AMENDMENT NO._____ Calendar No._____

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—115th Cong., 1st Sess.

H. R. 1628

To provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT IN THE NATURE OF A SUBSTITUTE intended to be proposed by _____

Viz:

Strike all after the enacting clause and insert the following:

TITLE I

SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

Subparagraph (B) of section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

"(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply

to taxable years ending after December 31, 2017.''.

SEC. 102. PREMIUM TAX CREDIT.

(a) PREMIUM TAX CREDIT.—

(1) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—

(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: ''or a plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest)''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2017.

(2) REPEAL.—

(A) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2019.

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act are repealed:

(A) Section 1411 (other than subsection (i), the last sentence of subsection (e)(4)(A)(ii), and such provisions of such section solely to the extent related to the application of the last sentence of subsection (e)(4)(A)(ii)).

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeals in paragraph (1) shall take effect on January 1, 2020.

SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(j) SHALL NOT APPLY.—This section shall not apply with respect to amounts paid or incurred in taxable years beginning after December 31, 2019.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term'', and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2017.

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (2)(B)(iii), by striking ''2.5 percent'' and inserting ''Zero percent'', and

(2) in paragraph (3)—

(A) by striking ''$695'' in subparagraph (A) and inserting ''$0'', and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$2,000''.

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$3,000''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 106. SHORT TERM ASSISTANCE FOR STATES AND MARKET-BASED HEALTH CARE GRANT PROGRAM.

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsections:

''(h) SHORT-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES.—

''(1) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $10,000,000,000 for calendar year 2019, and $15,000,000,000 for calendar year 2020, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (i) referred to as the 'Administrator') to fund arrangements with health insurance issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States. Funds appropriated under this paragraph shall remain available until expended.

''(2) PARTICIPATION REQUIREMENTS.—

''(A) GUIDANCE.—Not later than 30 days after the date of enactment of this subsection, the Administrator shall issue guidance to health

insurance issuers regarding how to submit a notice of intent to participate in the program established under this subsection.

"(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding for a calendar year under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate not later than March 31 of the previous fiscal year, in such form and manner as specified by the Administrator, and containing—

"(i) a certification that the health insurance issuer will use the funds in accordance with the requirements of paragraph (4); and

"(ii) such information as the Administrator may require to carry out this subsection.

"(3) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing and distributing funds under this subsection.

"(4) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) shall be subject to the requirements of paragraphs (1)(A)(iii)

and (7) of subsection (i) in the same manner as such requirements apply to States receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A)(i)(II) of subsection (i).

''(i) MARKET-BASED HEALTH CARE GRANT PROGRAM.—

''(1) APPLICATION AND CERTIFICATION REQUIREMENTS.—

''(A) IN GENERAL.—To be eligible for an allotment of funds under this subsection, a State shall submit to the Administrator an application, not later than March 31, 2019, in the case of allotments for calendar year 2020, and not later than March 31 of the previous year, in the case of allotments for any subsequent calendar year) and in such form and manner as specified by the Administrator, that contains the following:

''(i) A description of how the funds will be used to do 1 or more of the following:

''(I) To establish or maintain a program or mechanism to help high-risk individuals in the purchase of

health benefits coverage, including by reducing premium costs for such individuals, who have or are projected to have a high rate of utilization of health services, as measured by cost, and who do not have access to health insurance coverage offered through an employer, enroll in health insurance coverage under a plan offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(II) To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting State health insurance market participation and choice in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(III) To provide payments for health care providers for the provision

of health care services, as specified by the Administrator.

''(IV) To provide health insurance coverage by funding assistance to reduce out-of-pocket costs, such as copayments, coinsurance, and deductibles, of individuals enrolled in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(V) To establish or maintain a program or mechanism to help individuals purchase health benefits coverage, including by reducing premium costs for plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986) for individuals who do not have access to health insurance coverage offered through an employer.

''(VI) Subject to paragraph (4)(B)(iii), to provide health insurance coverage for individuals who are eligi-

ble for medical assistance under a State plan under title XIX by establishing or maintaining relationships with health insurance issuers to provide such coverage.

''(VII) To assist in the purchase of health benefits coverage by establishing or maintaining a program or mechanism, as specified by the State, to establish coverage programs through arrangements with managed care organizations for the provision of health care services to individuals who are not eligible for medical assistance or child health assistance under the State plans under title XIX or this title.

''(ii) A certification that the funds provided under this subsection shall only be used for the activities specified in clause (i).

''(iii) A certification that none of the funds provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovern-

mental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plans established under this title and title XIX or under a waiver of such plans.

''(iv) A description of any waiver of the provisions described in subparagraph (B)(i) that the State is requesting, and how the State intends to maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions if such waiver is approved.

''(v) Such other information as necessary for the Administrator to carry out this subsection.

''(B) WAIVERS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall waive the requirements of the following Federal statutory provisions with respect to health insurance coverage in a State for a plan year during which the State has an application ap-

proved under this subsection and to the extent that such application includes a request for such a waiver and the information described in subparagraph (A)(iv):

''(I) Any provision that restricts the criteria which a health insurance issuer may use to vary premium rates for health insurance coverage offered in the individual or small group market, or the degree to which an issuer may vary such rates, except that a health insurance issuer may not vary premium rates based on an individual's sex or membership in a protected class under the Constitution of the United States.

''(II) Any provision that prevents a health insurance issuer offering a coverage plan in the individual or small group market from requiring an individual to pay a premium or contribution (as a condition of enrollment or continued enrollment under the plan) which is greater than such premium or contribution for a similarly

situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

''(III) Any provision that requires a health insurance issuer offering a coverage plan in the individual or small group market to ensure that certain benefits are included in such coverage.

''(IV) Any provision that requires a health insurance issuer offering a coverage plan in the individual or small group market to provide a rebate to each enrollee under such coverage if the ratio of the amount of premium revenue expended by the issuer on the costs of providing such coverage for a plan year to the total amount of premium revenue for the plan year is less than a certain percentage.

''(ii) SCOPE OF WAIVER.—

"(I) RELATIONSHIP TO GRANT PROGRAM.—Any provision waived under this subparagraph shall only be waived with respect to health insurance coverage that is—

"(aa) provided by an health insurance issuer that is receiving funding under a State program that is funded by a grant under this subsection; and

"(bb) provided to an individual who is receiving a direct benefit (including reduced premium costs or reduced out-of-pocket costs) under a State program that is funded by a grant under this subsection.

"(II) LIMITATION.—The Secretary shall not waive any requirement under a Federal statute enacted before January 1, 2009.

"(2) ELIGIBILITY.—Only the 50 States and the District of Columbia shall be eligible for an allotment and payments under this subsection and all references in this subsection to a State shall be

treated as only referring to the 50 States and the District of Columbia.

''(3) ONE-TIME APPLICATION.—If an application of a State submitted under this subsection is approved by the Administrator for a year, the application shall be deemed to be approved by the Administrator for that year and each subsequent year through December 31, 2026.

''(4) MARKET-BASED HEALTH CARE GRANT ALLOTMENTS.—

''(A) APPROPRIATION.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(i) for calendar year 2020, $146,000,000,000;

''(ii) for calendar year 2021, $146,000,000,000;

''(iii) for calendar year 2022, $157,000,000,000;

''(iv) for calendar year 2023, $168,000,000,000;

''(v) for calendar year 2024, $179,000,000,000;

"(vi) for calendar year 2025, $190,000,000,000; and

"(vii) for calendar year 2026, $190,000,000,000.

"(B) ALLOTMENTS; AVAILABILITY OF ALLOTMENTS.—

"(i) IN GENERAL.—In the case of a State with an application approved under this subsection with respect to a year, the Administrator shall allot to the State for the year, from amounts appropriated for such year under subparagraph (A), the amount determined for the State and year under paragraph (5).

"(ii) AVAILABILITY OF ALLOTMENTS; UNUSED AMOUNTS.—

"(I) IN GENERAL.—Amounts allotted to a State for a calendar year under this subparagraph shall remain available for obligation by the State through December 31 of the second calendar year following the year for which the allotment is made, except that in no case shall amounts appropriated for any year before calendar

year 2027 remain available for obligation by a State after December 31, 2026.

''(II) UNUSED AMOUNTS TO BE USED FOR DEFICIT REDUCTION.—Amounts allotted to a State for a calendar year that remain unobligated on April 1 of the following year shall be deposited into the general fund of the Treasury and shall be used for deficit reduction

''(iii) LIMITATION.—

''(I) IN GENERAL.—Subject to subclause (II), in no case may a State use more than 15 percent of the amount allotted to the State for a year under this subparagraph for the purpose described in subclause (VI) of paragraph (1)(A)(i).

''(II) EXCEPTION.—The Secretary may permit a State to use not more than 20 percent of the amount allotted to the State for a year under this subparagraph for the purpose described in subclause (VI) of paragraph

(1)(A)(i) if the State submits an application to waive the restriction in subclause (I) and the Secretary determines that the State is using such amounts allotted to the State to supplement, and not supplant, State expenditures on the State plan under title XIX.

''(C) RESERVATION OF FUNDS FOR ADVANCED PAYMENTS TO STATES IN 2020.—

''(i) IN GENERAL.—From the amount appropriated for calendar year 2020, $10,000,000,000 shall be reserved for the purpose of increasing State allotments for calendar year 2020 under paragraph (9).

''(ii) AVAILABILITY OF RESERVED FUNDS.—

''(I) IN GENERAL.—Funds reserved under clause (i) shall be available for the purpose described in such clause until December 31, 2020.

''(II) AVAILABILITY FOR 2026 ALLOTMENTS.—To the extent that any funds reserved under clause (i) remain after December 31, 2020, such funds

shall be available for making allotments to States for calendar year 2026.

''(5) DETERMINATION OF ALLOTMENT AMOUNTS.—

''(A) CALENDAR YEAR 2020.—

''(i) IN GENERAL.—Subject to subparagraph (H), the amount determined under this paragraph for a State for calendar year 2020 shall be equal to the State's base period amount, as defined in clause (ii).

