individuals receiving services under HCBS in the state.

States receiving planning grant funds must also include in the plan to the Secretary information on how they will address gaps and disparities in access to and utilization of HCBS services. Such plans must be developed with input from stakeholders through a public notice and comment process and must include information on how the state will:

- conduct activities to enhance, expand, or strengthen HCBS and strengthening the workforce (including by updating payment rates);
- reduce barriers to and disparities in access to HCBS services;
- monitor and report on access to HCBS services, disparities in access to HCBS services, and utilization of HCBS services;
- monitor and report the amount of state Medicaid expenditures for HCBS as a proportion of the total amount of state expenditures for long-term services and supports in Medicaid;
- monitor and report on wages, benefits, and vacancy and turnover rates for direct care workers;
- assess and monitor the sufficiency of payment rates under the state Medicaid program for specific types of HCBS services; and
- coordinate implementation of the improvement plan.

The state must submit the plan to the Secretary for approval within two years after receiving the planning grants.

Once the Secretary approves the infrastructure plan submitted by the state, the state is eligible to receive an increase in federal funding — subject to certain conditions — through a bump in the state’s federal matching rate for Medicaid expenditures for each fiscal quarter so long as the state carries out the activities it describes in the approved plan.

Applicable FMAP Increase.

- **Increase in state-specific FMAP for HCBS expenditures.** For each fiscal quarter beginning with the fiscal quarter in which the state qualifies, the Federal Medical Assistance Percentages (FMAP) for allowable HCBS medical assistance expenditures would be increased by 6 percentage points, capped at 95 percent. Generally, the FMAP increase is applicable for allowable HCBS medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate, and this FMAP bump would apply to HCBS expenditures paid at the state-specific FMAP rate. Additionally, and to the extent applicable, the increased FMAP under this provision would be additive to: (1) the 6.8 percent point FMAP increase available under the Families First Coronavirus Response Act; (2) new adult group expenditures currently matched at 90 percent; (3) expenditures subject to the temporary increase in FMAP made available under the American Rescue Plan (ARP) for states that recently expanded Medicaid; and (4) HCBS expenditures matched at the increased FMAP under section 1915(k) of the Act.
- **Increase to administrative federal match for certain expenditures.** In general, federal Medicaid payments are available to states at the rate of 50 percent for expenditures necessary for administration of the state plan. This provision would increase the FMAP for administrative expenditures to 80 percent for amounts expended between the date a state qualifies for the FMAP increase and before October 1, 2031. This provision would permit this administrative FMAP increase for costs associated with expanding HCBS services, including:
 - enhancing the Medicaid data and technology infrastructure;
 - modifying rate setting processes;
 - adopting, using, and reporting quality measures;
 - adopting or improving training programs for direct care workers and family caregivers;
 - HCBS ombudsman office activities;
 - developing processes to identify direct care workers and assign unique identifiers, and;
 - adopting or enhancing programs that register qualified direct care workers.
- **Additional and temporary increase to state-specific FMAP for certain HCBS program improvements.** Under this proposal, a state could also receive an additional two percentage point increase to the state-specific FMAP for the first six fiscal quarters that a qualifying state establish certain models to support the delivery of self-directed care. Such programs would: (1) register qualified direct care workers and connect beneficiaries with providers; (2) recruit independent providers and provide training on self-directed care; (3) ensure the

safety of beneficiaries receiving HCBS; (4) facilitate coordination between state and local agencies and direct care workers on matter of public health and safety; (5) ensure that program policies and procedures do not support or deter unionization, and; (6) provide support to beneficiaries who wish to hire a family member as a caregiver, as permitted by the state. While this additional two percentage point increase is temporary, it is additive to the six percentage point increase for allowable HCBS expenditures described above.

