

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:

1 Strike all after the enacting clause and insert the following:
2

3 **TITLE I**

4 **SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF**
5 **EXCESS ADVANCE PAYMENTS OF PREMIUM**
6 **TAX CREDITS.**

7 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:

10 “(iii) NONAPPLICABILITY OF LIMITA-
11 TION.—This subparagraph shall not apply

1 to taxable years ending after December 31,
2 2017.”.

3 **SEC. 102. PREMIUM TAX CREDIT.**

4 (a) PREMIUM TAX CREDIT.—

5 (1) MODIFICATION OF DEFINITION OF QUALI-
6 FIED HEALTH PLAN.—

7 (A) IN GENERAL.—Section 36B(c)(3)(A)
8 of the Internal Revenue Code of 1986 is
9 amended by inserting before the period at the
10 end the following: “or a plan that includes cov-
11 erage for abortions (other than any abortion
12 necessary to save the life of the mother or any
13 abortion with respect to a pregnancy that is the
14 result of an act of rape or incest)”.

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

18 (2) REPEAL.—

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

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

1 (b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

2 (1) IN GENERAL.—The following sections of the
3 Patient Protection and Affordable Care Act are re-
4 pealed:

5 (A) Section 1411 (other than subsection
6 (i), the last sentence of subsection (e)(4)(A)(ii),
7 and such provisions of such section solely to the
8 extent related to the application of the last sen-
9 tence of subsection (e)(4)(A)(ii)).

10 (B) Section 1412.

11 (2) EFFECTIVE DATE.—The repeals in para-
12 graph (1) shall take effect on January 1, 2020.

13 **SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CRED-**
14 **IT.**

15 (a) SUNSET.—

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

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

22 (2) EFFECTIVE DATE.—The amendment made
23 by this subsection shall apply to taxable years begin-
24 ning after December 31, 2019.

1 (b) DISALLOWANCE OF SMALL EMPLOYER HEALTH
2 INSURANCE EXPENSE CREDIT FOR PLAN WHICH IN-
3 CLUDES COVERAGE FOR ABORTION.—

4 (1) IN GENERAL.—Subsection (h) of section
5 45R of the Internal Revenue Code of 1986 is
6 amended—

7 (A) by striking “Any term” and inserting
8 the following:

9 “(1) IN GENERAL.—Any term”, and

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

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

19 (2) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply to taxable years begin-
21 ning after December 31, 2017.

22 **SEC. 104. INDIVIDUAL MANDATE.**

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

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

3 (2) in paragraph (3)—

4 (A) by striking “\$695” in subparagraph
5 (A) and inserting “\$0”, and

6 (B) by striking subparagraph (D).

7 (b) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to months beginning after Decem-
9 ber 31, 2015.

10 **SEC. 105. EMPLOYER MANDATE.**

11 (a) IN GENERAL.—

12 (1) Paragraph (1) of section 4980H(c) of the
13 Internal Revenue Code of 1986 is amended by in-
14 sserting “(\$0 in the case of months beginning after
15 December 31, 2015)” after “\$2,000”.

16 (2) Paragraph (1) of section 4980H(b) of the
17 Internal Revenue Code of 1986 is amended by in-
18 sserting “(\$0 in the case of months beginning after
19 December 31, 2015)” after “\$3,000”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to months beginning after Decem-
22 ber 31, 2015.

1 **SEC. 106. SHORT TERM ASSISTANCE FOR STATES AND MAR-**
2 **KET-BASED HEALTH CARE GRANT PROGRAM.**

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

6 “(h) SHORT-TERM ASSISTANCE TO ADDRESS COV-
7 ERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT
8 FOR STATES.—

9 “(1) APPROPRIATION.—There are authorized to
10 be appropriated, and are appropriated, out of monies
11 in the Treasury not otherwise obligated,
12 \$10,000,000,000 for calendar year 2019, and
13 \$15,000,000,000 for calendar year 2020, to the Ad-
14 ministrator of the Centers for Medicare & Medicaid
15 Services (in this subsection and subsection (i) re-
16 ferred to as the ‘Administrator’) to fund arrange-
17 ments with health insurance issuers to assist in the
18 purchase of health benefits coverage by addressing
19 coverage and access disruption and responding to
20 urgent health care needs within States. Funds ap-
21 propriated under this paragraph shall remain avail-
22 able until expended.

23 “(2) PARTICIPATION REQUIREMENTS.—

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

1 insurance issuers regarding how to submit a no-
2 tice of intent to participate in the program es-
3 tablished under this subsection.

4 “(B) NOTICE OF INTENT TO PARTICI-
5 PATE.—To be eligible for funding for a cal-
6 endar year under this subsection, a health in-
7 surance issuer shall submit to the Adminis-
8 trator a notice of intent to participate not later
9 than March 31 of the previous fiscal year, in
10 such form and manner as specified by the Ad-
11 ministrator, and containing—

12 “(i) a certification that the health in-
13 surance issuer will use the funds in accord-
14 ance with the requirements of paragraph
15 (4); and

16 “(ii) such information as the Adminis-
17 trator may require to carry out this sub-
18 section.

19 “(3) PROCEDURE FOR DISTRIBUTION OF
20 FUNDS.—The Administrator shall determine an ap-
21 propriate procedure for providing and distributing
22 funds under this subsection.

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

1 and (7) of subsection (i) in the same manner as
2 such requirements apply to States receiving pay-
3 ments under subsection (i) and shall be used only
4 for the activities specified in paragraph (1)(A)(i)(II)
5 of subsection (i).

6 “(i) MARKET-BASED HEALTH CARE GRANT PRO-
7 GRAM.—

8 “(1) APPLICATION AND CERTIFICATION RE-
9 QUIREMENTS.—

10 “(A) IN GENERAL.—To be eligible for an
11 allotment of funds under this subsection, a
12 State shall submit to the Administrator an ap-
13 plication, not later than March 31, 2019, in the
14 case of allotments for calendar year 2020, and
15 not later than March 31 of the previous year,
16 in the case of allotments for any subsequent
17 calendar year) and in such form and manner as
18 specified by the Administrator, that contains
19 the following:

20 “(i) A description of how the funds
21 will be used to do 1 or more of the fol-
22 lowing:

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

1 health benefits coverage, including by
2 reducing premium costs for such indi-
3 viduals, who have or are projected to
4 have a high rate of utilization of
5 health services, as measured by cost,
6 and who do not have access to health
7 insurance coverage offered through an
8 employer, enroll in health insurance
9 coverage under a plan offered in the
10 individual market (within the meaning
11 of section 5000A(f)(1)(C) of the In-
12 ternal Revenue Code of 1986).

13 “(II) To establish or maintain a
14 program to enter into arrangements
15 with health insurance issuers to assist
16 in the purchase of health benefits cov-
17 erage by stabilizing premiums and
18 promoting State health insurance
19 market participation and choice in
20 plans offered in the individual market
21 (within the meaning of section
22 5000A(f)(1)(C) of the Internal Rev-
23 enue Code of 1986).

24 “(III) To provide payments for
25 health care providers for the provision

1 of health care services, as specified by
2 the Administrator.

3 “(IV) To provide health insur-
4 ance coverage by funding assistance to
5 reduce out-of-pocket costs, such as co-
6 payments, coinsurance, and
7 deductibles, of individuals enrolled in
8 plans offered in the individual market
9 (within the meaning of section
10 5000A(f)(1)(C) of the Internal Rev-
11 enue Code of 1986).

12 “(V) To establish or maintain a
13 program or mechanism to help indi-
14 viduals purchase health benefits cov-
15 erage, including by reducing premium
16 costs for plans offered in the indi-
17 vidual market (within the meaning of
18 section 5000A(f)(1)(C) of the Internal
19 Revenue Code of 1986) for individuals
20 who do not have access to health in-
21 surance coverage offered through an
22 employer.

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

1 ble for medical assistance under a
2 State plan under title XIX by estab-
3 lishing or maintaining relationships
4 with health insurance issuers to pro-
5 vide such coverage.

6 “(VII) To assist in the purchase
7 of health benefits coverage by estab-
8 lishing or maintaining a program or
9 mechanism, as specified by the State,
10 to establish coverage programs
11 through arrangements with managed
12 care organizations for the provision of
13 health care services to individuals who
14 are not eligible for medical assistance
15 or child health assistance under the
16 State plans under title XIX or this
17 title.

18 “(ii) A certification that the funds
19 provided under this subsection shall only
20 be used for the activities specified in clause
21 (i).

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

1 mental transfer, certified public expendi-
2 ture, or any other expenditure to finance
3 the non-Federal share of expenditures re-
4 quired under any provision of law, includ-
5 ing under the State plans established
6 under this title and title XIX or under a
7 waiver of such plans.

8 “(iv) A description of any waiver of
9 the provisions described in subparagraph
10 (B)(i) that the State is requesting, and
11 how the State intends to maintain access
12 to adequate and affordable health insur-
13 ance coverage for individuals with pre-ex-
14 isting conditions if such waiver is ap-
15 proved.

16 “(v) Such other information as nec-
17 essary for the Administrator to carry out
18 this subsection.

19 “(B) WAIVERS.—

20 “(i) IN GENERAL.—Subject to clause
21 (ii), the Secretary shall waive the require-
22 ments of the following Federal statutory
23 provisions with respect to health insurance
24 coverage in a State for a plan year during
25 which the State has an application ap-

1 proved under this subsection and to the ex-
2 tent that such application includes a re-
3 quest for such a waiver and the informa-
4 tion described in subparagraph (A)(iv):

5 “(I) Any provision that restricts
6 the criteria which a health insurance
7 issuer may use to vary premium rates
8 for health insurance coverage offered
9 in the individual or small group mar-
10 ket, or the degree to which an issuer
11 may vary such rates, except that a
12 health insurance issuer may not vary
13 premium rates based on an individ-
14 ual’s sex or membership in a pro-
15 tected class under the Constitution of
16 the United States.

17 “(II) Any provision that prevents
18 a health insurance issuer offering a
19 coverage plan in the individual or
20 small group market from requiring an
21 individual to pay a premium or con-
22 tribution (as a condition of enrollment
23 or continued enrollment under the
24 plan) which is greater than such pre-
25 mium or contribution for a similarly

1 situated individual enrolled in the plan
2 on the basis of any health status-re-
3 lated factor in relation to the indi-
4 vidual or to an individual enrolled
5 under the plan as a dependent of the
6 individual.

7 “(III) Any provision that re-
8 quires a health insurance issuer offer-
9 ing a coverage plan in the individual
10 or small group market to ensure that
11 certain benefits are included in such
12 coverage.

13 “(IV) Any provision that requires
14 a health insurance issuer offering a
15 coverage plan in the individual or
16 small group market to provide a re-
17 bate to each enrollee under such cov-
18 erage if the ratio of the amount of
19 premium revenue expended by the
20 issuer on the costs of providing such
21 coverage for a plan year to the total
22 amount of premium revenue for the
23 plan year is less than a certain per-
24 centage.

25 “(ii) SCOPE OF WAIVER.—

1 “(I) RELATIONSHIP TO GRANT
2 PROGRAM.—Any provision waived
3 under this subparagraph shall only be
4 waived with respect to health insur-
5 ance coverage that is—

6 “(aa) provided by an health
7 insurance issuer that is receiving
8 funding under a State program
9 that is funded by a grant under
10 this subsection; and

11 “(bb) provided to an indi-
12 vidual who is receiving a direct
13 benefit (including reduced pre-
14 mium costs or reduced out-of-
15 pocket costs) under a State pro-
16 gram that is funded by a grant
17 under this subsection.

18 “(II) LIMITATION.—The Sec-
19 retary shall not waive any require-
20 ment under a Federal statute enacted
21 before January 1, 2009.

22 “(2) ELIGIBILITY.—Only the 50 States and the
23 District of Columbia shall be eligible for an allot-
24 ment and payments under this subsection and all
25 references in this subsection to a State shall be

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

3 “(3) ONE-TIME APPLICATION.—If an applica-
4 tion of a State submitted under this subsection is
5 approved by the Administrator for a year, the appli-
6 cation shall be deemed to be approved by the Admin-
7 istrator for that year and each subsequent year
8 through December 31, 2026.

9 “(4) MARKET-BASED HEALTH CARE GRANT AL-
10 LOTMENTS.—

11 “(A) APPROPRIATION.—For the purpose of
12 providing allotments to States under this sub-
13 section, there is appropriated, out of any money
14 in the Treasury not otherwise appropriated—

15 “(i) for calendar year 2020,
16 \$146,000,000,000;

17 “(ii) for calendar year 2021,
18 \$146,000,000,000;

19 “(iii) for calendar year 2022,
20 \$157,000,000,000;

21 “(iv) for calendar year 2023,
22 \$168,000,000,000;

23 “(v) for calendar year 2024,
24 \$179,000,000,000;

1 “(vi) for calendar year 2025,
2 \$190,000,000,000; and

3 “(vii) for calendar year 2026,
4 \$190,000,000,000.

5 “(B) ALLOTMENTS; AVAILABILITY OF AL-
6 LOTMENTS.—

7 “(i) IN GENERAL.—In the case of a
8 State with an application approved under
9 this subsection with respect to a year, the
10 Administrator shall allot to the State for
11 the year, from amounts appropriated for
12 such year under subparagraph (A), the
13 amount determined for the State and year
14 under paragraph (5).

15 “(ii) AVAILABILITY OF ALLOTMENTS;
16 UNUSED AMOUNTS.—

17 “(I) IN GENERAL.—Amounts al-
18 lotted to a State for a calendar year
19 under this subparagraph shall remain
20 available for obligation by the State
21 through December 31 of the second
22 calendar year following the year for
23 which the allotment is made, except
24 that in no case shall amounts appro-
25 priated for any year before calendar

1 year 2027 remain available for obliga-
2 tion by a State after December 31,
3 2026.

4 “(II) UNUSED AMOUNTS TO BE
5 USED FOR DEFICIT REDUCTION.—
6 Amounts allotted to a State for a cal-
7 endar year that remain unobligated on
8 April 1 of the following year shall be
9 deposited into the general fund of the
10 Treasury and shall be used for deficit
11 reduction

12 “(iii) LIMITATION.—

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

20 “(II) EXCEPTION.—The Sec-
21 retary may permit a State to use not
22 more than 20 percent of the amount
23 allotted to the State for a year under
24 this subparagraph for the purpose de-
25 scribed in subclause (VI) of paragraph

1 (1)(A)(i) if the State submits an ap-
2 plication to waive the restriction in
3 subclause (I) and the Secretary deter-
4 mines that the State is using such
5 amounts allotted to the State to sup-
6 plement, and not supplant, State ex-
7 penditures on the State plan under
8 title XIX.

9 “(C) RESERVATION OF FUNDS FOR AD-
10 VANCED PAYMENTS TO STATES IN 2020.—

11 “(i) IN GENERAL.—From the amount
12 appropriated for calendar year 2020,
13 \$10,000,000,000 shall be reserved for the
14 purpose of increasing State allotments for
15 calendar year 2020 under paragraph (9).

