

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
12 to any taxable year beginning during the

1 period beginning on January 1, 2018, and
2 ending on December 31, 2019.”.

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

4 (a) MODIFICATION OF DEFINITION OF QUALIFIED
5 HEALTH PLAN.—

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

14 (2) EFFECTIVE DATE.—The amendment made
15 by this subsection shall apply to taxable years begin-
16 ning after December 31, 2017.

17 (b) REPEAL.—

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

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

1 **SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CRED-**
2 **IT.**

3 (a) SUNSET.—

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

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

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

13 (b) DISALLOWANCE OF SMALL EMPLOYER HEALTH
14 INSURANCE EXPENSE CREDIT FOR PLAN WHICH IN-
15 CLUDES COVERAGE FOR ABORTION.—

16 (1) IN GENERAL.—Subsection (h) of section
17 45R of the Internal Revenue Code of 1986 is
18 amended—

19 (A) by striking “Any term” and inserting
20 the following:

21 “(1) IN GENERAL.—Any term”, and

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

24 “(2) EXCLUSION OF HEALTH PLANS INCLUDING
25 COVERAGE FOR ABORTION.—The term ‘qualified
26 health plan’ does not include any health plan that

1 includes coverage for abortions (other than any
2 abortion necessary to save the life of the mother or
3 any abortion with respect to a pregnancy that is the
4 result of an act of rape or incest).”.

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

8 **SEC. 104. INDIVIDUAL MANDATE.**

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

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

13 (2) in paragraph (3)—

14 (A) by striking “\$695” in subparagraph

15 (A) and inserting “\$0”, and

16 (B) by striking subparagraph (D).

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

20 **SEC. 105. EMPLOYER MANDATE.**

21 (a) IN GENERAL.—

22 (1) Paragraph (1) of section 4980H(c) of the
23 Internal Revenue Code of 1986 is amended by in-
24 serting “(\$0 in the case of months beginning after
25 December 31, 2015)” after “\$2,000”.

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

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

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

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

13 “(h) SHORT-TERM ASSISTANCE TO ADDRESS COV-
14 ERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT
15 FOR STATES.—

16 “(1) APPROPRIATION.—There are authorized to
17 be appropriated, and are appropriated, out of monies
18 in the Treasury not otherwise obligated,
19 \$10,000,000,000 for calendar year 2019, and
20 \$15,000,000,000 for calendar year 2020, to the Ad-
21 ministrator of the Centers for Medicare & Medicaid
22 Services (in this subsection and subsection (i) re-
23 ferred to as the ‘Administrator’) to fund arrange-
24 ments with health insurance issuers to assist in the
25 purchase of health benefits coverage by addressing

1 coverage and access disruption and responding to
2 urgent health care needs within States. Funds ap-
3 propriated under this paragraph shall remain avail-
4 able until expended.

5 “(2) PARTICIPATION REQUIREMENTS.—

6 “(A) GUIDANCE.—Not later than 30 days
7 after the date of enactment of this subsection,
8 the Administrator shall issue guidance to health
9 insurance issuers regarding how to submit a no-
10 tice of intent to participate in the program es-
11 tablished under this subsection.

12 “(B) NOTICE OF INTENT TO PARTICI-
13 PATE.—To be eligible for funding for a cal-
14 endar year under this subsection, a health in-
15 surance issuer shall submit to the Adminis-
16 trator a notice of intent to participate not later
17 than March 31 of the previous calendar year, in
18 such form and manner as specified by the Ad-
19 ministrator, and containing—

20 “(i) a certification that the health in-
21 surance issuer will use the funds in accord-
22 ance with the requirements of paragraph
23 (4); and

1 “(ii) such information as the Adminis-
2 trator may require to carry out this sub-
3 section.

4 “(3) PROCEDURE FOR DISTRIBUTION OF
5 FUNDS.—The Administrator shall distribute funds
6 under this subsection to States for each of calendar
7 years 2019 and 2020 in the following manner:

8 “(A) 5 percent of the funds appropriated
9 for the year shall distributed to low-density
10 States (as defined in subsection (i)(7)(B)(i)).

11 “(B) 95 percent of the funds appropriated
12 for the year shall be distributed among States
13 that are not low-density States in a manner
14 that takes into account the proportion of each
15 State’s population that are low-income individ-
16 uals (as defined in subsection (i)(5)(H)), based
17 on the most recent data available.

18 “(4) USE OF FUNDS.—Funds provided to a
19 health insurance issuer under paragraph (1) shall be
20 subject to the requirements of paragraphs (1)(A)(iii)
21 and (10) of subsection (i) in the same manner as
22 such requirements apply to States receiving pay-
23 ments under subsection (i) and shall be used only
24 for the activities specified in paragraph (1)(A)(i)(II)
25 of subsection (i).

1 “(i) MARKET-BASED HEALTH CARE GRANT PRO-
2 GRAM.—

3 “(1) APPLICATION AND CERTIFICATION RE-
4 QUIREMENTS.—To be eligible for an allotment of
5 funds under this subsection, a State shall submit to
6 the Administrator an application, not later than
7 March 31, 2019, in the case of allotments for cal-
8 endar year 2020, and not later than March 31 of
9 the previous year, in the case of allotments for any
10 subsequent calendar year) and in such form and
11 manner as specified by the Administrator, that con-
12 tains the following:

13 “(A) A description of how the funds will be
14 used to do 1 or more of the following:

15 “(i) To establish or maintain a pro-
16 gram or mechanism to help high-risk indi-
17 viduals in the purchase of health benefits
18 coverage, including by reducing premium
19 costs for such individuals, who have or are
20 projected to have a high rate of utilization
21 of health services, as measured by cost,
22 and who do not have access to health in-
23 surance coverage offered through an em-
24 ployer, enroll in health insurance coverage
25 under a plan offered in the individual mar-

1 ket (within the meaning of section
2 5000A(f)(1)(C) of the Internal Revenue
3 Code of 1986).

4 “(ii) To establish or maintain a pro-
5 gram to enter into arrangements with
6 health insurance issuers to assist in the
7 purchase of health benefits coverage by
8 stabilizing premiums and promoting State
9 health insurance market participation and
10 choice in plans offered in the individual
11 market (within the meaning of section
12 5000A(f)(1)(C) of the Internal Revenue
13 Code of 1986).

14 “(iii) To provide payments for health
15 care providers for the provision of health
16 care services, as specified by the Adminis-
17 trator.

18 “(iv) To provide health insurance cov-
19 erage by funding assistance to reduce out-
20 of-pocket costs, such as copayments, coin-
21 surance, and deductibles, of individuals en-
22 rolled in plans offered in the individual
23 market (within the meaning of section
24 5000A(f)(1)(C) of the Internal Revenue
25 Code of 1986).

1 “(v) To establish or maintain a pro-
2 gram or mechanism to help individuals
3 purchase health benefits coverage, includ-
4 ing by reducing premium costs for plans
5 offered in the individual market (within
6 the meaning of section 5000A(f)(1)(C) of
7 the Internal Revenue Code of 1986) for in-
8 dividuals who do not have access to health
9 insurance coverage offered through an em-
10 ployer.

11 “(vi) Subject to paragraph (4)(B)(iii)
12 and clause (v), to provide health insurance
13 coverage for individuals who are eligible for
14 medical assistance under a State plan
15 under title XIX by establishing or main-
16 taining relationships with health insurance
17 issuers to provide such coverage.

18 “(vii) Assist in the purchase of health
19 benefits coverage by establishing or main-
20 taining a program or mechanism, as speci-
21 fied by the State, to establish coverage
22 programs through arrangements with man-
23 aged care organizations for the provision of
24 health care services to individuals who are
25 not eligible for medical assistance or child

1 health assistance under the State plans
2 under title XIX or this title.

3 “(B) A description of how the State shall
4 maintain access to adequate and affordable
5 health insurance coverage for individuals with
6 pre-existing conditions.

7 “(C) A certification that the funds pro-
8 vided under this subsection shall only be used
9 for the activities specified in subparagraph (A).

10 “(D) A certification that none of the funds
11 provided under this subsection shall be used by
12 the State for an expenditure that is attributable
13 to an intergovernmental transfer, certified pub-
14 lic expenditure, or any other expenditure to fi-
15 nance the non-Federal share of expenditures re-
16 quired under any provision of law, including
17 under the State plans established under this
18 title and title XIX or under a waiver of such
19 plans.

20 “(E) A certification that the State will en-
21 sure compliance with sections 2714, 2725,
22 2726, 2727, and 2753 of the Public Health
23 Service Act (42 U.S.C. 300gg-14, 300gg-25,
24 300gg-26, 3-00gg-27, 300gg-53), including

1 with respect to any program or mechanism
2 funded by allotments under this subsection.

3 “(F) Such other information as necessary
4 for the Administrator to carry out this sub-
5 section.

6 “(2) ELIGIBILITY.—Only the 50 States and the
7 District of Columbia shall be eligible for an allot-
8 ment and payments under this subsection and all
9 references in this subsection to a State shall be
10 treated as only referring to the 50 States and the
11 District of Columbia.

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

18 “(4) MARKET-BASED HEALTH CARE GRANT AL-
19 LOTMENTS AND PAYMENTS.—

20 “(A) APPROPRIATION.—For the purpose of
21 providing allotments to States under this sub-
22 section, there is appropriated to the Adminis-
23 trator, out of any money in the Treasury not
24 otherwise appropriated—

1 “(i) for calendar year 2020,
2 \$146,000,000,000;

3 “(ii) for calendar year 2021,
4 \$146,000,000,000;

5 “(iii) for calendar year 2022,
6 \$157,000,000,000;

7 “(iv) for calendar year 2023,
8 \$168,000,000,000;

9 “(v) for calendar year 2024,
10 \$179,000,000,000;

11 “(vi) for calendar year 2025,
12 \$190,000,000,000; and

13 “(vii) for calendar year 2026,
14 \$190,000,000,000.

15 “(B) ALLOTMENTS; AVAILABILITY OF AL-
16 LOTMENTS.—

17 “(i) IN GENERAL.—In the case of a
18 State with an application approved under
19 this subsection with respect to a calendar
20 year, the Administrator shall allot to the
21 State for the year, from amounts appro-
22 priated for such year under subparagraph
23 (A), the amount determined for the State
24 and year under paragraph (5).

1 “(ii) AVAILABILITY OF ALLOTMENTS;
2 UNUSED AMOUNTS.—

3 “(I) IN GENERAL.—Amounts al-
4 lotted to a State for a calendar year
5 under this subparagraph shall remain
6 available for obligation by the State
7 through December 31 of the second
8 calendar year following the year for
9 which the allotment is made, except
10 that in no case shall amounts appro-
11 priated for any year before calendar
12 year 2027 remain available for obliga-
13 tion by a State after December 31,
14 2026.