State Requirements to Receive Enhanced FMAP Increase

To qualify for the enhanced FMAP increase made available by this provision, states must undertake efforts to strengthen and expand access to HCBS and the HCBS workforce. States must also adhere to certain maintenance of effort, quality, and reporting requirements. States must complete **each of the following** activities:

- **Activities to improve access to HCBS.** States must: (1) reduce barriers to access and disparities in access or utilization identified in the state-specific improvement plan; (2) provide coverage of personal care services; (3) provide for navigation of HCBS through “no wrong door” programs, expedited eligibility, and improved HCBS counseling and education programs; (4) expand access to behavioral health services in HCBS settings; (5) improve coordination with employment, housing, and transportation services; (6) provide support for family caregivers, and; (7) provide new coverage under, or expand existing eligibility criteria for, one or more of certain eligibility categories.
- **Activities to strengthen and expand the direct HCBS workforce.** In addition to the above activities to improve access to HCBS, states must also: (1) adopt processes to ensure that payments for HCBS are sufficient to ensure access to the services described in the state-specific improvement plan; (2) update qualification standards and develop training opportunities for direct care workers and family caregivers; (3) address insufficient payment rates for delivery of HCBS, emphasizing supporting the recruitment and retention of the direct care workforce; (4) update payment rates for HCBS at least every three years (two years within the initial approval of the plan) with input from relevant stakeholders, and; (5) ensure that payment rate increases are proportionately passed through to direct care workers and incorporated into the managed care system.
- **Other requirements.**
 - **Maintenance of effort requirements.** Generally, states that receive the enhance FMAP increase under this proposal would be prohibited from reducing the amount, duration, and scope of HCBS services or from reducing payment rates for HCBS services that were available in the state at the time the state was awarded planning grant funds. States are also prohibited from adopting more restrictive eligibility standards for receipt of HCBS that were available in the state at the time the state was awarded planning grant funds. However, states would subsequently be permitted to

modify these standards so long as such modifications do not result in less comprehensive HCBS benefits, fewer individuals receiving HCBS, or an increase in cost-sharing for HCBS.

- **Adoption of quality measures.** The state must adopt the core quality measures for HCBS that are developed by the Secretary as required by subsequent sections of this legislative proposal.
- **Reporting of outcomes to the federal government.** Beginning with the fifth fiscal year quarter for which the state is receiving the enhanced FMAP increase made available by this proposal, the state is required to submit annual reports to HHS on the availability and utilization of HCBS in the state, updated payment rates, and other HCBS program enhancements resulting from the approved plan. After seven years of receiving the enhanced FMAP, states must demonstrate an increase in accessibility of HCBS, a reduction in disparities in the utilization and availability of HCBS, evidence that direct care workers receive adequate wages, and that at least 50 percent of state Medicaid funding for long-term services and supports is dedicated to HCBS.

Permanent Extension of Spousal Impoverishment Protections

Under current law pertaining to spousal impoverishment, state Medicaid agencies are required to exclude a certain share of a couple's income and resources from consideration of an applicant or beneficiary eligible for long-term services and supports (LTSS), including HCBS. This requirement protects the spouse who does not require such level of care from becoming impoverished due to financial eligibility criteria for Medicaid LTSS. While the application of these rules to HCBS were originally set to expire in 2018, Congress — through several short-term reauthorizations — has extended its required application to HCBS through September 30, 2023. If enacted, the BBBA would permanently require states to apply the spousal impoverishment rules to applicants and beneficiaries eligible for HCBS.

Permanent Extension of MFP

Originally authorized in 2005 by the Deficit Reduction Act, the MFP program was established to assist individuals transitioning from institutions, such as nursing homes, to HCBS settings. Currently, 41 states and the District of Columbia provide services through the MFP program. While Congress has authorized funding for MFP through a series of legislation over the years, funding for the current authorization of the program is set to expire in FY 2023. If enacted, the BBBA would permanently extend the authorization of the MFP program.

PROVISIONS TO EXPAND ACCESS TO MATERNAL HEALTH

Part 2 of Subtitle F of the Energy and Commerce provisions included in Title III of the House BBBA includes multiple policies aimed at improving access to Medicaid coverage of maternal health. Such

policies included in the BBBA would: (1) extend continuous coverage for pregnant and postpartum individuals and (2) create a state option to provide coordinate care for pregnant and postpartum individuals through a maternal health home.

Extension of Continuous Coverage for Pregnant and Postpartum Individuals

The ARP, included a provision that would provide states with an option to provide 12 months of continuous coverage for postpartum individuals eligible for Medicaid and CHIP. Outside of this state option, states must only provide such continuous coverage to such individuals for 60-days postpartum. If enacted, the House BBBA would require that states — beginning the first fiscal year quarter beginning one year after enactment of the BBBA — provide 12 months of continuous coverage for postpartum individuals eligible for Medicaid and CHIP.