16 “(ii) AVAILABILITY OF RESERVED
17 FUNDS.—

18 “(I) IN GENERAL.—Funds re-
19 served under clause (i) shall be avail-
20 able for the purpose described in such
21 clause until December 31, 2020.

22 “(II) AVAILABILITY FOR 2026 AL-
23 LOTMENTS.—To the extent that any
24 funds reserved under clause (i) remain
25 after December 31, 2020, such funds

1 shall be available for making allot-
2 ments to States for calendar year
3 2026.

4 “(5) DETERMINATION OF ALLOTMENT
5 AMOUNTS.—

6 “(A) CALENDAR YEAR 2020.—

7 “(i) IN GENERAL.—Subject to sub-
8 paragraph (H), the amount determined
9 under this paragraph for a State for cal-
10 endar year 2020 shall be equal to the
11 State’s base period amount, as defined in
12 clause (ii).

13 “(ii) BASE PERIOD AMOUNT.—In this
14 paragraph, the term ‘base period amount’
15 means, with respect to a State, the sum of
16 the following amounts:

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

20 “(aa) that were made to the
21 State during the State’s premium
22 assistance base period (as defined
23 in clause (iii)) for medical assist-
24 ance provided to individuals
25 under clause (i)(VIII) or (ii)(XX)

1 of section 1902(a)(10)(A) (in-
2 cluding medical assistance pro-
3 vided to individuals who are not
4 newly eligible (as defined in sec-
5 tion 1905(y)(2)) individuals de-
6 scribed in subclause (VIII) of
7 section 1902(a)(10)(A)(i)); or

8 “(bb) that would have been
9 made to a State during the
10 State’s premium assistance base
11 period for medical assistance pro-
12 vided to individuals who would
13 have been described in section
14 1902(a)(10)(A)(i)(VIII) (without
15 regard to the first sunset date in
16 such section) but who were pro-
17 vided such assistance under a
18 title XIX State plan waiver that
19 made medical assistance available
20 to all individuals described in
21 such subsection whose income did
22 not exceed 100 percent of the
23 poverty line and that was in ef-
24 fect on September 1, 2017, if

1 such assistance was treated as
2 assistance under such section.

3 “(II) The amount, increased by
4 the State growth factor described in
5 clause (iv)(II), of Federal payments
6 made to the State during the State’s
7 premium assistance base period for
8 operating a Basic Health Program
9 under section 1331 of the Patient
10 Protection and Affordable Care Act
11 during such period.

12 “(III) The amount, increased by
13 the State growth factor described in
14 clause (iv)(II), of advance payments
15 of premium assistance credits allow-
16 able under section 36B of the Internal
17 Revenue Code of 1986 made under
18 section 1412(a) of the Patient Protec-
19 tion and Affordable Care Act during
20 the State’s premium assistance base
21 period on behalf of individuals who
22 purchased insurance through the Ex-
23 change established for or by the State
24 pursuant to title I of such Act.

1 “(aa) only select a period of
2 4 consecutive fiscal quarters for
3 which all the data necessary to
4 make determinations required
5 under this paragraph is available,
6 as determined by the Secretary;
7 and

8 “(bb) shall not select any
9 period of 4 consecutive fiscal
10 quarters that begins with a fiscal
11 quarter earlier than the first
12 quarter of fiscal year 2014 or
13 ends with a fiscal quarter later
14 than the first fiscal quarter of
15 2018.

16 “(iv) GROWTH FACTORS.—The growth
17 factor described in this clause for a State
18 is—

19 “(I) for the amount described in
20 subclause (I) of clause (i), the pro-
21 jected percentage increase in Medicaid
22 expenditures from the last month of
23 the State’s premium assistance base
24 period to November of 2019, as deter-

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

3 “(II) for the amounts described
4 in subclauses (II), (III), and (IV) of
5 clause (i), the percentage increase in
6 the medical care component of the
7 consumer price index for all urban
8 consumers (U.S. city average) from
9 the last month of the State’s premium
10 assistance base period to November of
11 2019.

12 “(B) CALENDAR YEARS 2021 THROUGH
13 2025.—Subject to subparagraphs (D), (E), (F),
14 (G), and (H), for each of calendar years 2021
15 through 2025, the amount determined under
16 this paragraph for a State and calendar year
17 shall be equal to—

18 “(i) the amount determined for the
19 State under this paragraph (including any
20 applicable adjustments) for the previous
21 calendar year; plus

22 “(ii) an amount equal to $\frac{1}{6}$ of the dif-
23 ference between—

1 “(I) the projected 2026 amount
2 for the State and year (as defined in
3 subparagraph (J)); minus

4 “(II) the amount allotted to the
5 State for calendar year 2020.

6 “(C) CALENDAR YEAR 2026.—Subject to
7 subparagraphs (D), (E), (F), (G), and (H), for
8 calendar year 2026, the amount determined
9 under this paragraph for a State shall be equal
10 to the product of the amount appropriated for
11 the year under paragraph (4)(A)(vii) (increased
12 by any available amounts described in para-
13 graph (4)(C)(ii)(II)) and the ratio of—

14 “(i) the number of low-income individ-
15 uals (as defined in subparagraph (I)) in
16 the State for calendar year 2025; to

17 “(ii) the number of low-income indi-
18 viduals in all States for calendar year
19 2025.

20 “(D) POPULATION RISK ADJUSTMENT.—

21 “(i) IN GENERAL.—Subject to clauses
22 (ii) and (iii), for each calendar year after
23 2020, the Secretary shall adjust the
24 amount determined for each State for the
25 year under subparagraph (B) or (C) so

1 that the amount is equal to the product
2 of—

3 “(I) the amount so determined
4 for the State and year; and

5 “(II) the population risk index
6 (as defined in subparagraph (K)) for
7 the State and year.

8 “(ii) PHASE-IN OF POPULATION RISK
9 ADJUSTMENT.—For each of calendar years
10 2021 through 2023, the amount of the ad-
11 justment determined for a State for a year
12 under clause (i) shall be reduced—

13 “(I) in calendar year 2021, by 75
14 percent;

15 “(II) in calendar year 2022, by
16 50 percent; and

17 “(III) in calendar year 2023, by
18 25 percent.

19 “(iii) CAP ON RISK ADJUSTMENT.—In
20 no case shall the Secretary increase or re-
21 duce the amount determined for a State
22 and year under subparagraph (B) or (C)
23 by an amount that is greater than 10 per-
24 cent of the amount so determined.

25 “(E) COVERAGE VALUE ADJUSTMENT.—

1 year, as determined under sub-
2 paragraph (N); and

3 “(bb) the lowest possible ac-
4 tuarial value of health benefits
5 coverage that would satisfy the
6 requirements of section 2103(a)
7 (or, if applicable, any waiver of
8 such requirements that is effec-
9 tive in such State for such year)
10 if such coverage were provided as
11 child health assistance to a tar-
12 geted low-income child under the
13 State child health plan.

14 “(iii) PHASE-IN OF COVERAGE VALUE
15 ADJUSTMENT.—For each of calendar years
16 2024 through 2026, the amount of any re-
17 duction determined for a State for a year
18 under clause (ii) shall be reduced—

19 “(I) in calendar year 2024, by 75
20 percent;

21 “(II) in calendar year 2025, by
22 50 percent; and

23 “(III) in calendar year 2026, by
24 25 percent.

1 “(F) STATE SPECIFIC POPULATION AD-
2 JUSTMENT FACTOR.—

3 “(i) IN GENERAL.—For calendar
4 years after 2020, the Secretary may adjust
5 the amount determined for a State for a
6 year under subparagraph (B) or (C) and
7 adjusted under subparagraphs (D) and (E)
8 according to a population adjustment fac-
9 tor developed by the Secretary.

10 “(ii) DEVELOPMENT OF POPULATION
11 ADJUSTMENT FACTOR.—Not later than
12 July 31, 2019, the Secretary shall develop
13 a State specific population adjustment fac-
14 tor that accounts for legitimate factors
15 that impact the health care expenditures in
16 a State beyond the clinical characteristics
17 of the low-income individuals in the State.
18 Such factors may include State demo-
19 graphics, wage rates, income levels, and
20 other factors as determined by the Sec-
21 retary.

22 “(G) 2026 REDUCTION FOR STATES RE-
23 CEIVING ADVANCED PAYMENTS IN 2020.—For
24 calendar year 2026, the amount determined for
25 a State for such year under subparagraph (C)

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

5 “(H) PRORATION RULE.—

6 “(i) IN GENERAL.—In no case shall
7 the total amount of State allotments (in-
8 cluding any adjustments under subpara-
9 graphs (D), (E), (F), and (G)) determined
10 for a calendar year under this paragraph
11 exceed the amount appropriated for a cal-
12 endar year under paragraph (4)(A) (in-
13 creased, in the case of calendar year 2026,
14 by any available amounts described in
15 paragraph (4)(C)(ii)(II)).

16 “(ii) PRORATION.—If the amount so
17 appropriated—

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

1 “(II) is greater than the total
2 amount of State allotments deter-
3 mined for such year under this para-
4 graph (after any adjustments under
5 subparagraphs (D), (E), (F), and
6 (G)), the amount allotted to each
7 State for such year shall be increased
8 proportionally.

9 “(I) LOW-INCOME INDIVIDUAL.—In this
10 paragraph, the term ‘low-income individual’
11 means an individual—

12 “(i) who is a citizen or legal resident;
13 and

14 “(ii) whose income (as determined
15 under section 1902(e)(14) (relating to
16 modified adjusted gross income)) is greater
17 than 45 percent but less than 133 percent
18 of the poverty line (as defined in section
19 2110(c)(5), subject to subparagraph
20 (O)(ii)) applicable to a family of the size
21 involved.

22 “(J) PROJECTED 2026 AMOUNT.—The term
23 ‘projected 2026 amount’ means, with respect to
24 a State and calendar year, the product of the

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

3 “(i) the number of low-income individ-
4 uals (as defined in subparagraph (I)) in
5 the State for the calendar year preceding
6 the calendar year involved; to

7 “(ii) the number of low-income indi-
8 viduals in all States for such preceding
9 year.

10 “(K) POPULATION RISK INDEX.—The term
11 ‘population risk index’ means, for a State for a
12 calendar year, the ratio of—

13 “(i) the sum of the products, for each
14 of the clinical risk categories (as defined in
15 subparagraph (L)(i)), of—

16 “(I) the clinical risk factor for
17 the category (as defined in subpara-
18 graph (M)); and

19 “(II) the number of low-income
20 individuals for the State, year, and
21 category; to

22 “(ii) the number of enrollees in the
23 State.

24 “(L) CLINICAL RISK CATEGORY.—

1 “(i) IN GENERAL.—The term ‘clinical
2 risk category’ means a grouping of low-in-
3 come individuals based on their clinical
4 characteristics that is established by the
5 Secretary under this subparagraph.

6 “(ii) METHODOLOGY FOR ESTAB-
7 LISHING CATEGORIES AND ASSIGNING IN-
8 DIVIDUALS TO A CATEGORY.—The Sec-
9 retary shall select a methodology for estab-
10 lishing clinical risk categories and for as-
11 signing low-income individuals to such cat-
12 egories, except that any methodology se-
13 lected by the Secretary shall meet the fol-
14 lowing requirements:

15 “(I) The methodology shall be
16 composed of exhaustive and mutually
17 exclusive risk categories such that
18 every low-income individual is as-
19 signed to a risk category and each in-
20 dividual may be assigned to only one
21 risk category.

22 “(II) The methodology shall ac-
23 count for clinical characteristics of in-
24 dividuals that impact per capita
25 health care expenditures.

1 “(III) The methodology shall ac-
2 count for the chronic illness burden
3 associated with multiple comorbid
4 chronic diseases and be composed of
5 risk categories that explicitly differen-
6 tiate individuals based on their sever-
7 ity of illness.

8 “(IV) The methodology shall in-
9 clude risk categories that account for
10 complex pediatric enrollees.

11 “(V) The methodology for assign-
12 ing individuals to such clinical risk
13 categories shall be based on character-
14 istics of individuals contained in data
15 routinely collected in administrative
16 claims data and shall be capable of
17 utilizing pharmacy data and func-
18 tional health status data when such
19 data becomes routinely available.

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

1 sible for providing or arranging for
2 services for a population of enrollees
3 that includes enrollees with complex
4 pediatric conditions and enrollees who
5 are eligible for benefits under both ti-
6 tles XVIII and XIX.

7 “(VII) The methodology shall be
8 open, transparent, and available for
9 review and comment by the public.

10 “(iii) TIMELINE.—

11 “(I) IN GENERAL.—The Sec-
12 retary shall select the methodology for
13 establishing clinical risk categories
14 and assigning low-income individuals
15 to such categories not later than Jan-
16 uary 1, 2020.

17 “(II) ANNUAL UPDATES.—Not
18 later than 15 days prior to the begin-
19 ning of each calendar year, the Sec-
20 retary shall make publicly available
21 updates to the methodology selected
22 under subclause (I).

23 “(M) CLINICAL RISK FACTOR.—The term
24 ‘clinical risk factor’ means, with respect to each

1 clinical risk category and calendar year, the
2 ratio of—

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

7 “(ii) the average per capita amount of
8 expenditures for all States for the previous
9 calendar year for all low-income individ-
10 uals.

11 “(N) DETERMINATION OF ACTUARIAL
12 VALUE OF COVERAGE.—In determining the av-
13 erage actuarial value of coverage for low-income
14 individuals for a State and calendar year—

15 “(i) any plan offered on the health in-
16 surance marketplace established for or by
17 the State that does not offer a benefits
18 package that is at least equivalent to one
19 of the benchmark benefits packages de-
20 scribed in section 2103(b) shall be deemed
21 to have an actuarial value of 40 percent;
22 and

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

1 such year shall be deemed to have been en-
2 rolled in a plan for health benefits coverage
3 with an actuarial value of 0 percent.

4 “(O) POPULATION AND POVERTY DATA.—

5 “(i) IN GENERAL.—In making the de-
6 terminations required under this para-
7 graph, the Secretary shall, where appro-
8 priate, use data from the most recently
9 available Current Population Survey of the
10 Bureau of the Census.

11 “(ii) USE OF SEPARATE POVERTY
12 LINES.—In the case of a State for which
13 the Secretary has issued under the author-
14 ity of section 673(2) of the Omnibus
15 Budget Reconciliation Act of 1981 a sepa-
16 rate poverty guideline for 2017 that is
17 higher than the poverty line (as defined in
18 section 2110(c)(5)) that is applicable to
19 the majority of States, the Secretary shall
20 determine the number of low-income indi-
21 viduals in such State using such separate
22 poverty guideline instead of such poverty
23 line.

