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Build Back Better Act: Medicaid, Marketplace, Medicare, and Public Health Provisions

The Big Picture

The House passed the Build Back Better Act (BBB) (H.R. 5376) on November 19, with a vote of 220-213. The $1.7 trillion BBB represents a cornerstone of the Biden Administration's social policy agenda and includes key health policy investments.

This analysis summarizes key provisions related to coverage, including provisions to temporarily close coverage gaps in states that have not expanded Medicaid; extend American Rescue Plan premium subsidies through 2025; provide Medicare coverage for hearing aids and audiology services; invest in home- and community-based services (HCBS); require 12 months of postpartum coverage to pregnant people enrolled in Medicaid and the Children's Health Insurance Program (CHIP); and invest in improving maternal health outcomes, behavioral health, and other public health priorities.

These provisions represent significant new investments in Medicaid, Marketplace, and Medicare coverage, as described in a Congressional Budget Office score released on November 18. ***This updated summary includes CBO scores for select provisions.*** For more information about the Congressional Budget Office's score of the legislation, see *Manatt on Health's* overview.

This analysis reflects the bill text released by the House Rules Committee on November 3; the provisions described in this document were not impacted by a November 4 manager's amendment. A November 18 manager's amendment included technical changes to several public health provisions; ***the text in the below Manatt on Health summary is unchanged other than to note CBO scores for select provisions.*** Please see *Manatt on Health*'s companion analysis for a summary of the provisions in the bill that impact prescription drug pricing.

The text of H.R. 5376 is likely to change as the Senate considers the bill; *Manatt on Health* will provide updates.

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Medicaid & CHIP

Closing the Medicaid Coverage Gap

Ensuring Affordability of Coverage for Certain Low-Income Populations (Title III, Subtitle E, Section 30601; Title XIII, Subtitle C, Part 3, Section 137304). ***CBO Score: $55.452 billion/5 years; $43.798 billion/10 years***. Consistent with Congressional leaders' commitment to making coverage available to the estimated 4 million low-income Americans in the "coverage gap"—referring to adults living in states that have not expanded Medicaid—the bill makes fully subsidized Marketplace plans available to *all* individuals with income below 138% of the federal poverty level (FPL)if they are ineligible for Medicaid, Medicare, or any other form of comprehensive public health coverage. Previously, premium tax credits (PTCs) were unavailable to individuals with income below 100% FPL (because the Affordable Care Act's (ACA's)

Marketplace provisions were drafted under the assumption that all states would expand Medicaid; until now, those provisions had not been amended to reflect the Supreme Court's 2012 decision allowing each state to decide whether implement Medicaid expansion). Unlike earlier versions, the current bill no longer includes a "federal Medicaid fallback plan" to continue coverage after 2025.

Effective January 1, 2022 through December 31, 2025, individuals nationwide are eligible for Marketplace coverage with zero premiums if: (1) their income is below 138% FPL and, and (2) they are ineligible for a public coverage program, such as Medicaid or Medicare. The bill specifies additional details, including the following:

- Because this form of coverage is intended to mimic Medicaid eligibility, income calculations rely on "current"—as opposed to annual—income, and enrollment can occur at any time during the year (not just during the annual "open enrollment" periods). In addition, low-income adults may be eligible for PTCs even if they have access to "affordable" employer coverage; the bill also exempts employers from the "shared responsibility" penalty in those situations. (Under standard Marketplace rules, applicants will qualify for PTCs only if they lack any other form of "minimum essential coverage").

- The bill modifies the provisions on "recapturing" PTCs that were paid out in advance based on an individual's estimated eligibility, but that proved to be larger than the individual was in fact entitled to. For 2022 to 2025, the recapture provisions are waived entirely for any individual whose income is below 138% FPL, and who would not normally be required to file a tax return. In addition, the maximum recaptured amount for an individual with income below 200% FPL will be $300, down from the current max of $600.

In 2022, these low-income individuals will be required to pay modest cost-sharing, consistent with existing Marketplace rules for individuals with income at 100% FPL: issuers must offer plans with an actuarial value of 94%, meaning that the plan covers 94% of the total average cost of care. In 2023–2025, however, cost sharing will be further curtailed for individuals with income below 138% FPL, for whom the plans must have an actuarial value of 99%; in this period, the Department of Health and Human Services (HHS) will make payments to issuers totaling 12% of the total average cost of benefits provided in these three years (bringing issuer costs in line with current requirements).

In plan years 2024 and 2025, Marketplace plans for individuals at or below 138% FPL would have to cover, without cost sharing, non-emergency medical transportation (NEMT) services and family planning services and supplies. Family planning is already a required essential health benefit (EHB) for Marketplace plans; the bill specifies that family planning services not otherwise included as part of the EHB must be provided. Both family planning and NEMT must be provided without any restriction on the choice of qualified provider; this is akin to

Medicaid's freedom of choice provision, which guarantees that low-income enrollees may receive family planning services from any willing provider, even if they are not in-network.

The bill includes several provisions designed to help low-income individuals in non-expansion states enroll in this newly available coverage. First, as noted, the bill provides that between January 1, 2022 and December 31, 2025, individuals under 138% FPL can apply for Marketplace coverage at any point in the year as long as they are not eligible for Medicaid, Medicare, or other government coverage. The bill also includes $105 million (for use between 2022 and 2025) to support outreach and educational activities to inform low-income adults who reside in non-expansion states about the availability of coverage and financial assistance, as well as $100 million over four years for Consumer Assistance Programs (CAP) (see page 17 for more information on CAP funding). Finally, the bill obligates $10 million in fiscal year (FY) 2022 and $20 million in each of FY2023 and FY2024 from health insurer user fees to be used by HHS to support Navigators in connecting low-income people to coverage in federally facilitated Marketplace states; the bill specifies that such funding cannot be used to promote association health plans or short-term limited duration insurance, which generally offer less robust coverage.

New Incentives to Implement and Maintain Medicaid Expansion Under the ACA

Alongside the new coverage pathway for low-income adults in non-expansion states (described above), the bill also includes several "carrots and sticks" that encourage holdout states to implement expansion, and that discourage expansion states from reducing coverage below the ACA's threshold of 138% FPL. Because the U.S. Supreme Court ruled in 2012 that Congress cannot *require* states to implement Medicaid expansion, these provisions take the form of heightened federal match rate for the expansion group as well as reduced federal funding for non-expansion states. These two-sided incentives apply equally to states that have never adopted the Medicaid expansion and to states that might drop it.

Further Increase in FMAP for Medical Assistance for Newly Eligible Mandatory Individuals (Title III, Subtitle E, Section 30609). ***CBO Score: $10.4 billion/5 years and 10 years***. Under the ACA, states receive an enhanced federal medical assistance percentage (FMAP) of 90% for spending on newly eligible adults enrolled under the Medicaid expansion group. This bill would temporarily increase the expansion FMAP from 90% to 93% for 2023 through 2025. This enhancement would be available to any state that expands Medicaid at any point before or during this period. The provision also helps address concerns with earlier drafts that were criticized as "buying out" coverage in non-expansion states without providing any benefits to the 39 states (plus Washington, D.C.) that have already expanded Medicaid. Notably, newly expanding states are also eligible for the American Rescue Plan's two-year, 5-percentage-point increase in the regular FMAP for their non-expansion population.