15 “(II) UNUSED AMOUNTS TO BE
16 USED FOR DEFICIT REDUCTION.—
17 Amounts allotted to a State for a cal-
18 endar year that remain unobligated on
19 April 1 of the following year shall be
20 deposited into the general fund of the
21 Treasury and shall be used for deficit
22 reduction

23 “(iii) LIMITATION.—

24 “(I) IN GENERAL.—Subject to
25 subclause (II), in no case may a State

1 use more than 15 percent of the
2 amount allotted to the State for a
3 year under this subparagraph for the
4 purpose described in subclause (VI) of
5 paragraph (1)(A)(i).

6 “(II) EXCEPTION.—The Admin-
7 istrator may permit a State to use not
8 more than 20 percent of the amount
9 allotted to the State for a year under
10 this subparagraph for the purpose de-
11 scribed in subclause (VI) of paragraph
12 (1)(A)(i) if the State submits an ap-
13 plication to waive the restriction in
14 subclause (I) and the Administrator
15 determines that the State is using
16 such amounts allotted to the State to
17 supplement, and not supplant, State
18 expenditures on the State plan under
19 title XIX.

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

22 “(i) IN GENERAL.—Subject to clause
23 (ii)(II), from the amount appropriated for
24 calendar year 2020, \$10,000,000,000 shall
25 be reserved for the purpose of increasing

16

1 State allotments for calendar year 2020
2 under paragraph (8).

3 “(ii) AVAILABILITY OF RESERVED
4 FUNDS.—

5 “(I) IN GENERAL.—Funds re-
6 served under clause (i) shall be avail-
7 able for the purpose described in such
8 clause until December 31, 2020.

9 “(II) AVAILABILITY FOR 2026 AL-
10 LOTMENTS.—To the extent that any
11 funds reserved under clause (i) remain
12 after December 31, 2020, such funds
13 shall be available for making allot-
14 ments to States for calendar year
15 2026.

16 “(D) ANNUAL DISTRIBUTION OF FUNDS
17 TO STATES.—Each calendar year, beginning
18 with calendar year 2020, the Administrator
19 shall distribute funds, from the amount allotted
20 to each State that has an application approved
21 under this subsection for a calendar year, to
22 each such State for the year, in accordance with
23 paragraph (6).

24 “(E) REQUIRED USE OF FUNDS.—Not less
25 than 50 percent of the funds paid to a State

1 under this subsection for a calendar year shall
2 be used by the State to provide assistance (in
3 a manner consistent with the uses described in
4 paragraph (1)(A)) to individuals whose income
5 (as determined under section 1902(e)(14) (re-
6 lating to modified adjusted gross income))
7 equals or exceeds 45 percent but does not ex-
8 ceed 295 percent of the poverty line (as defined
9 in section 2110(e)(5)) applicable to a family of
10 the size involved.

11 “(5) DETERMINATION OF ALLOTMENT
12 AMOUNTS.—

13 “(A) CALENDAR YEAR 2020.—

14 “(i) IN GENERAL.—Subject to clause
15 (v) and the succeeding subparagraphs of
16 this paragraph, the amount determined
17 under this paragraph for a State for cal-
18 endar year 2020 shall be equal to the
19 State’s base period amount, as defined in
20 clause (ii).

21 “(ii) BASE PERIOD AMOUNT.—In this
22 paragraph, the term ‘base period amount’
23 means, with respect to a State, the sum of
24 the following amounts:

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

4 “(aa) that were made to the
5 State during the State’s premium
6 assistance base period (as defined
7 in clause (iii)) for medical assist-
8 ance provided to individuals
9 under clause (i)(VIII) or (ii)(XX)
10 of section 1902(a)(10)(A) (in-
11 cluding medical assistance pro-
12 vided to individuals who are not
13 newly eligible (as defined in sec-
14 tion 1905(y)(2)) individuals de-
15 scribed in subclause (VIII) of
16 section 1902(a)(10)(A)(i)); or

17 “(bb) that would have been
18 made to a State during the
19 State’s premium assistance base
20 period for medical assistance pro-
21 vided to individuals who would
22 have been described in section
23 1902(a)(10)(A)(i)(VIII) (without
24 regard to the first sunset date in
25 such section) but who were pro-

1 vided such assistance under a
2 title XIX State plan waiver that
3 made medical assistance available
4 to all individuals described in
5 such subsection whose income did
6 not exceed 100 percent of the
7 poverty line and that was in ef-
8 fect on September 1, 2017, if
9 such assistance was treated as
10 assistance under such section.

11 “(II) The amount, increased by
12 the State growth factor described in
13 clause (iv)(II), of Federal payments
14 made to the State during the State’s
15 premium assistance base period for
16 operating a Basic Health Program
17 under section 1331 of the Patient
18 Protection and Affordable Care Act
19 during such period.

20 “(III) The amount, increased by
21 the State growth factor described in
22 clause (iv)(II), of advance payments
23 of premium assistance credits allow-
24 able under section 36B of the Internal
25 Revenue Code of 1986 made under

1 section 1412(a) of the Patient Protec-
2 tion and Affordable Care Act during
3 the State’s premium assistance base
4 period on behalf of individuals who
5 purchased insurance through the Ex-
6 change established for or by the State
7 pursuant to title I of such Act.

8 “(IV) The amount, increased by
9 the State growth factor described in
10 clause (iv)(II), of Federal payments
11 for cost-sharing reductions provided
12 during the State’s premium assistance
13 base period under section 1402 of
14 such Act to individuals who purchased
15 insurance through the Exchange es-
16 tablished for or by the State pursuant
17 to title I of such Act.

18 “(iii) PREMIUM ASSISTANCE BASE PE-
19 RIOD.—

20 “(I) IN GENERAL.—In this para-
21 graph, the term ‘premium assistance
22 base period’ means, with respect to a
23 State, a period of 4 consecutive fiscal
24 quarters selected by the State.

21

1 “(II) TIMELINE.—Each State
2 shall submit its selection of a pre-
3 mium assistance base period to the
4 Administrator not later than July 1,
5 2018.

6 “(III) PARAMETERS.—In select-
7 ing a premium assistance base period
8 under this clause, a State shall—

9 “(aa) only select a period of
10 4 consecutive fiscal quarters for
11 which all the data necessary to
12 make determinations required
13 under this paragraph is available,
14 as determined by the Adminis-
15 trator; and

16 “(bb) shall not select any
17 period of 4 consecutive fiscal
18 quarters that begins with a fiscal
19 quarter earlier than the first
20 quarter of fiscal year 2014 or
21 ends with a fiscal quarter later
22 than the first fiscal quarter of
23 2018.

1 “(iv) GROWTH FACTORS.—The growth
2 factor described in this clause for a State
3 is—

4 “(I) for the amount described in
5 subclause (I) of clause (i), the pro-
6 jected percentage increase in Medicaid
7 expenditures from the last month of
8 the State’s premium assistance base
9 period to November of 2019, as deter-
10 mined by the Medicaid and CHIP
11 Payment and Access Commission; and

12 “(II) for the amounts described
13 in subclauses (II), (III), and (IV) of
14 clause (i), the percentage increase in
15 the medical care component of the
16 consumer price index for all urban
17 consumers (U.S. city average) from
18 the last month of the State’s premium
19 assistance base period to November of
20 2019.

21 “(v) HIGH-SPENDING LOW-DENSITY
22 STATE ADJUSTMENT.—In the case of a
23 State that, during its premium assistance
24 base period, is a low-density State (as de-
25 fined in paragraph (7)(B)(i)) and has

1 health care spending per capita that is
2 greater than 20 percent above the mean
3 health care spending per capita for all
4 States, as determined by the Adminis-
5 trator, the Administrator shall increase the
6 base period amount determined for such
7 State under clause (ii) by an amount that
8 is equal to the product of—

9 “(I) the base period amount de-
10 termined for the State under clause
11 (ii); and

12 “(II) the percentage by which the
13 State’s health care spending per cap-
14 ita during the premium assistance
15 base period is greater than the mean
16 health care spending per capita for all
17 States during such period.

18 “(vi) DEADLINE AND CALCULATION
19 OF PRELIMINARY BASE PERIOD AMOUNT.—

20 “(I) IN GENERAL.—The Admin-
21 istrator shall notify each State of its
22 base period amount not later than
23 November 1, 2019.

24 “(II) PRELIMINARY BASE PERIOD
25 AMOUNT.—If the Administrator does

1 not have the data required to make
2 the determinations under this sub-
3 paragraph, the Administrator shall—

4 “(aa) calculate a preliminary
5 base period amount for each
6 State based on the most recent
7 data available;

8 “(bb) notify each State of
9 such preliminary amount by the
10 date specified in subclause (I);
11 and

12 “(cc) shall calculate the base
13 period amount for each State and
14 notify such State of such amount
15 as soon as practicable after the
16 necessary data becomes available.

17 “(B) CALENDAR YEARS 2021 THROUGH
18 2026.—Subject to the succeeding subparagraphs
19 of this paragraph, for each of calendar years
20 2021 through 2026, the amount determined
21 under this paragraph for a State and calendar
22 year shall be equal to—

23 “(i) for calendar year 2021, the sum
24 of—

1 “(I) an amount equal to $\frac{5}{6}$ of
2 the amount determined under this
3 paragraph for the State for calendar
4 year 2020; and

5 “(II) an amount equal to $\frac{1}{6}$ of
6 the low-income population amount (as
7 defined in subparagraph (I)) for the
8 State for calendar year 2021;

9 “(ii) for calendar year 2022, the sum
10 of—

11 “(I) an amount equal to $\frac{4}{6}$ of
12 the amount determined under this
13 paragraph for the State for calendar
14 year 2021; and

15 “(II) an amount equal to $\frac{2}{6}$ of
16 the low-income population amount for
17 the State for calendar year 2022;

18 “(iii) for calendar year 2023, the sum
19 of—

20 “(I) an amount equal to $\frac{3}{6}$ of
21 the amount determined under this
22 paragraph for the State for calendar
23 year 2022; and

1 “(II) an amount equal to $\frac{3}{6}$ of
2 the low-income population amount for
3 the State for calendar year 2023;

4 “(iv) for calendar year 2024, the sum
5 of—

6 “(I) an amount equal to $\frac{2}{6}$ of
7 the amount determined under this
8 paragraph for the State for calendar
9 year 2023; and

10 “(II) an amount equal to $\frac{4}{6}$ of
11 the low-income population amount for
12 the State for calendar year 2024;

13 “(v) for calendar year 2025, the sum
14 of—

15 “(I) an amount equal to $\frac{1}{6}$ of
16 the amount determined under this
17 paragraph for the State for calendar
18 year 2024; and

19 “(II) an amount equal to $\frac{5}{6}$ of
20 the low-income population amount for
21 the State for calendar year 2025; and

22 “(vi) for calendar year 2026, the low-
23 income population amount for the State
24 for calendar year 2026.

25 “(C) POPULATION RISK ADJUSTMENT.—

1 and year under subparagraph (B) by an
2 amount that is greater than 10 percent of
3 the amount so determined.

4 “(iv) NON-APPLICATION DUE TO IN-
5 SUFFICIENT DATA.—If in any calendar
6 year the Administrator determines that
7 there is insufficient data available to make
8 the adjustment under this subparagraph
9 for the year, the Administrator may elect
10 not to make the adjustment for such year.