24 “(6) PAYMENTS.—

1 “(A) IN GENERAL.—The Administrator
2 shall pay to each State that has an application
3 approved under this subsection for a year, from
4 the amount allotted to the State under para-
5 graph (4)(B) for the year, an amount equal to
6 the State’s expenditures for the year on the ac-
7 tivities described by the State in its application
8 approved under paragraph (1).

9 “(B) ADVANCE PAYMENT; RETROSPECTIVE
10 ADJUSTMENT.—

11 “(i) IN GENERAL.—If the Adminis-
12 trator deems it appropriate, the Adminis-
13 trator shall make payments under this sub-
14 section for each 6 month period in a year
15 on the basis of advance estimates of ex-
16 penditures submitted by the State and
17 such other investigation as the Adminis-
18 trator shall find necessary, and shall re-
19 duce or increase the payments as necessary
20 to adjust for any overpayment or under-
21 payment for prior periods.

22 “(ii) MISUSE OF FUNDS.—If the Ad-
23 ministrator determines that a State is not
24 using funds paid to the State under this
25 subsection in a manner consistent with the

1 description provided by the State in its ap-
2 plication approved under paragraph (1) or
3 is inappropriately withholding payments
4 owed to providers of services or health in-
5 surance issuers, the Administrator may
6 withhold payments, reduce payments, or
7 recover previous payments to the State
8 under this subsection as the Administrator
9 deems appropriate.

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

15 “(7) EXEMPTIONS.—Paragraphs (2), (3), (5),
16 (6), (8), (10), and (11) of subsection (c) do not
17 apply to payments under this subsection.

18 “(8) CONTINGENCY FUND.—

19 “(A) IN GENERAL.—From the amount ap-
20 propriated under subparagraph (C), the Sec-
21 retary may increase the allotment amount de-
22 termined under paragraph (5) for each of cal-
23 endar years 2020 and 2021 for any State that
24 is a low-density State or a non-expansion State
25 for the year.

1 “(B) DEFINITIONS.—In this paragraph:

2 “(i) LOW-DENSITY STATE DEFINED.—

3 The term ‘low-density State’ means, with
4 respect to a calendar year, a State that
5 has a population density of less than 15 in-
6 dividuals per square mile, based on the
7 most recent data available from the Bu-
8 reau of the Census.

9 “(ii) NON-EXPANSION STATE.—The
10 term ‘non-expansion State’ means a State
11 that—

12 “(I) is not a low-density State;
13 and

14 “(II) did not provide eligibility
15 under section 1902(a)(10)(A)(i)(VIII)
16 for medical assistance under the State
17 plan under title XIX on September 1,
18 2017 (or provided eligibility for indi-
19 viduals described in such section
20 under a waiver of the State plan ap-
21 proved under section 1115).

22 “(C) FUNDING.—

23 “(i) IN GENERAL.—There is appro-
24 priated, out of any money in the Treasury
25 not otherwise appropriated,

1 \$6,000,000,000 for calendar year 2020,
2 and \$5,000,000,00 for calendar year 2021,
3 for the purpose of carrying out this para-
4 graph.

5 “(ii) RESERVATION OF FUNDS.—The
6 Secretary shall reserve, for each of cal-
7 endar years 2020 and 2021, from the
8 funds appropriated for each such year
9 under clause (i)—

10 “(I) 25 percent of such funds for
11 the purpose of increasing the grant
12 amounts for States that are low-den-
13 sity States; and

14 “(II) 75 percent of such funds
15 for the purpose of increasing the
16 grant amounts for States that are
17 non-expansion States.

18 “(9) ADVANCE PAYMENT FUND.—

19 “(A) IN GENERAL.—From the amount re-
20 served under paragraph (4)(C), the Secretary
21 may increase the allotment amount determined
22 under paragraph (5) for calendar year 2020 for
23 any State that applies for an increase under
24 this paragraph by the amount determined for
25 the State under subparagraph (B).

1 “(B) AMOUNT OF INCREASE.—Subject to
2 subparagraph (C), the Secretary shall increase
3 the allotment amount determined under para-
4 graph (5) for a State for calendar year 2020 by
5 the amount requested by the State, except that
6 in no case shall the Secretary increase a State’s
7 allotment amount by an amount that exceeds 5
8 percent of the amount so determined.

9 “(C) PRORATION RULE.—If the amount
10 reserved under paragraph (4)(C) is less than
11 the total amount of increases requested by
12 States under this paragraph, the amount of the
13 increase for each State shall be reduced propor-
14 tionally.”.

15 (b) OTHER TITLE XXI AMENDMENTS.—

16 (1) Section 2101 of such Act (42 U.S.C.
17 1397aa) is amended—

18 (A) in subsection (a), in the matter pre-
19 ceding paragraph (1), by striking “The pur-
20 pose” and inserting “Except with respect to
21 short-term assistance activities under section
22 2105(h) and the Market-Based Health Care
23 Grant Program established in section 2105(i),
24 the purpose”; and

1 (B) in subsection (b), in the matter pre-
2 ceding paragraph (1), by inserting “subsection
3 (a) or (g) of” before “section 2105”.

4 (2) Section 2105(c)(1) of such Act (42 U.S.C.
5 1397ee(c)(1)) is amended by striking “and may not
6 include” and inserting “or to carry out short-term
7 assistance activities under subsection (h) or the
8 Market-Based Health Care Grant Program estab-
9 lished in subsection (i) and, except in the case of
10 funds made available under subsection (h) or (i),
11 may not include”.

12 (3) Section 2106(a)(1) of such Act (42 U.S.C.
13 1397ff(a)(1)) is amended by inserting “subsection
14 (a) or (g) of” before “section 2105”.

15 **SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTA-**
16 **TION FUND.**

17 (a) IN GENERAL.—There is hereby established a Bet-
18 ter Care Reconciliation Implementation Fund (referred to
19 in this section as the “Fund”) within the Department of
20 Health and Human Services to provide for Federal admin-
21 istrative expenses in carrying out this Act.

22 (b) FUNDING.—There is appropriated to the Fund,
23 out of any funds in the Treasury not otherwise appro-
24 priated, \$2,000,000,000.

1 **SEC. 108. REPEAL OF TAX ON OVER-THE-COUNTER MEDICA-**
2 **TIONS.**

3 (a) HSAs.—Subparagraph (A) of section 223(d)(2)
4 of the Internal Revenue Code of 1986 is amended by strik-
5 ing “Such term” and all that follows through the period.

6 (b) ARCHER MSAs.—Subparagraph (A) of section
7 220(d)(2) of the Internal Revenue Code of 1986 is amend-
8 ed by striking “Such term” and all that follows through
9 the period.

10 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
11 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-
12 tion 106 of the Internal Revenue Code of 1986 is amended
13 by striking subsection (f).

14 (d) EFFECTIVE DATES.—

15 (1) DISTRIBUTIONS FROM SAVINGS AC-
16 COUNTS.—The amendments made by subsections (a)
17 and (b) shall apply to amounts paid with respect to
18 taxable years beginning after December 31, 2016.

19 (2) REIMBURSEMENTS.—The amendment made
20 by subsection (c) shall apply to expenses incurred
21 with respect to taxable years beginning after Decem-
22 ber 31, 2016.

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

24 (a) HSAs.—Section 223(f)(4)(A) of the Internal
25 Revenue Code of 1986 is amended by striking “20 per-
26 cent” and inserting “10 percent”.

1 (b) ARCHER MSAS.—Section 220(f)(4)(A) of the In-
2 ternal Revenue Code of 1986 is amended by striking “20
3 percent” and inserting “15 percent”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to distributions made after Decem-
6 ber 31, 2016.

7 **SEC. 110. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

8 Section 4191 of the Internal Revenue Code of 1986
9 is amended by adding at the end the following new sub-
10 section:

11 “(d) APPLICABILITY.—The tax imposed under sub-
12 section (a) shall not apply to sales after December 31,
13 2017.”.

14 **SEC. 111. REPEAL OF ELIMINATION OF DEDUCTION FOR**
15 **EXPENSES ALLOCABLE TO MEDICARE PART D**
16 **SUBSIDY.**

17 (a) IN GENERAL.—Section 139A of the Internal Rev-
18 enue Code of 1986 is amended by adding at the end the
19 following new sentence: “This section shall not be taken
20 into account for purposes of determining whether any de-
21 duction is allowable with respect to any cost taken into
22 account in determining such payment.”.

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

1 **SEC. 112. PURCHASE OF INSURANCE FROM HEALTH SAV-**
2 **INGS ACCOUNT.**

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

5 (1) by striking “and any dependent (as defined
6 in section 152, determined without regard to sub-
7 sections (b)(1), (b)(2), and (d)(1)(B) thereof) of
8 such individual” in subparagraph (A) and inserting
9 “any dependent (as defined in section 152, deter-
10 mined without regard to subsections (b)(1), (b)(2),
11 and (d)(1)(B) thereof) of such individual, and any
12 child (as defined in section 152(f)(1)) of such indi-
13 vidual who has not attained the age of 27 before the
14 end of such individual’s taxable year”,

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

17 “(B) HEALTH INSURANCE MAY NOT BE
18 PURCHASED FROM ACCOUNT.—Except as pro-
19 vided in subparagraph (C), subparagraph (A)
20 shall not apply to any payment for insurance.”,
21 and

22 (3) by striking “or” at the end of subparagraph
23 (C)(iii), by striking the period at the end of subpara-
24 graph (C)(iv) and inserting “, or”, and by adding at
25 the end the following:

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

4 “(I) any amount allowable as a
5 credit under section 36B for the tax-
6 able year with respect to such cov-
7 erage,

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

11 “(III) any amount excludable
12 from gross income with respect to
13 such coverage under section 106 (in-
14 cluding by reason of section 125) or
15 402(l).”.

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

21 **SEC. 113. PRIMARY CARE ENHANCEMENT.**

22 (a) TREATMENT OF DIRECT PRIMARY CARE SERVICE
23 ARRANGEMENTS.—Section 223(c) of the Internal Revenue
24 Code of 1986 is amended by adding at the end the fol-
25 lowing new paragraph:

1 “(6) TREATMENT OF DIRECT PRIMARY CARE
2 SERVICE ARRANGEMENTS.—An arrangement under
3 which an individual is provided coverage restricted to
4 primary care services in exchange for a fixed peri-
5 odic fee or payment for such services—

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

8 “(B) shall not be treated as insurance for
9 purposes of subsection (d)(2)(B).”.

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

14 “(12) PERIODIC PROVIDER FEES.—The term
15 ‘medical care’ shall include periodic fees paid for a
16 defined set of primary care medical services provided
17 on an as-needed basis.”.

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

1 **SEC. 114. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAV-**
2 **INGS ACCOUNT INCREASED TO AMOUNT OF**
3 **DEDUCTIBLE AND OUT-OF-POCKET LIMITA-**
4 **TION.**

5 (a) **SELF-ONLY COVERAGE.**—Section 223(b)(2)(A)
6 of the Internal Revenue Code of 1986 is amended by strik-
7 ing “\$2,250” and inserting “the amount in effect under
8 subsection (c)(2)(A)(ii)(I)”.

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

12 (c) **COST-OF-LIVING ADJUSTMENT.**—Section
13 223(g)(1) of such Code is amended—

14 (1) by striking “subsections (b)(2) and” both
15 places it appears and inserting “subsection”, and

16 (2) in subparagraph (B), by striking “deter-
17 mined by” and all that follows through “‘calendar
18 year 2003’.” and inserting “determined by sub-
19 stituting ‘calendar year 2003’ for ‘calendar year
20 1992’ in subparagraph (B) thereof.”.

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

1 **SEC. 115. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**
2 **TRIBUTIONS TO THE SAME HEALTH SAVINGS**
3 **ACCOUNT.**

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

6 “(5) SPECIAL RULE FOR MARRIED INDIVIDUALS
7 WITH FAMILY COVERAGE.—

8 “(A) IN GENERAL.—In the case of individ-
9 uals who are married to each other, if both
10 spouses are eligible individuals and either
11 spouse has family coverage under a high de-
12 ductible health plan as of the first day of any
13 month—

14 “(i) the limitation under paragraph
15 (1) shall be applied by not taking into ac-
16 count any other high deductible health
17 plan coverage of either spouse (and if such
18 spouses both have family coverage under
19 separate high deductible health plans, only
20 one such coverage shall be taken into ac-
21 count),

22 “(ii) such limitation (after application
23 of clause (i)) shall be reduced by the ag-
24 gregate amount paid to Archer MSAs of
25 such spouses for the taxable year, and

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

5 “(B) TREATMENT OF ADDITIONAL CON-
6 TRIBUTION AMOUNTS.—If both spouses referred
7 to in subparagraph (A) have attained age 55
8 before the close of the taxable year, the limita-
9 tion referred to in subparagraph (A)(iii) which
10 is subject to division between the spouses shall
11 include the additional contribution amounts de-
12 termined under paragraph (3) for both spouses.
13 In any other case, any additional contribution
14 amount determined under paragraph (3) shall
15 not be taken into account under subparagraph
16 (A)(iii) and shall not be subject to division be-
17 tween the spouses.”.

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

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

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

7 “(D) **TREATMENT OF CERTAIN MEDICAL**
8 **EXPENSES INCURRED BEFORE ESTABLISHMENT**
9 **OF ACCOUNT.**—If a health savings account is
10 established during the 60-day period beginning
11 on the date that coverage of the account bene-
12 ficiary under a high deductible health plan be-
13 gins, then, solely for purposes of determining
14 whether an amount paid is used for a qualified
15 medical expense, such account shall be treated
16 as having been established on the date that
17 such coverage begins.”.

18 (b) **EFFECTIVE DATE.**—The amendment made by
19 this subsection shall apply with respect to coverage under
20 a high deductible health plan beginning after December
21 31, 2017.

1 **SEC. 117. EXCLUSION FROM HSAS OF HIGH DEDUCTIBLE**
2 **HEALTH PLANS INCLUDING COVERAGE FOR**
3 **ABORTION.**

4 (a) IN GENERAL.—Subparagraph (C) of section
5 223(d)(2) of the Internal Revenue Code of 1986 is amend-
6 ed by adding at the end the following flush sentence:

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

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply with respect to coverage under a
15 high deductible health plan beginning after December 31,
16 2017.

17 **SEC. 118. FEDERAL PAYMENTS TO STATES.**

18 (a) IN GENERAL.—Notwithstanding section 504(a),
19 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or
20 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a),
21 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4),
22 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Med-
23 icaid waiver in effect on the date of enactment of this Act
24 that is approved under section 1115 or 1915 of the Social
25 Security Act (42 U.S.C. 1315, 1396n), for the 1-year pe-
26 riod beginning on the date of enactment of this Act, no

1 Federal funds provided from a program referred to in this
2 subsection that is considered direct spending for any year
3 may be made available to a State for payments to a pro-
4 hibited entity, whether made directly to the prohibited en-
5 tity or through a managed care organization under con-
6 tract with the State.