Adjustments to Uncompensated Care Pools and DSH Payments (Title III, Subtitle E, Section 30608). ***CBO Score: Savings of $18.264 billion/5 years and $34.517 billion/10 years***. Hospitals

and other institutional providers in nonexpansion states would see several changes to reimbursement for uncompensated care. Providers would receive Marketplace, rather than Medicaid, payment rates for individuals previously in the coverage gap that enroll in subsidized Marketplace coverage,. However, beginning in October 2022, the bill would reduce two types of federal funding for non-expansion states—uncompensated care pools authorized under Section 1115 demonstrations (in states that have such pools) and federal Disproportionate Share Hospital (DSH) allotments.

- **Uncompensated care pools.** The bill would require that, to the extent a non-expansion state has an uncompensated care pool authorized under a Section 1115 demonstration, that pool must exclude costs for individuals who could be eligible under the expansion group, if the state adopted that level of coverage. The requirement would affect any new authorization of an uncompensated care pool and could clear the way for the Centers for Medicare & Medicare Services (CMS) to revisit uncompensated care pools previously approved through waivers, such as those in Florida, Texas, and Tennessee.

- **Disproportionate Share Hospital payments.** The bill specifies a 12.5% reduction in each non-expansion state's annual federal DSH allotment, but would restore the cuts if the state were to adopt expansion.

The impact of the uncompensated care pool and DSH reductions would primarily fall on hospitals and other institutional providers and are highly dependent on the state, including whether the state *has* an uncompensated care pool, the size of its DSH allotment and whether it spends all of its DHS allotment currently. In some non-expansion states, the increased reimbursement that hospitals and other providers would receive under the expansion of Marketplace coverage could potentially offset uncompensated care pool and DSH losses, although the impact on particular hospitals will vary. States retain broad discretion to determine how their DSH allotments are distributed to hospitals.

"Unwinding" Measures Related to the COVID-19 Public Health Emergency

Revisions to Temporary Increase of Medicaid FMAP Under the Families First Coronavirus Response Act (Title III, Subtitle F, Part 4, Section 30741(b)). ***CBO Score: $17 billion in FY 2022; CBO scores Section 30741 as saving $14 billion over five years and $3 billion over ten years, accounting for other investments included in this section , as described below***.[1] A newly added bill section will phase out the enhanced federal match rate that the Families First Coronavirus Response Act (FFCRA) made available to states during the COVID-19 public health emergency (PHE), as well as the associated "continuous coverage" requirement. FFCRA Section 6008

[1] The CBO score of Section 30741 reflects both savings from the "unwinding" measures described here as well as new spending to provide Medicaid to justice-involved populations' during the 30-day period preceding release, access to Medicaid, 12 months continuous coverage for children, and a variety of other provisions described below.

increased states' FMAP by 6.2 percentage points for the duration of the PHE, conditioned on states meeting the following requirements: (1) continuous coverage, under which states may not disenroll any Medicaid beneficiaries during the PHE; (2) the maintenance of effort (MOE), under which states may not impose "eligibility standards, methodologies, or procedures" more restrictive than those that were in place before the pandemic (January 1, 2020); and (3) a requirement to cover COVID-19 testing, treatments, and vaccines without cost sharing. (For a summary of key health care provisions in FFCRA, see the *Manatt on Health* analysis.) The reconciliation bill decouples these provisions from the PHE, and instead establishes a fixed timeline for phasing out the FMAP bump and the associated state requirements.

Phasing Out FFCRA's FMAP Bump. The bill provides that, regardless of when the PHE expires, the FMAP enhancement will wind down as follows:

Time Period	FMAP Enhancement
Beginning of the PHE through March 2022	6.2 percentage points *(as under FFCRA)*
April through June 2022	3.0 percentage points
July through September 2022	1.5 percentage points
October 1, 2022	FMAP bump expires

Phasing Out the Continuous Coverage Requirement. The bill makes three important changes to the continuous coverage requirement:

- The continuous coverage requirement will not apply to individuals who enroll on or after April 1, 2022. These newly enrolling individuals may be disenrolled in accordance with standard pre-PHE procedures.
- With respect to individuals who enrolled at any point before March 31, 2022, the continuous coverage requirement remains in effect through September 30, 2022, with a key exception, as described below. Like the FMAP bump, the continuous coverage requirement expires entirely on October 1, 2022.
- During the period from April through September 2022, states may (if they wish) begin to process terminations for certain individuals who have already been enrolled in Medicaid for at least one year (that is, they are due or overdue for a redetermination of eligibility). States must, however, undertake a full eligibility redetermination in accordance with standard federal requirements, including an obligation to check for any available sources of coverage under Medicaid, the Children's Health Insurance Program (CHIP), or the Marketplace. States that elect this option may, each month, initiate redeterminations for up to 1/12 of Medicaid enrollees, and must follow delineated procedures, including taking steps to update contact information and reporting data to CMS on redeterminations and terminations.

***FFCRA's Other FMAP Conditions*.** The FFCRA MOE continues unaltered until the FMAP enhancement expires on October 1, 2022 (although the reconciliation bill establishes a new MOE requirement to help stabilize coverage post-PHE, as described below under Section 30751). FFCRA Section 6008's requirement to cover COVID-19 testing, treatment, and vaccines will similarly expire on October 1, 2022, but this requirement has been superseded by other provisions—in the American Rescue Plan and in the FFCRA itself—that impose more detailed coverage requirements for a longer period of time. (For more information on the FFCRA requirements to cover COVID-19 testing, see page 2 of *Manatt on Health*'s FFCRA summary; for more on treatment and vaccine coverage requirements, see page 5 of the October 29 edition of *Insights This Week*.) ,

Encouraging Continued Access After the End of the Public Health Emergency (Title III, Subtitle F, Part 5, Section 30751). ***CBO Score: $6.982 billion/5 and 10 years***. The bill includes a new MOE that incentivizes states to preserve their *current* levels of Medicaid coverage (standards and methodologies for determining eligibility as of October 1, 2021).[2] This MOE applies from October 1, 2022 (the same day the FFCRA MOE expires) through the end of 2025, and the penalty for noncompliant states is a 3.1-percentage-point FMAP reduction. Note that both MOEs apply solely to the Medicaid program; neither applies to CHIP, and the new MOE carves out certain additional exceptions as well.

The following chart illustrates the similarities and differences between the MOE provisions under FFCRA and the reconciliation bill:

[2] Note that the bill makes no distinction between a temporary Medicaid authority, like a disaster relief state plan amendment (SPA), and a more permanent authority. Since eligibility changes and other policies implemented through a disaster relief SPA will expire at the end of the PHE, it is likely that future CMS guidance will be needed about the implications if the PHE (and associated flexibilities) terminate while the MOE is still in effect.