11 “(D) STATE SPECIFIC POPULATION AD-
12 JUSTMENT FACTOR.—

13 “(i) IN GENERAL.—For calendar
14 years after 2022, the Administrator may
15 adjust the amount determined for a State
16 for a year under subparagraph (B) and ad-
17 justed under subparagraph (C) according
18 to a population adjustment factor devel-
19 oped by the Administrator.

20 “(ii) DEVELOPMENT OF POPULATION
21 ADJUSTMENT FACTOR.—Not later than
22 July 31, 2021, the Administrator shall de-
23 velop a State specific population adjust-
24 ment factor that accounts for legitimate
25 factors that impact the health care expend-

1 itures in a State beyond the clinical char-
2 acteristics of the low-income individuals in
3 the State. Such factors may include State
4 demographics, wage rates, cost of care, in-
5 come levels, and other factors as deter-
6 mined by the Administrator.

7 “(E) 2026 REDUCTION FOR STATES RE-
8 CEIVING ADVANCED PAYMENTS IN 2020.—For
9 calendar year 2026, the amount determined for
10 a State for such year under subparagraph (B)
11 and adjusted under subparagraphs (C) and (D),
12 shall be reduced by the amount of any increase
13 to the State’s allotment for calendar year 2020
14 under paragraph (8).

15 “(F) REDISTRIBUTION OF UNALLOTTED
16 AMOUNTS.—To the extent that the total
17 amount of State allotments determined for a
18 calendar year under this paragraph (after any
19 adjustments under (C), (D), and (E)) is less
20 than the amount appropriated for the year
21 under paragraph (4)(A), the amount of each
22 State’s allotment shall be increased by an
23 amount equal to the product of—

24 “(i) the amount by which such appro-
25 priated amount exceeds the total amount

1 of State allotments determined for the
2 year; and

3 “(ii) the ratio that—

4 “(I) the number of low-income
5 individuals (as defined in subpara-
6 graph (H)) in the State for the year;
7 bears to

8 “(II) the number of low-income
9 individuals in all States for the year.

10 “(G) PRORATION RULES.—

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

21 “(ii) PRORATION.—If the amount so
22 appropriated is less than the total amount
23 of State allotments determined for such
24 year under this paragraph (after any ad-
25 justments under subparagraphs (C), (D),

1 (E), and (F), the amount allotted to each
2 State for such year shall be reduced pro-
3 portionally.

4 “(H) LOW-INCOME INDIVIDUAL.—In this
5 paragraph, the term ‘low-income individual’
6 means an individual—

7 “(i) who is a citizen or legal resident;
8 and

9 “(ii) whose income (as determined
10 under section 1902(e)(14) (relating to
11 modified adjusted gross income)) equals or
12 exceeds 45 percent but does not exceed
13 133 percent of the poverty line (as defined
14 in section 2110(c)(5)) applicable to a fam-
15 ily of the size involved.

16 “(I) LOW-INCOME POPULATION AMOUNT.—
17 The term ‘low-income population amount’
18 means, for a State and calendar year, the prod-
19 uct of—

20 “(i) the amount appropriated for the
21 year under paragraph (4)(A); and

22 “(ii) the ratio that—

23 “(I) the number of low-income
24 individuals (as defined in subpara-
25 graph (H)) in the State for the pre-

1 ceding calendar year (as determined
2 by the Administrator based on the
3 most recent data available); bears to

4 “(II) the number of low-income
5 individuals in all States for such pre-
6 ceding calendar year (as determined
7 by the Administrator based on the
8 most recent data available).

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

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

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

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

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

23 “(K) CLINICAL RISK CATEGORY.—

24 “(i) IN GENERAL.—The term ‘clinical
25 risk category’ means a grouping of low-in-

1 come individuals based on their clinical
2 characteristics that is established by the
3 Administrator under this subparagraph.

4 “(ii) METHODODOLOGY FOR ESTAB-
5 LISHING CATEGORIES AND ASSIGNING IN-
6 DIVIDUALS TO A CATEGORY.—The Admin-
7 istrator shall select a methodology for es-
8 tablishing clinical risk categories and for
9 assigning low-income individuals to such
10 categories, except that any methodology se-
11 lected by the Administrator shall meet the
12 following requirements:

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

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

24 “(III) The methodology shall ac-
25 count for the chronic illness burden

1 associated with multiple comorbid
2 chronic diseases and be composed of
3 risk categories that explicitly differen-
4 tiate individuals based on their sever-
5 ity of illness.

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

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

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

1 that includes enrollees with complex
2 pediatric conditions and enrollees who
3 are eligible for benefits under both ti-
4 tles XVIII and XIX.

5 “(iii) TIMELINE.—

6 “(I) IN GENERAL.—The Admin-
7 istrator shall select the methodology
8 for establishing clinical risk categories
9 and assigning low-income individuals
10 to such categories not later than Jan-
11 uary 1, 2022.

12 “(II) ANNUAL UPDATES.—Not
13 later than 15 days prior to the begin-
14 ning of each calendar year, the Ad-
15 ministrator shall make publicly avail-
16 able updates to the methodology se-
17 lected under subclause (I).

18 “(L) CLINICAL RISK FACTOR.—The term
19 ‘clinical risk factor’ means, with respect to each
20 clinical risk category and calendar year, the
21 ratio of—

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

1 “(ii) the average per capita amount of
2 expenditures for all States for the previous
3 calendar year for all low-income individuals
4 in such category.

5 “(6) PAYMENTS.—

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

14 “(B) ADVANCE PAYMENT; RETROSPECTIVE
15 ADJUSTMENT.—

16 “(i) IN GENERAL.—If the Adminis-
17 trator deems it appropriate, the Adminis-
18 trator shall make payments under this sub-
19 section for each 6 month period in a year
20 on the basis of advance estimates of ex-
21 penditures submitted by the State and
22 such other investigation as the Adminis-
23 trator shall find necessary, and shall re-
24 duce or increase the payments as necessary

1 to adjust for any overpayment or under-
2 payment for prior periods.

3 “(ii) MISUSE OF FUNDS.—If the Ad-
4 ministrator determines that a State is not
5 using funds paid to the State under this
6 subsection in a manner consistent with the
7 description provided by the State in its ap-
8 plication approved under paragraph (1) or
9 is inappropriately withholding payments
10 owed to providers of services or health in-
11 surance issuers, the Administrator may
12 withhold payments, reduce payments, or
13 recover previous payments to the State
14 under this subsection as the Administrator
15 deems appropriate.

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

21 “(7) CONTINGENCY FUND.—

22 “(A) IN GENERAL.—From the amount ap-
23 propriated under subparagraph (C), the Admin-
24 istrator may increase the allotment amount de-
25 termined under paragraph (5) for each of cal-

1 grant amounts for States that are
2 non-expansion States; and

3 “(III) 25 percent of such funds
4 for the purpose of increasing the
5 grant amounts for States that are ex-
6 pansion States.

7 “(8) ADVANCE PAYMENT FUND.—

8 “(A) IN GENERAL.—From the amount re-
9 served under paragraph (4)(C), the Adminis-
10 trator may increase the allotment amount de-
11 termined under paragraph (5) for calendar year
12 2020 for any State that applies for an increase
13 under this paragraph by the amount determined
14 for the State under subparagraph (B).

15 “(B) AMOUNT OF INCREASE.—Subject to
16 subparagraph (C), the Administrator shall in-
17 crease the allotment amount determined under
18 paragraph (5) for a State for calendar year
19 2020 by the amount requested by the State, ex-
20 cept that in no case shall the Administrator in-
21 crease a State’s allotment amount by an
22 amount that exceeds 5 percent of the amount
23 so determined.

24 “(C) PRORATION RULE.—If the amount
25 reserved under paragraph (4)(C) is less than

1 the total amount of increases requested by
2 States under this paragraph, the amount of the
3 increase for each State shall be reduced propor-
4 tionally.

5 “(D) DISREGARD OF INCREASE.—The al-
6 lotment for calendar year 2021 for a State that
7 receives an increase to its allotment for cal-
8 endar year 2020 under this paragraph shall be
9 determined without regard to such increase.

10 “(9) CONTINUED AVAILABILITY OF PASS-
11 THROUGH FUNDING FOR 1332 WAIVERS.—

12 “(A) IN GENERAL.—With respect to any
13 State waiver granted under section 1332 of the
14 Patient Protection and Affordable Care Act be-
15 fore the date of enactment of this subsection,
16 for each year such waiver is in effect that be-
17 gins after December 31, 2019, and before Jan-
18 uary 1, 2024, the Secretary shall make pay-
19 ments under this subsection, from the amount
20 made available under subparagraph (B), to
21 such State in the same manner that the Sec-
22 retary would have made payments to such State
23 under subsection (a)(3) of such section 1332 if
24 section 36B of the Internal Revenue Code of
25 1986, as in effect on the day before the date of

1 enactment of this subsection, were still in ef-
2 fect.

3 “(B) APPROPRIATION.—For the purpose of
4 making the payments to States described in
5 subparagraph (A), there is appropriated to the
6 Secretary, out of any money in the Treasury
7 not otherwise appropriated, \$1,000,000,000 for
8 calendar year 2020, to remain available until
9 December 31, 2023.

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

13 (b) OTHER TITLE XXI AMENDMENTS.—

14 (1) Section 2101 of such Act (42 U.S.C.
15 1397aa) is amended—

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

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

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

9 (3) Section 2106(a)(1) of such Act (42 U.S.C.
10 1397ff(a)(1)) is amended by inserting “subsection
11 (a) or (g) of” before “section 2105”.

12 **SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTA-**
13 **TION FUND.**

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

19 (b) FUNDING.—There is appropriated to the Fund,
20 out of any funds in the Treasury not otherwise appro-
21 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.

1 **SEC. 113. 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. 114. 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. 115. 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. 116. 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. 117. 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. 118. 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 (i), by adding at the end
13 the following new subclause:

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

16 “(aa) are Indians;

17 “(bb) are described in sub-
18 clause (VIII) (without regard to
19 the sunset dates in such sub-
20 clause);

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

25 “(dd) were enrolled under
26 the State plan under this title (or

1 a waiver of such plan) on Decem-
2 ber 31, 2019; and

3 “(ee) after December 31,
4 2019, do not have a break in eli-
5 gibility for medical assistance
6 under the State plan under this
7 title for such a period of time as
8 the State may specify (but which
9 in no case shall be less than 6
10 months);” and

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

16 (2) in section 1905—

17 (A) in subsection (y)(1), by striking the
18 semicolon at the end of subparagraph (D) and
19 all that follows through “thereafter”; and

20 (B) in subsection (z)(2)—

21 (i) in subparagraph (A), by inserting
22 “through 2019” after “each year there-
23 after”; and

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

1 (I) in subclause (V), by striking
2 “2018 is 90” inserting “2018 and
3 2019 is 90 percent”; and

4 (II) in subclause (VI) by striking
5 “2019 and each subsequent year is 90
6 percent” and inserting “2020 and
7 each subsequent year is 0 percent”;

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

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

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

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

20 **SEC. 119. REDUCING STATE MEDICAID COSTS.**

21 (a) IN GENERAL.—

22 (1) STATE PLAN REQUIREMENTS.—Section
23 1902(a)(34) of the Social Security Act (42 U.S.C.
24 1396a(a)(34)) is amended by striking “in or after
25 the third month” and all that follows through “indi-

1 vidual)” and inserting “in or after the second month
2 before the month in which the individual (or, in the
3 case of a deceased individual, another individual act-
4 ing on the individual’s behalf) made application (or,
5 in the case of an individual who is 65 years of age
6 or older or who is eligible for medical assistance
7 under the plan on the basis of being blind or dis-
8 abled, in or after the month before such second
9 month)”.