State Option for Maternal Health Homes

The BBBA would also provide states an option to — within two years after enactment — establish a maternal health home to provide Medicaid and maternal health home services to eligible pregnant and postpartum Medicaid beneficiaries.

Under this provision, states have flexibility to determine eligible maternal health home providers — including physicians, clinical or group practices, rural health clinics, freestanding birth centers, community health centers, OB/GYNs, midwives who meet the minimum standards, or other health care entities determined by the state and approved by HHS. Maternal health home providers must provide a number of services, including:

- a standardized risk assessment for all participants to determine needs;
- comprehensive care management;
- care coordination and health promotion;
- comprehensive transitional care for individuals transitioning from inpatient care to other settings;
- individual and family supports;
- making referrals to other medical, community, and social support services; and
- the use of health information technology to link services and coordinate care.

Within a year of enactment, the HHS may award planning grants to states — matched by states at their regular FMAP — to develop state plans to implement the maternal health homes authorized under the House BBBA. Similar to other health home models in Medicaid, states would be provided with flexibility in designing their payment methodologies for providers. Notably, states that take up the new optional benefit would receive a 15-percentage point FMAP increase for the first two years of the program.

ADDRESSING THE FISCAL CLIFF FOR THE TERRITORIES

The House BBBA contains provisions that would permanently increase the federal Medicaid allotments for the U.S. territories —American Samoa, Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. While states receive open-ended federal funds subject to a specified percentage of their Medicaid expenditures, territories receive a capped amount of funding from the federal government. As a result of this financing structure, the U.S. territories have routinely faced a fiscal cliff in their Medicaid program, prompting Congress to act each time to temporarily increase the federal allotments for the territories so that they could continue to receive federal funds for allowable expenditures.

To address the current fiscal cliff faced by the U.S. territories, the House BBBA provides \$3.6 billion in Medicaid funding for Puerto Rico, \$135 million for the U.S. Virgin Islands, \$140 million for Guam, \$70 million for the Northern Mariana Islands, and \$90 million for American Samoa in 2022. While the BBBA does not alter the block grant structure of federal financing for the Medicaid program in these territories, it would automatically increase the territory-specific allotment caps by the percentage increase in Medicaid spending in the previous year.

Additionally, beginning in 2022, the BBBA will increase the FMAP for each of the territories to 83 percent FMAP. Puerto Rico will receive a 76 percent FMAP in 2022 before bumping up to 83 percent along with the other territories in 2023. Puerto Rico will also have a 70 percent FMAP floor. Together, these proposed changes are designed to minimize the risk that the territories will exhaust their federal funding for the Medicaid program while providing them with the ability to expand their programs.

PHASE-OUT OF TEMPORARY FMAP INCREASE AND MAINTENANCE OF EFFORT REQUIREMENTS INCLUDED IN PREVIOUS COVID-19 LEGISLATION

Part 4 of Subtitle F of the Committee on Energy and Commerce provisions included in Title III of the House BBBA provides for several changes to the temporary enhanced FMAP increase and requirements for states to be eligible for such an increase under section 6008 of the Families First Coronavirus Response Act (FFCRA).

Phase-out of the FFCRA FMAP Bump

Under current law, beginning January 1, 2020 and ending on the last day of the calendar quarter in which the COVID-19 public health emergency ends, eligible states may receive a 6.2 percentage point increase to their regular FMAP for Medicaid expenditures to which the regular FMAP applies. As currently drafted, the House BBBA will phase out the FFCRA FMAP bump with a final end date of September 30, 2022. The available FMAP bump would be as follows:

- 6.2 percentage points for each calendar quarter beginning January 1, 2020 and ending March 31, 2022;

- 3.0 percentage points for each calendar quarter beginning on April 1, 2022 and ending on June 30, 2022; and
- 1.0 percentage points for each calendar quarter beginning July 1, 2022 and ending on September 30, 2022.