Comparing the Maintenance of Effort (MOE) Provisions Under…	FFCRA § 6008 *(as amended by BBB)*	Build Back Better § 30741
MOE effective period	March 18, 2020 to September 30, 2022	October 1, 2022 to December 31, 2025
MOE baseline date *(i.e., the threshold below which future eligibility standards and procedures may not fall)*	January 1, 2020	October 1, 2021
Penalty for violating the MOE	6.2-percentage-point FMAP reduction *(or less, depending on the month; see 30741(b) above)*	3.1-percentage-point FMAP reduction
Exceptions to the MOE	Does not apply to CHIP	Does not apply to (1) CHIP, (2) certain eligibility groups for which no income determination is required; (3) certain elderly and disabled individuals; (4) dual-eligibles; and (5) if the state has a budget deficit, adults with income above 138% FPL who are neither pregnant nor disabled.

Coverage and Care Coordination for Pregnant and Postpartum Individuals

Consistent with the Biden Administration's goal of redressing disparities in maternal morbidity and mortality, the bill includes several provisions aimed at enhancing coverage and care coordination for pregnant and postpartum people enrolled in Medicaid and CHIP. See below for additional grant funding to support these priorities.

Extending Continuous Coverage for Pregnant and Postpartum Individuals (Title III, Subtitle F, Part 2, Section 30721). ***CBO Score: $1.054 billion/5 years and $2.206 billion/10 years***. The bill requires all states to provide 12 months of postpartum coverage to any pregnant person covered by Medicaid or CHIP. Currently, federal law requires 60 days of postpartum coverage, although the American Rescue Plan created a time-limited option (April 1, 2022 to March 31, 2027) for states to provide 12 months of postpartum coverage. This bill requires *all* states to implement extended postpartum coverage, starting with the first calendar quarter that begins one year after the bill's enactment (which likely means January 1, 2023, although a longer period is available to states that require new legislation). As described below, this section of the

bill also clarifies and strengthens other aspects of maternal and postpartum coverage, and allows states to claim an enhanced FMAP for certain individuals during the postpartum period.

- **Clarifying postpartum coverage for lawfully residing immigrants.** For states that have elected the so-called "CHIPRA 214" option to cover lawfully residing immigrant children and/or pregnant people without the usual five-year waiting period,[3] the bill confirms that these lawfully residing enrollees are entitled to the extensions of postpartum coverage, under both the American Rescue Plan and the reconciliation bill, on the same terms as other enrollees.

- **Providing full benefits to all pregnant enrollees.** Currently, states may limit coverage for certain pregnant enrollees to "services related to pregnancy, … services related to other conditions which may complicate pregnancy," and vaccines. The bill provides that people enrolled in Medicaid on the basis of pregnancy are entitled to full Medicaid benefits during pregnancy and for the authorized postpartum period.

- **Authorizing enhanced FMAP for certain postpartum individuals.** Under the ACA, states receive an enhanced FMAP of 90% for spending on nonpregnant adults enrolled under the Medicaid expansion group, while continuing to claim at their regular FMAP for individuals enrolled under a pregnancy-related eligibility pathway.[4] In expansion states, individuals who were covered through such a pathway would switch to the expansion group (and the enhanced FMAP) at the end of the 60-day postpartum period if their income was below 138% of the FPL. To maintain that enhanced funding, a new section in the reconciliation bill provides as follows: For any pregnant individual who *would* have switched into the expansion group after the standard 60-day postpartum period, the state may claim at the enhanced 90% rate for the remaining ten months of mandatory postpartum coverage. Note that this enhanced FMAP does *not* apply to the American Rescue Plan's optional postpartum extension, which states remain free to implement before the bill's mandatory extension goes into effect.

State Option to Provide Coordinated Care Through a Maternal Health Home for Pregnant and Postpartum Individuals (Title III, Subtitle F, Part 2, Section 30722). ***CBO Score: $332 million/5 years and $954 million/10 years***. This new section in the reconciliation bill authorizes states to implement—and claim federal Medicaid funding for—"maternal health homes" to coordinate care for pregnant and postpartum Medicaid enrollees. The legislative language is modeled on existing provisions that authorize Medicaid health home models for individuals with chronic

[3] The term "CHIPRA 214" refers to the fact that this optional form of coverage was made available under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
[4] An adult who is pregnant at the time of enrollment will be enrolled in a pregnancy-related eligibility group. However, with respect to an adult who is already enrolled under the ACA expansion group and later becomes pregnant, CMS has clarified that the adult may choose to remain enrolled under the expansion group's Alternative Benefit Plan rather than switching into "traditional" state plan coverage for the pregnancy-related eligibility group.

diseases[5] and for children with medically complex conditions.[6] Key features of the maternal health home model include the following:

- Maternal health home services include risk assessments; comprehensive care management, care coordination, and health promotion; and individual and family support.
- The health home may be led by an individual provider (such as a physician or midwife), an institutional provider (such as a community health center or freestanding birth center), or a health team (as defined under the ACA and CMS guidance).
- States and health homes must abide by federal parameters with respect to health home qualifications, payment methodologies, use of health technology for communication and care coordination, education and outreach to providers and beneficiaries about the health home model, and data collection and reporting.

The maternal health home model will become available two years after enactment of the reconciliation bill. States may opt in by submitting a state plan amendment (SPA), and may apply for a grant to support SPA planning (out of a total available pool of $5 million). For the first two years of a maternal health home model, states will be entitled to a 15-percentage-point FMAP increase for maternal health home services, up to a maximum match rate of 90%.

Medicaid/CHIP Coverage Provisions for Children

Investments to Ensure Continued Access to Health Care for Children (Title III, Subtitle F, Part 4, Sections 30741(a) & (d), Subtitle G, Section 30801(b)(2)). This section makes several changes to enhance eligibility and covered benefits for children and incarcerated individuals. The bill:

- Requires that states provide 12 months of continuous eligibility to children enrolled in Medicaid and CHIP. Currently, states are permitted, but not required, to provide a year of continuous eligibility. This provision goes into effect one year after enactment (or longer if state legislation is needed).
- Permanently extends the "express lane" eligibility option for children, which is otherwise scheduled to expire on October 1, 2027. The bill also permanently extends the provision requiring states to maintain certain Medicaid and CHIP child eligibility standards, methodologies, and procedures that are no more restrictive than those in effect on March 23, 2010. This provision, which was similarly scheduled to expire in 2027, applies only to eligibility for children in households with income below 300% FPL.

Investments to Strengthen CHIP (Title III, Subtitle G, Section 30801). ***CBO Score: Savings of $753 million/5 years and $1.168 billion/10 years***. The bill includes several provisions to strengthen coverage for children enrolled in Medicaid and CHIP, including:

[5] Social Security Act (SSA) § 1945, enacted in 2010 under the ACA.
[6] SSA § 1945A, enacted in 2019.

- **Permanent Extension of CHIP (Section 30801(a)-(b))**. The bill retains an earlier provision to authorize permanent funding for CHIP, avoiding the need for reauthorizations and the risk of gaps in funding. It also provides permanent funding (which will increase annually based on the consumer price index) for the Pediatric Quality Measures Program and the Child Enrollment Contingency Fund, and extends the CHIP "qualifying states option," which permits qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed uninsured children whose family income exceeds 133% FPL.