7 (b) DEFINITIONS.—In this section:

8 (1) PROHIBITED ENTITY.—The term “prohib-
9 ited entity” means an entity, including its affiliates,
10 subsidiaries, successors, and clinics—

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

13 (i) is an organization described in sec-
14 tion 501(c)(3) of the Internal Revenue
15 Code of 1986 and exempt from tax under
16 section 501(a) of such Code;

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

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

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

3 (II) in the case where a woman
4 suffers from a physical disorder, phys-
5 ical injury, or physical illness that
6 would, as certified by a physician,
7 place the woman in danger of death
8 unless an abortion is performed, in-
9 cluding a life-endangering physical
10 condition caused by or arising from
11 the pregnancy itself; and

12 (B) for which the total amount of Federal
13 and State expenditures under the Medicaid pro-
14 gram under title XIX of the Social Security Act
15 in fiscal year 2014 made directly to the entity
16 and to any affiliates, subsidiaries, successors, or
17 clinics of the entity, or made to the entity and
18 to any affiliates, subsidiaries, successors, or
19 clinics of the entity as part of a nationwide
20 health care provider network, exceeded
21 \$1,000,000.

22 (2) DIRECT SPENDING.—The term “direct
23 spending” has the meaning given that term under
24 section 250(c) of the Balanced Budget and Emer-
25 gency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

1 **SEC. 119. MEDICAID.**

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

4 (1) in section 1902—

5 (A) in subsection (a)(10)(A)—

6 (i) in each of clauses (i)(VIII) and
7 (ii)(XX), by inserting “and ending Sep-
8 tember 1, 2017 (or, in the case of a State
9 that provided for medical assistance under
10 this subclause on July 1, 2016, December
11 31, 2019),” after “January 1, 2014,”; and

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

14 “(XXIII) beginning January 1,
15 2020, who—

16 “(aa) are members of an In-
17 dian tribe;

18 “(bb) are described in sub-
19 clause (VIII) of clause (i) (with-
20 out regard to the sunset dates in
21 such subclause);

22 “(cc) reside in a State that
23 provided for medical assistance
24 under such subclause on Decem-
25 ber 31, 2019;

1 “(dd) were enrolled under
2 the State plan under this title (or
3 a waiver of such plan) on Decem-
4 ber 31, 2019; and

5 “(ee) after December 31,
6 2019, do not have a break in eli-
7 gibility for medical assistance
8 under the State plan under this
9 title for such a period of time as
10 the State may specify (but which
11 in no case shall be less than 6
12 months);” and

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

18 (2) in section 1905—

19 (A) in the first sentence of subsection (b),
20 by inserting “(50 percent on or after January
21 1, 2020)” after “55 percent”;

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

25 (C) in subsection (z)(2)—

1 (i) in subparagraph (A), by inserting
2 “through 2019” after “each year there-
3 after”; and

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

5 (I) in subclause (V), by striking
6 “2018 is 90” inserting “2018 and
7 2019 is 90 percent”; and

8 (II) in subclause (VI) by striking
9 “2019 and each subsequent year is 90
10 percent” and inserting “2020 and
11 each subsequent year is 0 percent”;

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

16 (4) in section 1920(e), by adding at the end the
17 following: “This subsection shall not apply after De-
18 cember 31, 2019.”;

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

22 (6) in section 1943(a), by inserting “and before
23 January 1, 2020,” after “January 1, 2014,”.

24 **SEC. 120. REDUCING STATE MEDICAID COSTS.**

25 (a) IN GENERAL.—

1 (1) STATE PLAN REQUIREMENTS.—Section
2 1902(a)(34) of the Social Security Act (42 U.S.C.
3 1396a(a)(34)) is amended by striking “in or after
4 the third month” and all that follows through “indi-
5 vidual)” and inserting “in or after the second month
6 before the month in which the individual (or, in the
7 case of a deceased individual, another individual act-
8 ing on the individual’s behalf) made application (or,
9 in the case of an individual who is 65 years of age
10 or older or who is eligible for medical assistance
11 under the plan on the basis of being blind or dis-
12 abled, in or after the month before such second
13 month)”.

14 (2) DEFINITION OF MEDICAL ASSISTANCE.—
15 Section 1905(a) of the Social Security Act (42
16 U.S.C. 1396d(a)) is amended by striking “in or
17 after the third month before the month in which the
18 recipient makes application for assistance” and in-
19 serting “in or after the second month before the
20 month in which the recipient makes application for
21 assistance, or, in the case of a recipient who is 65
22 years of age or older or who is eligible for medical
23 assistance on the basis of being blind or disabled at
24 the time application is made, in or after the month
25 before such second month,”.

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

6 **SEC. 121. ELIGIBILITY REDETERMINATIONS.**

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

11 “(J) FREQUENCY OF ELIGIBILITY REDE-
12 TERMINATIONS.—Beginning on October 1,
13 2017, and notwithstanding subparagraph (H),
14 in the case of an individual whose eligibility for
15 medical assistance under the State plan under
16 this title (or a waiver of such plan) is deter-
17 mined based on the application of modified ad-
18 justed gross income under subparagraph (A)
19 and who is so eligible on the basis of clause
20 (i)(VIII) or (ii)(XX) of subsection (a)(10)(A),
21 at the option of the State, the State plan may
22 provide that the individual’s eligibility shall be
23 redetermined every 6 months (or such shorter
24 number of months as the State may elect).”.

1 (b) INCREASED ADMINISTRATIVE MATCHING PER-
2 CENTAGE.—For each calendar quarter during the period
3 beginning on October 1, 2017, and ending on December
4 31, 2019, the Federal matching percentage otherwise ap-
5 plicable under section 1903(a) of the Social Security Act
6 (42 U.S.C. 1396b(a)) with respect to State expenditures
7 during such quarter that are attributable to meeting the
8 requirement of section 1902(e)(14) (relating to determina-
9 tions of eligibility using modified adjusted gross income)
10 of such Act shall be increased by 5 percentage points with
11 respect to State expenditures attributable to activities car-
12 ried out by the State (and approved by the Secretary) to
13 exercise the option described in subparagraph (J) of such
14 section (relating to eligibility redeterminations made on a
15 6-month or shorter basis) (as added by subsection (a)) to
16 increase the frequency of eligibility redeterminations.

17 **SEC. 122. OPTIONAL WORK REQUIREMENT FOR NON-**
18 **DISABLED, NONELDERLY, NONPREGNANT IN-**
19 **DIVIDUALS.**

20 (a) IN GENERAL.—Section 1902 of the Social Secu-
21 rity Act (42 U.S.C. 1396a), as previously amended, is fur-
22 ther amended by adding at the end the following new sub-
23 section:

1 “(oo) OPTIONAL WORK REQUIREMENT FOR NON-
2 DISABLED, NONELDERLY, NONPREGNANT INDIVID-
3 UALS.—

4 “(1) IN GENERAL.—Beginning October 1,
5 2017, subject to paragraph (3), a State may elect to
6 condition medical assistance to a nondisabled, non-
7 elderly, nonpregnant individual under this title upon
8 such an individual’s satisfaction of a work require-
9 ment (as defined in paragraph (2)).

10 “(2) WORK REQUIREMENT DEFINED.—In this
11 section, the term ‘work requirement’ means, with re-
12 spect to an individual, the individual’s participation
13 in work activities (as defined in section 407(d)) for
14 such period of time as determined by the State, and
15 as directed and administered by the State.

16 “(3) REQUIRED EXCEPTIONS.—States admin-
17 istering a work requirement under this subsection
18 may not apply such requirement to—

19 “(A) a woman during pregnancy through
20 the end of the month in which the 60-day pe-
21 riod (beginning on the last day of her preg-
22 nancy) ends;

23 “(B) an individual who is under 19 years
24 of age;

1 “(C) an individual who is the only parent
2 or caretaker relative in the family of a child
3 who has not attained 6 years of age or who is
4 the only parent or caretaker of a child with dis-
5 abilities;

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

9 “(i) maintains satisfactory attendance
10 at secondary school or the equivalent; or

11 “(ii) participates in education directly
12 related to employment;

13 “(E) an individual who is a regular partici-
14 pant in an inpatient or intensive outpatient
15 drug addiction or alcoholic treatment and reha-
16 bilitation program that satisfies such criteria as
17 the State shall require; or

18 “(F) an individual who is a full-time stu-
19 dent at an institution of higher education as de-
20 fined in sections 101 and 102 of the Higher
21 Education Act of 1965.”.

22 (b) INCREASE IN MATCHING RATE FOR IMPLEMEN-
23 TATION.—Section 1903 of the Social Security Act (42
24 U.S.C. 1396b) is amended by adding at the end the fol-
25 lowing:

1 “(aa) The Federal matching percentage otherwise ap-
2 plicable under subsection (a) with respect to State admin-
3 istrative expenditures during a calendar quarter for which
4 the State receives payment under such subsection shall,
5 in addition to any other increase to such Federal matching
6 percentage, be increased for such calendar quarter by 5
7 percentage points with respect to State expenditures at-
8 tributable to activities carried out by the State (and ap-
9 proved by the Secretary) to implement subsection (oo) of
10 section 1902.”.

11 **SEC. 123. PROVIDER TAXES.**

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

15 “(iii) For purposes of clause (i), a de-
16 termination of the existence of an indirect
17 guarantee shall be made under paragraph
18 (3)(i) of section 433.68(f) of title 42, Code
19 of Federal Regulations, as in effect on
20 June 1, 2017, except that—

21 “(I) for fiscal year 2021, ‘5.6
22 percent’ shall be substituted for ‘6
23 percent’ each place it appears;

1 “(II) for fiscal year 2022, ‘5.2
2 percent’ shall be substituted for ‘6
3 percent’ each place it appears;

4 “(III) for fiscal year 2023, ‘4.8
5 percent’ shall be substituted for ‘6
6 percent’ each place it appears;

7 “(IV) for fiscal year 2024, ‘4.4
8 percent’ shall be substituted for ‘6
9 percent’ each place it appears; and

10 “(V) for fiscal year 2025 and
11 each subsequent fiscal year, ‘4 per-
12 cent’ shall be substituted for ‘6 per-
13 cent’ each place it appears.”.

14 **SEC. 124. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-**
15 **ANCE.**

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

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

19 (A) in subsection (a), in the matter before
20 paragraph (1), by inserting “and section
21 1903A(a)” after “except as otherwise provided
22 in this section”; and

23 (B) in subsection (d)(1), by striking “to
24 which” and inserting “to which, subject to sec-
25 tion 1903A(a),”; and

1 (2) by inserting after such section 1903 the fol-
2 lowing new section:

3 **“SEC. 1903A. PER CAPITA-BASED CAP ON PAYMENTS FOR**
4 **MEDICAL ASSISTANCE.**

5 “(a) APPLICATION OF PER CAPITA CAP ON PAY-
6 MENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

7 “(1) IN GENERAL.—Subject to subsection (i), if
8 a State which is one of the 50 States or the District
9 of Columbia has excess aggregate medical assistance
10 expenditures (as defined in paragraph (2)) for a fis-
11 cal year (beginning with fiscal year 2020), the
12 amount of payment to the State under section
13 1903(a)(1) for each quarter in the following fiscal
14 year shall be reduced by $\frac{1}{4}$ of the excess aggregate
15 medical assistance payments (as defined in para-
16 graph (3)) for that previous fiscal year. In this sec-
17 tion, the term ‘State’ means only the 50 States and
18 the District of Columbia.

19 “(2) EXCESS AGGREGATE MEDICAL ASSISTANCE
20 EXPENDITURES.—In this subsection, the term ‘ex-
21 cess aggregate medical assistance expenditures’
22 means, for a State for a fiscal year, the amount (if
23 any) by which—

24 “(A) the amount of the adjusted total med-
25 ical assistance expenditures (as defined in sub-

1 section (b)(1)) for the State and fiscal year; ex-
2 ceeds

3 “(B) the amount of the target total med-
4 ical assistance expenditures (as defined in sub-
5 section (c)) for the State and fiscal year.

6 “(3) EXCESS AGGREGATE MEDICAL ASSISTANCE
7 PAYMENTS.—In this subsection, the term ‘excess ag-
8 gregate medical assistance payments’ means, for a
9 State for a fiscal year, the product of—

10 “(A) the excess aggregate medical assist-
11 ance expenditures (as defined in paragraph (2))
12 for the State for the fiscal year; and

13 “(B) the Federal average medical assist-
14 ance matching percentage (as defined in para-
15 graph (4)) for the State for the fiscal year.

16 “(4) FEDERAL AVERAGE MEDICAL ASSISTANCE
17 MATCHING PERCENTAGE.—In this subsection, the
18 term ‘Federal average medical assistance matching
19 percentage’ means, for a State for a fiscal year, the
20 ratio (expressed as a percentage) of—

21 “(A) the amount of the Federal payments
22 that would be made to the State under section
23 1903(a)(1) for medical assistance expenditures
24 for calendar quarters in the fiscal year if para-
25 graph (1) did not apply; to

1 “(B) the amount of the medical assistance
2 expenditures for the State and fiscal year.

3 “(5) PER CAPITA BASE PERIOD.—

4 “(A) IN GENERAL.—In this section, the
5 term ‘per capita base period’ means, with re-
6 spect to a State, a period of 8 consecutive fiscal
7 quarters selected by the State.

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

11 “(C) PARAMETERS.—In selecting a per
12 capita base period under this paragraph, a
13 State shall—

14 “(i) only select a period of 8 consecu-
15 tive fiscal quarters for which all the data
16 necessary to make determinations required
17 under this section is available, as deter-
18 mined by the Secretary; and

19 “(ii) shall not select any period of 8
20 consecutive fiscal quarters that begins with
21 a fiscal quarter earlier than the first quar-
22 ter of fiscal year 2014 or ends with a fiscal
23 quarter later than the third fiscal quarter
24 of 2017.

1 “(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EX-
2 PENDING.—Subject to subsection (g), the following
3 shall apply:

4 “(1) IN GENERAL.—In this section, the term
5 ‘adjusted total medical assistance expenditures’
6 means, for a State—

7 “(A) for the State’s per capita base period
8 (as defined in subsection (a)(5)), the product
9 of—

10 “(i) the amount of the medical assist-
11 ance expenditures (as defined in paragraph
12 (2) and adjusted under paragraph (5)) for
13 the State and period, reduced by the
14 amount of any excluded expenditures (as
15 defined in paragraph (3) and adjusted
16 under paragraph (5)) for the State and pe-
17 riod otherwise included in such medical as-
18 sistance expenditures; and

19 “(ii) the 1903A base period popu-
20 lation percentage (as defined in paragraph
21 (4)) for the State; or

22 “(B) for fiscal year 2019 or a subsequent
23 fiscal year, the amount of the medical assist-
24 ance expenditures (as defined in paragraph (2))
25 for the State and fiscal year that is attributable

1 to 1903A enrollees, reduced by the amount of
2 any excluded expenditures (as defined in para-
3 graph (3)) for the State and fiscal year other-
4 wise included in such medical assistance ex-
5 penditures and includes non-DSH supplemental
6 payments (as defined in subsection
7 (d)(4)(A)(ii)) and payments described in sub-
8 section (d)(4)(A)(iii) but shall not be construed
9 as including any expenditures attributable to
10 the program under section 1928 (relating to
11 State pediatric vaccine distribution programs).
12 In applying subparagraph (B), non-DSH sup-
13 plemental payments (as defined in subsection
14 (d)(4)(A)(ii)) and payments described in sub-
15 section (d)(4)(A)(iii) shall be treated as fully at-
16 tributable to 1903A enrollees.