10 (2) DEFINITION OF MEDICAL ASSISTANCE.—

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

22 (b) EFFECTIVE DATE.—The amendments made by
23 subsection (a) shall apply to medical assistance with re-
24 spect to individuals whose eligibility for such assistance

1 is based on an application for such assistance made (or
2 deemed to be made) on or after October 1, 2017.

3 **SEC. 120. ELIGIBILITY REDETERMINATIONS.**

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

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

22 (b) INCREASED ADMINISTRATIVE MATCHING PER-
23 CENTAGE.—For each calendar quarter during the period
24 beginning on October 1, 2017, and ending on December
25 31, 2019, the Federal matching percentage otherwise ap-

1 plicable under section 1903(a) of the Social Security Act
2 (42 U.S.C. 1396b(a)) with respect to State expenditures
3 during such quarter that are attributable to meeting the
4 requirement of section 1902(e)(14) (relating to determina-
5 tions of eligibility using modified adjusted gross income)
6 of such Act shall be increased by 5 percentage points with
7 respect to State expenditures attributable to activities car-
8 ried out by the State (and approved by the Secretary) to
9 exercise the option described in subparagraph (J) of such
10 section (relating to eligibility redeterminations made on a
11 6-month or shorter basis) (as added by subsection (a)) to
12 increase the frequency of eligibility redeterminations.

13 **SEC. 121. OPTIONAL WORK REQUIREMENT FOR NON-**
14 **DISABLED, NONELDERLY, NONPREGNANT IN-**
15 **DIVIDUALS.**

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

20 “(00) OPTIONAL WORK REQUIREMENT FOR NON-
21 DISABLED, NONELDERLY, NONPREGNANT INDIVID-
22 UALS.—

23 “(1) IN GENERAL.—Beginning October 1,
24 2017, subject to paragraph (3), a State may elect to
25 condition medical assistance to a nondisabled, non-

1 elderly, nonpregnant individual under this title upon
2 such an individual's satisfaction of a work require-
3 ment (as defined in paragraph (2)).

4 “(2) WORK REQUIREMENT DEFINED.—In this
5 section, the term ‘work requirement’ means, with re-
6 spect to an individual, the individual's participation
7 in work activities (as defined in section 407(d)) for
8 such period of time as determined by the State, and
9 as directed and administered by the State.

10 “(3) REQUIRED EXCEPTIONS.—States admin-
11 istering a work requirement under this subsection
12 may not apply such requirement to—

13 “(A) a woman during pregnancy through
14 the end of the month in which the 60-day pe-
15 riod (beginning on the last day of her preg-
16 nancy) ends;

17 “(B) an individual who is under 19 years
18 of age;

19 “(C) an individual who is the only parent
20 or caretaker relative in the family of a child
21 who has not attained 6 years of age or who is
22 the only parent or caretaker of a child with dis-
23 abilities;

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

4 “(i) maintains satisfactory attendance
5 at secondary school or the equivalent; or

6 “(ii) participates in education directly
7 related to employment;

8 “(E) an individual who is a regular partici-
9 pant in an inpatient or intensive outpatient
10 drug addiction or alcoholic treatment and reha-
11 bilitation program that satisfies such criteria as
12 the State shall require; or

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

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

21 “(aa) The Federal matching percentage otherwise ap-
22 plicable under subsection (a) with respect to State admin-
23 istrative expenditures during a calendar quarter for which
24 the State receives payment under such subsection shall,
25 in addition to any other increase to such Federal matching

1 percentage, be increased for such calendar quarter by 5
2 percentage points with respect to State expenditures at-
3 tributable to activities carried out by the State (and ap-
4 proved by the Secretary) to implement subsection (oo) of
5 section 1902.”.

6 **SEC. 122. PROVIDER TAXES.**

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

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

16 “(I) for fiscal year 2021, ‘5.6
17 percent’ shall be substituted for ‘6
18 percent’ each place it appears;

19 “(II) for fiscal year 2022, ‘5.2
20 percent’ shall be substituted for ‘6
21 percent’ each place it appears;

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

1 “(IV) for fiscal year 2024, ‘4.4
2 percent’ shall be substituted for ‘6
3 percent’ each place it appears; and

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

8 **SEC. 123. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-**
9 **ANCE.**

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

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

13 (A) in subsection (a), in the matter before
14 paragraph (1), by inserting “and section
15 1903A(a)” after “except as otherwise provided
16 in this section”; and

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

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

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

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

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

13 “(2) EXCESS AGGREGATE MEDICAL ASSISTANCE
14 EXPENDITURES.—In this subsection, the term ‘ex-
15 cess aggregate medical assistance expenditures’
16 means, for a State for a fiscal year, the amount (if
17 any) by which—

18 “(A) the amount of the adjusted total med-
19 ical assistance expenditures (as defined in sub-
20 section (b)(1)) for the State and fiscal year; ex-
21 ceeds

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

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

5 “(A) the excess aggregate medical assist-
6 ance expenditures (as defined in paragraph (2))
7 for the State for the fiscal year; and

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

11 “(4) FEDERAL AVERAGE MEDICAL ASSISTANCE
12 MATCHING PERCENTAGE.—In this subsection, the
13 term ‘Federal average medical assistance matching
14 percentage’ means, for a State for a fiscal year, the
15 ratio (expressed as a percentage) of—

16 “(A) the amount of the Federal payments
17 that would be made to the State under section
18 1903(a)(1) for medical assistance expenditures
19 for calendar quarters in the fiscal year if para-
20 graph (1) did not apply; to

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

23 “(5) PER CAPITA BASE PERIOD.—

24 “(A) IN GENERAL.—In this section, the
25 term ‘per capita base period’ means, with re-

1 spect to a State, a period of 8 (or, in the case
2 of a State selecting a period under subpara-
3 graph (D), not less than 4) consecutive fiscal
4 quarters selected by the State.

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

8 “(C) PARAMETERS.—In selecting a per
9 capita base period under this paragraph, a
10 State shall—

11 “(i) only select a period of 8 (or, in
12 the case of a State selecting a base period
13 under subparagraph (D), not less than 4)
14 consecutive fiscal quarters for which all the
15 data necessary to make determinations re-
16 quired under this section is available, as
17 determined by the Secretary; and

18 “(ii) shall not select any period of 8
19 (or, in the case of a State selecting a base
20 period under subparagraph (D), not less
21 than 4) consecutive fiscal quarters that be-
22 gins with a fiscal quarter earlier than the
23 first quarter of fiscal year 2014 or ends
24 with a fiscal quarter later than the third
25 fiscal quarter of 2017.

1 “(D) BASE PERIOD FOR LATE-EXPANDING
2 STATES.—

3 “(i) IN GENERAL.—In the case of a
4 State that did not provide for medical as-
5 sistance for the 1903A enrollee category
6 described in subsection (e)(2)(D) as of the
7 first day of the fourth fiscal quarter of fis-
8 cal year 2015 but which provided for such
9 assistance for such category in a subse-
10 quent fiscal quarter that is not later than
11 the fourth quarter of fiscal year 2016, the
12 State may select a per capita base period
13 that is less than 8 consecutive fiscal quar-
14 ters, but in no case shall the period se-
15 lected be less than 4 consecutive fiscal
16 quarters.

17 “(ii) APPLICATION OF OTHER RE-
18 QUIREMENTS.—Except for the requirement
19 that a per capita base period be a period
20 of 8 consecutive fiscal quarters, all other
21 requirements of this paragraph shall apply
22 to a per capita base period selected under
23 this subparagraph.

24 “(iii) APPLICATION OF BASE PERIOD
25 ADJUSTMENTS.—The adjustments to

1 amounts for per capita base periods re-
2 quired under subsections (b)(5) and
3 (d)(4)(E) shall be applied to amounts for
4 per capita base periods selected under this
5 subparagraph by substituting ‘divided by
6 the ratio that the number of quarters in
7 the base period bears to 4’ for ‘divided by
8 2’.

9 “(E) ADJUSTMENT BY THE SECRETARY.—
10 If the Secretary determines that a State took
11 actions after the date of enactment of this sec-
12 tion (including making retroactive adjustments
13 to supplemental payment data in a manner that
14 affects a fiscal quarter in the per capita base
15 period) to diminish the quality of the data from
16 the per capita base period used to make deter-
17 minations under this section, the Secretary may
18 adjust the data as the Secretary deems appro-
19 priate.

20 “(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EX-
21 PENDITURES.—Subject to subsection (g), the following
22 shall apply:

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

1 “(A) for the State’s per capita base period
2 (as defined in subsection (a)(5)), the product
3 of—

4 “(i) the amount of the medical assist-
5 ance expenditures (as defined in paragraph
6 (2) and adjusted under paragraph (5)) for
7 the State and period, reduced by the
8 amount of any excluded expenditures (as
9 defined in paragraph (3) and adjusted
10 under paragraph (5)) for the State and pe-
11 riod otherwise included in such medical as-
12 sistance expenditures; and

13 “(ii) the 1903A base period popu-
14 lation percentage (as defined in paragraph
15 (4)) for the State; or

16 “(B) for fiscal year 2019 or a subsequent
17 fiscal year, the amount of the medical assist-
18 ance expenditures (as defined in paragraph (2))
19 for the State and fiscal year that is attributable
20 to 1903A enrollees, reduced by the amount of
21 any excluded expenditures (as defined in para-
22 graph (3)) for the State and fiscal year other-
23 wise included in such medical assistance ex-
24 penditures and includes non-DSH supplemental
25 payments (as defined in subsection

1 (d)(4)(A)(ii)) and payments described in sub-
2 section (d)(4)(A)(iii) but shall not be construed
3 as including any expenditures attributable to
4 the program under section 1928 (relating to
5 State pediatric vaccine distribution programs).
6 In applying subparagraph (B), non-DSH sup-
7 plemental payments (as defined in subsection
8 (d)(4)(A)(ii)) and payments described in sub-
9 section (d)(4)(A)(iii) shall be treated as fully at-
10 tributable to 1903A enrollees.

11 “(2) MEDICAL ASSISTANCE EXPENDITURES.—
12 In this section, the term ‘medical assistance expendi-
13 tures’ means, for a State and fiscal year or per cap-
14 ita base period, the medical assistance payments as
15 reported by medical service category on the Form
16 CMS-64 quarterly expense report (or successor to
17 such a report form, and including enrollment data
18 and subsequent adjustments to any such report, in
19 this section referred to collectively as a ‘CMS-64 re-
20 port’) for quarters in the year or base period for
21 which payment is (or may otherwise be) made pur-
22 suant to section 1903(a)(1), adjusted, in the case of
23 a per capita base period, under paragraph (5).