- **CHIP Outreach and Enrollment Program (Section 30801(b)(4)).** This provision would amend funding for the long-standing Title XXI outreach program designed to increase the enrollment and participation of eligible children under Medicaid and CHIP. This section would permanently extend funding past the current cliff of FY2027; it provides $60 million in grant funding for FY2028 through FY2030 and annually increases this amount for inflation through FY2033. As is true under current law, 10% of this funding would be set aside to support a national enrolment campaign, and another 10% would be set aside to evaluate and provide technical assistance to grantees.

- **CHIP Drug Rebates (Section 30801(c))**. The bill expands the Medicaid Drug Rebate Program to include outpatient drugs covered under CHIP as well. Starting in 2024, manufacturers will be required to pay rebates for utilization of their drugs under CHIP in accordance with existing rules for Medicaid. Rebate requirements already apply to CHIP programs that are financed with Medicaid dollars, but the bill extends rebate requirements—and the associated coverage requirements for states—to drugs provided to approximately 7 million children and pregnant people that are paid for under Title XXI. (In comparison, about 76 million people are enrolled in Medicaid, which has higher per-capita drug utilization than CHIP given the different population.)

Other Medicaid/CHIP Coverage Provisions

Improving Access to Adult Vaccines Under Medicaid and CHIP (Title XIII, Subtitle I, Part 5, Section 139405). ***CBO Score: $1.183 billion/5 years and $2.816 billion/10 years***. The bill requires Medicaid and CHIP to cover, without cost sharing, all vaccines recommended for adults by the Advisory Committee on Immunization Practices. (Currently, states are required to provide this level of coverage for children and for adults enrolled under Medicaid expansion, but not for "traditional" adult populations such as pregnant people, parents, and people with disabilities.) This section also increases the FMAP for such vaccines and their administration by one percentage point for the first eight fiscal quarters beginning one year plus one quarter after the bill's enactment (which likely means January 2023).

Medical Assistance For Inmates During 30-Day Period Preceding Release. (Title III, Subtitle F, Part 4, Section 30741(c)).[7] The bill requires states to begin covering Medicaid and CHIP services for eligible incarcerated individuals beginning 30 days before their release from incarceration. Currently, although incarcerated individuals may be enrolled in Medicaid, the so-called inmate exclusion prevents states from claiming federal reimbursement for most services provided to these individuals. This change will take effect in the first calendar quarter that begins two years after the bill's enactment (which likely means January 1, 2024).

Expansion of Community Mental Health Services Demonstration (Title III, Subtitle F, Part 4, Section 30741(e)). This section expands access to behavioral health services by extending additional planning grants and incentives for states to cover Certified Community Behavioral Health Care Clinics (CCBHCs), which are behavioral health centers that are designed to cover a comprehensive range of mental health and substance use disorder services to individuals in need regardless of their ability to pay in return for receiving enhanced Medicaid reimbursement. To do so, it extends the demonstrations through March 2026 and makes an additional $40 million in funding available for FY2022.

Making Permanent the State Option for Mobile Crisis Units (Title III, Subtitle F, Part 4, Section 30741(f)). This section permanently extends the option for states to cover Qualifying Community-Based Mobile Crisis Intervention Services and rapidly dispatch a multi-disciplinary behavioral health teams on a 24/7 basis to assess and stabilize individuals experiencing behavioral health emergencies.

Medicaid Home and Community-Based Services (HCBS)

The bill includes several provisions aimed at enhancing access to, and the quality of, HCBS, especially in the Medicaid program, which is the dominant payer for HCBS. Currently, states vary widely in their coverage of HCBS, including with respect to the number of optional benefits covered, the eligibility parameters (including waitlists as a result of eligibility caps), the available care delivery models. States also vary in the extent to which they have invested in "professionalizing" the direct care workforce through, for example, training and qualifications, benefits, and state-run registries for personal care services.

This summary focuses on the bill's changes that apply specifically to the Medicaid program. We note, however, that the bill also appropriates $1 billion in grant funding for eligible entities—including states, tribes, labor organizations, and non-profit organizations—to invest in strategies to recruit, retain, and advance the direct care workforce (see bill sections 22301 and 22302). These grants will be administered by the Department of Labor in coordination with the HHS Administration for Community Living. In addition, the bill permanently extends the Independence at Home Medical Practice Demonstration Program, as described below.

[7] As noted previously, the CBO score for Section 30741 does not separately score the specific provisions described here.

HCBS Improvement Planning Grants and the HCBS Improvement Program (Title III, Subtitle F, Part 1, Sections 30711–30713). As in prior versions, the bill provides offers substantial federal funding as an incentive for states to develop and implement "HCBS Improvement Plans." As with the postpartum coverage provisions, discussed above, these HCBS provisions build on temporary measures enacted earlier this year under the American Rescue Plan, namely a 10 percentage point increase in the FMAP for HCBS one year, conditional on states either maintaining or enhancing each component of their HCBS program. The HCBS Improvement Plans, by contrast, are intended as a long-term roadmap for each state to enhance HCBS eligibility and benefits, address disparities, support the direct care workforce, and improve data collection and oversight. Key components of the bill include:

- **HCBS Improvement Planning Grants (Section 30711).** ***CBO Score: $135 million/5 and 10 years***. The bill appropriates $130 million in grant funding to support states in developing their HCBS Improvement Plans. Within one year of enactment, CMS must outline application criteria, accept applications, and award grants to the states. States then have up to two years to develop a proposed HCBS Improvement Plan, including a public notice and comment process. CMS will review each state's plan for compliance with federal parameters. Among other requirements, an HCBS Improvement Plan must:
    - Include an assessment of the "existing Medicaid HCBS landscape," including a review of current eligibility and benefits, utilization and access barriers, long-term care service delivery structures and supports (including both institutional services and HCBS), the direct care workforce, reimbursement rates, and quality measures.
    - Describe how the state intends to meet all "HCBS Improvement" requirements (discussed below).

- **Increased Federal Match for HCBS Program Improvement States (Section 30712).** ***CBO Score: $39.626 billion/5 years and $146.493 billion/10 years***. Once CMS has approved a state's HCBS Improvement Plan, the state becomes eligible for three types of enhancements to their federal match rate, subject to meeting all HCBS Improvement requirements (discussed below).
    - Two enhancements pertain to the FMAP for HCBS:
        - A permanent 6 percentage point FMAP increase for HCBS (down from 7 points in the September version of the bill); and
        - A temporary 2 percentage point increase for states state implement a "self-directed model" for the delivery of HCBS; this enhancement lasts for up to 6 quarters (down from 8 quarters in the September version).

      Both of these FMAP increases apply on top of other enhancements—including the American Rescue Plan's temporary enhancement for newly expanding states—subject to an overall cap of 95% FMAP.