17 “(2) MEDICAL ASSISTANCE EXPENDITURES.—

18 In this section, the term ‘medical assistance expendi-
19 tures’ means, for a State and fiscal year or per cap-
20 ita base period, the medical assistance payments as
21 reported by medical service category on the Form
22 CMS-64 quarterly expense report (or successor to
23 such a report form, and including enrollment data
24 and subsequent adjustments to any such report, in
25 this section referred to collectively as a ‘CMS-64 re-

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

5 “(3) EXCLUDED EXPENDITURES.—In this sec-
6 tion, the term ‘excluded expenditures’ means, for a
7 State and fiscal year or per capita base period, ex-
8 penditures under the State plan (or under a waiver
9 of such plan) that are attributable to any of the fol-
10 lowing:

11 “(A) DSH.—Payment adjustments made
12 for disproportionate share hospitals under sec-
13 tion 1923.

14 “(B) MEDICARE COST-SHARING.—Pay-
15 ments made for medicare cost-sharing (as de-
16 fined in section 1905(p)(3)).

17 “(C) EXPENDITURES FOR PUBLIC HEALTH
18 EMERGENCIES.—Any expenditures that are sub-
19 ject to a public health emergency exclusion
20 under paragraph (6).

21 “(4) 1903A BASE PERIOD POPULATION PER-
22 CENTAGE.—In this subsection, the term ‘1903A base
23 period population percentage’ means, for a State,
24 the Secretary’s calculation of the percentage of the
25 actual medical assistance expenditures, as reported

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

5 “(5) ADJUSTMENTS FOR PER CAPITA BASE PE-
6 RIOD.—In calculating medical assistance expendi-
7 tures under paragraph (2) and excluded expendi-
8 tures under paragraph (3) for a State for the State’s
9 per capita base period, the total amount of each type
10 of expenditure for the State and base period shall be
11 divided by 2.

12 “(6) AUTHORITY TO EXCLUDE STATE EXPENDI-
13 TURES FROM CAPS DURING PUBLIC HEALTH EMER-
14 GENCY.—

15 “(A) IN GENERAL.—During the period
16 that begins on January 1, 2020, and ends on
17 December 31, 2024, the Secretary may exclude,
18 from a State’s medical assistance expenditures
19 for a fiscal year or portion of a fiscal year that
20 occurs during such period, an amount that shall
21 not exceed the amount determined under sub-
22 paragraph (B) for the State and year or portion
23 of a year if—

24 “(i) a public health emergency de-
25 clared by the Secretary pursuant to section

1 319 of the Public Health Service Act ex-
2 isted within the State during such year or
3 portion of a year; and

4 “(ii) the Secretary determines that
5 such an exemption would be appropriate.

6 “(B) MAXIMUM AMOUNT OF ADJUST-
7 MENT.—The amount excluded for a State and
8 fiscal year or portion of a fiscal year under this
9 paragraph shall not exceed the amount by
10 which—

11 “(i) the amount of State expenditures
12 for medical assistance for 1903A enrollees
13 in areas of the State which are subject to
14 a declaration described in subparagraph
15 (A)(i) for the fiscal year or portion of a fis-
16 cal year; exceeds

17 “(ii) the amount of such expenditures
18 for such enrollees in such areas during the
19 most recent fiscal year or portion of a fis-
20 cal year of equal length to the portion of
21 a fiscal year involved during which no such
22 declaration was in effect.

23 “(C) AGGREGATE LIMITATION ON EXCLU-
24 SIONS AND ADDITIONAL BLOCK GRANT PAY-
25 MENTS.—The aggregate amount of expendi-

1 tures excluded under this paragraph and addi-
2 tional payments made under section
3 1903B(c)(3)(E) for the period described in sub-
4 paragraph (A) shall not exceed \$5,000,000,000.

5 “(D) REVIEW.—If the Secretary exercises
6 the authority under this paragraph with respect
7 to a State for a fiscal year or portion of a fiscal
8 year, the Secretary shall, not later than 6
9 months after the declaration described in sub-
10 paragraph (A)(i) ceases to be in effect, conduct
11 an audit of the State’s medical assistance ex-
12 penditures for 1903A enrollees during the year
13 or portion of a year to ensure that all of the ex-
14 penditures so excluded were made for the pur-
15 pose of ensuring that the health care needs of
16 1903A enrollees in areas affected by a public
17 health emergency are met.

18 “(c) TARGET TOTAL MEDICAL ASSISTANCE EXPEND-
19 ITURES.—

20 “(1) CALCULATION.—In this section, the term
21 ‘target total medical assistance expenditures’ means,
22 for a State for a fiscal year, the sum of the prod-
23 ucts, for each of the 1903A enrollee categories (as
24 defined in subsection (e)(2)), of—

1 “(A) the target per capita medical assist-
2 ance expenditures (as defined in paragraph (2))
3 for the enrollee category, State, and fiscal year;
4 and

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

8 “(2) TARGET PER CAPITA MEDICAL ASSISTANCE
9 EXPENDITURES.—In this subsection, the term ‘tar-
10 get per capita medical assistance expenditures’
11 means, for a 1903A enrollee category and State—

12 “(A) for fiscal year 2020, an amount equal
13 to—

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

18 “(ii) the applicable annual inflation
19 factor (as defined in paragraph (3)) for
20 fiscal year 2020; and

21 “(B) for each succeeding fiscal year, an
22 amount equal to—

23 “(i) the target per capita medical as-
24 sistance expenditures (under subparagraph
25 (A) or this subparagraph) for the 1903A

1 enrollee category and State for the pre-
2 ceding fiscal year; increased by

3 “(ii) the applicable annual inflation
4 factor for that succeeding fiscal year.

5 “(3) APPLICABLE ANNUAL INFLATION FAC-
6 TOR.—In paragraph (2), the term ‘applicable annual
7 inflation factor’ means—

8 “(A) for fiscal years before 2025—

9 “(i) for each of the 1903A enrollee
10 categories described in subparagraphs (C)
11 and (D) of subsection (e)(2), the percent-
12 age increase in the medical care component
13 of the consumer price index for all urban
14 consumers (U.S. city average) from Sep-
15 tember of the previous fiscal year to Sep-
16 tember of the fiscal year involved; and

17 “(ii) for each of the 1903A enrollee
18 categories described in subparagraphs (A)
19 and (B) of subsection (e)(2), the percent-
20 age increase described in clause (i) plus 1
21 percentage point; and

22 “(B) for fiscal years after 2024—

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

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

6 “(ii) for each of the 1903A enrollee
7 categories described in subparagraphs (A)
8 and (B) of subsection (e)(2), the percent-
9 age increase in the medical care component
10 of the consumer price index for all urban
11 consumers (U.S. city average) from Sep-
12 tember of the previous fiscal year to Sep-
13 tember of the fiscal year involved.

14 “(4) ADJUSTMENTS TO STATE EXPENDITURES
15 TARGETS TO PROMOTE PROGRAM EQUITY ACROSS
16 STATES.—

17 “(A) IN GENERAL.—Beginning with fiscal
18 year 2020, the target per capita medical assist-
19 ance expenditures for a 1903A enrollee cat-
20 egory, State, and fiscal year, as determined
21 under paragraph (2), shall be adjusted (subject
22 to subparagraph (C)(i)) in accordance with this
23 paragraph.

24 “(B) ADJUSTMENT BASED ON LEVEL OF
25 PER CAPITA SPENDING FOR 1903A ENROLLEE

1 CATEGORIES.—Subject to subparagraph (C),
2 with respect to a State, fiscal year, and 1903A
3 enrollee category, if the State’s per capita cat-
4 egorical medical assistance expenditures (as de-
5 fined in subparagraph (D)) for the State and
6 category in the preceding fiscal year—

7 “(i) exceed the mean per capita cat-
8 egorical medical assistance expenditures
9 for the category for all States for such pre-
10 ceding year by not less than 25 percent,
11 the State’s target per capita medical as-
12 sistance expenditures for such category for
13 the fiscal year involved shall be reduced by
14 a percentage that shall be determined by
15 the Secretary but which shall not be less
16 than 0.5 percent or greater than 2 percent;
17 or

18 “(ii) are less than the mean per capita
19 categorical medical assistance expenditures
20 for the category for all States for such pre-
21 ceding year by not less than 25 percent,
22 the State’s target per capita medical as-
23 sistance expenditures for such category for
24 the fiscal year involved shall be increased
25 by a percentage that shall be determined

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

4 “(C) RULES OF APPLICATION.—

5 “(i) BUDGET NEUTRALITY REQUIRE-
6 MENT.—In determining the appropriate
7 percentages by which to adjust States’ tar-
8 get per capita medical assistance expendi-
9 tures for a category and fiscal year under
10 this paragraph, the Secretary shall make
11 such adjustments in a manner that does
12 not result in a net increase in Federal pay-
13 ments under this section for such fiscal
14 year, and if the Secretary cannot adjust
15 such expenditures in such a manner there
16 shall be no adjustment under this para-
17 graph for such fiscal year.

18 “(ii) ASSUMPTION REGARDING STATE
19 EXPENDITURES.—For purposes of clause
20 (i), in the case of a State that has its tar-
21 get per capita medical assistance expendi-
22 tures for a 1903A enrollee category and
23 fiscal year increased under this paragraph,
24 the Secretary shall assume that the cat-
25 egorical medical assistance expenditures

1 (as defined in subparagraph (D)(ii)) for
2 such State, category, and fiscal year will
3 equal such increased target medical assist-
4 ance expenditures.

5 “(iii) NONAPPLICATION TO LOW-DEN-
6 SITY STATES.—This paragraph shall not
7 apply to any State that has a population
8 density of less than 15 individuals per
9 square mile, based on the most recent data
10 available from the Bureau of the Census.

11 “(iv) APPLICATION FOR FISCAL YEARS
12 2020 AND 2021.—In fiscal years 2020 and
13 2021, the Secretary shall apply this para-
14 graph by deeming all categories of 1903A
15 enrollees to be a single category.

16 “(D) PER CAPITA CATEGORICAL MEDICAL
17 ASSISTANCE EXPENDITURES.—

18 “(i) IN GENERAL.—In this paragraph,
19 the term ‘per capita categorical medical as-
20 sistance expenditures’ means, with respect
21 to a State, 1903A enrollee category, and
22 fiscal year, an amount equal to—

23 “(I) the categorical medical ex-
24 penditures (as defined in clause (ii))

1 for the State, category, and year; di-
2 vided by

3 “(II) the number of 1903A en-
4 rollees for the State, category, and
5 year.

6 “(ii) CATEGORICAL MEDICAL ASSIST-
7 ANCE EXPENDITURES.—The term ‘categor-
8 ical medical assistance expenditures’
9 means, with respect to a State, 1903A en-
10 rollee category, and fiscal year, an amount
11 equal to the total medical assistance ex-
12 penditures (as defined in paragraph (2))
13 for the State and fiscal year that are at-
14 tributable to 1903A enrollees in the cat-
15 egory, excluding any excluded expenditures
16 (as defined in paragraph (3)) for the State
17 and fiscal year that are attributable to
18 1903A enrollees in the category.

19 “(d) CALCULATION OF FY19 PROVISIONAL TARGET
20 AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Sub-
21 ject to subsection (g), the following shall apply:

22 “(1) CALCULATION OF BASE AMOUNTS FOR PER
23 CAPITA BASE PERIOD.—For each State the Sec-
24 retary shall calculate (and provide notice to the
25 State not later than April 1, 2018, of) the following:

1 “(A) The amount of the adjusted total
2 medical assistance expenditures (as defined in
3 subsection (b)(1)) for the State for the State’s
4 per capita base period.

5 “(B) The number of 1903A enrollees for
6 the State in the State’s per capita base period
7 (as determined under subsection (e)(4)).

8 “(C) The average per capita medical as-
9 sistance expenditures for the State for the
10 State’s per capita base period equal to—

11 “(i) the amount calculated under sub-
12 paragraph (A); divided by

13 “(ii) the number calculated under sub-
14 paragraph (B).

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

21 “(A) the average per capita medical assist-
22 ance expenditures for the State for the State’s
23 per capita base period (calculated under para-
24 graph (1)(C)); increased by

1 “(B) the percentage increase in the med-
2 ical care component of the consumer price index
3 for all urban consumers (U.S. city average)
4 from the last month of the State’s per capita
5 base period to September of fiscal year 2019.

6 “(3) AGGREGATE AND AVERAGE EXPENDI-
7 TURES PER CAPITA FOR FISCAL YEAR 2019.—The
8 Secretary shall calculate for each State the fol-
9 lowing:

10 “(A) The amount of the adjusted total
11 medical assistance expenditures (as defined in
12 subsection (b)(1)) for the State for fiscal year
13 2019.

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

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

22 “(A)(i) For each 1903A enrollee category,
23 the amount of the adjusted total medical assist-
24 ance expenditures (as defined in subsection
25 (b)(1)) for the State for fiscal year 2019 for in-

1 individuals in the enrollee category, calculated by
2 excluding from medical assistance expenditures
3 those expenditures attributable to expenditures
4 described in clause (iii) or non-DSH supple-
5 mental expenditures (as defined in clause (ii)).

6 “(ii) In this paragraph, the term ‘non-
7 DSH supplemental expenditure’ means a pay-
8 ment to a provider under the State plan (or
9 under a waiver of the plan) that—

10 “(I) is not made under section 1923;

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

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

16 “(IV) complies with the limits for ad-
17 ditional payments to providers under the
18 plan (or waiver) imposed pursuant to sec-
19 tion 1902(a)(30)(A), including the regula-
20 tions specifying upper payment limits
21 under the State plan in part 447 of title
22 42, Code of Federal Regulations (or any
23 successor regulations).

24 “(iii) An expenditure described in this
25 clause is an expenditure that meets the criteria

1 specified in subclauses (I), (II), and (III) of
2 clause (ii) and is authorized under section 1115
3 for the purposes of funding a delivery system
4 reform pool, uncompensated care pool, a des-
5 ignated State health program, or any other
6 similar expenditure (as defined by the Sec-
7 retary).

8 “(B) For each 1903A enrollee category,
9 the number of 1903A enrollees for the State in
10 fiscal year 2019 in the enrollee category (as de-
11 termined under subsection (e)(4)).