''(ii) BASE PERIOD AMOUNT.—In this paragraph, the term 'base period amount' means, with respect to a State, the sum of the following amounts:

''(I) The amount, increased by the State growth factor described in clause (iv)(I), of Federal payments—

''(aa) that were made to the State during the State's premium assistance base period (as defined in clause (iii)) for medical assistance provided to individuals under clause (i)(VIII) or (ii)(XX)

of section 1902(a)(10)(A) (including medical assistance provided to individuals who are not newly eligible (as defined in section 1905(y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i)); or

''(bb) that would have been made to a State during the State's premium assistance base period for medical assistance provided to individuals who would have been described in section 1902(a)(10)(A)(i)(VIII) (without regard to the first sunset date in such section) but who were provided such assistance under a title XIX State plan waiver that made medical assistance available to all individuals described in such subsection whose income did not exceed 100 percent of the poverty line and that was in effect on September 1, 2017, if

such assistance was treated as assistance under such section.

''(II) The amount, increased by the State growth factor described in clause (iv)(II), of Federal payments made to the State during the State's premium assistance base period for operating a Basic Health Program under section 1331 of the Patient Protection and Affordable Care Act during such period.

''(III) The amount, increased by the State growth factor described in clause (iv)(II), of advance payments of premium assistance credits allowable under section 36B of the Internal Revenue Code of 1986 made under section 1412(a) of the Patient Protection and Affordable Care Act during the State's premium assistance base period on behalf of individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act.

''(IV) The amount, increased by the State growth factor described in clause (iv)(II), of Federal payments for cost-sharing reductions provided during the State's premium assistance base period under section 1402 of such Act to individuals who purchased insurance through the Exchange established for or by the State pursuant to title I of such Act.

''(iii) PREMIUM ASSISTANCE BASE PERIOD.—

''(I) IN GENERAL.—In this paragraph, the term 'premium assistance base period' means, with respect to a State, a period of 4 consecutive fiscal quarters selected by the State.

''(II) TIMELINE.—Each State shall submit its selection of a premium assistance base period to the Secretary not later than July 1, 2018.

''(III) PARAMETERS.—In selecting a premium assistance base period under this clause, a State shall—

"(aa) only select a period of 4 consecutive fiscal quarters for which all the data necessary to make determinations required under this paragraph is available, as determined by the Secretary; and

"(bb) shall not select any period of 4 consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter later than the first fiscal quarter of 2018.

"(iv) GROWTH FACTORS.—The growth factor described in this clause for a State is—

"(I) for the amount described in subclause (I) of clause (i), the projected percentage increase in Medicaid expenditures from the last month of the State's premium assistance base period to November of 2019, as deter-

mined by the Medicaid and CHIP Payment and Access Commission; and

"(II) for the amounts described in subclauses (II), (III), and (IV) of clause (i), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from the last month of the State's premium assistance base period to November of 2019.

"(B) CALENDAR YEARS 2021 THROUGH 2025.—Subject to subparagraphs (D), (E), (F), (G), and (H), for each of calendar years 2021 through 2025, the amount determined under this paragraph for a State and calendar year shall be equal to—

"(i) the amount determined for the State under this paragraph (including any applicable adjustments) for the previous calendar year; plus

"(ii) an amount equal to ⅙ of the difference between—

"(I) the projected 2026 amount for the State and year (as defined in subparagraph (J)); minus

"(II) the amount allotted to the State for calendar year 2020.

"(C) CALENDAR YEAR 2026.—Subject to subparagraphs (D), (E), (F), (G), and (H), for calendar year 2026, the amount determined under this paragraph for a State shall be equal to the product of the amount appropriated for the year under paragraph (4)(A)(vii) (increased by any available amounts described in paragraph (4)(C)(ii)(II)) and the ratio of—

"(i) the number of low-income individuals (as defined in subparagraph (I)) in the State for calendar year 2025; to

"(ii) the number of low-income individuals in all States for calendar year 2025.

"(D) POPULATION RISK ADJUSTMENT.—

"(i) IN GENERAL.—Subject to clauses (ii) and (iii), for each calendar year after 2020, the Secretary shall adjust the amount determined for each State for the year under subparagraph (B) or (C) so

that the amount is equal to the product of—

''(I) the amount so determined for the State and year; and

''(II) the population risk index (as defined in subparagraph (K)) for the State and year.

''(ii) PHASE-IN OF POPULATION RISK ADJUSTMENT.—For each of calendar years 2021 through 2023, the amount of the adjustment determined for a State for a year under clause (i) shall be reduced—

''(I) in calendar year 2021, by 75 percent;

''(II) in calendar year 2022, by 50 percent; and

''(III) in calendar year 2023, by 25 percent.

''(iii) CAP ON RISK ADJUSTMENT.—In no case shall the Secretary increase or reduce the amount determined for a State and year under subparagraph (B) or (C) by an amount that is greater than 10 percent of the amount so determined.

''(E) COVERAGE VALUE ADJUSTMENT.—

''(i) IN GENERAL.—Subject to clause (iii), for each calendar year after 2023, the amount determined for a State under subparagraph (B) or (C) and adjusted under subparagraph (D) shall be reduced by the coverage value adjustment amount determined for the State and year under clause (ii).

''(ii) COVERAGE VALUE ADJUSTMENT AMOUNT.—The coverage value adjustment amount determined under this clause for a State and year shall be equal to the amount, if any, by which the amount determined for the State and year under subparagraph (B) or (C) and adjusted under subparagraph (D) exceeds the product of—

''(I) the amount so determined and adjusted for the State and year; and

''(II) the ratio of—

''(aa) the average actuarial value of health care coverage for low-income individuals in the State for the previous calendar

year, as determined under subparagraph (N); and

''(bb) the lowest possible actuarial value of health benefits coverage that would satisfy the requirements of section 2103(a) (or, if applicable, any waiver of such requirements that is effective in such State for such year) if such coverage were provided as child health assistance to a targeted low-income child under the State child health plan.

''(iii) PHASE-IN OF COVERAGE VALUE ADJUSTMENT.—For each of calendar years 2024 through 2026, the amount of any reduction determined for a State for a year under clause (ii) shall be reduced—

''(I) in calendar year 2024, by 75 percent;

''(II) in calendar year 2025, by 50 percent; and

''(III) in calendar year 2026, by 25 percent.

"(F) STATE SPECIFIC POPULATION ADJUSTMENT FACTOR.—

"(i) IN GENERAL.—For calendar years after 2020, the Secretary may adjust the amount determined for a State for a year under subparagraph (B) or (C) and adjusted under subparagraphs (D) and (E) according to a population adjustment factor developed by the Secretary.

"(ii) DEVELOPMENT OF POPULATION ADJUSTMENT FACTOR.—Not later than July 31, 2019, the Secretary shall develop a State specific population adjustment factor that accounts for legitimate factors that impact the health care expenditures in a State beyond the clinical characteristics of the low-income individuals in the State. Such factors may include State demographics, wage rates, income levels, and other factors as determined by the Secretary.

"(G) 2026 REDUCTION FOR STATES RECEIVING ADVANCED PAYMENTS IN 2020.—For calendar year 2026, the amount determined for a State for such year under subparagraph (C)

and adjusted under subparagraphs (D), (E), and (F), shall be reduced by the amount of any increase to the State's allotment for calendar year 2020 under paragraph (9).

"(H) PRORATION RULE.—

"(i) IN GENERAL.—In no case shall the total amount of State allotments (including any adjustments under subparagraphs (D), (E), (F), and (G)) determined for a calendar year under this paragraph exceed the amount appropriated for a calendar year under paragraph (4)(A) (increased, in the case of calendar year 2026, by any available amounts described in paragraph (4)(C)(ii)(II)).

"(ii) PRORATION.—If the amount so appropriated—

"(I) is less than the total amount of State allotments determined for such year under this paragraph (after any adjustments under subparagraphs (D), (E), (F), and (G)), the amount allotted to each State for such year shall be reduced proportionally; and

''(II) is greater than the total amount of State allotments determined for such year under this paragraph (after any adjustments under subparagraphs (D), (E), (F), and (G)), the amount allotted to each State for such year shall be increased proportionally.

''(I) LOW-INCOME INDIVIDUAL.—In this paragraph, the term 'low-income individual' means an individual—

''(i) who is a citizen or legal resident; and

''(ii) whose income (as determined under section 1902(e)(14) (relating to modified adjusted gross income)) is greater than 45 percent but less than 133 percent of the poverty line (as defined in section 2110(c)(5), subject to subparagraph (O)(ii)) applicable to a family of the size involved.

''(J) PROJECTED 2026 AMOUNT.—The term 'projected 2026 amount' means, with respect to a State and calendar year, the product of the

amount appropriated for calendar year 2026 under paragraph (4)(A)(vii) and the ratio of—

"(i) the number of low-income individuals (as defined in subparagraph (I)) in the State for the calendar year preceding the calendar year involved; to

"(ii) the number of low-income individuals in all States for such preceding year.

"(K) POPULATION RISK INDEX.—The term 'population risk index' means, for a State for a calendar year, the ratio of—

"(i) the sum of the products, for each of the clinical risk categories (as defined in subparagraph (L)(i)), of—

"(I) the clinical risk factor for the category (as defined in subparagraph (M)); and

"(II) the number of low-income individuals for the State, year, and category; to

"(ii) the number of enrollees in the State.

"(L) CLINICAL RISK CATEGORY.—

"(i) IN GENERAL.—The term 'clinical risk category' means a grouping of low-income individuals based on their clinical characteristics that is established by the Secretary under this subparagraph.

"(ii) METHODOLOGY FOR ESTABLISHING CATEGORIES AND ASSIGNING INDIVIDUALS TO A CATEGORY.—The Secretary shall select a methodology for establishing clinical risk categories and for assigning low-income individuals to such categories, except that any methodology selected by the Secretary shall meet the following requirements:

"(I) The methodology shall be composed of exhaustive and mutually exclusive risk categories such that every low-income individual is assigned to a risk category and each individual may be assigned to only one risk category.

"(II) The methodology shall account for clinical characteristics of individuals that impact per capita health care expenditures.

''(III) The methodology shall account for the chronic illness burden associated with multiple comorbid chronic diseases and be composed of risk categories that explicitly differentiate individuals based on their severity of illness.