- The third enhancement allows states to claim for HCBS-related administrative expenditures at an 80% match rate, as opposed to the 50% rate that generally applies to administrative services.[8]

- **HCBS Improvement Requirements (Section 30712).** A state's HCBS Improvement Plan must explain how the state intends to satisfy all the requirements listed below. Once a state's Improvement Plan has been approved, the state must continue to meet all requirements as a condition of claiming the enhanced federal match rates described above. States must:
  - Maintain HCBS eligibility, coverage, and provider payment rates at or above the applicable levels as of the date the state received an HCBS Planning Grant (subject to certain deviations, with CMS permission). This provision is intended to ensure that the new funding adds to rather than supplants existing investments.
  - Reduce HCBS access barriers and disparities in access or utilization.[9]
  - Cover personal care services as part of the state's Medicaid plan.
  - Expand and strengthen the direct care workforce, including establishing appropriate qualification standards, developing training opportunities, and ensuring on an ongoing basis that payment rates are sufficient to support recruitment and retention. States must, in addition, ensure that any changes in payment rates result in proportionate increase to payments for direct care workers.
  - To qualify for the optional 2-point FMAP increase for "self-directed models," must, either directly or through a contract with an outside entity, support beneficiaries in taking responsibility for managing certain HCBS, including hiring direct care workers (as opposed to receiving services through a personal care services agency or other institutional provider). The state or contracted entity must register qualified direct care workers, assist beneficiaries in finding direct care workers, and perform certain other functions.[10]

[8] Eligible HCBS-related administrative expenditures may include, for example: enhancing Medicaid data and technology infrastructure; modifying rate setting processes; adopting or improving training programs for direct care workers and family caregivers; and adopting, carrying out, or enhancing programs that register direct care workers or connect beneficiaries to direct care workers.

[9] Specifically, states must implement strategies such as: providing for navigation of HCBS through "no wrong door" programs and expedited eligibility for HCBS; improving HCBS counseling and education programs; expanding access to behavioral health services furnished through HCBS; improving coordination with employment, housing, and transportation supports; and providing supports to family caregivers.

[10] The entity must, for example, recruit and train independent providers; ensure the safety of, and support the quality of, care provided; facilitate coordination between State and local agencies and direct care workers; provide support to beneficiaries who wish to a hire a family caregiver; and ensure that the program does not deter or promote the ability of workers to form a labor organization.

  - Comply with oversight and reporting requirements, including submitting annual monitoring reports to CMS, establishing an HCBS ombudsperson, and (after seven years) demonstrating that the state has achieved certain benchmarks for HCBS access.

- **Funding for Federal Activities Related to Medicaid HCBS (Section 30713).** ***CBO Score: $40 million/5 and 10 years***. This section appropriates $40 million (an additional $25 million over the previous proposal) for CMS to issue necessary guidance and provide technical assistance for states undertaking HCBS Improvement Plans. This section also requires CMS to report periodically to Congress on the progress of the HCBS Improvement activities.

Funding for HCBS Quality Measurement and Improvement (Title III, Subtitle F, Part 1, Section 30714). ***CBO Score: $32 million/5 and 10 years***. This section requires CMS, in consultation with stakeholders such as beneficiaries and providers, to develop HCBS-related metrics for the Child and Adult Core Health Care Quality Measures. States will be required to report on these measures, and will be entitled to claim an 80% match rate for administrative expenditures associated with this reporting.

Permanent Extension of Medicaid Protections Against Spousal Impoverishment (Title III, Subtitle F, Part 1, Section 30715). ***CBO Score: $178 million/5 years and $670 million/10 years***. This section would permanently extend the "spousal impoverishment protections" that allow states to disregard individuals' spousal income and assets when determining eligibility for Medicaid HCBS. The Consolidated Appropriations Act of 2021 (passed in December 2020) extended these protections through 2023.

Permanent Extension of Money Follows the Person (Title III, Subtitle F, Part 1, Section 30716). ***CBO Score: $318 million/5 years and $2.196 billion/10 years***. This provision would permanently extend the Money Follows the Person Rebalancing Demonstration and provides $450 million annually. This demonstration project helps states rebalance utilization and spending toward HCBS rather than institutional care.

Medicaid Funding for Territories and Urban Indian Health Organizations and Native Hawaiian Health Care Systems

Increasing Medicaid Cap Amounts and the FMAP for Territories (Title III, Subtitle F, Part 3, Section 30731). ***CBO Score: $4.003 billion/5 years and $9.455 billion/10 years***. This section permanently increases federal Medicaid funding for the territories and permanently increases each territory's FMAP to 83%. Under current law, federal Medicaid funding in Puerto Rico and the other territories is subject to a statutory cap and a fixed federal matching rate (unlike in the states, where federal Medicaid funding is not capped and the federal share varies based on states' per capita income). As a result of capped financing, the effective FMAP is generally lower than the statutory levels. To achieve this increase, the provision would provide the following:

- **Cap amount adjustments.** The bill provides an increase in federal funding for each of the territories in FY2022 and provides that each future year's allotment will be determined by adding the previous year's allotment plus the percentage increase in Medicaid expenditures during the previous year. Puerto Rico's FY2022 allotment is $3.6 billion; the other territories receive FY2022 allotments ranging from $70 million to $140 million.

- **FMAP adjustments.** The provision specifies, starting in FY2022, an 83% federal matching rate for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For Puerto Rico, the FMAP would increase to 76% in FY2022 and then to 83% in FY2023 and subsequent years.

The bill also includes a requirement that Puerto Rico establish a Medicaid "payment floor" for physician services that are covered under the Medicare Part B fee schedule, directing the establishment of a directed payment arrangement to assure that payments are not less than 70% of the payment that would apply under Medicare. Failure to adopt this payment floor would result in graduated FMAP penalties.

The bill also provides (in **Title XIII, Subtitle J, Section 131001**) an extension of the Supplemental Security Income (SSI) program to Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa, effective January 1, 2024. This provision is significant not only because it will provide significant income support for people with disabilities but also because it paves the way for the territories to link Medicaid eligibility to SSI eligibility.

Extension of 100% FMAP for Urban Indian Health Organizations and Native Hawaiian Health Care Systems (Title III, Subtitle F, Part 4, Section 30741(g)). This section extends for an additional two years the 100% FMAP for Urban Indian Health Programs and Native Hawaiian Health Centers that was first authorized in the American Rescue Plan as a two-year bump beginning on April 1, 2021. Prior to the American Rescue Plan's enactment, services provided to Medicaid beneficiaries were matched at 100% FMAP only if they were provided through an Indian Health Service (IHS) facility.

Marketplaces

Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers (Title XIII, Subtitle G, Part 3, Section 137301). ***CBO Score: $39.897 billion/5 years and $43.573 billion/10 years***.[11] The bill extends American Rescue Plan expansions of Marketplace premium tax credit (PTC) support through 2025, including:

[11] The CBO score for Section 137301 includes an estimate for this section and for Title XIII, Subtitle G, Part 3, Section 137302, Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit.

- Increasing subsidy amounts for individuals eligible for assistance with household incomes below 400% FPL; and

- Extending premium assistance eligibility to those with household incomes above 400% FPL, so that no family shall be required to spend more than 8.5% of their household income toward the cost of a benchmark or less expensive plan.

