

Deficit Reduction Act of 2005

The following are some selected sections of the Deficit Reduction Act of 2005 which may impact long term care for seniors.

Sec. 6011. Lengthening Look-back Period; Change in Beginning Date for Period of Ineligibility.

Sec. 6012. Disclosure and Treatment of Annuities.

Sec. 6013. Application of 'Income-first' Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse

Sec. 6014. Disqualification for Long-term Care Assistance for Individuals with Substantial Home Equity

Sec. 6015. Enforceability of Continuing Care Retirement Communities (Ccrc) and Life Care Community Admission Contracts.

Sec. 6016. Additional Reforms of Medicaid Asset Transfer Rules.

Sec. 6021. Expansion of State Long-term Care Partnership Program.

Sec. 6036. Improved Enforcement of Documentation Requirements.

Sec. 6071. Money Follows the Person Rebalancing Demonstration.

Sec. 6086. Expanded Access to Home and Community-based Services for the Elderly and Disabled.

Sec. 6087. Optional Choice of Self-directed Personal Assistance Services (Cash and Counseling).

S.1932

Deficit Reduction Act of 2005

TITLE VI

CHAPTER 2--LONG-TERM CARE UNDER MEDICAID

Subchapter A--Reform of Asset Transfer Rules

SEC. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.

(a) Lengthening Look-Back Period for All Disposals to 5 Years- Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is amended by inserting 'or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005' before ', 60 months'.

(b) Change in Beginning Date for Period of Ineligibility- Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended--

(1) by striking '(D) The date' and inserting '(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date'; and

(2) by adding at the end the following new clause:

'(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.'

(c) Effective Date- The amendments made by this section shall apply to transfers made on or after the date of the enactment of this Act.

(d) Availability of Hardship Waivers- Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))--

(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual--

(A) of medical care such that the individual's health or life would be endangered; or

(B) of food, clothing, shelter, or other necessities of life; and

(2) which provides for--

(A) notice to recipients that an undue hardship exception exists;

(B) a timely process for determining whether an undue hardship waiver will be granted; and

(C) a process under which an adverse determination can be appealed.

(e) Additional Provisions on Hardship Waivers-

(1) APPLICATION BY FACILITY- Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended--

(A) by striking the semicolon at the end of subparagraph (D) and inserting a period; and

(B) by adding after and below such subparagraph the following:

'The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.'

(2) Authority to make bed hold payments for hardship applicants- Such section is further amended by adding at the end the following: `While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.`.

SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.

(a) In General- Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

`(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

`(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

`(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

`(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

`(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).`.

(b) REQUIREMENT FOR STATE TO BE NAMED AS A REMAINDER BENEFICIARY- Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the end the following:

`(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless--

`(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

`(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.'

(c) INCLUSION OF TRANSFERS TO PURCHASE BALLOON ANNUITIES- Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

`(G) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless--

`(i) the annuity is--

`(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

`(II) purchased with proceeds from--

`(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

`(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

`(cc) a Roth IRA described in section 408A of such Code;

or

`(ii) the annuity--

`(I) is irrevocable and nonassignable;

`(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

`(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.'

(d) Effective Date- The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

SEC. 6013. APPLICATION OF 'INCOME-FIRST' RULE IN APPLYING COMMUNITY SPOUSE'S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) In General- Section 1924(d) of the Social Security Act (42 U.S.C. 1396r-5(d)) is amended by adding at the end the following new subparagraph:

`(6) APPLICATION OF 'INCOME FIRST' RULE TO REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE- For purposes of this subsection and subsections (c) and (e), a State must consider that all

income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.'

(b) Effective Date- The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) In General- Section 1917 of the Social Security Act, as amended by section 6012(a), is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

`(f)(1)(A) Notwithstanding any other provision of this title, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.

`(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for '\$500,000', an amount that exceeds such amount, but does not exceed \$750,000.

`(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

`(2) Paragraph (1) shall not apply with respect to an individual if--

`(A) the spouse of such individual, or

`(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual's home.

`(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

`(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.'

(b) Effective Date- The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RETIREMENT COMMUNITIES (CCRC) AND LIFE CARE COMMUNITY ADMISSION CONTRACTS.

(a) Admission Policies of Nursing Facilities- Section 1919(c)(5) of the Social Security Act (42 U.S.C. 1396r(c)(5)) is amended--

(1) in subparagraph (A)(i)(II), by inserting 'subject to clause (v),' after '(II)'; and

(2) by adding at the end of subparagraph (B) the following new clause:

(v) TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITIES ADMISSION CONTRACTS- Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1924, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.'

(b) Treatment of Entrance Fees- Section 1917 of such Act (42 U.S.C. 1396p), as amended by sections 6012(a) and 6014(a), is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

(g) Treatment of Entrance Fees of Individuals Residing in Continuing Care Retirement Communities-

(1) IN GENERAL- For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) TREATMENT OF ENTRANCE FEE- For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that--

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing

care retirement community or life care community contract and leaves the community; and
`(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.'

SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET TRANSFER RULES.