''(IV) The methodology shall include risk categories that account for complex pediatric enrollees.

''(V) The methodology for assigning individuals to such clinical risk categories shall be based on characteristics of individuals contained in data routinely collected in administrative claims data and shall be capable of utilizing pharmacy data and functional health status data when such data becomes routinely available.

''(VI) To the extent possible, the methodology shall be a methodology that has been implemented for the purpose of determining per capita payments by a State plan under title XIX to a managed care entity respon-

sible for providing or arranging for services for a population of enrollees that includes enrollees with complex pediatric conditions and enrollees who are eligible for benefits under both titles XVIII and XIX.

''(VII) The methodology shall be open, transparent, and available for review and comment by the public.

''(iii) TIMELINE.—

''(I) IN GENERAL.—The Secretary shall select the methodology for establishing clinical risk categories and assigning low-income individuals to such categories not later than January 1, 2020.

''(II) ANNUAL UPDATES.—Not later than 15 days prior to the beginning of each calendar year, the Secretary shall make publicly available updates to the methodology selected under subclause (I).

''(M) CLINICAL RISK FACTOR.—The term 'clinical risk factor' means, with respect to each

clinical risk category and calendar year, the ratio of—

"(i) the average per capita amount of expenditures for all States for the previous calendar year for low-income individuals in the category; to

"(ii) the average per capita amount of expenditures for all States for the previous calendar year for all low-income individuals.

"(N) DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—In determining the average actuarial value of coverage for low-income individuals for a State and calendar year—

"(i) any plan offered on the health insurance marketplace established for or by the State that does not offer a benefits package that is at least equivalent to one of the benchmark benefits packages described in section 2103(b) shall be deemed to have an actuarial value of 40 percent; and

"(ii) any low-income individual who is not enrolled in any plan for health benefits coverage for more than 3 months during

such year shall be deemed to have been enrolled in a plan for health benefits coverage with an actuarial value of 0 percent.

''(O) POPULATION AND POVERTY DATA.—

''(i) IN GENERAL.—In making the determinations required under this paragraph, the Secretary shall, where appropriate, use data from the most recently available Current Population Survey of the Bureau of the Census.

''(ii) USE OF SEPARATE POVERTY LINES.—In the case of a State for which the Secretary has issued under the authority of section 673(2) of the Omnibus Budget Reconciliation Act of 1981 a separate poverty guideline for 2017 that is higher than the poverty line (as defined in section 2110(c)(5)) that is applicable to the majority of States, the Secretary shall determine the number of low-income individuals in such State using such separate poverty guideline instead of such poverty line.

''(6) PAYMENTS.—

"(A) IN GENERAL.—The Administrator shall pay to each State that has an application approved under this subsection for a year, from the amount allotted to the State under paragraph (4)(B) for the year, an amount equal to the State's expenditures for the year on the activities described by the State in its application approved under paragraph (1).

"(B) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

"(i) IN GENERAL.—If the Administrator deems it appropriate, the Administrator shall make payments under this subsection for each 6 month period in a year on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Administrator shall find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior periods.

"(ii) MISUSE OF FUNDS.—If the Administrator determines that a State is not using funds paid to the State under this subsection in a manner consistent with the

description provided by the State in its application approved under paragraph (1) or is inappropriately withholding payments owed to providers of services or health insurance issuers, the Administrator may withhold payments, reduce payments, or recover previous payments to the State under this subsection as the Administrator deems appropriate.

''(C) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the year expenditures that were incurred in a previous year.

''(7) EXEMPTIONS.—Paragraphs (2), (3), (5), (6), (8), (10), and (11) of subsection (c) do not apply to payments under this subsection.

''(8) CONTINGENCY FUND.—

''(A) IN GENERAL.—From the amount appropriated under subparagraph (C), the Secretary may increase the allotment amount determined under paragraph (5) for each of calendar years 2020 and 2021 for any State that is a low-density State or a non-expansion State for the year.

"(B) DEFINITIONS.—In this paragraph:

"(i) LOW-DENSITY STATE DEFINED.—The term 'low-density State' means, with respect to a calendar year, a State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

"(ii) NON-EXPANSION STATE.—The term 'non-expansion State' means a State that—

"(I) is not a low-density State; and

"(II) did not provide eligibility under section 1902(a)(10)(A)(i)(VIII) for medical assistance under the State plan under title XIX on September 1, 2017 (or provided eligibility for individuals described in such section under a waiver of the State plan approved under section 1115).

"(C) FUNDING.—

"(i) IN GENERAL.—There is appropriated, out of any money in the Treasury not otherwise appropriated,

$6,000,000,000 for calendar year 2020, and $5,000,000,00 for calendar year 2021, for the purpose of carrying out this paragraph.

''(ii) RESERVATION OF FUNDS.—The Secretary shall reserve, for each of calendar years 2020 and 2021, from the funds appropriated for each such year under clause (i)—

''(I) 25 percent of such funds for the purpose of increasing the grant amounts for States that are low-density States; and

''(II) 75 percent of such funds for the purpose of increasing the grant amounts for States that are non-expansion States.

''(9) ADVANCE PAYMENT FUND.—

''(A) IN GENERAL.—From the amount reserved under paragraph (4)(C), the Secretary may increase the allotment amount determined under paragraph (5) for calendar year 2020 for any State that applies for an increase under this paragraph by the amount determined for the State under subparagraph (B).

"(B) AMOUNT OF INCREASE.—Subject to subparagraph (C), the Secretary shall increase the allotment amount determined under paragraph (5) for a State for calendar year 2020 by the amount requested by the State, except that in no case shall the Secretary increase a State's allotment amount by an amount that exceeds 5 percent of the amount so determined.

"(C) PRORATION RULE.—If the amount reserved under paragraph (4)(C) is less than the total amount of increases requested by States under this paragraph, the amount of the increase for each State shall be reduced proportionally.".

(b) OTHER TITLE XXI AMENDMENTS.—

(1) Section 2101 of such Act (42 U.S.C. 1397aa) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking "The purpose" and inserting "Except with respect to short-term assistance activities under section 2105(h) and the Market-Based Health Care Grant Program established in section 2105(i), the purpose"; and

(B) in subsection (b), in the matter preceding paragraph (1), by inserting ''subsection (a) or (g) of'' before ''section 2105''.

(2) Section 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is amended by striking ''and may not include'' and inserting ''or to carry out short-term assistance activities under subsection (h) or the Market-Based Health Care Grant Program established in subsection (i) and, except in the case of funds made available under subsection (h) or (i), may not include''.

(3) Section 2106(a)(1) of such Act (42 U.S.C. 1397ff(a)(1)) is amended by inserting ''subsection (a) or (g) of'' before ''section 2105''.

SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established a Better Care Reconciliation Implementation Fund (referred to in this section as the ''Fund'') within the Department of Health and Human Services to provide for Federal administrative expenses in carrying out this Act.

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000.

SEC. 108. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(b) Archer MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(c) Health Flexible Spending Arrangements and Health Reimbursement Arrangements.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(d) Effective Dates.—

(1) Distributions from savings accounts.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

(2) Reimbursements.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2016.

SEC. 109. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.

(a) HSAs.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''10 percent''.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''15 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2016.

SEC. 110. REPEAL OF MEDICAL DEVICE EXCISE TAX.

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2017.''.

SEC. 111. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 112. PURCHASE OF INSURANCE FROM HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual'' in subparagraph (A) and inserting ''any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, and any child (as defined in section 152(f)(1)) of such individual who has not attained the age of 27 before the end of such individual's taxable year'',

(2) by striking subparagraph (B) and inserting the following:

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance.'', and

(3) by striking ''or'' at the end of subparagraph (C)(iii), by striking the period at the end of subparagraph (C)(iv) and inserting '', or'', and by adding at the end the following:

"(v) a high deductible health plan but only to the extent of the portion of such expense in excess of—

"(I) any amount allowable as a credit under section 36B for the taxable year with respect to such coverage,

"(II) any amount allowable as a deduction under section 162(l) with respect to such coverage, or

"(III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125) or 402(l).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to amounts paid for expenses incurred for, and distributions made for, coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 113. PRIMARY CARE ENHANCEMENT.

(a) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—Section 223(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(6) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—An arrangement under which an individual is provided coverage restricted to primary care services in exchange for a fixed periodic fee or payment for such services—

''(A) shall not be treated as a health plan for purposes of paragraph (1)(A)(ii), and

''(B) shall not be treated as insurance for purposes of subsection (d)(2)(B).''.

(b) CERTAIN PROVIDER FEES TO BE TREATED AS MEDICAL CARE.—Section 213(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(12) PERIODIC PROVIDER FEES.—The term 'medical care' shall include periodic fees paid for a defined set of primary care medical services provided on an as-needed basis.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 114. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking ''$2,250'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(I)''.

(b) FAMILY COVERAGE.—Section 223(b)(2)(B) of such Code is amended by striking ''$4,500'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(II)''.

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by striking ''subsections (b)(2) and'' both places it appears and inserting ''subsection'', and

(2) in subparagraph (B), by striking ''determined by'' and all that follows through '' 'calendar year 2003'.'' and inserting ''determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 115. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

''(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

"(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

"(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 116. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.''.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 117. EXCLUSION FROM HSAS OF HIGH DEDUCTIBLE HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

> ''A high deductible health plan shall not be treated as described in clause (v) if such plan includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 118. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of enactment of this Act, no

Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term ''prohibited entity'' means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

(2) DIRECT SPENDING.—The term ''direct spending'' has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 119. MEDICAID.