24 “(3) EXCLUDED EXPENDITURES.—In this sec-
25 tion, the term ‘excluded expenditures’ means, for a

1 State and fiscal year or per capita base period, ex-
2 penditures under the State plan (or under a waiver
3 of such plan) that are attributable to any of the fol-
4 lowing:

5 “(A) DSH.—Payment adjustments made
6 for disproportionate share hospitals under sec-
7 tion 1923.

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

11 “(C) EXPENDITURES FOR PUBLIC HEALTH
12 EMERGENCIES.—Any expenditures that are sub-
13 ject to a public health emergency exclusion
14 under paragraph (6).

15 “(4) 1903A BASE PERIOD POPULATION PER-
16 CENTAGE.—In this subsection, the term ‘1903A base
17 period population percentage’ means, for a State,
18 the Secretary’s calculation of the percentage of the
19 actual medical assistance expenditures, as reported
20 by the State on the CMS–64 reports for calendar
21 quarters in the State’s per capita base period, that
22 are attributable to 1903A enrollees (as defined in
23 subsection (e)(1)).

24 “(5) ADJUSTMENTS FOR PER CAPITA BASE PE-
25 RIOD.—In calculating medical assistance expendi-

1 tures under paragraph (2) and excluded expendi-
2 tures under paragraph (3) for a State for the State’s
3 per capita base period, the total amount of each type
4 of expenditure for the State and base period shall be
5 divided by 2.

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

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

18 “(i) a public health emergency de-
19 clared by the Secretary pursuant to section
20 319 of the Public Health Service Act ex-
21 isted within the State during such year or
22 portion of a year; and

23 “(ii) the Secretary determines that
24 such an exemption would be appropriate.

1 “(B) MAXIMUM AMOUNT OF ADJUST-
2 MENT.—The amount excluded for a State and
3 fiscal year or portion of a fiscal year under this
4 paragraph shall not exceed the amount by
5 which—

6 “(i) the amount of State expenditures
7 for medical assistance for 1903A enrollees
8 in areas of the State which are subject to
9 a declaration described in subparagraph
10 (A)(i) for the fiscal year or portion of a fis-
11 cal year; exceeds

12 “(ii) the amount of such expenditures
13 for such enrollees in such areas during the
14 most recent fiscal year or portion of a fis-
15 cal year of equal length to the portion of
16 a fiscal year involved during which no such
17 declaration was in effect.

18 “(C) AGGREGATE LIMITATION ON EXCLU-
19 SIONS AND ADDITIONAL BLOCK GRANT PAY-
20 MENTS.—The aggregate amount of expendi-
21 tures excluded under this paragraph and addi-
22 tional payments made under section
23 1903B(c)(3)(E) for the period described in sub-
24 paragraph (A) shall not exceed \$5,000,000,000.

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

14 “(c) TARGET TOTAL MEDICAL ASSISTANCE EXPEND-
15 ITURES.—

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

21 “(A) the target per capita medical assist-
22 ance expenditures (as defined in paragraph (2))
23 for the enrollee category, State, and fiscal year;
24 and

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

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

8 “(A) for fiscal year 2020, an amount equal
9 to—

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

14 “(ii) the applicable annual inflation
15 factor (as defined in paragraph (3)) for
16 fiscal year 2020; and

17 “(B) for each succeeding fiscal year, an
18 amount equal to—

19 “(i) the target per capita medical as-
20 sistance expenditures (under subparagraph
21 (A) or this subparagraph) for the 1903A
22 enrollee category and State for the pre-
23 ceding fiscal year; increased by

24 “(ii) the applicable annual inflation
25 factor for that succeeding fiscal year.

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

4 “(A) for fiscal years before 2025—

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

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

18 “(B) for fiscal years after 2024—

19 “(i) for each of the 1903A enrollee
20 categories described in subparagraphs (C)
21 and (D) of subsection (e)(2), the percent-
22 age increase in the consumer price index
23 for all urban consumers (U.S. city average)
24 from September of the previous fiscal year

1 to September of the fiscal year involved;
2 and

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

11 “(4) ADJUSTMENTS TO STATE EXPENDITURES
12 TARGETS TO PROMOTE PROGRAM EQUITY ACROSS
13 STATES.—

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

21 “(B) ADJUSTMENT BASED ON LEVEL OF
22 PER CAPITA SPENDING FOR 1903A ENROLLEE
23 CATEGORIES.—Subject to subparagraph (C),
24 with respect to a State, fiscal year, and 1903A
25 enrollee category, if the State’s per capita cat-

1 egorical medical assistance expenditures (as de-
2 fined in subparagraph (D)) for the State and
3 category in the preceding fiscal year—

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

15 “(ii) are less than the mean per capita
16 categorical medical assistance expenditures
17 for the category for all States for such pre-
18 ceding year by not less than 25 percent,
19 the State’s target per capita medical as-
20 sistance expenditures for such category for
21 the fiscal year involved shall be increased
22 by a percentage that shall be determined
23 by the Secretary but which shall not be
24 less than 0.5 percent or greater than 3
25 percent.

1 “(C) RULES OF APPLICATION.—

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

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

1 equal such increased target medical assist-
2 ance expenditures.

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

9 “(iv) APPLICATION FOR FISCAL YEARS
10 2020 AND 2021.—In fiscal years 2020 and
11 2021, the Secretary shall apply this para-
12 graph by deeming all categories of 1903A
13 enrollees to be a single category.

14 “(D) PER CAPITA CATEGORICAL MEDICAL
15 ASSISTANCE EXPENDITURES.—

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

21 “(I) the categorical medical ex-
22 penditures (as defined in clause (ii))
23 for the State, category, and year; di-
24 vided by

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

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

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

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

24 “(A) The amount of the adjusted total
25 medical assistance expenditures (as defined in

1 subsection (b)(1)) for the State for the State's
2 per capita base period.

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

6 “(C) The average per capita medical as-
7 sistance expenditures for the State for the
8 State's per capita base period equal to—

9 “(i) the amount calculated under sub-
10 paragraph (A); divided by

11 “(ii) the number calculated under sub-
12 paragraph (B).

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

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

23 “(B) the percentage increase in the med-
24 ical care component of the consumer price index
25 for all urban consumers (U.S. city average)

1 from the last month of the State's per capita
2 base period to September of fiscal year 2019.

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

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

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

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

19 “(A)(i) For each 1903A enrollee category,
20 the amount of the adjusted total medical assist-
21 ance expenditures (as defined in subsection
22 (b)(1)) for the State for fiscal year 2019 for in-
23 dividuals in the enrollee category, calculated by
24 excluding from medical assistance expenditures
25 those expenditures attributable to expenditures

1 described in clause (iii) or non-DSH supple-
2 mental expenditures (as defined in clause (ii)).

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

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

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

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

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

21 “(iii) An expenditure described in this
22 clause is an expenditure that meets the criteria
23 specified in subclauses (I), (II), and (III) of
24 clause (ii) and is authorized under section 1115
25 for the purposes of funding a delivery system

1 reform pool, uncompensated care pool, a des-
2 ignated State health program, or any other
3 similar expenditure (as defined by the Sec-
4 retary).

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

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

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

20 “(ii) the amount described in sub-
21 section (b)(1)(A) for the State for the
22 State’s per capita base period.

23 “(D) For each 1903A enrollee category an
24 average medical assistance expenditures per

1 capita for the State for fiscal year 2019 for the
2 enrollee category equal to—

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

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

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

20 “(5) PROVISIONAL FY19 PER CAPITA TARGET
21 AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—

22 Subject to subsection (f)(2), the Secretary shall cal-
23 culate for each State a provisional FY19 per capita
24 target amount for each 1903A enrollee category
25 equal to the average medical assistance expenditures

1 per capita for the State for fiscal year 2019 (as cal-
2 culated under paragraph (4)(D)) for such enrollee
3 category multiplied by the ratio of—

4 “(A) the product of—

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

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

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

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

18 “(1) 1903A ENROLLEE.—The term ‘1903A en-
19 rollee’ means, with respect to a State and a month
20 and subject to subsection (i)(1)(B), any Medicaid
21 enrollee (as defined in paragraph (3)) for the month,
22 other than such an enrollee who for such month is
23 in any of the following categories of excluded indi-
24 viduals:

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

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

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

14 “(D) PARTIAL-BENEFIT ENROLLEES.—An
15 individual who—

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

19 “(ii) is eligible for medical assistance
20 under this title only on the basis of sub-
21 clause (XII) or (XXI) of section
22 1902(a)(10)(A)(ii) (or on the basis of a
23 waiver that provides only comparable bene-
24 fits);

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

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

15 “(E) BLIND AND DISABLED CHILDREN.—

16 An individual who—

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

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

22 “(2) 1903A ENROLLEE CATEGORY.—The term
23 ‘1903A enrollee category’ means each of the fol-
24 lowing:

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

3 “(B) BLIND AND DISABLED.—A category
4 of 1903A enrollees (not described in the pre-
5 vious subparagraph) who—

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

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

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

13 “(D) OTHER NONELDERLY, NONDISABLED,
14 NON-EXPANSION ADULTS.—A category of
15 1903A enrollees who are not described in any
16 previous subparagraph.

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

23 “(4) DETERMINATION OF NUMBER OF 1903A
24 ENROLLEES.—The number of 1903A enrollees for a
25 State and fiscal year or the State’s per capita base

1 period, and, if applicable, for a 1903A enrollee cat-
2 egory, is the average monthly number of Medicaid
3 enrollees for such State and fiscal year or base pe-
4 riod (and, if applicable, in such category) that are
5 reported through the CMS–64 report under (and
6 subject to audit under) subsection (h).

7 “(f) SPECIAL PAYMENT RULES.—

8 “(1) APPLICATION IN CASE OF RESEARCH AND
9 DEMONSTRATION PROJECTS AND OTHER WAIVERS.—

10 In the case of a State with a waiver of the State
11 plan approved under section 1115, section 1915, or
12 another provision of this title, this section shall
13 apply to medical assistance expenditures and medical
14 assistance payments under the waiver, in the same
15 manner as if such expenditures and payments had
16 been made under a State plan under this title and
17 the limitations on expenditures under this section
18 shall supersede any other payment limitations or
19 provisions (including limitations based on a per cap-
20 ita limitation) otherwise applicable under such a
21 waiver.