Change in Certain FFCRA MOE Requirements

Under current law, states are required to meet four maintenance of effort (MOE) requirements in order to be eligible to receive the current 6.2 percentage point FMAP increase during a calendar quarter. Currently, these MOE provisions prohibit states from:

- implementing any eligibility standards, methodologies, or procedures that are more restrictive than those in effect on January 1, 2020;
- imposing new or increased premiums on any beneficiary that exceed the amount of the premium on effect as of January 1, 2020;
- disenrolling any individual who is enrolled as of March 18, 2020 or who newly enrolls during the public health emergency from Medicaid through the last day of the month in which the public health emergency ends; and
- fails to cover, without cost-sharing, testing services and treatment for COVID-19 in Medicaid, including vaccines, specialized equipment, and therapies.

Notably, the third MOE requirement requires states to maintain Medicaid eligibility for an individual through the end of the month in which the public health emergency period ends.

As drafted, the House BBBA would sunset the current third MOE requirement pertaining to Medicaid eligibility. Specifically, should this provision become law, states would only need to treat individuals enrolled in Medicaid as of March 18, 2020 or individuals who are enrolled between March 18, 2020 through March 31, 2022 as eligible for Medicaid benefits through September 30, 2022. This would permit states to disenroll certain Medicaid beneficiaries, subject to the special rule described below.

Special Rule for States that Terminate Medicaid Coverage for Certain Enrollees

The House BBBA also creates a special rule to permit states to disenroll certain beneficiaries who are no longer eligible for Medicaid. Beginning calendar quarters on or after April 1, 2022, states—subject to certain conditions—would be permitted to terminate coverage for Medicaid enrollees the state determines are no longer eligible for coverage. Importantly, states that take these actions will not be deemed ineligible for the FMAP bump and deemed out of compliance with the MOE requirements. In order to not be deemed out of compliance with the Medicaid eligibility MOE requirements, a state, in terminating coverage for a Medicaid enrollee between April 1, 2022 through September 30, 2022 must:

- Conduct eligibility redeterminations with respect to an individual based on the current circumstances of such individual; and

- Assess whether the individual is eligible for all categories under the Medicaid state plan or waiver;

Under the House BBBA provision, if a state determines that an individual is ineligible for Medicaid as a result of a redetermination for all eligibility categories in the Medicaid state plan or waiver, the State must:

- Determine the individual's potential eligibility for other insurance affordability programs; and
- Undertake a good faith effort to ensure that the state has contact information for such individuals prior to terminating coverage.

Finally, this provision includes additional parameters around who the state is permitted to terminate, including restrictions on only terminating from Medicaid coverage individuals that have been enrolled in Medicaid for at least 12 consecutive months. States are also not permitted to initiate eligibility redeterminations for more than 1/12th of the individuals enrolled in Medicaid in the state with respect to any month between April 1, 2022 through September 30, 2022. States will be required to submit monthly reports, beginning April 1, 2022, to the Secretary on its activities surrounding Medicaid eligibility redeterminations.

FMAP Reduction for Certain State Actions After the End of the PHE

Notably, the House BBBA includes a provision that would impose a 3.1 percentage point reduction in the state's regular FMAP for any calendar quarter between September 1, 2022 and December 31, 2025 that a state imposes eligibility standards, methodologies, or procedures under the state plan or waiver that are more restrictive than such standards, methodologies, or procedures that are in effect on October 1, 2021.

CHANGES TO THE CHILDREN'S HEALTH INSURANCE PROGRAM

Subtitle G of the Energy and Commerce provisions including in Title III of the BBBA would enact comprehensive changes to the CHIP to permanently fund and expand access to the program. Currently, CHIP is funded through 2027, upon which the program would require reauthorization. However, most provisions that were set to expire in 2027 are being permanently extended in BBBA. The bill also makes additional policy changes to support accessibility and funding.

- **Permanent Program Extension.** The House BBBA makes CHIP permanent. The program is currently funded through 2027, and new language would provide continuous funding from 2027 onwards.
 - Unlike federal matching for Medicaid, CHIP's federal match comes from a block grant that requires period replenishing.