12 “(C) For the State’s per capita base pe-
13 riod, the State’s non-DSH supplemental and
14 pool payment percentage is equal to the ratio
15 (expressed as a percentage) of—

16 “(i) the total amount of non-DSH
17 supplemental expenditures (as defined in
18 subparagraph (A)(ii) and adjusted under
19 subparagraph (E)) and payments described
20 in subparagraph (A)(iii) (and adjusted
21 under subparagraph (E)) for the State for
22 the period; to

23 “(ii) the amount described in sub-
24 section (b)(1)(A) for the State for the
25 State’s per capita base period.

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

5 “(i) the amount calculated under sub-
6 paragraph (A) for the State, increased by
7 the non-DSH supplemental and pool pay-
8 ment percentage for the State (as cal-
9 culated under subparagraph (C)); divided
10 by

11 “(ii) the number calculated under sub-
12 paragraph (B) for the State for the en-
13 rollee category.

14 “(E) For purposes of subparagraph (C)(i),
15 in calculating the total amount of non-DSH
16 supplemental expenditures and payments de-
17 scribed in subparagraph (A)(iii) for a State for
18 the per capita base period, the total amount of
19 such expenditures and the total amount of such
20 payments for the State and base period shall
21 each be divided by 2.

22 “(5) PROVISIONAL FY19 PER CAPITA TARGET
23 AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—
24 Subject to subsection (f)(2), the Secretary shall cal-
25 culate for each State a provisional FY19 per capita

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

6 “(A) the product of—

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

10 “(ii) the number of 1903A enrollees
11 for the State in fiscal year 2019, as cal-
12 culated under paragraph (3)(B); to

13 “(B) the amount of the adjusted total
14 medical assistance expenditures for the State
15 for fiscal year 2019, as calculated under para-
16 graph (3)(A).

17 “(e) 1903A ENROLLEE; 1903A ENROLLEE CAT-
18 EGORY.—Subject to subsection (g), for purposes of this
19 section, the following shall apply:

20 “(1) 1903A ENROLLEE.—The term ‘1903A en-
21 rollee’ means, with respect to a State and a month
22 and subject to subsection (i)(1)(B), any Medicaid
23 enrollee (as defined in paragraph (3)) for the month,
24 other than such an enrollee who for such month is

1 in any of the following categories of excluded indi-
2 viduals:

3 “(A) CHIP.—An individual who is pro-
4 vided, under this title in the manner described
5 in section 2101(a)(2), child health assistance
6 under title XXI.

7 “(B) IHS.—An individual who receives
8 any medical assistance under this title for serv-
9 ices for which payment is made under the third
10 sentence of section 1905(b).

11 “(C) BREAST AND CERVICAL CANCER
12 SERVICES ELIGIBLE INDIVIDUAL.—An indi-
13 vidual who is eligible for medical assistance
14 under this title only on the basis of section
15 1902(a)(10)(A)(ii)(XVIII).

16 “(D) PARTIAL-BENEFIT ENROLLEES.—An
17 individual who—

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

21 “(ii) is eligible for medical assistance
22 under this title only on the basis of sub-
23 clause (XII) or (XXI) of section
24 1902(a)(10)(A)(ii) (or on the basis of a

1 waiver that provides only comparable bene-
2 fits);

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

9 “(iv) is eligible for medical assistance
10 under this title and for whom the State is
11 providing a payment or subsidy to an em-
12 ployer for coverage of the individual under
13 a group health plan pursuant to section
14 1906 or section 1906A (or pursuant to a
15 waiver that provides only comparable bene-
16 fits).

17 “(E) BLIND AND DISABLED CHILDREN.—

18 An individual who—

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

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

1 “(2) 1903A ENROLLEE CATEGORY.—The term
2 ‘1903A enrollee category’ means each of the fol-
3 lowing:

4 “(A) ELDERLY.—A category of 1903A en-
5 rollees who are 65 years of age or older.

6 “(B) BLIND AND DISABLED.—A category
7 of 1903A enrollees (not described in the pre-
8 vious subparagraph) who—

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

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

13 “(C) CHILDREN.—A category of 1903A
14 enrollees (not described in a previous subpara-
15 graph) who are children under 19 years of age.

16 “(D) OTHER NONELDERLY, NONDISABLED,
17 NON-EXPANSION ADULTS.—A category of
18 1903A enrollees who are not described in any
19 previous subparagraph.

20 “(3) MEDICAID ENROLLEE.—The term ‘Med-
21 icaid enrollee’ means, with respect to a State for a
22 month, an individual who is eligible for medical as-
23 sistance for items or services under this title and en-
24 rolled under the State plan (or a waiver of such
25 plan) under this title for the month.

1 “(4) DETERMINATION OF NUMBER OF 1903A
2 ENROLLEES.—The number of 1903A enrollees for a
3 State and fiscal year or the State’s per capita base
4 period, and, if applicable, for a 1903A enrollee cat-
5 egory, is the average monthly number of Medicaid
6 enrollees for such State and fiscal year or base pe-
7 riod (and, if applicable, in such category) that are
8 reported through the CMS–64 report under (and
9 subject to audit under) subsection (h).

10 “(f) SPECIAL PAYMENT RULES.—

11 “(1) APPLICATION IN CASE OF RESEARCH AND
12 DEMONSTRATION PROJECTS AND OTHER WAIVERS.—
13 In the case of a State with a waiver of the State
14 plan approved under section 1115, section 1915, or
15 another provision of this title, this section shall
16 apply to medical assistance expenditures and medical
17 assistance payments under the waiver, in the same
18 manner as if such expenditures and payments had
19 been made under a State plan under this title and
20 the limitations on expenditures under this section
21 shall supersede any other payment limitations or
22 provisions (including limitations based on a per cap-
23 ita limitation) otherwise applicable under such a
24 waiver.

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

8 “(A) the Secretary shall calculate and
9 apply subsections (a) through (e) with respect
10 to the State as if all 1903A enrollee categories
11 for which such expenditure and enrollee data
12 were not satisfactorily submitted were a single
13 1903A enrollee category; and

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

17 “(g) RECALCULATION OF CERTAIN AMOUNTS FOR
18 DATA ERRORS.—The amounts and percentage calculated
19 under paragraphs (1) and (4)(C) of subsection (d) for a
20 State for the State’s per capita base period, and the
21 amounts of the adjusted total medical assistance expendi-
22 tures calculated under subsection (b) and the number of
23 Medicaid enrollees and 1903A enrollees determined under
24 subsection (e)(4) for a State for the State’s per capita
25 base period, fiscal year 2019, and any subsequent fiscal

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

9 “(h) REQUIRED REPORTING AND AUDITING; TRANSI-
10 TIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE
11 FOR CERTAIN ADMINISTRATIVE EXPENSES.—

12 “(1) AUDITING OF CMS-64 DATA.—The Sec-
13 retary shall conduct for each State an audit of the
14 number of individuals and expenditures reported
15 through the CMS-64 report for the State’s per cap-
16 ita base period, fiscal year 2019, and each subse-
17 quent fiscal year, which audit may be conducted on
18 a representative sample (as determined by the Sec-
19 retary).

20 “(2) AUDITING OF STATE SPENDING.—The In-
21 spector General of the Department of Health and
22 Human Services shall conduct an audit (which shall
23 be conducted using random sampling, as determined
24 by the Inspector General) of each State’s spending
25 under this section not less than once every 3 years.

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

11 “(A) the Federal matching percentage ap-
12 plied under section 1903(a)(3)(A)(i) shall be in-
13 creased by 10 percentage points to 100 percent;
14 and

15 “(B) the Federal matching percentage ap-
16 plied under section 1903(a)(3)(B) shall be in-
17 creased by 25 percentage points to 100 percent.

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

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

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

1 “(B) that is allotted an amount under sec-
2 tion 2105(i) for the calendar year that begins
3 on January 1 of such fiscal year that—

4 “(i) is less than—

5 “(I) the amount allotted to such
6 State under such section for calendar
7 year 2020; increased by

8 “(II) the percentage increase in
9 the medical care component of the
10 consumer price index for all urban
11 consumers (U.S. city average) from
12 September of 2020 to September of
13 the last calendar year that ended be-
14 fore the fiscal year involved; or

15 “(ii) is insufficient, as determined by
16 the Secretary (after taking into consider-
17 ation the unique circumstances of such
18 State), to provide comprehensive and ade-
19 quate assistance to individuals in the State
20 under a market-based health care grant
21 program under such section; and

22 “(C) for each fiscal year after fiscal year
23 2020, to which subsection (a) did not apply for
24 the previous fiscal year as a result of the appli-
25 cation of this subsection.

1 “If a State elects to terminate a Med-
2 icaid Flexibility Program, the per capita
3 cap limitations under section 1903A shall
4 apply effective with the day described in
5 clause (i), and such limitations shall be ap-
6 plied as if the State had never conducted
7 a Medicaid Flexibility Program.

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

13 “(A) shall apply to such State effective
14 with the first day of such subsequent fiscal
15 year; and

16 “(B) shall be applied as if it had applied
17 to the State from the first day of fiscal year
18 2020.”.

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

23 “(1) INCENTIVE PAYMENTS FOR HOME AND COMMU-
24 NITY-BASED SERVICES.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish a demonstration project (referred to in this sub-
3 section as the ‘demonstration project’) under which
4 eligible States may make HCBS payment adjust-
5 ments for the purpose of continuing to provide and
6 improving the quality of home and community-based
7 services provided under a waiver under subsection
8 (c) or (d) or a State plan amendment under sub-
9 section (i).

10 “(2) SELECTION OF ELIGIBLE STATES.—

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

16 “(i) an assurance that any HCBS
17 payment adjustment made by the State
18 under this subsection will comply with the
19 health and welfare and financial account-
20 ability safeguards taken by the State under
21 subsection (c)(2)(A); and

22 “(ii) such other information and as-
23 surances as the Secretary shall require.

24 “(B) SELECTION.—The Secretary shall se-
25 lect States to participate in the demonstration

1 project on a competitive basis except that, in
2 making selections under this paragraph, the
3 Secretary shall give priority to any State that
4 is one of the 15 States in the United States
5 with the lowest population density, as deter-
6 mined by the Secretary based on data from the
7 Bureau of the Census.

8 “(3) TERM OF DEMONSTRATION PROJECT.—
9 The demonstration project shall be conducted for the
10 4-year period beginning on January 1, 2020, and
11 ending on December 31, 2023.

12 “(4) STATE ALLOTMENTS AND INCREASED
13 FMAP FOR PAYMENT ADJUSTMENTS.—

14 “(A) IN GENERAL.—

15 “(i) ANNUAL ALLOTMENT.—Subject
16 to clause (ii), for each year of the dem-
17 onstration project, the Secretary shall allot
18 an amount to each State that is an eligible
19 State for the year.

20 “(ii) LIMITATION ON FEDERAL
21 SPENDING.—The aggregate amount that
22 may be allotted to eligible States under
23 clause (i) for all years of the demonstra-
24 tion project shall not exceed
25 \$8,000,000,000.

100

1 “(B) FMAP APPLICABLE TO HCBS PAY-
2 MENT ADJUSTMENTS.—For each year of the
3 demonstration project, notwithstanding section
4 1905(b) but subject to the limitations described
5 in subparagraph (C), the Federal medical as-
6 sistance percentage applicable with respect to
7 expenditures by an eligible State that are at-
8 tributable to HCBS payment adjustments shall
9 be equal to (and shall in no case exceed) 100
10 percent.

11 “(C) INDIVIDUAL PROVIDER AND ALLOT-
12 MENT LIMITATIONS.—Payment under section
13 1903(a) shall not be made to an eligible State
14 for expenditures for a year that are attributable
15 to an HCBS payment adjustment—

16 “(i) that is paid to a single provider
17 and exceeds a percentage which shall be
18 established by the Secretary of the pay-
19 ment otherwise made to the provider; or

20 “(ii) to the extent that the aggregate
21 amount of HCBS payment adjustments
22 made by the State in the year exceeds the
23 amount allotted to the State for the year
24 under clause (i).

25 “(5) REPORTING AND EVALUATION.—

1 “(A) IN GENERAL.—As a condition of re-
2 ceiving the increased Federal medical assistance
3 percentage described in paragraph (4)(B), each
4 eligible State shall collect and report informa-
5 tion, as determined necessary by the Secretary,
6 for the purposes of providing Federal oversight
7 and evaluating the State’s compliance with the
8 health and welfare and financial accountability
9 safeguards taken by the State under subsection
10 (c)(2)(A).

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

15 “(6) DEFINITIONS.—In this subsection:

16 “(A) ELIGIBLE STATE.—The term ‘eligible
17 State’ means a State that—

18 “(i) is one of the 50 States or the
19 District of Columbia;

20 “(ii) has in effect—

21 “(I) a waiver under subsection
22 (c) or (d); or

23 “(II) a State plan amendment
24 under subsection (i);

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

3 “(iv) is selected by the Secretary to
4 participate in the demonstration project.

5 “(B) HCBS PAYMENT ADJUSTMENT.—The
6 term ‘HCBS payment adjustment’ means a
7 payment adjustment made by an eligible State
8 to the amount of payment otherwise provided
9 under a waiver under subsection (c) or (d) or
10 a State plan amendment under subsection (i)
11 for a home and community-based service which
12 is provided to a 1903A enrollee (as defined in
13 section 1903A(e)(1)) who is in the enrollee cat-
14 egory described in subparagraph (A) or (B) of
15 section 1903A(e)(2).”.

16 **SEC. 125. FLEXIBLE BLOCK GRANT OPTION FOR STATES.**

17 Title XIX of the Social Security Act, as previously
18 amended, is further amended by inserting after section
19 1903A the following new section:

20 **“SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.**

21 “(a) IN GENERAL.—Beginning with fiscal year 2020,
22 any State (as defined in subsection (e)) that has an appli-
23 cation approved by the Secretary under subsection (b)
24 may conduct a Medicaid Flexibility Program to provide
25 targeted health assistance to program enrollees.

1 “(b) STATE APPLICATION.—

2 “(1) IN GENERAL.—To be eligible to conduct a
3 Medicaid Flexibility Program, a State shall submit
4 an application to the Secretary that meets the re-
5 quirements of this subsection.

6 “(2) CONTENTS OF APPLICATION.—An applica-
7 tion under this subsection shall include the fol-
8 lowing:

9 “(A) A description of the proposed Med-
10 icaid Flexibility Program and how the State will
11 satisfy the requirements described in subsection
12 (d).

13 “(B) The proposed conditions for eligibility
14 of program enrollees.

15 “(C) A description of the types, amount,
16 duration, and scope of services which will be of-
17 fered as targeted health assistance under the
18 program, including a description of the pro-
19 posed package of services which will be provided
20 to program enrollees to whom the State would
21 otherwise be required to make medical assist-
22 ance available under section 1902(a)(10)(A)(i).