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A)—

(i) in each of clauses (i)(VIII) and (ii)(XX), by inserting ''and ending September 1, 2017 (or, in the case of a State that provided for medical assistance under this subclause on July 1, 2016, December 31, 2019),'' after ''January 1, 2014,''; and

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

''(XXIII) beginning January 1, 2020, who—

''(aa) are members of an Indian tribe;

''(bb) are described in subclause (VIII) of clause (i) (without regard to the sunset dates in such subclause);

''(cc) reside in a State that provided for medical assistance under such subclause on December 31, 2019;

''(dd) were enrolled under the State plan under this title (or a waiver of such plan) on December 31, 2019; and

''(ee) after December 31, 2019, do not have a break in eligibility for medical assistance under the State plan under this title for such a period of time as the State may specify (but which in no case shall be less than 6 months);'' and

(B) in subsection (a)(47)(B), by inserting ''and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date'' before the semicolon at the end;

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting ''(50 percent on or after January 1, 2020)'' after ''55 percent'';

(B) in subsection (y)(1), by striking the semicolon at the end of subparagraph (D) and all that follows through ''thereafter''; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting ''through 2019'' after ''each year thereafter''; and

(ii) in subparagraph (B)(ii):

(I) in subclause (V), by striking ''2018 is 90'' inserting ''2018 and 2019 is 90 percent''; and

(II) in subclause (VI) by striking ''2019 and each subsequent year is 90 percent'' and inserting ''2020 and each subsequent year is 0 percent'';

(3) in section 1915(k)(2), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020'';

(4) in section 1920(e), by adding at the end the following: ''This subsection shall not apply after December 31, 2019.'';

(5) in section 1937(b)(5), by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''; and

(6) in section 1943(a), by inserting ''and before January 1, 2020,'' after ''January 1, 2014,''.

SEC. 120. REDUCING STATE MEDICAID COSTS.

(a) IN GENERAL.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month'' and all that follows through ''individual)'' and inserting ''in or after the second month before the month in which the individual (or, in the case of a deceased individual, another individual acting on the individual's behalf) made application (or, in the case of an individual who is 65 years of age or older or who is eligible for medical assistance under the plan on the basis of being blind or disabled, in or after the month before such second month)''.

(2) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the second month before the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance on the basis of being blind or disabled at the time application is made, in or after the month before such second month,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assistance made (or deemed to be made) on or after October 1, 2017.

SEC. 121. ELIGIBILITY REDETERMINATIONS.

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)) (relating to modified adjusted gross income) is amended by adding at the end the following:

"(J) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII) or (ii)(XX) of subsection (a)(10)(A), at the option of the State, the State plan may provide that the individual's eligibility shall be redetermined every 6 months (or such shorter number of months as the State may elect).".

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to exercise the option described in subparagraph (J) of such section (relating to eligibility redeterminations made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

SEC. 122. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

"(oo) OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

"(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

"(2) WORK REQUIREMENT DEFINED.—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section 407(d)) for such period of time as determined by the State, and as directed and administered by the State.

"(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

"(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

"(B) an individual who is under 19 years of age;

"(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities;

"(D) an individual who is married or a head of household and has not attained 20 years of age and who—

"(i) maintains satisfactory attendance at secondary school or the equivalent; or

"(ii) participates in education directly related to employment;

"(E) an individual who is a regular participant in an inpatient or intensive outpatient drug addiction or alcoholic treatment and rehabilitation program that satisfies such criteria as the State shall require; or

"(F) an individual who is a full-time student at an institution of higher education as defined in sections 101 and 102 of the Higher Education Act of 1965.".

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.''.

SEC. 123. PROVIDER TAXES.

Section 1903(w)(4)(C) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)) is amended by adding at the end the following new clause:

''(iii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on June 1, 2017, except that—

''(I) for fiscal year 2021, '5.6 percent' shall be substituted for '6 percent' each place it appears;

''(II) for fiscal year 2022, '5.2 percent' shall be substituted for '6 percent' each place it appears;

''(III) for fiscal year 2023, '4.8 percent' shall be substituted for '6 percent' each place it appears;

''(IV) for fiscal year 2024, '4.4 percent' shall be substituted for '6 percent' each place it appears; and

''(V) for fiscal year 2025 and each subsequent fiscal year, '4 percent' shall be substituted for '6 percent' each place it appears.''.

SEC. 124. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

(1) in section 1903 (42 U.S.C. 1396b)—

(A) in subsection (a), in the matter before paragraph (1), by inserting ''and section 1903A(a)'' after ''except as otherwise provided in this section''; and

(B) in subsection (d)(1), by striking ''to which'' and inserting ''to which, subject to section 1903A(a),''; and

(2) by inserting after such section 1903 the following new section:

"SEC. 1903A. PER CAPITA-BASED CAP ON PAYMENTS FOR MEDICAL ASSISTANCE.

"(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

"(1) IN GENERAL.—Subject to subsection (i), if a State which is one of the 50 States or the District of Columbia has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term 'State' means only the 50 States and the District of Columbia.

"(2) EXCESS AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'excess aggregate medical assistance expenditures' means, for a State for a fiscal year, the amount (if any) by which—

"(A) the amount of the adjusted total medical assistance expenditures (as defined in sub-

section (b)(1)) for the State and fiscal year; exceeds

"(B) the amount of the target total medical assistance expenditures (as defined in subsection (c)) for the State and fiscal year.

"(3) EXCESS AGGREGATE MEDICAL ASSISTANCE PAYMENTS.—In this subsection, the term 'excess aggregate medical assistance payments' means, for a State for a fiscal year, the product of—

"(A) the excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

"(B) the Federal average medical assistance matching percentage (as defined in paragraph (4)) for the State for the fiscal year.

"(4) FEDERAL AVERAGE MEDICAL ASSISTANCE MATCHING PERCENTAGE.—In this subsection, the term 'Federal average medical assistance matching percentage' means, for a State for a fiscal year, the ratio (expressed as a percentage) of—

"(A) the amount of the Federal payments that would be made to the State under section 1903(a)(1) for medical assistance expenditures for calendar quarters in the fiscal year if paragraph (1) did not apply; to

"(B) the amount of the medical assistance expenditures for the State and fiscal year.

"(5) PER CAPITA BASE PERIOD.—

"(A) IN GENERAL.—In this section, the term 'per capita base period' means, with respect to a State, a period of 8 consecutive fiscal quarters selected by the State.

"(B) TIMELINE.—Each State shall submit its selection of a per capita base period to the Secretary not later than January 1, 2018.

"(C) PARAMETERS.—In selecting a per capita base period under this paragraph, a State shall—

"(i) only select a period of 8 consecutive fiscal quarters for which all the data necessary to make determinations required under this section is available, as determined by the Secretary; and

"(ii) shall not select any period of 8 consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter later than the third fiscal quarter of 2017.

"(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXPENDITURES.—Subject to subsection (g), the following shall apply:

"(1) IN GENERAL.—In this section, the term 'adjusted total medical assistance expenditures' means, for a State—

"(A) for the State's per capita base period (as defined in subsection (a)(5)), the product of—

"(i) the amount of the medical assistance expenditures (as defined in paragraph (2) and adjusted under paragraph (5)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3) and adjusted under paragraph (5)) for the State and period otherwise included in such medical assistance expenditures; and

"(ii) the 1903A base period population percentage (as defined in paragraph (4)) for the State; or

"(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable

to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928 (relating to State pediatric vaccine distribution programs). In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year or per capita base period, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 re-

port') for quarters in the year or base period for which payment is (or may otherwise be) made pursuant to section 1903(a)(1), adjusted, in the case of a per capita base period, under paragraph (5).

''(3) EXCLUDED EXPENDITURES.—In this section, the term 'excluded expenditures' means, for a State and fiscal year or per capita base period, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

''(A) DSH.—Payment adjustments made for disproportionate share hospitals under section 1923.

''(B) MEDICARE COST-SHARING.—Payments made for medicare cost-sharing (as defined in section 1905(p)(3)).

''(C) EXPENDITURES FOR PUBLIC HEALTH EMERGENCIES.—Any expenditures that are subject to a public health emergency exclusion under paragraph (6).

''(4) 1903A BASE PERIOD POPULATION PERCENTAGE.—In this subsection, the term '1903A base period population percentage' means, for a State, the Secretary's calculation of the percentage of the actual medical assistance expenditures, as reported

by the State on the CMS–64 reports for calendar quarters in the State's per capita base period, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

''(5) ADJUSTMENTS FOR PER CAPITA BASE PERIOD.—In calculating medical assistance expenditures under paragraph (2) and excluded expenditures under paragraph (3) for a State for the State's per capita base period, the total amount of each type of expenditure for the State and base period shall be divided by 2.

''(6) AUTHORITY TO EXCLUDE STATE EXPENDITURES FROM CAPS DURING PUBLIC HEALTH EMERGENCY.—

''(A) IN GENERAL.—During the period that begins on January 1, 2020, and ends on December 31, 2024, the Secretary may exclude, from a State's medical assistance expenditures for a fiscal year or portion of a fiscal year that occurs during such period, an amount that shall not exceed the amount determined under subparagraph (B) for the State and year or portion of a year if—

''(i) a public health emergency declared by the Secretary pursuant to section

319 of the Public Health Service Act existed within the State during such year or portion of a year; and

''(ii) the Secretary determines that such an exemption would be appropriate.

''(B) MAXIMUM AMOUNT OF ADJUSTMENT.—The amount excluded for a State and fiscal year or portion of a fiscal year under this paragraph shall not exceed the amount by which—

''(i) the amount of State expenditures for medical assistance for 1903A enrollees in areas of the State which are subject to a declaration described in subparagraph (A)(i) for the fiscal year or portion of a fiscal year; exceeds

''(ii) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year or portion of a fiscal year of equal length to the portion of a fiscal year involved during which no such declaration was in effect.

''(C) AGGREGATE LIMITATION ON EXCLUSIONS AND ADDITIONAL BLOCK GRANT PAYMENTS.—The aggregate amount of expendi-

tures excluded under this paragraph and additional payments made under section 1903B(c)(3)(E) for the period described in subparagraph (A) shall not exceed $5,000,000,000.

''(D) REVIEW.—If the Secretary exercises the authority under this paragraph with respect to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in subparagraph (A)(i) ceases to be in effect, conduct an audit of the State's medical assistance expenditures for 1903A enrollees during the year or portion of a year to ensure that all of the expenditures so excluded were made for the purpose of ensuring that the health care needs of 1903A enrollees in areas affected by a public health emergency are met.

''(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

''(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year, the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

"(A) the target per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year; and

"(B) the number of 1903A enrollees for such enrollee category, State, and fiscal year, as determined under subsection (e)(4).