22 “(2) IN CASE OF STATE FAILURE TO REPORT
23 NECESSARY DATA.—If a State for any quarter in a
24 fiscal year (beginning with fiscal year 2019) fails to
25 satisfactorily submit data on expenditures and en-

1 rollees in accordance with subsection (h)(1), for such
2 fiscal year and any succeeding fiscal year for which
3 such data are not satisfactorily submitted—

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

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

13 “(g) RECALCULATION OF CERTAIN AMOUNTS FOR
14 DATA ERRORS.—The amounts and percentage calculated
15 under paragraphs (1) and (4)(C) of subsection (d) for a
16 State for the State’s per capita base period, and the
17 amounts of the adjusted total medical assistance expendi-
18 tures calculated under subsection (b) and the number of
19 Medicaid enrollees and 1903A enrollees determined under
20 subsection (e)(4) for a State for the State’s per capita
21 base period, fiscal year 2019, and any subsequent fiscal
22 year, may be adjusted by the Secretary based upon an ap-
23 peal (filed by the State in such a form, manner, and time,
24 and containing such information relating to data errors
25 that support such appeal, as the Secretary specifies) that

1 the Secretary determines to be valid, except that any ad-
2 justment by the Secretary under this subsection for a
3 State may not result in an increase of the target total
4 medical assistance expenditures exceeding 2 percent.

5 “(h) REQUIRED REPORTING AND AUDITING; TRANSI-
6 TIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE
7 FOR CERTAIN ADMINISTRATIVE EXPENSES.—

8 “(1) REPORTING OF CMS-64 DATA.—

9 “(A) IN GENERAL.—In addition to the
10 data required on form Group VIII on the CMS-
11 64 report form as of January 1, 2017, in each
12 CMS-64 report required to be submitted (for
13 each quarter beginning on or after October 1,
14 2018), the State shall include data on medical
15 assistance expenditures within such categories
16 of services and categories of enrollees (including
17 each 1903A enrollee category and each category
18 of excluded individuals under subsection (e)(1))
19 and the numbers of enrollees within each of
20 such enrollee categories, as the Secretary deter-
21 mines are necessary (including timely guidance
22 published as soon as possible after the date of
23 the enactment of this section) in order to imple-
24 ment this section and to enable States to com-

1 ply with the requirement of this paragraph on
2 a timely basis.

3 “(B) REPORTING ON QUALIFIED INPA-
4 TIENT PSYCHIATRIC HOSPITAL SERVICES.—Not
5 later than 60 days after the date of the enact-
6 ment of this section, the Secretary shall modify
7 the CMS–64 report form to require that States
8 submit data with respect to medical assistance
9 expenditures for qualified inpatient psychiatric
10 hospital services (as defined in section
11 1905(h)(3)).

12 “(C) REPORTING ON CHILDREN WITH
13 COMPLEX MEDICAL CONDITIONS.—Not later
14 than January 1, 2020, the Secretary shall mod-
15 ify the CMS–64 report form to require that
16 States submit data with respect to individuals
17 who—

18 “(i) are enrolled in a State plan under
19 this title or title XXI or under a waiver of
20 such plan;

21 “(ii) are under 21 years of age; and

22 “(iii) have a chronic medical condition
23 or serious injury that—

24 “(I) affects two or more body
25 systems;

1 “(II) affects cognitive or physical
2 functioning (such as reducing the abil-
3 ity to perform the activities of daily
4 living, including the ability to engage
5 in movement or mobility, eat, drink,
6 communicate, or breathe independ-
7 ently); and

8 “(III) either—

9 “(aa) requires intensive
10 healthcare interventions (such as
11 multiple medications, therapies,
12 or durable medical equipment)
13 and intensive care coordination to
14 optimize health and avoid hos-
15 pitalizations or emergency de-
16 partment visits; or

17 “(bb) meets the criteria for
18 medical complexity under existing
19 risk adjustment methodologies
20 using a recognized, publicly avail-
21 able pediatric grouping system
22 (such as the pediatric complex
23 conditions classification system
24 or the Pediatric Medical Com-
25 plexity Algorithm) selected by the

1 Secretary in close collaboration
2 with the State agencies respon-
3 sible for administering State
4 plans under this title and a na-
5 tional panel of pediatric, pedi-
6 atric specialty, and pediatric sub-
7 specialty experts.

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

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

22 “(4) TEMPORARY INCREASE IN FEDERAL
23 MATCHING PERCENTAGE TO SUPPORT IMPROVED
24 DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018
25 AND 2019.—In the case of any State that selects as

1 its per capita base period the most recent 8 consecu-
2 tive quarter period for which the data necessary to
3 make the determinations required under this section
4 is available, for amounts expended during calendar
5 quarters beginning on or after October 1, 2017, and
6 before October 1, 2019—

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

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

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

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

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

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

25 “(i) is less than—

1 “(I) the amount allotted to such
2 State under such section for calendar
3 year 2020; increased by

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

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

18 “(C) for each fiscal year after fiscal year
19 2020, to which subsection (a) did not apply for
20 the previous fiscal year as a result of the appli-
21 cation of this subsection.

22 “(2) APPLICATION OF PER CAPITA CAP AFTER
23 DELAY.—If a State to which subsection (a) does not
24 apply for a fiscal year as a result of the application

1 of this subsection is not described in paragraph (1)
2 in any subsequent fiscal year, subsection (a)—

3 “(A) shall apply to such State effective
4 with the first day of such subsequent fiscal
5 year; and

6 “(B) shall be applied as if it had applied
7 to the State from the first day of fiscal year
8 2020.”.

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

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

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish a demonstration project (referred to in this sub-
17 section as the ‘demonstration project’) under which
18 eligible States may make HCBS payment adjust-
19 ments for the purpose of continuing to provide and
20 improving the quality of home and community-based
21 services provided under a waiver under subsection
22 (c) or (d) or a State plan amendment under sub-
23 section (i).

24 “(2) SELECTION OF ELIGIBLE STATES.—

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

6 “(i) an assurance that any HCBS
7 payment adjustment made by the State
8 under this subsection will comply with the
9 health and welfare and financial account-
10 ability safeguards taken by the State under
11 subsection (c)(2)(A); and

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

14 “(B) SELECTION.—The Secretary shall se-
15 lect States to participate in the demonstration
16 project on a competitive basis except that, in
17 making selections under this paragraph, the
18 Secretary shall give priority to any State that
19 is one of the 15 States in the United States
20 with the lowest population density, as deter-
21 mined by the Secretary based on data from the
22 Bureau of the Census.

23 “(3) TERM OF DEMONSTRATION PROJECT.—
24 The demonstration project shall be conducted for the

1 4-year period beginning on January 1, 2020, and
2 ending on December 31, 2023.

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

5 “(A) IN GENERAL.—

6 “(i) ANNUAL ALLOTMENT.—Subject
7 to clause (ii), for each year of the dem-
8 onstration project, the Secretary shall allot
9 an amount to each State that is an eligible
10 State for the year.

11 “(ii) LIMITATION ON FEDERAL
12 SPENDING.—The aggregate amount that
13 may be allotted to eligible States under
14 clause (i) for all years of the demonstra-
15 tion project shall not exceed
16 \$8,000,000,000, and in no case may the
17 aggregate amount of payments made by
18 the Secretary to eligible States for pay-
19 ment adjustments under this subsection
20 exceed such amount.

21 “(B) FMAP APPLICABLE TO HCBS PAY-
22 MENT ADJUSTMENTS.—For each year of the
23 demonstration project, notwithstanding section
24 1905(b) but subject to the limitations described
25 in subparagraph (C), the Federal medical as-

1 sistance percentage applicable with respect to
2 expenditures by an eligible State that are at-
3 tributable to HCBS payment adjustments shall
4 be equal to (and shall in no case exceed) 100
5 percent.

6 “(C) INDIVIDUAL PROVIDER AND ALLOT-
7 MENT LIMITATIONS.—Payment under section
8 1903(a) shall not be made to an eligible State
9 for expenditures for a year that are attributable
10 to an HCBS payment adjustment—

11 “(i) that is paid to a single provider
12 and exceeds a percentage which shall be
13 established by the Secretary of the pay-
14 ment otherwise made to the provider; or

15 “(ii) to the extent that the aggregate
16 amount of HCBS payment adjustments
17 made by the State in the year exceeds the
18 amount allotted to the State for the year
19 under clause (i).

20 “(5) REPORTING AND EVALUATION.—

21 “(A) IN GENERAL.—As a condition of re-
22 ceiving the increased Federal medical assistance
23 percentage described in paragraph (4)(B), each
24 eligible State shall collect and report informa-
25 tion, as determined necessary by the Secretary,

1 for the purposes of providing Federal oversight
2 and evaluating the State’s compliance with the
3 health and welfare and financial accountability
4 safeguards taken by the State under subsection
5 (c)(2)(A).

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

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

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

13 “(i) is one of the 50 States or the
14 District of Columbia;

15 “(ii) has in effect—

16 “(I) a waiver under subsection
17 (c) or (d); or

18 “(II) a State plan amendment
19 under subsection (i);

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

22 “(iv) is selected by the Secretary to
23 participate in the demonstration project.

24 “(B) HCBS PAYMENT ADJUSTMENT.—The
25 term ‘HCBS payment adjustment’ means a

1 payment adjustment made by an eligible State
2 to the amount of payment otherwise provided
3 under a waiver under subsection (c) or (d) or
4 a State plan amendment under subsection (i)
5 for a home and community-based service which
6 is provided to a 1903A enrollee (as defined in
7 section 1903A(e)(1)) who is in the enrollee cat-
8 egory described in subparagraph (A) or (B) of
9 section 1903A(e)(2).”.

10 **SEC. 124. FLEXIBLE BLOCK GRANT OPTION FOR STATES.**

11 Title XIX of the Social Security Act, as previously
12 amended, is further amended by inserting after section
13 1903A the following new section:

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

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

20 “(b) STATE APPLICATION.—

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

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

4 “(A) A description of the proposed Med-
5 icaid Flexibility Program and how the State will
6 satisfy the requirements described in subsection
7 (d).

8 “(B) The proposed conditions for eligibility
9 of program enrollees.

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

18 “(D) A description of how the State will
19 notify individuals currently enrolled in the State
20 plan for medical assistance under this title of
21 the transition to such program.

22 “(E) Statements certifying that the State
23 agrees to—

24 “(i) submit regular enrollment data
25 with respect to the program to the Centers

1 for Medicare & Medicaid Services at such
2 time and in such manner as the Secretary
3 may require;

4 “(ii) submit timely and accurate data
5 to the Transformed Medicaid Statistical
6 Information System (T-MSIS);

7 “(iii) report annually to the Secretary
8 on adult health quality measures imple-
9 mented under the program and informa-
10 tion on the quality of health care furnished
11 to program enrollees under the program as
12 part of the annual report required under
13 section 1139B(d)(1);

14 “(iv) submit such additional data and
15 information not described in any of the
16 preceding clauses of this subparagraph but
17 which the Secretary determines is nec-
18 essary for monitoring, evaluation, or pro-
19 gram integrity purposes, including—

20 “(I) survey data, such as the
21 data from Consumer Assessment of
22 Healthcare Providers and Systems
23 (CAHPS) surveys;

24 “(II) birth certificate data; and

1 “(H) Such other information as the Sec-
2 retary may require.

3 “(3) STATE NOTICE AND COMMENT PERIOD.—

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

8 “(B) NOTICE AND COMMENT PROCESS.—

9 During the notice and comment period de-
10 scribed in subparagraph (A), the State shall
11 provide opportunities for a meaningful level of
12 public input, which shall include public hearings
13 on the proposed Medicaid Flexibility Program.