(a) REQUIREMENT TO IMPOSE PARTIAL MONTHS OF INELIGIBILITY- Section 1917(c)(1)(E) of the Social Security Act (42 U.S.C. 1396p(c)(1)(E)) is amended by adding at the end the following:

`(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.'

(b) Authority for States To Accumulate Multiple Transfers Into One Penalty Period- Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsections (b) and (c) of section 6012, is amended by adding at the end the following:

`(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by--

`(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

`(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.'

(c) INCLUSION OF TRANSFER OF CERTAIN NOTES AND LOANS ASSETS- Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

`(I) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage--

`(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

`(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

`(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage

shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).'

(d) INCLUSION OF TRANSFERS TO PURCHASE LIFE ESTATES- Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (c), is amended by adding at the end the following:

`(J) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.'

(e) EFFECTIVE DATES-

(1) IN GENERAL- Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) EXCEPTIONS- The amendments made by this section shall not apply--

(A) to medical assistance provided for services furnished before the date of enactment;

(B) with respect to assets disposed of on or before the date of enactment of this Act; or

(C) with respect to trusts established on or before the date of enactment of this Act.

(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW

AMENDMENT- In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subchapter B--Expanded Access to Certain Benefits

SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) EXPANSION AUTHORITY-

(1) IN GENERAL- Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended--

(A) in paragraph (1)(C)--

(i) in clause (ii), by inserting `and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))' after `1993,'; and

(ii) by adding at the end the following new clauses:

`(iii) For purposes of this paragraph, the term `qualified State long-term care insurance partnership' means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

`(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

`(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

`(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

`(IV) If the policy is sold to an individual who--

`(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

`(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

`(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

`(V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

`(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

`(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard

to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term 'long-term care insurance policy' includes a certificate issued under a group insurance contract.

'(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

'(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

'(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.'; and

(B) by adding at the end the following:

'(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

'(i) In the case of the model regulation, the following requirements:

'(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

'(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

'(III) Section 6C (relating to extension of benefits).

'(IV) Section 6D (relating to continuation or conversion of coverage).

`(V) Section 6E (relating to discontinuance and replacement of policies).

`(VI) Section 7 (relating to unintentional lapse).

`(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

`(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

`(IX) Section 11 (relating to prohibitions against post-claims underwriting).

`(X) Section 12 (relating to minimum standards).

`(XI) Section 14 (relating to application forms and replacement coverage).

`(XII) Section 15 (relating to reporting requirements).

`(XIII) Section 22 (relating to filing requirements for marketing).

`(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

`(XV) Section 24 (relating to suitability).

`(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

`(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

`(XVIII) Section 29 (relating to standard format outline of coverage).

`(XIX) Section 30 (relating to requirement to deliver shopper's guide).

`(ii) In the case of the model Act, the following:

`(I) Section 6C (relating to preexisting conditions).

`(II) Section 6D (relating to prior hospitalization).

`(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

`(IV) Section 6F (relating to right to return).

`(V) Section 6G (relating to outline of coverage).

`(VI) Section 6H (relating to requirements for certificates under group plans).

`(VII) Section 6J (relating to policy summary).

`(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

`(IX) Section 7 (relating to incontestability period).

`(B) For purposes of this paragraph and paragraph (1)(C)--

`(i) the terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

*`(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and
` (iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.*

`(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.'

(2) STATE REPORTING REQUIREMENTS- Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

(3) EFFECTIVE DATE- A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES- In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which--

(1) benefits paid under such policies will be treated the same by all such States; and

(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

(c) ANNUAL REPORTS TO CONGRESS-

(1) IN GENERAL- The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)).

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SEC. 6036. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) In General- Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended--

(1) in subsection (i), as amended by section 104 of Public Law 109-91--

(A) by striking 'or' at the end of paragraph (20);

(B) by striking the period at the end of paragraph (21) and inserting '; or'; and

(C) by inserting after paragraph (21) the following new paragraph:

'(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.';
and

(2) by adding at the end the following new subsection:

'(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

'(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title--

'(A) and is entitled to or enrolled for benefits under any part of title XVIII;

'(B) on the basis of receiving supplemental security income benefits under title XVI; or

'(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

'(3)(A) For purposes of this subsection, the term 'satisfactory documentary evidence of citizenship or nationality' means--

'(i) any document described in subparagraph (B); or

'(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

- `(B) The following are documents described in this subparagraph:*
- `(i) A United States passport.*
 - `(ii) Form N-550 or N-570 (Certificate of Naturalization).*
 - `(iii) Form N-560 or N-561 (Certificate of United States Citizenship).*
 - `(iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.*
 - `(v) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.*
- `(C) The following are documents described in this subparagraph:*
- `(i) A certificate of birth in the United States.*
 - `(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).*
 - `(iii) Form I-97 (United States Citizen Identification Card).*
 - `(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).*
 - `(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.*
- `(D) The following are documents described in this subparagraph:*
- `(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.*
 - `(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.*
- `(E) A reference in this paragraph to a form includes a reference to any successor form.'*

(b) Effective Date- The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

(c) IMPLEMENTATION REQUIREMENT- As soon as practicable after the date of enactment of this Act, the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(23) and (x) of section 1903 of the Social Security Act (as added by subsection (a)) about such requirements and how they may be satisfied.