"(2) TARGET PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'target per capita medical assistance expenditures' means, for a 1903A enrollee category and State—

"(A) for fiscal year 2020, an amount equal to—

"(i) the provisional FY19 target per capita amount for such enrollee category (as calculated under subsection (d)(5)) for the State; increased by

"(ii) the applicable annual inflation factor (as defined in paragraph (3)) for fiscal year 2020; and

"(B) for each succeeding fiscal year, an amount equal to—

"(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A

enrollee category and State for the preceding fiscal year; increased by

''(ii) the applicable annual inflation factor for that succeeding fiscal year.

''(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term 'applicable annual inflation factor' means—

''(A) for fiscal years before 2025—

''(i) for each of the 1903A enrollee categories described in subparagraphs (C) and (D) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

''(ii) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in clause (i) plus 1 percentage point; and

''(B) for fiscal years after 2024—

''(i) for each of the 1903A enrollee categories described in subparagraphs (C) and (D) of subsection (e)(2), the percent-

age increase in the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

''(ii) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved.

''(4) ADJUSTMENTS TO STATE EXPENDITURES TARGETS TO PROMOTE PROGRAM EQUITY ACROSS STATES.—

''(A) IN GENERAL.—Beginning with fiscal year 2020, the target per capita medical assistance expenditures for a 1903A enrollee category, State, and fiscal year, as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(i)) in accordance with this paragraph.

''(B) ADJUSTMENT BASED ON LEVEL OF PER CAPITA SPENDING FOR 1903A ENROLLEE

CATEGORIES.—Subject to subparagraph (C), with respect to a State, fiscal year, and 1903A enrollee category, if the State's per capita categorical medical assistance expenditures (as defined in subparagraph (D)) for the State and category in the preceding fiscal year—

"(i) exceed the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be reduced by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 2 percent; or

"(ii) are less than the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be increased by a percentage that shall be determined

by the Secretary but which shall not be less than 0.5 percent or greater than 3 percent.

''(C) RULES OF APPLICATION.—

''(i) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States' target per capita medical assistance expenditures for a category and fiscal year under this paragraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Federal payments under this section for such fiscal year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such fiscal year.

''(ii) ASSUMPTION REGARDING STATE EXPENDITURES.—For purposes of clause (i), in the case of a State that has its target per capita medical assistance expenditures for a 1903A enrollee category and fiscal year increased under this paragraph, the Secretary shall assume that the categorical medical assistance expenditures

(as defined in subparagraph (D)(ii)) for such State, category, and fiscal year will equal such increased target medical assistance expenditures.

''(iii) NONAPPLICATION TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

''(iv) APPLICATION FOR FISCAL YEARS 2020 AND 2021.—In fiscal years 2020 and 2021, the Secretary shall apply this paragraph by deeming all categories of 1903A enrollees to be a single category.

''(D) PER CAPITA CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—

''(i) IN GENERAL.—In this paragraph, the term 'per capita categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to—

''(I) the categorical medical expenditures (as defined in clause (ii))

for the State, category, and year; divided by

"(II) the number of 1903A enrollees for the State, category, and year.

"(ii) CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—The term 'categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to the total medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that are attributable to 1903A enrollees in the category, excluding any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year that are attributable to 1903A enrollees in the category.

"(d) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

"(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA BASE PERIOD.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

"(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for the State's per capita base period.

"(B) The number of 1903A enrollees for the State in the State's per capita base period (as determined under subsection (e)(4)).

"(C) The average per capita medical assistance expenditures for the State for the State's per capita base period equal to—

"(i) the amount calculated under subparagraph (A); divided by

"(ii) the number calculated under subparagraph (B).

"(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE PER CAPITA BASE PERIOD AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

"(A) the average per capita medical assistance expenditures for the State for the State's per capita base period (calculated under paragraph (1)(C)); increased by

"(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from the last month of the State's per capita base period to September of fiscal year 2019.

"(3) AGGREGATE AND AVERAGE EXPENDITURES PER CAPITA FOR FISCAL YEAR 2019.—The Secretary shall calculate for each State the following:

"(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019.

"(B) The number of 1903A enrollees for the State in fiscal year 2019 (as determined under subsection (e)(4)).

"(4) PER CAPITA EXPENDITURES FOR FISCAL YEAR 2019 FOR EACH 1903A ENROLLEE CATEGORY.—The Secretary shall calculate (and provide notice to each State not later than January 1, 2020, of) the following:

"(A)(i) For each 1903A enrollee category, the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019 for in-

dividuals in the enrollee category, calculated by excluding from medical assistance expenditures those expenditures attributable to expenditures described in clause (iii) or non-DSH supplemental expenditures (as defined in clause (ii)).

''(ii) In this paragraph, the term 'non-DSH supplemental expenditure' means a payment to a provider under the State plan (or under a waiver of the plan) that—

''(I) is not made under section 1923;

''(II) is not made with respect to a specific item or service for an individual;

''(III) is in addition to any payments made to the provider under the plan (or waiver) for any such item or service; and

''(IV) complies with the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations).

''(iii) An expenditure described in this clause is an expenditure that meets the criteria

specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated State health program, or any other similar expenditure (as defined by the Secretary).

''(B) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category (as determined under subsection (e)(4)).

''(C) For the State's per capita base period, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

''(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii) and adjusted under subparagraph (E)) and payments described in subparagraph (A)(iii) (and adjusted under subparagraph (E)) for the State for the period; to

''(ii) the amount described in subsection (b)(1)(A) for the State for the State's per capita base period.

"(D) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 for the enrollee category equal to—

"(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool payment percentage for the State (as calculated under subparagraph (C)); divided by

"(ii) the number calculated under subparagraph (B) for the State for the enrollee category.

"(E) For purposes of subparagraph (C)(i), in calculating the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(iii) for a State for the per capita base period, the total amount of such expenditures and the total amount of such payments for the State and base period shall each be divided by 2.

"(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita

target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

"(A) the product of—

"(i) the fiscal year 2019 average per capita amount for the State, as calculated under paragraph (2); and

"(ii) the number of 1903A enrollees for the State in fiscal year 2019, as calculated under paragraph (3)(B); to

"(B) the amount of the adjusted total medical assistance expenditures for the State for fiscal year 2019, as calculated under paragraph (3)(A).

"(e) 1903A ENROLLEE; 1903A ENROLLEE CATEGORY.—Subject to subsection (g), for purposes of this section, the following shall apply:

"(1) 1903A ENROLLEE.—The term '1903A enrollee' means, with respect to a State and a month and subject to subsection (i)(1)(B), any Medicaid enrollee (as defined in paragraph (3)) for the month, other than such an enrollee who for such month is

in any of the following categories of excluded individuals:

"(A) CHIP.—An individual who is provided, under this title in the manner described in section 2101(a)(2), child health assistance under title XXI.

"(B) IHS.—An individual who receives any medical assistance under this title for services for which payment is made under the third sentence of section 1905(b).

"(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is eligible for medical assistance under this title only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

"(D) PARTIAL-BENEFIT ENROLLEES.—An individual who—

"(i) is an alien who is eligible for medical assistance under this title only on the basis of section 1903(v)(2);

"(ii) is eligible for medical assistance under this title only on the basis of subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or on the basis of a

waiver that provides only comparable benefits);

''(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is eligible for medical assistance under this title (or under a waiver) only for some or all of medicare cost-sharing (as defined in section 1905(p)(3)); or

''(iv) is eligible for medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

''(E) BLIND AND DISABLED CHILDREN.—An individual who—

''(i) is a child under 19 years of age; and

''(ii) is eligible for medical assistance under this title on the basis of being blind or disabled.

"(2) 1903A ENROLLEE CATEGORY.—The term '1903A enrollee category' means each of the following:

"(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older.

"(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who—

"(i) are 19 years of age or older; and

"(ii) are eligible for medical assistance under this title on the basis of being blind or disabled.

"(C) CHILDREN.—A category of 1903A enrollees (not described in a previous subparagraph) who are children under 19 years of age.

"(D) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—A category of 1903A enrollees who are not described in any previous subparagraph.

"(3) MEDICAID ENROLLEE.—The term 'Medicaid enrollee' means, with respect to a State for a month, an individual who is eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month.

''(4) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State and fiscal year or the State's per capita base period, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such State and fiscal year or base period (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (h).

''(f) SPECIAL PAYMENT RULES.—

''(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

"(2) IN CASE OF STATE FAILURE TO REPORT NECESSARY DATA.—If a State for any quarter in a fiscal year (beginning with fiscal year 2019) fails to satisfactorily submit data on expenditures and enrollees in accordance with subsection (h)(1), for such fiscal year and any succeeding fiscal year for which such data are not satisfactorily submitted—

"(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

"(B) the growth factor otherwise applied under subsection (c)(2)(B) shall be decreased by 1 percentage point.

"(g) RECALCULATION OF CERTAIN AMOUNTS FOR DATA ERRORS.—The amounts and percentage calculated under paragraphs (1) and (4)(C) of subsection (d) for a State for the State's per capita base period, and the amounts of the adjusted total medical assistance expenditures calculated under subsection (b) and the number of Medicaid enrollees and 1903A enrollees determined under subsection (e)(4) for a State for the State's per capita base period, fiscal year 2019, and any subsequent fiscal

year, may be adjusted by the Secretary based upon an appeal (filed by the State in such a form, manner, and time, and containing such information relating to data errors that support such appeal, as the Secretary specifies) that the Secretary determines to be valid, except that any adjustment by the Secretary under this subsection for a State may not result in an increase of the target total medical assistance expenditures exceeding 2 percent.

''(h) REQUIRED REPORTING AND AUDITING; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

''(1) AUDITING OF CMS–64 DATA.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for the State's per capita base period, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

''(2) AUDITING OF STATE SPENDING.—The Inspector General of the Department of Health and Human Services shall conduct an audit (which shall be conducted using random sampling, as determined by the Inspector General) of each State's spending under this section not less than once every 3 years.

"(3) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 8 consecutive quarter period for which the data necessary to make the determinations required under this section is available, for amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

"(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be increased by 10 percentage points to 100 percent; and

"(B) the Federal matching percentage applied under section 1903(a)(3)(B) shall be increased by 25 percentage points to 100 percent.