Household Income (% of the FPL)	Original 2021 Premium Percentage (pre-American Rescue Plan)	Updated Premium Percentage, 2021–2025
Up to 150%	2.07%–4.14%	0%
150%–200%	4.14%–6.52%	0%–2%
200%–250%	6.52%–8.33%	2%–4%
250%–300%	8.33%–9.83%	4%–6%
300%–400%	9.83%	6%–8.5%
Over 400%	No subsidies	8.5%

Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit (Title XIII, Subtitle G, Part 3, Section 137302). The bill would reduce the employer-sponsored coverage affordability test—the threshold above which a consumer's offer of employer coverage is deemed unaffordable, thereby making the consumer eligible for the PTC—from the current 9.5% (which is re-indexed each year) to 8.5% of income through 2025, making the 8.5% of income a standard across programs while the enhanced tax credits are in effect. The bill also specifies that after 2025, when the 9.5% threshold resumes, it will no longer be indexed annually until 2027. Despite this change to the affordability threshold, the "family glitch" remains, which prevents entire families from being eligible for Marketplace financial assistance if an offer of individual employer coverage (rather than family coverage) is deemed affordable per the 8.5% of income threshold.

Special Rule for Individuals Receiving Unemployment Compensation (Title XIII, Subtitle G, Part 3, Section 137305) and Cost-Sharing Reductions for Individuals Receiving Unemployment Compensation (Title III, Subtitle E, Section 30605). ***CBO Score: $804 million/5 and 10 years***. Under the American Rescue Plan, people who receive unemployment insurance for any week in 2021 are eligible for financial assistance on the Marketplace, allowing them to buy a Silver-level plan with $0 premiums and with the maximum cost-sharing subsidies amount, regardless of their income. The new bill would extend these provisions through 2022, making consumers eligible for such financial assistance for the full 2022 plan year if they receive some unemployment benefits that year.

Health Insurance Affordability Fund (Title III, Subtitle E, Section 30602). ***CBO Score: $11.563 billion/5 years and $12.133 billion/10 years***. The bill makes $10 billion available annually to states, from 2023 to 2025, providing them with the option to establish a state reinsurance program or use the funds to provide financial assistance to reduce out-of-pocket costs for individuals enrolled in individual market health insurance coverage or Basic Health Program

plans. States that have not adopted the ACA Medicaid expansion would not be eligible to apply for such funding directly; as an alternative, CMS would implement a reinsurance program in those states.

The $10 billion fund, which is prorated based on state market size, is enough to allow all states to develop an impactful reinsurance program. Many of the current 15 programs operate on less state funding than the $200 million this fund would provide to the average state, and $200 million would go even further in reducing cost sharing for consumers who find their out-of-pocket costs unaffordable.

Funding for the Provision of Health Insurance Consumer Information (Title III, Subtitle E, Section 30603). ***CBO Score: $83 million/5 years and $95 million/10 years***. This section provides $100 million for the ACA's Consumer Assistance Program (CAP) grants for calendar years 2022 through 2025 ($25 million each year). The ACA provided funding to establish and support state-run CAPs to educate consumers on health insurance issues, assist consumers with enrollment, help consumers file complaints and appeals, and resolve any issues with obtaining PTCs. In 2010, HHS distributed nearly $30 million for CAPs and continued to fund CAPs through 2014, after which CAPs have had to rely on nonfederal funding. This new influx of funding over four years, in alignment with the Biden Administration's heightened investment in Navigator programs (see the September 2 edition of *Insights this Week* for more), aims to bolster consumer assistance and Marketplace enrollment.

Funding to Support State Applications for Section 1332 Waivers and Administration (Title III, Subtitle E, Section 30607). ***CBO Score: $45 million/5 years and $50 million/10 years***. The bill includes $50 million in grants to states to develop new Section 1332 applications, extensions, and amendments, as well as for Section 1332 waiver implementation.

Medicare

Providing Coverage for Hearing Care Under Medicare (Title III, Subtitle H, Section 30901). ***CBO Score: $12.986 billion/5 years and $36.72 billion/10 years***. This section extends coverage for audiology services under Medicare, beginning on January 1, 2023. The extended coverage would include:

- Coverage of prescription hearing aids as prosthetic devices under Medicare Part B for individuals with severe or profound hearing loss in one or both ears, not more than once per ear every five years and only if furnished through a written order by a physician, qualified audiologist, hearing aid professional, physician assistant, nurse practitioner, or clinical nurse specialist qualified to write such order in the state

- Allowing qualified audiologists to deliver aural rehabilitation and treatment services in addition to the hearing and balance assessment services provided under current law

- Allowing qualified hearing aid professionals to deliver hearing assessments

Permanent Extension of the Independence at Home Medical Practice Demonstration Program (Title XIII, Subtitle B, Section 132001). ***CBO Score: $422 million/5 years and $1.456 billion/10 years***. The bill permanently extends the Independence at Home Medical Practice Demonstration Program. This demonstration, facilitated through the CMS Innovation Center (CMMI), works with medical practices to test the effectiveness of delivering comprehensive primary care services to patients with multiple chronic conditions and functional limitations at home with the aim of lowering Medicare costs by preventing the need for hospitalization. For more information on other investments in HCBS included in the bill, see above.

Long-Term Care

Skilled Nursing Services (Title III, Subtitle F, Part 1, Sections 30717–30719). This section provides funding for HHS to improve data on skilled nursing facilities (SNFs), including:

- **Skilled Nursing Facility Data (Section 30717).** ***CBO Score: $48 million/5 years and $50 million/10 years***. This section provides $50 million to conduct data validation of nursing home quality data submitted through the Minimum Data Set, SNF Value-Based Purchasing Program, or Payroll-Based Journal staffing dataset. Failure to submit accurate data through any of these three data systems will lead to a 2-percentage-point penalty for SNFs beginning in FY2026.

- **Ensuring Accurate Information on Cost Reports (Section 30718).** ***CBO Score: $242 million/5 years and $250 million/10 years***. This section appropriates $250 million to audit Medicare cost reports submitted by SNFs.

- **Survey Improvements (Section 30719).** ***CBO Score: $315 million/5 years and $325 million/10 years***. This section allocates $325 million for HHS to improve existing surveys and enforcement processes to ensure compliance with SNF conditions of participation.

Nursing Staffing Requirements (Section 30720). ***CBO Score: $50 million/5 and 10 years***. This section appropriates $50 million for HHS to conduct studies on the appropriateness of establishing staff-to-resident ratios in SNFs.

Registered Professional Nurses (Title XIII, Subtitle B, Section 132000). ***CBO Score: $237 million/5 years and $979 million/10 years***. Related to the nursing staff requirements in section 30720, the bill adds a requirement that, beginning on October 1, 2024, SNFs and nursing homes participating in Medicare or Medicaid employ a registered professional nurse (RN) for 24 hours a day, seven days a week, subject to existing statutory waivers relating to RN services.