23 “(D) A description of how the State will
24 notify individuals currently enrolled in the State

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

3 “(E) Statements certifying that the State
4 agrees to—

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

10 “(ii) submit timely and accurate data
11 to the Transformed Medicaid Statistical
12 Information System (T-MSIS);

13 “(iii) report annually to the Secretary
14 on adult health quality measures imple-
15 mented under the program and informa-
16 tion on the quality of health care furnished
17 to program enrollees under the program as
18 part of the annual report required under
19 section 1139B(d)(1);

20 “(iv) submit such additional data and
21 information not described in any of the
22 preceding clauses of this subparagraph but
23 which the Secretary determines is nec-
24 essary for monitoring, evaluation, or pro-
25 gram integrity purposes, including—

1 “(I) survey data, such as the
2 data from Consumer Assessment of
3 Healthcare Providers and Systems
4 (CAHPS) surveys;

5 “(II) birth certificate data; and

6 “(III) clinical patient data for
7 quality measurements which may not
8 be present in a claim, such as labora-
9 tory data, body mass index, and blood
10 pressure; and

11 “(v) on an annual basis, conduct a re-
12 port evaluating the program and make
13 such report available to the public.

14 “(F) An information technology systems
15 plan demonstrating that the State has the capa-
16 bility to support the technological administra-
17 tion of the program and comply with reporting
18 requirements under this section.

19 “(G) A statement of the goals of the pro-
20 posed program, which shall include—

21 “(i) goals related to quality, access,
22 rate of growth targets, consumer satisfac-
23 tion, and outcomes;

1 “(5) TIMELINE FOR SUBMISSION.—

2 “(A) IN GENERAL.—A State may submit
3 an application under this subsection to conduct
4 a Medicaid Flexibility Program that would
5 begin in the next fiscal year at any time, sub-
6 ject to subparagraph (B).

7 “(B) DEADLINES.—Each year beginning
8 with 2019, the Secretary shall specify a dead-
9 line for submitting an application under this
10 subsection to conduct a Medicaid Flexibility
11 Program that would begin in the next fiscal
12 year, but such deadline shall not be earlier than
13 60 days after the date that the Secretary pub-
14 lishes the amounts of State block grants as re-
15 quired under subsection (c)(4).

16 “(c) FINANCING.—

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

23 “(2) AMOUNT OF BLOCK GRANT FUNDS.—

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

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

3 “(B) ENROLLEE CATEGORY AMOUNTS.—

4 “(i) FOR INITIAL YEAR.—Subject to
5 subparagraph (C), for the first fiscal year
6 in which a Medicaid Flexibility Program is
7 conducted by a State, the amount deter-
8 mined under this subparagraph for the
9 State and year shall be equal to the Fed-
10 eral average medical assistance matching
11 percentage (as defined in section
12 1903A(a)(4)) for the State and year multi-
13 plied by the product of—

14 “(I) the target per capita medical
15 assistance expenditures (as defined in
16 section 1903A(c)(2)) for the State
17 and year; and

18 “(II) the number of 1903A en-
19 rollees in the category described in
20 section 1903A(e)(2)(D) for the State
21 for the second fiscal year preceding
22 such first fiscal year, increased by the
23 percentage increase in State popu-
24 lation from such second preceding fis-
25 cal year to such first fiscal year, based

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

3 “(ii) FOR ANY SUBSEQUENT YEAR.—

4 For any fiscal year that is not the first fis-
5 cal year in which a Medicaid Flexibility
6 Program is conducted by the State, the
7 block grant amount under this paragraph
8 for the State and year shall be equal to the
9 amount determined for the State for the
10 most recent previous fiscal year in which
11 the State conducted a Medicaid Flexibility
12 Program, except that such amount shall be
13 increased by the percentage increase in the
14 consumer price index for all urban con-
15 sumers (U.S. city average) from April of
16 the second fiscal year preceding the fiscal
17 year involved to April of the fiscal year
18 preceding the fiscal year involved.

19 “(C) CAP ON TOTAL POPULATION OF 1903A
20 ENROLLEES FOR PURPOSES OF BLOCK GRANT
21 CALCULATION.—

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

1 graph (B)(i), the total number of 1903A
2 enrollees in the category described in sec-
3 tion 1903A(e)(2)(D) for the State and
4 year shall not exceed the adjusted number
5 of base period enrollees for the State (as
6 defined in clause (ii)).

7 “(ii) ADJUSTED NUMBER OF BASE PE-
8 RIOD ENROLLEES.—The term ‘adjusted
9 number of base period enrollees’ means,
10 with respect to a State, the number of
11 1903A enrollees in the enrollee category
12 described in section 1903A(e)(2)(D) for
13 the State for the State’s per capita base
14 period (as determined under section
15 1903A(e)(4)), increased by the percentage
16 increase, if any, in the total State popu-
17 lation from the last April in the State’s per
18 capita base period to April of the fiscal
19 year preceding the fiscal year involved (de-
20 termined using the best available data
21 from the Bureau of the Census) plus 3
22 percentage points.

23 “(3) FEDERAL PAYMENT AND STATE MAINTEN-
24 NANCE OF EFFORT.—

1 “(A) FEDERAL PAYMENT.—Subject to sub-
2 paragraphs (D) and (E), the Secretary shall
3 pay to each State conducting a Medicaid Flexi-
4 bility Program under this section for a fiscal
5 year, from its block grant amount under para-
6 graph (2) for such year, an amount for each
7 quarter of such year equal to the Federal aver-
8 age medical assistance percentage (as defined in
9 section 1903A(a)(4)) of the total amount ex-
10 pended under the program during such quarter
11 as targeted health assistance, and the State is
12 responsible for the balance of the funds to carry
13 out such program.

14 “(B) STATE MAINTENANCE OF EFFORT
15 EXPENDITURES.—For each year during which a
16 State is conducting a Medicaid Flexibility Pro-
17 gram, the State shall make expenditures for
18 targeted health assistance under the program in
19 an amount equal to the product of—

20 “(i) the block grant amount deter-
21 mined for the State and year under para-
22 graph (2); and

23 “(ii) the enhanced FMAP described in
24 the first sentence of section 2105(b) for
25 the State and year.

1 “(C) REDUCTION IN BLOCK GRANT
2 AMOUNT FOR STATES FAILING TO MEET MOE
3 REQUIREMENT.—

4 “(i) IN GENERAL.—In the case of a
5 State conducting a Medicaid Flexibility
6 Program that makes expenditures for tar-
7 geted health assistance under the program
8 for a fiscal year in an amount that is less
9 than the required amount for the fiscal
10 year under subparagraph (B), the amount
11 of the block grant determined for the State
12 under paragraph (2) for the succeeding fis-
13 cal year shall be reduced by the amount by
14 which such expenditures are less than such
15 required amount.

16 “(ii) DISREGARD OF REDUCTION.—
17 For purposes of determining the amount of
18 a State block grant under paragraph (2),
19 any reduction made under this subpara-
20 graph to a State’s block grant amount in
21 a previous fiscal year shall be disregarded.

22 “(iii) APPLICATION TO STATES THAT
23 TERMINATE PROGRAM.—In the case of a
24 State described in clause (i) that termi-
25 nates the State Medicaid Flexibility Pro-

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

9 “(D) REDUCTION FOR NONCOMPLIANCE.—

10 If the Secretary determines that a State con-
11 ducting a Medicaid Flexibility Program is not
12 complying with the requirements of this section,
13 the Secretary may withhold payments, reduce
14 payments, or recover previous payments to the
15 State under this section as the Secretary deems
16 appropriate.

17 “(E) ADDITIONAL FEDERAL PAYMENTS
18 DURING PUBLIC HEALTH EMERGENCY.—

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

1 make an additional payment to such State
2 equal to the Federal average medical as-
3 sistance percentage (as defined in section
4 1903A(a)(4)) for the year or portion of a
5 year of the amount of such uncompensated
6 targeted health assistance expenditures, ex-
7 cept that the amount of such payment
8 shall not exceed the amount determined for
9 the State and year or portion of a year
10 under clause (ii).

11 “(ii) MAXIMUM AMOUNT OF ADDI-
12 TIONAL PAYMENT.—The amount deter-
13 mined for a State and fiscal year or por-
14 tion of a fiscal year under this subpara-
15 graph shall not exceed the Federal average
16 medical assistance percentage (as defined
17 in section 1903A(a)(4)) for such year or
18 portion of a year of the amount by
19 which—

20 “(I) the amount of State expend-
21 itures for targeted health assistance
22 for program enrollees in areas of the
23 State which are subject to a declara-
24 tion described in section

1 1903A(b)(6)(A)(i) for the year or por-
2 tion of a year; exceeds

3 “(II) the amount of such expend-
4 itures for such enrollees in such areas
5 during the most recent fiscal year in-
6 volved (or portion of a fiscal year of
7 equal length to the portion of a fiscal
8 year involved) during which no such
9 declaration was in effect.

10 “(iii) UNCOMPENSATED TARGETED
11 HEALTH ASSISTANCE.—In this subpara-
12 graph, the term ‘uncompensated targeted
13 health assistance expenditures’ means,
14 with respect to a State and fiscal year or
15 portion of a fiscal year, an amount equal
16 to the amount (if any) by which—

17 “(I) the total amount expended
18 by the State under the program for
19 targeted health assistance for the year
20 or portion of a year; exceeds

21 “(II) the amount equal to the
22 amount of the block grant (reduced,
23 in the case of a portion of a year, to
24 the same proportion of the full block
25 grant amount that the portion of the

1 year bears to the whole year) divided
2 by the Federal average medical assist-
3 ance percentage for the year or por-
4 tion of a year.

5 “(iv) REVIEW.—If the Secretary
6 makes a payment to a State for a fiscal
7 year or portion of a fiscal year, the Sec-
8 retary shall, not later than 6 months after
9 the declaration described in section
10 1903A(b)(6)(A)(i) ceases to be in effect,
11 conduct an audit of the State’s targeted
12 health assistance expenditures for program
13 enrollees during the year or portion of a
14 year to ensure that all of the expenditures
15 for which the additional payment was
16 made were made for the purpose of ensur-
17 ing that the health care needs of program
18 enrollees in areas affected by a public
19 health emergency are met.

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

1 the amount of the block grant for the State under
2 paragraph (2) which would apply for the upcoming
3 fiscal year if the State were to conduct such a pro-
4 gram in such fiscal year, and shall publish such de-
5 terminations not later than June 1 of each year.

6 “(d) PROGRAM REQUIREMENTS.—

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

11 “(2) TERM OF PROGRAM.—

12 “(A) IN GENERAL.—A State Medicaid
13 Flexibility Program approved under subsection
14 (b)—

15 “(i) shall be conducted for not less
16 than 1 program period;

17 “(ii) at the option of the State, may
18 be continued for succeeding program peri-
19 ods without resubmitting an application
20 under subsection (b), provided that—

21 “(I) the State provides notice to
22 the Secretary of its decision to con-
23 tinue the program; and

24 “(II) no significant changes are
25 made to the program; and

1 “(iii) shall be subject to termination
2 only by the State, which may terminate the
3 program by making an election under sub-
4 paragraph (B).

5 “(B) ELECTION TO TERMINATE PRO-
6 GRAM.—

7 “(i) IN GENERAL.—Subject to clause
8 (ii), a State conducting a Medicaid Flexi-
9 bility Program may elect to terminate the
10 program effective with the first day after
11 the end of the program period in which the
12 State makes the election.

13 “(ii) TRANSITION PLAN REQUIRE-
14 MENT.—A State may not elect to termi-
15 nate a Medicaid Flexibility Program unless
16 the State has in place an appropriate tran-
17 sition plan approved by the Secretary.

18 “(iii) EFFECT OF TERMINATION.—If a
19 State elects to terminate a Medicaid Flexi-
20 bility Program, the per capita cap limita-
21 tions under section 1903A shall apply ef-
22 fective with the day described in clause (i),
23 and such limitations shall be applied as if
24 the State had never conducted a Medicaid
25 Flexibility Program.

1 “(3) PROVISION OF TARGETED HEALTH ASSIST-
2 ANCE.—

3 “(A) IN GENERAL.—A State Medicaid
4 Flexibility Program shall provide targeted
5 health assistance to program enrollees and such
6 assistance shall be instead of medical assistance
7 which would otherwise be provided to the enroll-
8 ees under this title.

9 “(B) CONDITIONS FOR ELIGIBILITY.—

10 “(i) IN GENERAL.—A State con-
11 ducting a Medicaid Flexibility Program
12 shall establish conditions for eligibility of
13 program enrollees, which shall be instead
14 of other conditions for eligibility under this
15 title, except that the program must provide
16 for eligibility for program enrollees to
17 whom the State would otherwise be re-
18 quired to make medical assistance available
19 under section 1902(a)(10)(A)(i).

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

1 come in accordance with section
2 1902(e)(14).

3 “(4) BENEFITS AND SERVICES.—

4 “(A) REQUIRED SERVICES.—In the case of
5 program enrollees to whom the State would oth-
6 erwise be required to make medical assistance
7 available under section 1902(a)(10)(A)(i), a
8 State conducting a Medicaid Flexibility Pro-
9 gram shall provide as targeted health assistance
10 the following types of services:

11 “(i) Inpatient and outpatient hospital
12 services.

13 “(ii) Laboratory and X-ray services.

14 “(iii) Nursing facility services for indi-
15 viduals aged 21 and older.

16 “(iv) Physician services.

17 “(v) Home health care services (in-
18 cluding home nursing services, medical
19 supplies, equipment, and appliances).

20 “(vi) Rural health clinic services (as
21 defined in section 1905(l)(1)).

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

24 “(viii) Family planning services and
25 supplies.

1 “(ix) Nurse midwife services.

2 “(x) Certified pediatric and family
3 nurse practitioner services.

4 “(xi) Freestanding birth center serv-
5 ices (as defined in section 1905(1)(3)).

6 “(xii) Emergency medical transpor-
7 tation.

8 “(xiii) Non-cosmetic dental services.

9 “(xiv) Pregnancy-related services, in-
10 cluding postpartum services for the 12-
11 week period beginning on the last day of a
12 pregnancy.

13 “(B) OPTIONAL BENEFITS.—A State may,
14 at its option, provide services in addition to the
15 services described in subparagraph (A) as tar-
16 geted health assistance under a Medicaid Flexi-
17 bility Program.

18 “(C) BENEFIT PACKAGES.—

19 “(i) IN GENERAL.—The targeted
20 health assistance provided by a State to
21 any group of program enrollees under a
22 Medicaid Flexibility Program shall have an
23 aggregate actuarial value that is equal to
24 at least 95 percent of the aggregate actu-
25 arial value of the benchmark coverage de-

1 scribed in subsection (b)(1) of section 1937
2 or benchmark-equivalent coverage de-
3 scribed in subsection (b)(2) of such sec-
4 tion, as such subsections were in effect
5 prior to the enactment of the Patient Pro-
6 tection and Affordable Care Act.