"(i) DELAY OF PER CAPITA CAP FOR CERTAIN LOW-DENSITY STATES.—

"(1) IN GENERAL.—Subsection (a) shall not to apply for a fiscal year with respect to any State—

"(A) that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census;

"(B) that is allotted an amount under section 2105(i) for the calendar year that begins on January 1 of such fiscal year that—

"(i) is less than—

"(I) the amount allotted to such State under such section for calendar year 2020; increased by

"(II) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2020 to September of the last calendar year that ended before the fiscal year involved; or

"(ii) is insufficient, as determined by the Secretary (after taking into consideration the unique circumstances of such State), to provide comprehensive and adequate assistance to individuals in the State under a market-based health care grant program under such section; and

"(C) for each fiscal year after fiscal year 2020, to which subsection (a) did not apply for the previous fiscal year as a result of the application of this subsection.

"If a State elects to terminate a Medicaid Flexibility Program, the per capita cap limitations under section 1903A shall apply effective with the day described in clause (i), and such limitations shall be applied as if the State had never conducted a Medicaid Flexibility Program.

"(2) APPLICATION OF PER CAPITA CAP AFTER DELAY.—If a State to which subsection (a) does not apply for a fiscal year as a result of the application of this subsection is not described in paragraph (1) in any subsequent fiscal year, subsection (a)—

"(A) shall apply to such State effective with the first day of such subsequent fiscal year; and

"(B) shall be applied as if it had applied to the State from the first day of fiscal year 2020.".

(b) ENSURING ACCESS TO HOME AND COMMUNITY BASED SERVICES.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

"(l) INCENTIVE PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project (referred to in this subsection as the 'demonstration project') under which eligible States may make HCBS payment adjustments for the purpose of continuing to provide and improving the quality of home and community-based services provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

''(2) SELECTION OF ELIGIBLE STATES.—

''(A) APPLICATION.—A State seeking to participate in the demonstration project shall submit to the Secretary, at such time and in such manner as the Secretary shall require, an application that includes—

''(i) an assurance that any HCBS payment adjustment made by the State under this subsection will comply with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A); and

''(ii) such other information and assurances as the Secretary shall require.

''(B) SELECTION.—The Secretary shall select States to participate in the demonstration

project on a competitive basis except that, in making selections under this paragraph, the Secretary shall give priority to any State that is one of the 15 States in the United States with the lowest population density, as determined by the Secretary based on data from the Bureau of the Census.

''(3) TERM OF DEMONSTRATION PROJECT.—The demonstration project shall be conducted for the 4-year period beginning on January 1, 2020, and ending on December 31, 2023.

''(4) STATE ALLOTMENTS AND INCREASED FMAP FOR PAYMENT ADJUSTMENTS.—

''(A) IN GENERAL.—

''(i) ANNUAL ALLOTMENT.—Subject to clause (ii), for each year of the demonstration project, the Secretary shall allot an amount to each State that is an eligible State for the year.

''(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that may be allotted to eligible States under clause (i) for all years of the demonstration project shall not exceed $8,000,000,000.

"(B) FMAP APPLICABLE TO HCBS PAYMENT ADJUSTMENTS.—For each year of the demonstration project, notwithstanding section 1905(b) but subject to the limitations described in subparagraph (C), the Federal medical assistance percentage applicable with respect to expenditures by an eligible State that are attributable to HCBS payment adjustments shall be equal to (and shall in no case exceed) 100 percent.

"(C) INDIVIDUAL PROVIDER AND ALLOTMENT LIMITATIONS.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment—

"(i) that is paid to a single provider and exceeds a percentage which shall be established by the Secretary of the payment otherwise made to the provider; or

"(ii) to the extent that the aggregate amount of HCBS payment adjustments made by the State in the year exceeds the amount allotted to the State for the year under clause (i).

"(5) REPORTING AND EVALUATION.—

"(A) IN GENERAL.—As a condition of receiving the increased Federal medical assistance percentage described in paragraph (4)(B), each eligible State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and evaluating the State's compliance with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A).

"(B) FORMS.—Expenditures by eligible States on HCBS payment adjustments shall be separately reported on the CMS-64 Form and in T-MSIS.

"(6) DEFINITIONS.—In this subsection:

"(A) ELIGIBLE STATE.—The term 'eligible State' means a State that—

"(i) is one of the 50 States or the District of Columbia;

"(ii) has in effect—

"(I) a waiver under subsection (c) or (d); or

"(II) a State plan amendment under subsection (i);

"(iii) submits an application under paragraph (2)(A); and

"(iv) is selected by the Secretary to participate in the demonstration project.

"(B) HCBS PAYMENT ADJUSTMENT.—The term 'HCBS payment adjustment' means a payment adjustment made by an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i) for a home and community-based service which is provided to a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the enrollee category described in subparagraph (A) or (B) of section 1903A(e)(2).".

SEC. 125. FLEXIBLE BLOCK GRANT OPTION FOR STATES.

Title XIX of the Social Security Act, as previously amended, is further amended by inserting after section 1903A the following new section:

"SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.

"(a) IN GENERAL.—Beginning with fiscal year 2020, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

''(b) STATE APPLICATION.—

''(1) IN GENERAL.—To be eligible to conduct a Medicaid Flexibility Program, a State shall submit an application to the Secretary that meets the requirements of this subsection.

''(2) CONTENTS OF APPLICATION.—An application under this subsection shall include the following:

''(A) A description of the proposed Medicaid Flexibility Program and how the State will satisfy the requirements described in subsection (d).

''(B) The proposed conditions for eligibility of program enrollees.

''(C) A description of the types, amount, duration, and scope of services which will be offered as targeted health assistance under the program, including a description of the proposed package of services which will be provided to program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

''(D) A description of how the State will notify individuals currently enrolled in the State

plan for medical assistance under this title of the transition to such program.

''(E) Statements certifying that the State agrees to—

''(i) submit regular enrollment data with respect to the program to the Centers for Medicare & Medicaid Services at such time and in such manner as the Secretary may require;

''(ii) submit timely and accurate data to the Transformed Medicaid Statistical Information System (T–MSIS);

''(iii) report annually to the Secretary on adult health quality measures implemented under the program and information on the quality of health care furnished to program enrollees under the program as part of the annual report required under section 1139B(d)(1);

''(iv) submit such additional data and information not described in any of the preceding clauses of this subparagraph but which the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

"(I) survey data, such as the data from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys;

"(II) birth certificate data; and

"(III) clinical patient data for quality measurements which may not be present in a claim, such as laboratory data, body mass index, and blood pressure; and

"(v) on an annual basis, conduct a report evaluating the program and make such report available to the public.

"(F) An information technology systems plan demonstrating that the State has the capability to support the technological administration of the program and comply with reporting requirements under this section.

"(G) A statement of the goals of the proposed program, which shall include—

"(i) goals related to quality, access, rate of growth targets, consumer satisfaction, and outcomes;

"(ii) a plan for monitoring and evaluating the program to determine whether such goals are being met; and

"(iii) a proposed process for the State, in consultation with the Centers for Medicare & Medicaid Services, to take remedial action to make progress on unmet goals.

"(H) Such other information as the Secretary may require.

"(3) STATE NOTICE AND COMMENT PERIOD.—

"(A) IN GENERAL.—Before submitting an application under this subsection, a State shall make the application publicly available for a 30 day notice and comment period.

"(B) NOTICE AND COMMENT PROCESS.—During the notice and comment period described in subparagraph (A), the State shall provide opportunities for a meaningful level of public input, which shall include public hearings on the proposed Medicaid Flexibility Program.

"(4) FEDERAL NOTICE AND COMMENT PERIOD.—The Secretary shall not approve of any application to conduct a Medicaid Flexibility Program without making such application publicly available for a 30 day notice and comment period.

''(5) TIMELINE FOR SUBMISSION.—

''(A) IN GENERAL.—A State may submit an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year at any time, subject to subparagraph (B).

''(B) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submitting an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year, but such deadline shall not be earlier than 60 days after the date that the Secretary publishes the amounts of State block grants as required under subsection (c)(4).

''(c) FINANCING.—

''(1) IN GENERAL.—For each fiscal year during which a State is conducting a Medicaid Flexibility Program, the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance for program enrollees, the amount specified in paragraph (3)(A).

''(2) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) IN GENERAL.—The block grant amount under this paragraph for a State and

year shall be equal to the amount determined under subparagraph (B) for the State and year.

''(B) ENROLLEE CATEGORY AMOUNTS.—

''(i) FOR INITIAL YEAR.—Subject to subparagraph (C), for the first fiscal year in which a Medicaid Flexibility Program is conducted by a State, the amount determined under this subparagraph for the State and year shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year multiplied by the product of—

''(I) the target per capita medical assistance expenditures (as defined in section 1903A(c)(2)) for the State and year; and

''(II) the number of 1903A enrollees in the category described in section 1903A(e)(2)(D) for the State for the second fiscal year preceding such first fiscal year, increased by the percentage increase in State population from such second preceding fiscal year to such first fiscal year, based

on the best available estimates of the Bureau of the Census.

''(ii) FOR ANY SUBSEQUENT YEAR.—For any fiscal year that is not the first fiscal year in which a Medicaid Flexibility Program is conducted by the State, the block grant amount under this paragraph for the State and year shall be equal to the amount determined for the State for the most recent previous fiscal year in which the State conducted a Medicaid Flexibility Program, except that such amount shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) from April of the second fiscal year preceding the fiscal year involved to April of the fiscal year preceding the fiscal year involved.

''(C) CAP ON TOTAL POPULATION OF 1903A ENROLLEES FOR PURPOSES OF BLOCK GRANT CALCULATION.—

''(i) IN GENERAL.—In calculating the amount of a block grant for the first year in which a Medicaid Flexibility Program is conducted by the State under subpara-

graph (B)(i), the total number of 1903A enrollees in the category described in section 1903A(e)(2)(D) for the State and year shall not exceed the adjusted number of base period enrollees for the State (as defined in clause (ii)).

''(ii) ADJUSTED NUMBER OF BASE PERIOD ENROLLEES.—The term 'adjusted number of base period enrollees' means, with respect to a State, the number of 1903A enrollees in the enrollee category described in section 1903A(e)(2)(D) for the State for the State's per capita base period (as determined under section 1903A(e)(4)), increased by the percentage increase, if any, in the total State population from the last April in the State's per capita base period to April of the fiscal year preceding the fiscal year involved (determined using the best available data from the Bureau of the Census) plus 3 percentage points.