Maternal Mortality

In addition to the extension of postpartum Medicaid coverage (see above), the bill provides investments in a range of public health efforts to address maternal mortality, including the following select provisions.[12]

Local Entities Addressing Social Determinants of Maternal Health (Title III, Subtitle I, Part 3, Section 31031). This section provides $100 million in grant funding to local community-based organizations to address social determinants of maternal health for pregnant and postpartum individuals.

Office of Minority Health (Title III, Subtitle I, Part 3, Section 31032). This section provides $75 million in funding for the Office of Minority Health at HHS for the purpose of awarding grants to organizations in areas with high rates of adverse maternal health outcomes or significant racial or ethnic disparities in maternal health outcomes.

Growing and Diversifying the Nursing Workforce in Maternal and Perinatal Health; the Doula Workforce; and the Maternal Mental Health and Substance Use Disorder Treatment Workforce (Title III, Subtitle I, Part 3, Sections 31033, 31035, and 31036). Section 31033 provides $170 million to award grants or contracts to schools of nursing to grow and diversify the perinatal nursing workforce. Section 31035 includes $50 million for grants to establish or expand programs to grow and diversify the doula workforce. Finally, Section 31036 provides $75 million in funding for grants to establish or expand programs to grow and diversify the maternal mental health and substance use disorder treatment workforce.

Perinatal Quality Collaboratives (Title III, Subtitle I, Part 3, Section 31034). This section provides $50 million to carry out a program to establish or support perinatal quality collaboratives to improve care and health outcomes for pregnant and postpartum individuals and their infants.

Maternal Mental Health Equity Programs (Title III, Subtitle I, Part 3, Section 31037). This section provides $100 million in funding to establish or expand maternity care that improves integration of mental health and substance use disorder treatment services for pregnant, lactating, and postpartum individuals.

Education and Training at Health Professions Schools to Identify and Address Health Risks Associated with Climate Change (Title III, Subtitle I, Part 3, Section 31038). This section provides $85 million in grants to support and develop education and training programs to identify and address health risks associated with climate change for pregnant, lactating, and postpartum individuals.

[12] CBO estimates are not listed for each provision in this section since outlays resembled closely the budget authority granted in each of these provisions. If outlay estimates differed by more than $20 million of budget authority, we noted the CBO scores. For more, see the CBO analyses here.

Maternal Health Outcome Studies at Minority-Serving Institutions (Title III, Subtitle I, Part 3, Section 31039). This section provides $50 million in funding to minority-serving institutions to study maternal mortality, severe maternal morbidity, and adverse maternal health outcomes.

Maternity Care Health Professional Target Areas (Title III, Subtitle I, Part 3, Section 31040). This section provides $25 million for the identification of maternity care health professional target areas, which are geographic areas within health professional shortage areas that have a shortage of maternity care health professionals.

Maternal Mortality Review Committees (Title III, Subtitle I, Part 3, Section 31041). This section provides $50 million to promote community engagement in maternal mortality review committees (MMRCs).

Emerging Threats to Mothers and Babies (Title III, Subtitle I, Part 3, Section 31042). This section provides $100 million in funding for the CDC's National Center on Birth Defects and Developmental Disabilities in order to conduct surveillance on emerging threats to mothers and babies.

Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (Title III, Subtitle I, Part 3, Section 31043). This section provides $30 million to carry out the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program (commonly known as the "ERASE MM" program), including by expanding the program and its partnerships with state, territorial, and Tribal organizations to support MMRCs.

Pregnancy Risk Assessment Monitoring System (Title III, Subtitle I, Part 3, Section 31044). This section provides $15 million to support the Pregnancy Risk Assessment Monitoring System, including to support the addition of COVID-19 supplements to this risk assessment questionnaire.

National Institute of Child Health and Human Development (Title III, Subtitle I, Part 3, Section 31045). This section provides $15 million to support the activities of the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institutes of Health (NIH).

Utilizing Technology-Enabled Collaborative Learning (Title III, Subtitle I, Part 3, Section 31046). This section provides $30 million in grants to expand the use of technology-enabled collaborative learning and capacity-building models for pregnant and postpartum individuals. Awardees can use the funds to train maternal health care providers, students, and staff.

Promoting Equity in Maternal Health Outcomes Through Digital Tools (Title III, Subtitle I, Part 3, Section 31047). This section provides $30 million to enhance access to digital tools related to maternal health care in order to reduce racial and ethnic disparities in maternal health outcomes.

Antidiscrimination and Bias Training (Title III, Subtitle I, Part 3, Section 31048). This section provides $50 million to facilitate the development, dissemination, review, research, and evaluation of training for health professionals and staff who interact with patients to reduce discrimination and bias in the provision of health care, with an emphasis on maternal health care.

Health Care Workforce and Infrastructure

Health Center Capital Grants (Title III, Subtitle I, Part 1, Section 31002). ***CBO Score: $3.648 billion/5 years and $6.93 billion/10 years***. The bill invests $2 billion for health center infrastructure. Notably, the bill no longer contains, as in previous versions, infrastructure investments in hospitals/medical facilities.

Pathways to Health Careers (Title XIII, Subtitle D, Part 1, Section 134101). ***CBO Score: $1.259 billion/5 years and $2.204 billion/10 years***. This section amends the Social Security Act to authorize new Health Professional Opportunity Grants (HPOG) competitive grants. This program, to be administered by the Administration for Children and Families, will award grants to organizations to provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for occupations in the health care field that pay well and that are expected to experience either labor shortages or high demand. This section lays out application requirements, eligible participants, and eligible uses of funds for the new grant programs. It also establishes a Maternal Mortality Career Pathway (for trainees in the field of pregnancy, birth, or postpartum services) and the Second Chance Career Pathway (for trainees with arrest or conviction records). It also appropriates funding for these projects.

Rural and Underserved Pathway to Practice Training Programs (Title XIII, Subtitle E, Part 4, Sections 137401 to 137404). ***Combined CBO Score: $256 million/5 years and $3.548 billion/10 years***. Sections 137401 through 137404 establish and fund a Rural and Underserved Pathway to Practice Training Program for post-baccalaureate students, medical students, and medical residents. This new program would help recruit students from rural and underserved areas, provide rural-focused training and experience, and support efforts to recruit and retain medical school graduates to practice in underserved rural communities. The program also would provide scholarships to students who agree to complete medical school (and a post-baccalaureate program, as applicable); complete a residency; and practice for at least one year per scholarship year in a health professional shortage area, a medically underserved area, or a rural area. As an incentive for institutions to support this new program, Section 137403 creates a new refundable Pathway to Practice medical scholarship voucher tax credit for medical schools and post-baccalaureate programs to offset the value of medical scholarship vouchers awarded to qualified students.

Distribution of Additional Residency Positions (Title XIII, Subtitle E, Part 4, Section 137405). ***CBO Score: $339 million/5 years and $4.865 billion/10 years***. Tied to the Rural and Underserved Pathway to Practice program, the bill invests in residency training by distributing

4,000 additional Medicare residency positions, with a specified percent of positions to be made available in primary care and psychiatry. The bill also requires a portion of residency slots be distributed to hospitals in rural areas and hospitals in health professional shortage areas.