14 “(4) FEDERAL NOTICE AND COMMENT PE-
15 RIOD.—The Secretary shall not approve of any ap-
16 plication to conduct a Medicaid Flexibility Program
17 without making such application publicly available
18 for a 30 day notice and comment period.

19 “(5) TIMELINE FOR SUBMISSION.—

20 “(A) IN GENERAL.—A State may submit
21 an application under this subsection to conduct
22 a Medicaid Flexibility Program that would
23 begin in the next fiscal year at any time, sub-
24 ject to subparagraph (B).

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

10 “(c) FINANCING.—

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

17 “(2) AMOUNT OF BLOCK GRANT FUNDS.—

18 “(A) IN GENERAL.—The block grant
19 amount under this paragraph for a State and
20 year shall be equal to the amount determined
21 under subparagraph (B) for the State and year.

22 “(B) ENROLLEE CATEGORY AMOUNTS.—

23 “(i) FOR INITIAL YEAR.—Subject to
24 subparagraph (C), for the first fiscal year
25 in which a Medicaid Flexibility Program is

1 conducted by a State, the amount deter-
2 mined under this subparagraph for the
3 State and year shall be equal to the Fed-
4 eral average medical assistance matching
5 percentage (as defined in section
6 1903A(a)(4)) for the State and year multi-
7 plied by the product of—

8 “(I) the target per capita medical
9 assistance expenditures (as defined in
10 section 1903A(c)(2)) for the State
11 and year; and

12 “(II) the number of 1903A en-
13 rollees in the category described in
14 section 1903A(e)(2)(D) for the State
15 for the second fiscal year preceding
16 such first fiscal year, increased by the
17 percentage increase in State popu-
18 lation from such second preceding fis-
19 cal year to such first fiscal year, based
20 on the best available estimates of the
21 Bureau of the Census.

22 “(ii) FOR ANY SUBSEQUENT YEAR.—
23 For any fiscal year that is not the first fis-
24 cal year in which a Medicaid Flexibility
25 Program is conducted by the State, the

1 block grant amount under this paragraph
2 for the State and year shall be equal to the
3 amount determined for the State for the
4 most recent previous fiscal year in which
5 the State conducted a Medicaid Flexibility
6 Program, except that such amount shall be
7 increased by the percentage increase in the
8 consumer price index for all urban con-
9 sumers (U.S. city average) from April of
10 the second fiscal year preceding the fiscal
11 year involved to April of the fiscal year
12 preceding the fiscal year involved.

13 “(C) CAP ON TOTAL POPULATION OF 1903A
14 ENROLLEES FOR PURPOSES OF BLOCK GRANT
15 CALCULATION.—

16 “(i) IN GENERAL.—In calculating the
17 amount of a block grant for the first year
18 in which a Medicaid Flexibility Program is
19 conducted by the State under subpara-
20 graph (B)(i), the total number of 1903A
21 enrollees in the category described in sec-
22 tion 1903A(e)(2)(D) for the State and
23 year shall not exceed the adjusted number
24 of base period enrollees for the State (as
25 defined in clause (ii)).

1 “(ii) ADJUSTED NUMBER OF BASE PE-
2 RIOD ENROLLEES.—The term ‘adjusted
3 number of base period enrollees’ means,
4 with respect to a State, the number of
5 1903A enrollees in the enrollee category
6 described in section 1903A(e)(2)(D) for
7 the State for the State’s per capita base
8 period (as determined under section
9 1903A(e)(4)), increased by the percentage
10 increase, if any, in the total State popu-
11 lation from the last April in the State’s per
12 capita base period to April of the fiscal
13 year preceding the fiscal year involved (de-
14 termined using the best available data
15 from the Bureau of the Census) plus 3
16 percentage points.

17 “(3) FEDERAL PAYMENT AND STATE MAINTEN-
18 NANCE OF EFFORT.—

19 “(A) FEDERAL PAYMENT.—Subject to sub-
20 paragraphs (D) and (E), the Secretary shall
21 pay to each State conducting a Medicaid Flexi-
22 bility Program under this section for a fiscal
23 year, from its block grant amount under para-
24 graph (2) for such year, an amount for each
25 quarter of such year equal to the Federal aver-

1 age medical assistance percentage (as defined in
2 section 1903A(a)(4)) of the total amount ex-
3 pended under the program during such quarter
4 as targeted health assistance, and the State is
5 responsible for the balance of the funds to carry
6 out such program.

7 “(B) STATE MAINTENANCE OF EFFORT
8 EXPENDITURES.—For each year during which a
9 State is conducting a Medicaid Flexibility Pro-
10 gram, the State shall make expenditures for
11 targeted health assistance under the program in
12 an amount equal to the product of—

13 “(i) the block grant amount deter-
14 mined for the State and year under para-
15 graph (2); and

16 “(ii) the enhanced FMAP described in
17 the first sentence of section 2105(b) for
18 the State and year.

19 “(C) REDUCTION IN BLOCK GRANT
20 AMOUNT FOR STATES FAILING TO MEET MOE
21 REQUIREMENT.—

22 “(i) IN GENERAL.—In the case of a
23 State conducting a Medicaid Flexibility
24 Program that makes expenditures for tar-
25 geted health assistance under the program

1 for a fiscal year in an amount that is less
2 than the required amount for the fiscal
3 year under subparagraph (B), the amount
4 of the block grant determined for the State
5 under paragraph (2) for the succeeding fis-
6 cal year shall be reduced by the amount by
7 which such expenditures are less than such
8 required amount.

9 “(ii) DISREGARD OF REDUCTION.—

10 For purposes of determining the amount of
11 a State block grant under paragraph (2),
12 any reduction made under this subpara-
13 graph to a State’s block grant amount in
14 a previous fiscal year shall be disregarded.

15 “(iii) APPLICATION TO STATES THAT

16 TERMINATE PROGRAM.—In the case of a
17 State described in clause (i) that termi-
18 nates the State Medicaid Flexibility Pro-
19 gram under subsection (d)(2)(B) and such
20 termination is effective with the end of the
21 fiscal year in which the State fails to make
22 the required amount of expenditures under
23 subparagraph (B), the reduction amount
24 determined for the State and succeeding

1 fiscal year under clause (i) shall be treated
2 as an overpayment under this title.

3 “(D) REDUCTION FOR NONCOMPLIANCE.—

4 If the Secretary determines that a State con-
5 ducting a Medicaid Flexibility Program is not
6 complying with the requirements of this section,
7 the Secretary may withhold payments, reduce
8 payments, or recover previous payments to the
9 State under this section as the Secretary deems
10 appropriate.

11 “(E) ADDITIONAL FEDERAL PAYMENTS
12 DURING PUBLIC HEALTH EMERGENCY.—

13 “(i) IN GENERAL.—In the case of a
14 State and fiscal year or portion of a fiscal
15 year for which the Secretary has excluded
16 expenditures under section 1903A(b)(6), if
17 the State has uncompensated targeted
18 health assistance expenditures for the year
19 or portion of a year, the Secretary may
20 make an additional payment to such State
21 equal to the Federal average medical as-
22 sistance percentage (as defined in section
23 1903A(a)(4)) for the year or portion of a
24 year of the amount of such uncompensated
25 targeted health assistance expenditures, ex-

1 cept that the amount of such payment
2 shall not exceed the amount determined for
3 the State and year or portion of a year
4 under clause (ii).

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

14 “(I) the amount of State expend-
15 itures for targeted health assistance
16 for program enrollees in areas of the
17 State which are subject to a declara-
18 tion described in section
19 1903A(b)(6)(A)(i) for the year or por-
20 tion of a year; exceeds

21 “(II) the amount of such expend-
22 itures for such enrollees in such areas
23 during the most recent fiscal year in-
24 volved (or portion of a fiscal year of
25 equal length to the portion of a fiscal

1 year involved) during which no such
2 declaration was in effect.

3 “(iii) UNCOMPENSATED TARGETED
4 HEALTH ASSISTANCE.—In this subpara-
5 graph, the term ‘uncompensated targeted
6 health assistance expenditures’ means,
7 with respect to a State and fiscal year or
8 portion of a fiscal year, an amount equal
9 to the amount (if any) by which—

10 “(I) the total amount expended
11 by the State under the program for
12 targeted health assistance for the year
13 or portion of a year; exceeds

14 “(II) the amount equal to the
15 amount of the block grant (reduced,
16 in the case of a portion of a year, to
17 the same proportion of the full block
18 grant amount that the portion of the
19 year bears to the whole year) divided
20 by the Federal average medical assist-
21 ance percentage for the year or por-
22 tion of a year.

23 “(iv) REVIEW.—If the Secretary
24 makes a payment to a State for a fiscal
25 year or portion of a fiscal year, the Sec-

1 retary shall, not later than 6 months after
2 the declaration described in section
3 1903A(b)(6)(A)(i) ceases to be in effect,
4 conduct an audit of the State’s targeted
5 health assistance expenditures for program
6 enrollees during the year or portion of a
7 year to ensure that all of the expenditures
8 for which the additional payment was
9 made were made for the purpose of ensur-
10 ing that the health care needs of program
11 enrollees in areas affected by a public
12 health emergency are met.

13 “(4) DETERMINATION AND PUBLICATION OF
14 BLOCK GRANT AMOUNT.—Beginning in 2019 and
15 each year thereafter, the Secretary shall determine
16 for each State, regardless of whether the State is
17 conducting a Medicaid Flexibility Program or has
18 submitted an application to conduct such a program,
19 the amount of the block grant for the State under
20 paragraph (2) which would apply for the upcoming
21 fiscal year if the State were to conduct such a pro-
22 gram in such fiscal year, and shall publish such de-
23 terminations not later than June 1 of each year.

24 “(d) PROGRAM REQUIREMENTS.—

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

5 “(2) TERM OF PROGRAM.—

6 “(A) IN GENERAL.—A State Medicaid
7 Flexibility Program approved under subsection
8 (b)—

9 “(i) shall be conducted for not less
10 than 1 program period;

11 “(ii) at the option of the State, may
12 be continued for succeeding program peri-
13 ods without resubmitting an application
14 under subsection (b), provided that—

15 “(I) the State provides notice to
16 the Secretary of its decision to con-
17 tinue the program; and

18 “(II) no significant changes are
19 made to the program; and

20 “(iii) shall be subject to termination
21 only by the State, which may terminate the
22 program by making an election under sub-
23 paragraph (B).

24 “(B) ELECTION TO TERMINATE PRO-
25 GRAM.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), a State conducting a Medicaid Flexi-
3 bility Program may elect to terminate the
4 program effective with the first day after
5 the end of the program period in which the
6 State makes the election.

7 “(ii) TRANSITION PLAN REQUIRE-
8 MENT.—A State may not elect to termi-
9 nate a Medicaid Flexibility Program unless
10 the State has in place an appropriate tran-
11 sition plan approved by the Secretary.

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

20 “(3) PROVISION OF TARGETED HEALTH ASSIST-
21 ANCE.—

22 “(A) IN GENERAL.—A State Medicaid
23 Flexibility Program shall provide targeted
24 health assistance to program enrollees and such
25 assistance shall be instead of medical assistance

1 which would otherwise be provided to the enroll-
2 ees under this title.