''(3) FEDERAL PAYMENT AND STATE MAINTENANCE OF EFFORT.—

"(A) FEDERAL PAYMENT.—Subject to subparagraphs (D) and (E), the Secretary shall pay to each State conducting a Medicaid Flexibility Program under this section for a fiscal year, from its block grant amount under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targeted health assistance, and the State is responsible for the balance of the funds to carry out such program.

"(B) STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall make expenditures for targeted health assistance under the program in an amount equal to the product of—

"(i) the block grant amount determined for the State and year under paragraph (2); and

"(ii) the enhanced FMAP described in the first sentence of section 2105(b) for the State and year.

"(C) REDUCTION IN BLOCK GRANT AMOUNT FOR STATES FAILING TO MEET MOE REQUIREMENT.—

"(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that makes expenditures for targeted health assistance under the program for a fiscal year in an amount that is less than the required amount for the fiscal year under subparagraph (B), the amount of the block grant determined for the State under paragraph (2) for the succeeding fiscal year shall be reduced by the amount by which such expenditures are less than such required amount.

"(ii) DISREGARD OF REDUCTION.—For purposes of determining the amount of a State block grant under paragraph (2), any reduction made under this subparagraph to a State's block grant amount in a previous fiscal year shall be disregarded.

"(iii) APPLICATION TO STATES THAT TERMINATE PROGRAM.—In the case of a State described in clause (i) that terminates the State Medicaid Flexibility Pro-

gram under subsection (d)(2)(B) and such termination is effective with the end of the fiscal year in which the State fails to make the required amount of expenditures under subparagraph (B), the reduction amount determined for the State and succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

''(D) REDUCTION FOR NONCOMPLIANCE.—If the Secretary determines that a State conducting a Medicaid Flexibility Program is not complying with the requirements of this section, the Secretary may withhold payments, reduce payments, or recover previous payments to the State under this section as the Secretary deems appropriate.

''(E) ADDITIONAL FEDERAL PAYMENTS DURING PUBLIC HEALTH EMERGENCY.—

''(i) IN GENERAL.—In the case of a State and fiscal year or portion of a fiscal year for which the Secretary has excluded expenditures under section 1903A(b)(6), if the State has uncompensated targeted health assistance expenditures for the year or portion of a year, the Secretary may

make an additional payment to such State equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for the year or portion of a year of the amount of such uncompensated targeted health assistance expenditures, except that the amount of such payment shall not exceed the amount determined for the State and year or portion of a year under clause (ii).

''(ii) MAXIMUM AMOUNT OF ADDITIONAL PAYMENT.—The amount determined for a State and fiscal year or portion of a fiscal year under this subparagraph shall not exceed the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for such year or portion of a year of the amount by which—

''(I) the amount of State expenditures for targeted health assistance for program enrollees in areas of the State which are subject to a declaration described in section

1903A(b)(6)(A)(i) for the year or portion of a year; exceeds

''(II) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year involved (or portion of a fiscal year of equal length to the portion of a fiscal year involved) during which no such declaration was in effect.

''(iii) UNCOMPENSATED TARGETED HEALTH ASSISTANCE.—In this subparagraph, the term 'uncompensated targeted health assistance expenditures' means, with respect to a State and fiscal year or portion of a fiscal year, an amount equal to the amount (if any) by which—

''(I) the total amount expended by the State under the program for targeted health assistance for the year or portion of a year; exceeds

''(II) the amount equal to the amount of the block grant (reduced, in the case of a portion of a year, to the same proportion of the full block grant amount that the portion of the

year bears to the whole year) divided by the Federal average medical assistance percentage for the year or portion of a year.

''(iv) REVIEW.—If the Secretary makes a payment to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in section 1903A(b)(6)(A)(i) ceases to be in effect, conduct an audit of the State's targeted health assistance expenditures for program enrollees during the year or portion of a year to ensure that all of the expenditures for which the additional payment was made were made for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

''(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and each year thereafter, the Secretary shall determine for each State, regardless of whether the State is conducting a Medicaid Flexibility Program or has submitted an application to conduct such a program,

the amount of the block grant for the State under paragraph (2) which would apply for the upcoming fiscal year if the State were to conduct such a program in such fiscal year, and shall publish such determinations not later than June 1 of each year.

''(d) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—No payment shall be made under this section to a State conducting a Medicaid Flexibility Program unless such program meets the requirements of this subsection.

''(2) TERM OF PROGRAM.—

''(A) IN GENERAL.—A State Medicaid Flexibility Program approved under subsection (b)—

''(i) shall be conducted for not less than 1 program period;

''(ii) at the option of the State, may be continued for succeeding program periods without resubmitting an application under subsection (b), provided that—

''(I) the State provides notice to the Secretary of its decision to continue the program; and

''(II) no significant changes are made to the program; and

"(iii) shall be subject to termination only by the State, which may terminate the program by making an election under subparagraph (B).

"(B) ELECTION TO TERMINATE PROGRAM.—

"(i) IN GENERAL.—Subject to clause (ii), a State conducting a Medicaid Flexibility Program may elect to terminate the program effective with the first day after the end of the program period in which the State makes the election.

"(ii) TRANSITION PLAN REQUIREMENT.—A State may not elect to terminate a Medicaid Flexibility Program unless the State has in place an appropriate transition plan approved by the Secretary.

"(iii) EFFECT OF TERMINATION.—If a State elects to terminate a Medicaid Flexibility Program, the per capita cap limitations under section 1903A shall apply effective with the day described in clause (i), and such limitations shall be applied as if the State had never conducted a Medicaid Flexibility Program.

"(3) PROVISION OF TARGETED HEALTH ASSISTANCE.—

"(A) IN GENERAL.—A State Medicaid Flexibility Program shall provide targeted health assistance to program enrollees and such assistance shall be instead of medical assistance which would otherwise be provided to the enrollees under this title.

"(B) CONDITIONS FOR ELIGIBILITY.—

"(i) IN GENERAL.—A State conducting a Medicaid Flexibility Program shall establish conditions for eligibility of program enrollees, which shall be instead of other conditions for eligibility under this title, except that the program must provide for eligibility for program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

"(ii) MAGI.—Any determination of income necessary to establish the eligibility of a program enrollee for purposes of a State Medicaid Flexibility Program shall be made using modified adjusted gross in-

come in accordance with section 1902(e)(14).

''(4) BENEFITS AND SERVICES.—

''(A) REQUIRED SERVICES.—In the case of program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i), a State conducting a Medicaid Flexibility Program shall provide as targeted health assistance the following types of services:

''(i) Inpatient and outpatient hospital services.

''(ii) Laboratory and X-ray services.

''(iii) Nursing facility services for individuals aged 21 and older.

''(iv) Physician services.

''(v) Home health care services (including home nursing services, medical supplies, equipment, and appliances).

''(vi) Rural health clinic services (as defined in section 1905(l)(1)).

''(vii) Federally-qualified health center services (as defined in section 1905(l)(2)).

''(viii) Family planning services and supplies.

"(ix) Nurse midwife services.

"(x) Certified pediatric and family nurse practitioner services.

"(xi) Freestanding birth center services (as defined in section 1905(l)(3)).

"(xii) Emergency medical transportation.

"(xiii) Non-cosmetic dental services.

"(xiv) Pregnancy-related services, including postpartum services for the 12-week period beginning on the last day of a pregnancy.

"(B) OPTIONAL BENEFITS.—A State may, at its option, provide services in addition to the services described in subparagraph (A) as targeted health assistance under a Medicaid Flexibility Program.

"(C) BENEFIT PACKAGES.—

"(i) IN GENERAL.—The targeted health assistance provided by a State to any group of program enrollees under a Medicaid Flexibility Program shall have an aggregate actuarial value that is equal to at least 95 percent of the aggregate actuarial value of the benchmark coverage de-

scribed in subsection (b)(1) of section 1937 or benchmark-equivalent coverage described in subsection (b)(2) of such section, as such subsections were in effect prior to the enactment of the Patient Protection and Affordable Care Act.

''(ii) AMOUNT, DURATION, AND SCOPE OF BENEFITS.—Subject to clause (i), the State shall determine the amount, duration, and scope with respect to services provided as targeted health assistance under a Medicaid Flexibility Program, including with respect to services that are required to be provided to certain program enrollees under subparagraph (A) except as otherwise provided under such subparagraph.

''(iii) MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE AND PARITY.—The targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program shall include mental health services and substance use disorder services and the financial requirements and treatment limitations

applicable to such services under the program shall comply with the requirements of section 2726 of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(iv) PRESCRIPTION DRUGS.—If the targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program includes assistance for covered outpatient drugs, such drugs shall be subject to a rebate agreement that complies with the requirements of section 1927, and any requirements applicable to medical assistance for covered outpatient drugs under a State plan (including the requirement that the State provide information to a manufacturer) shall apply in the same manner to targeted health assistance for covered outpatient drugs under a Medicaid Flexibility Program.

''(D) COST SHARING.—A State conducting a Medicaid Flexibility Program may impose premiums, deductibles, cost-sharing, or other similar charges, except that the total annual ag-

gregate amount of all such charges imposed with respect to all program enrollees in a family shall not exceed 5 percent of the family's income for the year involved.

''(5) ADMINISTRATION OF PROGRAM.—Each State conducting a Medicaid Flexibility Program shall do the following:

''(A) SINGLE AGENCY.—Designate a single State agency responsible for administering the program.

''(B) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.—Provide for simplified enrollment processes (such as online enrollment and reenrollment and electronic verification) and coordination with State health insurance exchanges.

''(C) BENEFICIARY PROTECTIONS.—Establish a fair process (which the State shall describe in the application required under subsection (b)) for individuals to appeal adverse eligibility determinations with respect to the program.

''(6) APPLICATION OF REST OF TITLE XIX.—

"(A) IN GENERAL.—To the extent that a provision of this section is inconsistent with another provision of this title, the provision of this section shall apply.