- **Application of Medicaid Drug Rebate Program to CHIP.** Starting in January 2024, the BBBA would subject CHIP to Medicaid Drug Rebate Program (MDRP). As a result, manufacturers with a signed National Drug Rebate Agreement must provide rebates to states for drug dispensed to CHIP enrollees, including those enrolled through a managed care organization (MCO).
- **Program Eligibility.** The BBBA offers states the option to expand CHIP income eligibility levels beyond the existing statutory ceiling. In its current form, this provision prohibits states from restricting eligibility for those whose income is \leq 300 percent FPL through 2027. As such, the new eligibility parameters will extend past 2027.
- **Additional CHIP Policies.** Beginning in 2028 and increasing in accordance with CPI-U, \$15 million will be appropriated to implement the pediatric quality measures program. The bill also provides a child enrollment contingency fund. Additionally, the BBBA would extend the outreach and enrollment program to match the permanent extension of CHIP. The outreach and enrollment program would receive \$8 million from 2024 through 2027, and the new provision would provide \$60 million per year from 2028 to 2030. From 2031 onwards, the set aside would increase based on CPI-U.

PROVISIONS TO EXPAND ACCESS TO OTHER SERVICES

Permanent Extension of State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services

The ARP established an option for states to provide these mobile services starting in April 2022 for five years with an 85 percent FMAP for the first three. The House BBBA would make the state option to provide community-based mobile crisis intervention services permanent past the current March 31, 2027 statutory end date.

Expansions of Community Mental Health Services Demonstration

Section 223 of the [Protecting Access to Medicare Act of 2014](#) created a demonstration program to improve behavioral health services through certified community behavioral health clinics (CCBHCs). While the statute limited participation in the demonstration to eight states, Congress recently extended the demonstration to provide for the participation of an additional two states.

The House BBBA would further extend the CCBHC demonstration program to provide the Secretary with \$40 million for FY 2022 to award additional planning grants for states and territories to develop proposals to participate in the community mental health demonstration programs. Of the states or territories that receive planning grants, the Secretary would be required to select any state, including any state that received initial planning grants in 2015, that meets certain criteria to participate in the two-year CCBHC demonstration program. Until the demonstration ends, the state will be required to

submit a report each year on its use of funds. The report to Congress will include an assessment of access to services, quality and scope of services, and impact on state and deferral spending. By March 31, 2026, HHS will then recommend whether the programs should be modified based on demonstration data from states participating in the programs.

Access to Vaccines for Adults

The BBBA aims to increase coverage of vaccines for adults under Medicaid and CHIP by requiring coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) to certain Medicaid and CHIP beneficiaries with no cost-sharing. The provision would provide an increase in the FMAP to states for vaccine administration by one percentage point. Vaccine-specific ACIP recommendations include:

Medicaid Coverage for Inmates 30-Days Before Release

Under current law, Medicaid cannot cover incarcerated individuals. In the past, states have terminated coverage for inmates, leaving them to reapply upon release. However, states have been increasingly shifting their policies to instead suspend coverage during incarceration to reduce hurdles of reobtaining coverage after a prison or jail sentence.

Part four of Subtitle F makes an exception to the provision that inmates in nonmedical institutions are not eligible for Medicaid. This regulation would go into effect two years after BBBA is enacted. The provision in BBBA stipulates that inmates are eligible for Medicaid coverage 30 days prior to their release. This policy change also includes juveniles and children.

OTHER PROVISIONS

One-year Continuous Eligibility for Children

Under current law, states have the option to provide children with 12 months of continuous coverage through Medicaid and the CHIP, even if the family experiences a change in income during the year. While approximately half of states have implemented this state option, the BBBA would require states to provide 12 months of continuous eligibility for children enrolled in Medicaid. Such states will have one year after enactment of the BBBA to implement the 12-month continuous coverage requirement.

Extension of FMAP Increase for Urban Indian Health Organizations and Native Hawaiian Health Care Systems

In March 2021, the ARP provided states with 100 percent FMAP for Medicaid services provided to beneficiaries received through Urban Indian Organizations (UIO) and Native Hawaiian Health Care Systems. Under current law, this FMAP increase is available to states for two years, beginning April 2021 through March 31, 2023. The BBBA would extend further extend this 100 percent match for an

additional six years. Thus, this increased FMAP would be available to states between April 1, 2021 and ending March 31, 2029.