3 “(B) CONDITIONS FOR ELIGIBILITY.—

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

14 “(ii) MAGI.—Any determination of
15 income necessary to establish the eligibility
16 of a program enrollee for purposes of a
17 State Medicaid Flexibility Program shall
18 be made using modified adjusted gross in-
19 come in accordance with section
20 1902(e)(14).

21 “(4) BENEFITS AND SERVICES.—

22 “(A) REQUIRED SERVICES.—In the case of
23 program enrollees to whom the State would oth-
24 erwise be required to make medical assistance
25 available under section 1902(a)(10)(A)(i), a

1 State conducting a Medicaid Flexibility Pro-
2 gram shall provide as targeted health assistance
3 the following types of services:

4 “(i) Inpatient and outpatient hospital
5 services.

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

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

9 “(iv) Physician services.

10 “(v) Home health care services (in-
11 cluding home nursing services, medical
12 supplies, equipment, and appliances).

13 “(vi) Rural health clinic services (as
14 defined in section 1905(1)(1)).

15 “(vii) Federally-qualified health center
16 services (as defined in section 1905(1)(2)).

17 “(viii) Family planning services and
18 supplies.

19 “(ix) Nurse midwife services.

20 “(x) Certified pediatric and family
21 nurse practitioner services.

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

24 “(xii) Emergency medical transpor-
25 tation.

1 “(xiii) Non-cosmetic dental services.

2 “(xiv) Pregnancy-related services, in-
3 cluding postpartum services for the 12-
4 week period beginning on the last day of a
5 pregnancy.

6 “(B) OPTIONAL BENEFITS.—A State may,
7 at its option, provide services in addition to the
8 services described in subparagraph (A) as tar-
9 geted health assistance under a Medicaid Flexi-
10 bility Program.

11 “(C) BENEFIT PACKAGES.—

12 “(i) IN GENERAL.—The targeted
13 health assistance provided by a State to
14 any group of program enrollees under a
15 Medicaid Flexibility Program shall have an
16 aggregate actuarial value that is equal to
17 at least 95 percent of the aggregate actu-
18 arial value of the benchmark coverage de-
19 scribed in subsection (b)(1) of section 1937
20 or benchmark-equivalent coverage de-
21 scribed in subsection (b)(2) of such sec-
22 tion, as such subsections were in effect
23 prior to the enactment of the Patient Pro-
24 tection and Affordable Care Act.

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

17 “(D) COST SHARING.—A State conducting
18 a Medicaid Flexibility Program may impose
19 premiums, deductibles, cost-sharing, or other
20 similar charges, except that the total annual ag-
21 gregate amount of all such charges imposed
22 with respect to all program enrollees in a family
23 shall not exceed 5 percent of the family’s in-
24 come for the year involved.

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

4 “(A) SINGLE AGENCY.—Designate a single
5 State agency responsible for administering the
6 program.

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

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

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

21 “(A) IN GENERAL.—To the extent that a
22 provision of this section is inconsistent with an-
23 other provision of this title, the provision of this
24 section shall apply.

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

7 “(C) WAIVERS AND STATE PLAN AMEND-
8 MENTS.—

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

17 “(ii) REPLICATION OF WAIVER OR
18 AMENDMENT.—In designing a Medicaid
19 Flexibility Program, a State may mirror
20 provisions of a waiver or State plan
21 amendment described in clause (i) in the
22 program to the extent that such provisions
23 are otherwise consistent with the require-
24 ments of this section.

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

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

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

19 “(1) MEDICAID FLEXIBILITY PROGRAM.—The
20 term ‘Medicaid Flexibility Program’ means a State
21 program for providing targeted health assistance to
22 program enrollees funded by a block grant under
23 this section.

24 “(2) PROGRAM ENROLLEE.—

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

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

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

18 “(A) the first fiscal year in which the State
19 conducts the program; or

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

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

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

5 **SEC. 125. MEDICAID AND CHIP QUALITY PERFORMANCE**
6 **BONUS PAYMENTS.**

7 Section 1903 of the Social Security Act (42 U.S.C.
8 1396b), as previously amended, is further amended by
9 adding at the end the following new subsection:

10 “(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

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

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

21 “(B) submits to the Secretary, in accord-
22 ance with such manner and format as specified
23 by the Secretary and for the performance pe-
24 riod (as defined by the Secretary) for such fis-
25 cal year—

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

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

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

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

24 “(A) such an allotment to a State is deter-
25 mined based on the performance, including im-

1 provement, of such State under this title and
2 title XXI with respect to the quality measures
3 submitted under paragraph (3) by such State
4 for the performance period (as defined by the
5 Secretary) for such fiscal year; and

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

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

1 ceiving benefits or services under this title or title
2 XXI.

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

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

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

19 **SEC. 126. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT**
20 **PSYCHIATRIC SERVICES.**

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

23 (1) in subsection (a)—

24 (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. 127. 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 an Indian
8 who is eligible for assistance under the State plan” before
9 the period.

10 **SEC. 128. 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 **SEC. 129. DETERMINATION OF FMAP FOR HIGH-POVERTY**
6 **STATES.**

7 Section 1905(b) of the Social Security Act (42 U.S.C.
8 1396d) is amended in the first sentence—

9 (1) by striking “, and (5)” and inserting “,
10 (5)”;

11 (2) by inserting before the period the following:
12 “, and (6) only for purposes of payments for medical
13 assistance under this title (excluding any such pay-
14 ments that are based on the enhanced FMAP de-
15 scribed in section 2105(b)), in the case of a State
16 for which the Secretary issued under the authority
17 of section 673(2) of the Omnibus Budget Reconcili-
18 ation Act of 1981 a separate poverty guideline for
19 2017 that is higher than the poverty guideline issued
20 by the Secretary for 2017 which is applicable to the
21 majority of States, the Federal medical assistance
22 percentage determined for such a State under this
23 subsection for the second, third, and fourth quarters
24 of fiscal year 2018, and for each fiscal year there-
25 after, shall be increased (after such determination

1 but prior to any other increase which may be appli-
2 cable and in no case to exceed 100 percent) by, in
3 the case of the State with the highest separate pov-
4 erty guideline for 2017, 25 percent of the weighted
5 average (based on spending) of the Federal medical
6 assistance percentages determined for the fiscal year
7 for States which did not have a separate poverty
8 guideline issued for them for 2017, and in the case
9 of the State with the second highest separate pov-
10 erty guideline for 2017, 15 percent of the weighted
11 average (based on spending) of the Federal medical
12 assistance percentages determined for the fiscal year
13 for States which did not have a separate poverty
14 guideline issued for them for 2017”.

15 **TITLE II**

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

17 Subsection (b) of section 4002 of the Patient Protec-
18 tion and Affordable Care Act (42 U.S.C. 300u-11) is
19 amended—

20 (1) in paragraph (3), by striking “each of fiscal
21 years 2018 and 2019” and inserting “fiscal year
22 2018”; and

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

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

2 Effective as if included in the enactment of the Medi-
3 care Access and CHIP Reauthorization Act of 2015 (Pub-
4 lic Law 114–10, 129 Stat. 87), paragraph (1) of section
5 221(a) of such Act is amended by inserting “, and an ad-
6 ditional \$422,000,000 for fiscal year 2017” after “2017”.

7 **SEC. 203. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

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

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

14 **SEC. 204. CONDITIONS FOR RECEIVING MARKET-BASED**
15 **HEALTH CARE GRANT.**

16 (a) NON-APPLICATION OF EXISTING RULES.—For
17 any of plan years 2020 through 2026 for which a State
18 receives funds under subsection (i) of section 2105 of the
19 Social Security Act (42 U.S.C. 1397ee), if the State estab-
20 lishes rules, in accordance with subsection (c), to the ex-
21 tent that such rules conflict with any provision described
22 in subsection (b), any such provision shall be treated as
23 not applying (directly or through reference) with respect
24 to health insurance coverage described in subsection (d),
25 provided that such coverage complies with the applicable

1 State health insurance requirements, including the rules
2 so established.

3 (b) NON-APPLICABLE PROVISIONS DESCRIBED.—The
4 provisions described in this subsection are the following:

5 (1) Subsections (b), (c), and (d) of section 1302
6 of the Patient Protection and Affordable Care Act
7 (42 U.S.C. 18022).

8 (2) Clauses (ii) and (iii) of section
9 2701(a)(1)(A) the Public Health Service Act (42
10 U.S.C. 300gg(a)(1)(A)).

11 (3) Subsections (a) and (c) of section 2707 of
12 the Public Health Service Act (42 U.S.C. 300gg–6).

13 (4) Section 2713 of the Public Health Service
14 Act (42 U.S.C. 300gg–13(a)).

15 (5) Section 1312(c)(1) of the Patient Protection
16 and Affordable Care Act (42 U.S.C. 18032(c)(1)).

17 (c) APPLICATION.—An application submitted by a
18 State under subsection (i) of section 2105 of the Social
19 Security Act (42 U.S.C. 1397ee), with respect to health
20 insurance coverage under a program or mechanism de-
21 scribed subclause (I), (V), or (VII) of paragraph (1)(A)(i)
22 of such subsection, or for which funding assistance is pro-
23 vided under paragraph (1)(A)(i)(IV) of such subsection,
24 as applicable, shall include a description of the following
25 rules, which shall be established by the State:

1 (1) The criteria by which, and the degree to
2 which, a health insurance issuer of such coverage
3 may vary premium rates for such coverage, except
4 that in no case may an issuer vary premium rates
5 on the basis of sex [or on the basis of genetic infor-
6 mation].

7 (2) Whether, and the degree to which, a health
8 insurance issuer of such coverage may require an in-
9 dividual, as a condition of enrollment or continued
10 enrollment in such coverage, to pay a premium or
11 contribution which is greater than the premium or
12 contribution for a similarly situated individual en-
13 rolled in such coverage on the basis of any health
14 status-related factor in relation to the individual or
15 to an individual enrolled under such coverage as a
16 dependent of the individual.

17 (3) The benefits or levels of benefits which a
18 health insurance issuer of such coverage shall be re-
19 quired to include in such coverage.

20 (4) The number of risk pools into which a
21 health insurance issuer of such coverage may group
22 individuals enrolled in such coverage.

23 (d) HEALTH INSURANCE COVERAGE DESCRIBED.—
24 In this section, the term “health insurance coverage”
25 means health insurance coverage that is—

1 (1) offered by a health insurance issuer in the
2 individual market under a program or mechanism
3 described in subclauses (I), (V), or (VII) of sub-
4 section (i)(1)(A)(i) of section 2105 of the Social Se-
5 curity Act, or for which funding assistance is pro-
6 vided under paragraph (i)(1)(A)(i)(IV) of such sec-
7 tion; and

8 (2) provided to an individual who is receiving a
9 direct benefit (which shall not include benefits de-
10 rived from a program described in section
11 2105(i)(1)(A)(i)(II) of the Social Security Act under
12 a State program that is funded by a grant under
13 section 2105(i) of the Social Security Act.