"(B) APPLICATION OF SECTION 1903A.—With respect to a State that is conducting a Medicaid Flexibility Program, section 1903A shall be applied as if program enrollees were not 1903A enrollees for each program period during which the State conducts the program.

"(C) WAIVERS AND STATE PLAN AMENDMENTS.—

"(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that has in effect a waiver or State plan amendment, such waiver or amendment shall not apply with respect to the program, targeted health assistance provided under the program, or program enrollees.

"(ii) REPLICATION OF WAIVER OR AMENDMENT.—In designing a Medicaid Flexibility Program, a State may mirror provisions of a waiver or State plan amendment described in clause (i) in the

program to the extent that such provisions are otherwise consistent with the requirements of this section.

''(iii) EFFECT OF TERMINATION.—In the case of a State described in clause (i) that terminates its program under subsection (d)(2)(B), any waiver or amendment which was limited pursuant to subparagraph (A) shall cease to be so limited effective with the effective date of such termination.

''(D) NONAPPLICATION OF PROVISIONS.—With respect to the design and implementation of Medicaid Flexibility Programs conducted under this section, paragraphs (1), (10)(B), (17), and (23) of section 1902(a), as well as any other provision of this title (except for this section and as otherwise provided by this section) that the Secretary deems appropriate, shall not apply.

''(e) DEFINITIONS.—For purposes of this section:

''(1) MEDICAID FLEXIBILITY PROGRAM.—The term 'Medicaid Flexibility Program' means a State program for providing targeted health assistance to

program enrollees funded by a block grant under this section.

''(2) PROGRAM ENROLLEE.—

''(A) IN GENERAL.—The term 'program enrollee' means, with respect to a State that is conducting a Medicaid Flexibility Program for a program period, an individual who is a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the 1903A enrollee category described in section 1903A(e)(2)(D).

''(B) RULE OF CONSTRUCTION.—For purposes of section 1903A(e)(3), eligibility and enrollment of an individual under a Medicaid Flexibility Program shall be deemed to be eligibility and enrollment under a State plan (or waiver of such plan) under this title.

''(3) PROGRAM PERIOD.—The term 'program period' means, with respect to a State Medicaid Flexibility Program, a period of 5 consecutive fiscal years that begins with either—

''(A) the first fiscal year in which the State conducts the program; or

''(B) the next fiscal year in which the State conducts such a program that begins after the end of a previous program period.

''(4) STATE.—The term 'State' means one of the 50 States or the District of Columbia.

''(5) TARGETED HEALTH ASSISTANCE.—The term 'targeted health assistance' means assistance for health-care-related items and medical services for program enrollees.''.

SEC. 126. MEDICAID AND CHIP QUALITY PERFORMANCE BONUS PAYMENTS.

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as previously amended, is further amended by adding at the end the following new subsection:

''(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

''(1) INCREASED FEDERAL SHARE.—With respect to each of fiscal years 2023 through 2026, in the case of one of the 50 States or the District of Columbia (each referred to in this subsection as a 'State') that—

''(A) equals or exceeds the qualifying amount (as established by the Secretary) of lower than expected aggregate medical assistance expenditures (as defined in paragraph (4)) for that fiscal year; and

''(B) submits to the Secretary, in accordance with such manner and format as specified by the Secretary and for the performance pe-

riod (as defined by the Secretary) for such fiscal year—

"(i) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individuals under the State plan or a waiver of such plan; and

"(ii) a plan for spending a portion of additional funds resulting from application of this subsection on quality improvement within the State plan under this title or under a waiver of such plan,

the Federal matching percentage otherwise applied under subsection (a)(7) for such fiscal year shall be increased by such percentage (as determined by the Secretary) so that the aggregate amount of the resulting increase pursuant to this subsection for the State and fiscal year does not exceed the State allotment established under paragraph (2) for the State and fiscal year.

"(2) ALLOTMENT DETERMINATION.—The Secretary shall establish a formula for computing State allotments under this paragraph for each fiscal year described in paragraph (1) such that—

"(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and title XXI with respect to the quality measures submitted under paragraph (3) by such State for the performance period (as defined by the Secretary) for such fiscal year; and

"(B) the total of the allotments under this paragraph for all States for the period of the fiscal years described in paragraph (1) is equal to $8,000,000,000.

"(3) QUALITY MEASURES REQUIRED FOR BONUS PAYMENTS.—For purposes of this subsection, the Secretary shall, pursuant to rulemaking and after consultation with State agencies administering State plans under this title, identify and publish (and update as necessary) peer-reviewed quality measures (which shall include health care and long-term care outcome measures and may include the quality measures that are overseen or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1139A or 1139B) that are quantifiable, objective measures that take into account the clinically appropriate measures of

quality for different types of patient populations receiving benefits or services under this title or title XXI.

''(4) LOWER THAN EXPECTED AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'lower than expected aggregate medical assistance expenditures' means, with respect to a State the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures for the State and fiscal year determined in section 1903A(b)(1) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E); is less than

''(B) the amount of the target total medical assistance expenditures for the State and fiscal year determined in section 1903A(c) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E).''.

SEC. 127. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES.

(a) STATE OPTION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''and, (B)'' and inserting ''(B)''; and

(ii) by inserting before the semicolon at the end the following: '', and (C) subject to subsection (h)(4), qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for individuals who are over 21 years of age and under 65 years of age''; and

(B) in the subdivision (B) that follows paragraph (29), by inserting ''(other than services described in subparagraph (C) of paragraph (16) for individuals described in such subparagraph)'' after ''patient in an institution for mental diseases''; and

(2) in subsection (h), by adding at the end the following new paragraphs:

''(3) For purposes of subsection (a)(16)(C), the term 'qualified inpatient psychiatric hospital services' means, with respect to individuals described in such subsection, services described in subparagraph (B) of paragraph (1) that are not otherwise covered under subsection (a)(16)(A) and are furnished—

''(A) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1861(f)); and

''(B) with respect to such an individual, for a period not to exceed 30 consecutive days in any month and not to exceed 90 days in any calendar year.

''(4) As a condition for a State including qualified inpatient psychiatric hospital services as medical assistance under subsection (a)(16)(C), the State must (during the period in which it furnishes medical assistance under this title for services and individuals described in such subsection)—

''(A) maintain at least the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the State that were being maintained as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection; and

''(B) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title from non-Federal funds for inpatient services in an institution described in paragraph (3)(A), and for active psy-

chiatric care and treatment provided on an outpatient basis, that is not less than the level of such funding for such services and care as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection.''.

(b) SPECIAL MATCHING RATE.—Section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b)) is amended by adding at the end the following: ''Notwithstanding the previous provisions of this subsection, the Federal medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(16)(C), except that, in the case of a State for which the Federal medical assistance percentage applicable to such assistance for such services and individuals on September 30, 2018, was greater than 50 percent, such greater percentage shall continue to apply with respect to medical assistance provided by such State for such services and individuals.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified inpatient psychiatric hospital services furnished on or after October 1, 2018.

SEC. 128. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO ELIGIBLE INDIANS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ''and with respect to amounts expended by a State as medical assistance for services provided by any other provider under the State plan to an individual who is a member of an Indian tribe who is eligible for assistance under the State plan'' before the period.

SEC. 129. NON-APPLICATION OF DSH CUTS FOR STATES WITH LOW MARKET-BASED HEALTH CARE GRANT ALLOTMENTS; ONE-TIME DSH ALLOTMENT INCREASE FOR 2026.

Section 1923(f)(7) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)) is amended by adding at the end the following new subparagraph:

''(C) LOW-GRANT STATES.—

''(i) IN GENERAL.—For each of fiscal years 2021 through 2025, the amount of the reduction specified under subparagraph (B) for a State and fiscal year shall be reduced by the grant shortfall amount for the State and year.

''(ii) ONE-TIME INCREASE FOR FISCAL 2026.—

"(I) IN GENERAL.—Any State that has a grant shortfall amount for fiscal year 2026 shall be eligible for a one-time increase in the State's DSH allotment for fiscal year 2026 in the amount described in subclause (II).

"(II) AMOUNT OF INCREASE.—Subject to clause (III), the amount described in this subclause for a State shall be equal to—

"(aa) the total amount of the reductions specified for the State under subparagraph (B) for each of fiscal years 2018 through 2025; minus

"(bb) the total amount of any reductions for each of fiscal years 2021 through 2025 under clause (i).

"(III) LIMITATION.—The amount of the increase for a State and fiscal year under this clause shall not exceed the grant shortfall amount for the State and year.

"(iii) GRANT SHORTFALL AMOUNT DEFINED.—

"(I) IN GENERAL.—In this subparagraph, the term 'grant shortfall amount' means, with respect to a State and a fiscal year, the amount, if any, by which the amount that was allotted to the State under section 2105(i) for the last calendar year that began before the end of such fiscal year is less than—

"(aa) the amount allotted to such State under such section for calendar year 2020; increased by

"(bb) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2020 to September of the last calendar year that ended before the fiscal year involved.

"(II) LIMITATION.—For fiscal years before fiscal year 2026, in no case shall the grant shortfall amount

for a State and a fiscal year exceed the amount of the reduction specified under subparagraph (B) for the State and fiscal year.''.

TITLE II

SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

(2) by striking paragraphs (4) through (8).

SEC. 202. COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

SEC. 203. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

''(4) CONSUMER FREEDOM.—For plan years beginning on or after January 1, 2019, paragraph (1)(A) shall not apply with respect to any plan offered in the State.''.

(b) RISK POOLS.—Section 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended—

(1) in paragraph (1), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''; and

(2) in paragraph (2), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''.

SEC. 204. APPLICATION OF ENFORCEMENT PENALTIES.

(a) IN GENERAL.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting ''and of section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''; and

(B) in paragraph (2), by inserting ''or in such section 1303'' after ''this part''; and

(2) in subsection (b)—

(A) in paragraphs (1) and (2)(A), by inserting ''or section 1303 of the Patient Protection and Affordable Care Act'' after ''this part'' each place such term appears;

(B) in paragraph (2)(C)(ii), by inserting ''and section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''.

(b) EFFECT OF WAIVER.—A State waiver pursuant to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not affect the authority of the Secretary to impose penalties under section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22).

SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.