Programs to Prevent and Investigate Elder Abuse, Neglect, and Exploitation (Title XIII, Subtitle D, Part 2, Sections 134201 and 134202). ***Combined CBO Score: $2.489 billion/5 years and $3.943 billion/10 years***. The bill authorizes and appropriates funds to promote recruitment and retention of post-acute and long-term care workers; fund elder justice and long-term care ombudsman programs to protect seniors from abuse or neglect; and enhance state and local investments to improve services for the elderly. The bill also provides technical funding for HHS in order to prepare and submit a report to Congress on the extent to which coordinating bodies, programs, and registries have improved access to, and the quality of, resources available to aging Americans and their caregivers to ultimately prevent, detect, and treat abuse, neglect, and exploitation. Funding authorized by the bill includes:

- **Nursing Home Worker Training Grants.** This provision provides $415 million per year in FY2023 through FY2026 for the Nursing Home Worker Training Grants, and $8 million per year in the same period for Tribes and Tribal organizations to invest in worker recruitment and retention. The allocated funds must be used to provide wage subsidies to eligible workers; provide student loan repayment or tuition assistance to eligible individuals; guarantee affordable and accessible childcare for eligible workers; and provide transportation assistance for workers. The funds may also be used to provide the following, among other things: in-kind resource donations like interview clothing and conference attendance fees, assistance with programs deemed necessary to address arrest or conviction records that are an employment barrier, and support services to allow for the successful recruitment of workers.

- **Adult protective services.** This section provides $8 million for HHS administrative costs for each of FY2023 through FY2025 specifically for adult protective services.

- **Long-term care ombudsman programs.** This section provides $23 million for FY2023 and $31 million for each of FY2024 and FY2025 to fund grants to states for long-term care ombudsman programs. Further, the provision provides $31 million for each of FY2023 through FY2025 to establish programs that provide and improve ombudsman training for national organizations and state ombudsman programs, focusing on elder abuse, neglect, and exploitation.

- **Incentives for developing and sustaining structural competency in providing health and human services.** This section provides funding for two programs seeking to provide additional services and supports that older adults and individuals with disabilities may need. One fund provides $530 million for states to develop “medical-legal partnerships,” which are multidisciplinary teams that combine clinical staff with social workers and lawyers. The other funding stream provides $265 million for area agencies on aging and

other community-based organizations to address social isolation among vulnerable seniors and individuals with disabilities.

Workforce Training Programs (Title III, Subtitle I, Part 1, Sections 31003-31013).[13] The bill includes a number of provisions to support workforce training and to help improve provider capacity in underserved regions, including:

- **Teaching Health Center Graduate Medical Education (Section 31003).** ***CBO Score: $3.337 billion/5 and 10 years***. The bill includes $3.37 billion for teaching health center graduate medical education (GME) programs.

- **Children's Hospitals that Operate Graduate Medical Education Programs (Section 31004).** The bill includes $200 million for the Children's Hospital GME Programs.

- **National Health Service Corps (Section 31005).** ***CBO Score: $1.980 billion/5 and 10 years***. The bill includes $2 billion for the National Health Service Corps which provides scholarships and loan repayment to qualified health care providers in exchange for their service in underserved areas across the country.

- **Nurse Corps (Section 31006).** The bill includes $500 million in funding for Nurse Corps, which provides loan repayment assistance to registered nurses (RNs) and advanced practice registered nurses (APRNs) in return for a commitment to work at eligible health care facilities with a critical shortage of nurses or to serve as nurse faculty in eligible schools of nursing.

- **Schools of Medicine and Nursing in Underserved Areas (Sections 31007–31008).** The bill includes $500 million for the expansion, establishment, or improvement of medical schools, and $500 million for enhancing and modernizing nursing schools, both focusing on underserved areas.

- **Palliative Care and Hospice Workforce (Sections 31009–31013).** The bill includes $90 million to bolster palliative and hospice care, including funding for workforce training, academic career awards, and a public awareness campaign.

Behavioral Health

In addition to provisions to expand Medicaid community mental health services and mobile crisis unites, (see above), the bill includes investments to address community violence and traumatic stress and investments to enhance communities' response to behavioral health and substance use disorder issues. Selected provisions include the following:[14]

[13] See Footnote 11 above on CBO scores included in this section.
[14] See Footnote 11 above on CBO scores included in this section.

Mental Health and Substance Use Disorder Professionals (Title III, Subtitle I, Part 4, Section 31051). The bill includes $50 million for the Minority Fellowship Program at SAMHSA to promote culturally competent behavioral health care for underserved communities.

Project AWARE (Title III, Subtitle I, Part 4, Section 31053). The bill includes $15 million for Project AWARE, which supports coordination among state and local governments to address youth mental health issues by increasing awareness, training school personnel, and connecting youth to needed services.

National Suicide Prevention Lifeline (Title III, Subtitle I, Part 4, Section 31054). The bill includes $75 million for the National Suicide Prevention Lifeline, the 24/7 free, confidential national suicide prevention hotline. The funding will support the Lifeline and its local crisis centers in implementing the new "988" Lifeline number in 2022.

Research Funding[15]

Increasing Research Capacity at Certain Institutions (Title III, Subtitle I, Part 4, Section 31060). The bill includes $75 million for the NIH to increase research capacity at minority-serving institutions (including Historically Black Colleges and Universities) and to recruit and retain underrepresented individuals in biomedical research.

Research Related to Developmental Delays (Title III, Subtitle I, Part 4, Section 31061). The bill includes $10 million for NIH research related to developmental delays in children.

Other Public Health Funding[16]

Core Public Health Infrastructure Funding (Title III, Subtitle I, Part 1, Section 31001). ***CBO Score: $3.648 billion/5 years and $6.93 billion/10 years***. The bill provides $7 billion in funding to support core public health infrastructure activities through grants to state, territorial, local, or Tribal health departments, and through expanding and improving CDC activities.

Pandemic Preparedness (Title III, Subtitle I, Part 2, Sections 31021–31023). ***Combined CBO Score: $2.952 billion/5 years and $2.986 billion/10 years***. The bill includes $3 billion in funding for public health laboratory infrastructure, FDA infrastructure (including technological and facilities infrastructure), and for other preparations for public health emergencies, such as supporting surge capacity, vaccine production capacity, and activities to mitigate supply chain risks.

HIV Health Care Services Programs (Title III, Subtitle I, Part 4, Section 31057). The bill includes $75 million in funding for the Ryan White HIV/AIDS program.

[15] See Footnote 11 above on CBO scores included in this section.
[16] See Footnote 11 above on CBO scores included in this section.

Clinical Services Demonstration Project (Title III, Subtitle I, Part 4, Section 31058). The bill provides $60 million to support demonstration grants and contracts to prevent and control sexually transmitted diseases.

Supporting the Lifespan Respite Care Program (Title III, Subtitle I, Part 4, Section 31059). The bill includes $5 million to support the Lifespan Respite Care program to provide community-based assistance to family caregivers of children and adults with special needs.

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