7 “(ii) AMOUNT, DURATION, AND SCOPE
8 OF BENEFITS.—Subject to clause (i), the
9 State shall determine the amount, dura-
10 tion, and scope with respect to services
11 provided as targeted health assistance
12 under a Medicaid Flexibility Program, in-
13 cluding with respect to services that are re-
14 quired to be provided to certain program
15 enrollees under subparagraph (A) except
16 as otherwise provided under such subpara-
17 graph.

18 “(iii) MENTAL HEALTH AND SUB-
19 STANCE USE DISORDER COVERAGE AND
20 PARITY.—The targeted health assistance
21 provided by a State to program enrollees
22 under a Medicaid Flexibility Program shall
23 include mental health services and sub-
24 stance use disorder services and the finan-
25 cial requirements and treatment limitations

1 applicable to such services under the pro-
2 gram shall comply with the requirements
3 of section 2726 of the Public Health Serv-
4 ice Act in the same manner as such re-
5 quirements apply to a group health plan.

6 “(iv) PRESCRIPTION DRUGS.—If the
7 targeted health assistance provided by a
8 State to program enrollees under a Med-
9 icaid Flexibility Program includes assist-
10 ance for covered outpatient drugs, such
11 drugs shall be subject to a rebate agree-
12 ment that complies with the requirements
13 of section 1927, and any requirements ap-
14 plicable to medical assistance for covered
15 outpatient drugs under a State plan (in-
16 cluding the requirement that the State pro-
17 vide information to a manufacturer) shall
18 apply in the same manner to targeted
19 health assistance for covered outpatient
20 drugs under a Medicaid Flexibility Pro-
21 gram.

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

1 gregate amount of all such charges imposed
2 with respect to all program enrollees in a family
3 shall not exceed 5 percent of the family's in-
4 come for the year involved.

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

8 “(A) SINGLE AGENCY.—Designate a single
9 State agency responsible for administering the
10 program.

11 “(B) ENROLLMENT SIMPLIFICATION AND
12 COORDINATION WITH STATE HEALTH INSUR-
13 ANCE EXCHANGES.—Provide for simplified en-
14 rollment processes (such as online enrollment
15 and reenrollment and electronic verification)
16 and coordination with State health insurance
17 exchanges.

18 “(C) BENEFICIARY PROTECTIONS.—Estab-
19 lish a fair process (which the State shall de-
20 scribe in the application required under sub-
21 section (b)) for individuals to appeal adverse
22 eligibility determinations with respect to the
23 program.

24 “(6) APPLICATION OF REST OF TITLE XIX.—

1 “(A) IN GENERAL.—To the extent that a
2 provision of this section is inconsistent with an-
3 other provision of this title, the provision of this
4 section shall apply.

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

11 “(C) WAIVERS AND STATE PLAN AMEND-
12 MENTS.—

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

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

1 program to the extent that such provisions
2 are otherwise consistent with the require-
3 ments of this section.

4 “(iii) EFFECT OF TERMINATION.—In
5 the case of a State described in clause (i)
6 that terminates its program under sub-
7 section (d)(2)(B), any waiver or amend-
8 ment which was limited pursuant to sub-
9 paragraph (A) shall cease to be so limited
10 effective with the effective date of such ter-
11 mination.

12 “(D) NONAPPLICATION OF PROVISIONS.—
13 With respect to the design and implementation
14 of Medicaid Flexibility Programs conducted
15 under this section, paragraphs (1), (10)(B),
16 (17), and (23) of section 1902(a), as well as
17 any other provision of this title (except for this
18 section and as otherwise provided by this sec-
19 tion) that the Secretary deems appropriate,
20 shall not apply.

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

22 “(1) MEDICAID FLEXIBILITY PROGRAM.—The
23 term ‘Medicaid Flexibility Program’ means a State
24 program for providing targeted health assistance to

1 program enrollees funded by a block grant under
2 this section.

3 “(2) PROGRAM ENROLLEE.—

4 “(A) IN GENERAL.—The term ‘program
5 enrollee’ means, with respect to a State that is
6 conducting a Medicaid Flexibility Program for
7 a program period, an individual who is a 1903A
8 enrollee (as defined in section 1903A(e)(1)) who
9 is in the 1903A enrollee category described in
10 section 1903A(e)(2)(D).

11 “(B) RULE OF CONSTRUCTION.—For pur-
12 poses of section 1903A(e)(3), eligibility and en-
13 rollment of an individual under a Medicaid
14 Flexibility Program shall be deemed to be eligi-
15 bility and enrollment under a State plan (or
16 waiver of such plan) under this title.

17 “(3) PROGRAM PERIOD.—The term ‘program
18 period’ means, with respect to a State Medicaid
19 Flexibility Program, a period of 5 consecutive fiscal
20 years that begins with either—

21 “(A) the first fiscal year in which the State
22 conducts the program; or

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

1 “(4) STATE.—The term ‘State’ means one of
2 the 50 States or the District of Columbia.

3 “(5) TARGETED HEALTH ASSISTANCE.—The
4 term ‘targeted health assistance’ means assistance
5 for health-care-related items and medical services for
6 program enrollees.”.

7 **SEC. 126. MEDICAID AND CHIP QUALITY PERFORMANCE**
8 **BONUS PAYMENTS.**

9 Section 1903 of the Social Security Act (42 U.S.C.
10 1396b), as previously amended, is further amended by
11 adding at the end the following new subsection:

12 “(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

13 “(1) INCREASED FEDERAL SHARE.—With re-
14 spect to each of fiscal years 2023 through 2026, in
15 the case of one of the 50 States or the District of
16 Columbia (each referred to in this subsection as a
17 ‘State’) that—

18 “(A) equals or exceeds the qualifying
19 amount (as established by the Secretary) of
20 lower than expected aggregate medical assist-
21 ance expenditures (as defined in paragraph (4))
22 for that fiscal year; and

23 “(B) submits to the Secretary, in accord-
24 ance with such manner and format as specified
25 by the Secretary and for the performance pe-

1 riod (as defined by the Secretary) for such fis-
2 cal year—

3 “(i) information on the applicable
4 quality measures identified under para-
5 graph (3) with respect to each category of
6 Medicaid eligible individuals under the
7 State plan or a waiver of such plan; and

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

13 the Federal matching percentage otherwise ap-
14 plied under subsection (a)(7) for such fiscal
15 year shall be increased by such percentage (as
16 determined by the Secretary) so that the aggre-
17 gate amount of the resulting increase pursuant
18 to this subsection for the State and fiscal year
19 does not exceed the State allotment established
20 under paragraph (2) for the State and fiscal
21 year.

22 “(2) ALLOTMENT DETERMINATION.—The Sec-
23 retary shall establish a formula for computing State
24 allotments under this paragraph for each fiscal year
25 described in paragraph (1) such that—

1 “(A) such an allotment to a State is deter-
2 mined based on the performance, including im-
3 provement, of such State under this title and
4 title XXI with respect to the quality measures
5 submitted under paragraph (3) by such State
6 for the performance period (as defined by the
7 Secretary) for such fiscal year; and

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

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

1 quality for different types of patient populations re-
2 ceiving benefits or services under this title or title
3 XXI.

4 “(4) LOWER THAN EXPECTED AGGREGATE
5 MEDICAL ASSISTANCE EXPENDITURES.—In this sub-
6 section, the term ‘lower than expected aggregate
7 medical assistance expenditures’ means, with respect
8 to a State the amount (if any) by which—

9 “(A) the amount of the adjusted total med-
10 ical assistance expenditures for the State and
11 fiscal year determined in section 1903A(b)(1)
12 without regard to the 1903A enrollee category
13 described in section 1903A(e)(2)(E); is less
14 than

15 “(B) the amount of the target total med-
16 ical assistance expenditures for the State and
17 fiscal year determined in section 1903A(c) with-
18 out regard to the 1903A enrollee category de-
19 scribed in section 1903A(e)(2)(E).”.

20 **SEC. 127. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT**
21 **PSYCHIATRIC SERVICES.**

22 (a) STATE OPTION.—Section 1905 of the Social Se-
23 curity Act (42 U.S.C. 1396d) is amended—

24 (1) in subsection (a)—

25 (A) in paragraph (16)—

1 (i) by striking “and, (B)” and insert-
2 ing “(B)”; and

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

10 (B) in the subdivision (B) that follows
11 paragraph (29), by inserting “(other than serv-
12 ices described in subparagraph (C) of para-
13 graph (16) for individuals described in such
14 subparagraph)” after “patient in an institution
15 for mental diseases”; and

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

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

1 “(A) in an institution (or distinct part thereof)
2 which is a psychiatric hospital (as defined in section
3 1861(f)); and

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

8 “(4) As a condition for a State including qualified
9 inpatient psychiatric hospital services as medical assist-
10 ance under subsection (a)(16)(C), the State must (during
11 the period in which it furnishes medical assistance under
12 this title for services and individuals described in such
13 subsection)—

14 “(A) maintain at least the number of licensed
15 beds at psychiatric hospitals owned, operated, or
16 contracted for by the State that were being main-
17 tained as of the date of the enactment of this para-
18 graph or, if higher, as of the date the State applies
19 to the Secretary to include medical assistance under
20 such subsection; and

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

1 chiatric care and treatment provided on an out-
2 patient basis, that is not less than the level of such
3 funding for such services and care as of the date of
4 the enactment of this paragraph or, if higher, as of
5 the date the State applies to the Secretary to include
6 medical assistance under such subsection.”.

7 (b) SPECIAL MATCHING RATE.—Section 1905(b) of
8 the Social Security Act (42 U.S.C. 1395d(b)) is amended
9 by adding at the end the following: “Notwithstanding the
10 previous provisions of this subsection, the Federal medical
11 assistance percentage shall be 50 percent with respect to
12 medical assistance for services and individuals described
13 in subsection (a)(16)(C), except that, in the case of a
14 State for which the Federal medical assistance percentage
15 applicable to such assistance for such services and individ-
16 uals on September 30, 2018, was greater than 50 percent,
17 such greater percentage shall continue to apply with re-
18 spect to medical assistance provided by such State for
19 such services and individuals.”.

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

1 **SEC. 128. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO**
2 **ELIGIBLE INDIANS.**

3 Section 1905(b) of the Social Security Act (42 U.S.C.
4 1396d(b)) is amended, in the third sentence, by inserting
5 “and with respect to amounts expended by a State as med-
6 ical assistance for services provided by any other provider
7 under the State plan to an individual who is a member
8 of an Indian tribe who is eligible for assistance under the
9 State plan” before the period.

10 **SEC. 129. NON-APPLICATION OF DSH CUTS FOR STATES**
11 **WITH LOW MARKET-BASED HEALTH CARE**
12 **GRANT ALLOTMENTS; ONE-TIME DSH ALLOT-**
13 **MENT INCREASE FOR 2026.**

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

17 “(C) LOW-GRANT STATES.—

18 “(i) IN GENERAL.—For each of fiscal
19 years 2021 through 2025, the amount of
20 the reduction specified under subparagraph
21 (B) for a State and fiscal year shall be re-
22 duced by the grant shortfall amount for
23 the State and year.

24 “(ii) ONE-TIME INCREASE FOR FISCAL
25 2026.—

1 “(I) IN GENERAL.—Any State
2 that has a grant shortfall amount for
3 fiscal year 2026 shall be eligible for a
4 one-time increase in the State’s DSH
5 allotment for fiscal year 2026 in the
6 amount described in subclause (II).

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

11 “(aa) the total amount of
12 the reductions specified for the
13 State under subparagraph (B)
14 for each of fiscal years 2018
15 through 2025; minus

16 “(bb) the total amount of
17 any reductions for each of fiscal
18 years 2021 through 2025 under
19 clause (i).

20 “(III) LIMITATION.—The amount
21 of the increase for a State and fiscal
22 year under this clause shall not exceed
23 the grant shortfall amount for the
24 State and year.

1 “(iii) GRANT SHORTFALL AMOUNT
2 DEFINED.—

3 “(I) IN GENERAL.—In this sub-
4 paragraph, the term ‘grant shortfall
5 amount’ means, with respect to a
6 State and a fiscal year, the amount, if
7 any, by which the amount that was al-
8 lotted to the State under section
9 2105(i) for the last calendar year that
10 began before the end of such fiscal
11 year is less than—

12 “(aa) the amount allotted to
13 such State under such section for
14 calendar year 2020; increased by

15 “(bb) the percentage in-
16 crease in the medical care compo-
17 nent of the consumer price index
18 for all urban consumers (U.S.
19 city average) from September of
20 2020 to September of the last
21 calendar year that ended before
22 the fiscal year involved.

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

1 for a State and a fiscal year exceed
2 the amount of the reduction specified
3 under subparagraph (B) for the State
4 and fiscal year.”.

5 **TITLE II**

6 **SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.**

7 Subsection (b) of section 4002 of the Patient Protec-
8 tion and Affordable Care Act (42 U.S.C. 300u–11) is
9 amended—

10 (1) in paragraph (3), by striking “each of fiscal
11 years 2018 and 2019” and inserting “fiscal year
12 2018”; and

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

14 **SEC. 202. COMMUNITY HEALTH CENTER PROGRAM.**

15 Effective as if included in the enactment of the Medi-
16 care Access and CHIP Reauthorization Act of 2015 (Pub-
17 lic Law 114–10, 129 Stat. 87), paragraph (1) of section
18 221(a) of such Act is amended by inserting “, and an ad-
19 ditional \$422,000,000 for fiscal year 2017” after “2017”.

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

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

8 “(4) CONSUMER FREEDOM.—For plan years be-
9 ginning on or after January 1, 2019, paragraph
10 (1)(A) shall not apply with respect to any plan of-
11 fered in the State.”.

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

15 (1) in paragraph (1), by inserting “and includ-
16 ing, with respect to plan years beginning on or after
17 January 1, 2019, enrollees in catastrophic plans de-
18 scribed in section 1302(e)” after “Exchange”; and

19 (2) in paragraph (2), by inserting “and includ-
20 ing, with respect to plan years beginning on or after
21 January 1, 2019, enrollees in catastrophic plans de-
22 scribed in section 1302(e)” after “Exchange”.

23 **SEC. 204. APPLICATION OF ENFORCEMENT PENALTIES.**

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

26 (1) in subsection (a)—

1 (A) in paragraph (1), by inserting “and of
2 section 1303 of the Patient Protection and Af-
3 fordable Care Act” after “this part”; and

4 (B) in paragraph (2), by inserting “or in
5 such section 1303” after “this part”; and

6 (2) in subsection (b)—

7 (A) in paragraphs (1) and (2)(A), by in-
8 serting “or section 1303 of the Patient Protec-
9 tion and Affordable Care Act” after “this part”
10 each place such term appears;

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

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

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

20 (a) IN GENERAL.—Section 1402 of the Patient Pro-
21 tection and Affordable Care Act is repealed.

22 (b) EFFECTIVE DATE.—The repeal made by sub-
23 section (a) shall apply to cost-sharing reductions (and pay-
24 ments to issuers for such reductions) for plan years begin-
25 ning after December 31, 2019.