* * * * *

Subchapter B--Money Follows the Person Rebalancing Demonstration

SEC. 6071. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) PROGRAM PURPOSE AND AUTHORITY- The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an `MFP demonstration project') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

(1) REBALANCING- Increase the use of home and community-based, rather than institutional, long-term care services.

(2) MONEY FOLLOWS THE PERSON- Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

(3) CONTINUITY OF SERVICE- Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

(4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT- Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

(b) DEFINITIONS- For purposes of this section:

(1) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES- The term `home and community-based long-term care services' means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

(2) ELIGIBLE INDIVIDUAL- The term `eligible individual' means, with respect to an MFP demonstration project of a State, an individual in the State--

(A) who, immediately before beginning participation in the MFP demonstration project--

(i) resides (and has resided, for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State) in an inpatient facility;

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution; and

(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

(3) INPATIENT FACILITY- The term 'inpatient facility' means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

(4) MEDICAID- The term 'Medicaid' means, with respect to a State, the State program under title XIX of the Social Security Act (including any waiver or demonstration under such title or under section 1115 of such Act relating to such title).

(5) QUALIFIED HCB PROGRAM- The term 'qualified HCB program' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

(6) QUALIFIED RESIDENCE- The term 'qualified residence' means, with respect to an eligible individual--

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

(7) QUALIFIED EXPENDITURES- The term 'qualified expenditures' means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

(8) SELF-DIRECTED SERVICES- The term 'self-directed' means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the

individual's authorized representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

(A) ASSESSMENT- There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(B) SERVICE PLAN- Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that--

(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(iv) is developed through a person-centered process that--

(I) is directed by the individual or the individual's authorized representative;

(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(C) BUDGET PROCESS- With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)--

- (i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;*
- (ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and*
- (iii) provides a procedure to evaluate expenditures under such budgets.*

(9) STATE- The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act.

(c) STATE APPLICATION- A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

(1) ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS- The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

(2) OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES- The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

(3) DEMONSTRATION PROJECT PERIOD- The application shall specify the period of the MFP demonstration project, which shall include at least 2 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2007.

(4) SERVICE AREA- The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

(5) TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED- The application shall specify--

(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

(6) INDIVIDUAL CHOICE, CONTINUITY OF CARE- The application shall contain assurances that--

(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, meeting the requirement for at least the level of care which had resulted in the individual's admission to the institution).

(7) REBALANCING- The application shall--

(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services;

(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services; and

(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a).

(8) MONEY FOLLOWS THE PERSON- The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

(9) MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS- The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that--

(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for--

(i) fiscal year 2005; or

(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

(B) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

(10) WAIVER REQUESTS- The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

(11) QUALITY ASSURANCE AND QUALITY IMPROVEMENT- The application shall include--

(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.

(12) OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES- If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

(A) MEETING REQUIREMENTS- A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

(B) VOLUNTARY ELECTION- A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

(C) STATE SUPPORT IN SERVICE PLAN DEVELOPMENT- Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.

(D) OVERSIGHT OF RECEIPT OF SERVICES- Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

(13) REPORTS AND EVALUATION- The application shall provide that--

(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States; and

(B) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS-

(1) IN GENERAL- The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS- In selecting State applications for the awarding of such a grant, the Secretary--

(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

(C) shall give preference to State applications proposing--

(i) to provide transition assistance to eligible individuals within multiple target groups; and

(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

(3) WAIVER AUTHORITY- The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

(A) STATEWIDENESS- Section 1902(a)(1), in order to permit implementation of a State initiative in a selected area or areas of the State.

(B) COMPARABILITY- Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

(C) INCOME AND RESOURCES ELIGIBILITY- Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

(D) PROVIDER AGREEMENTS- Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT- In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

(A) NUMERICAL BENCHMARKS- The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for--

(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

(ii) numbers of eligible individuals assisted to transition to qualified residences.

(B) QUALITY OF CARE- The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

(e) PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS-

(1) PAYMENTS- For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of--

(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

(2) CARRYOVER OF UNUSED AMOUNTS- Any portion of a State grant award for a fiscal year under this section remaining at the end of such

fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3).

(3) REAWARDING OF CERTAIN UNUSED AMOUNTS- In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

(4) PREVENTING DUPLICATION OF PAYMENT- The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

(5) MFP-ENHANCED FMAP- For purposes of paragraph (1)(A), the 'MFP-enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

(f) QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT-

(1) IN GENERAL- The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including--

(A) dissemination of information on promising practices;

(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

(D) guidance on remedying programmatic and systemic problems.

(2) FUNDING- From the amounts appropriated under subsection (h)(1) for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, not more than \$2,400,000 shall be available to the Secretary to carry out this subsection during the period that begins on January 1, 2007, and ends on September 30, 2011.

(g) RESEARCH AND EVALUATION-

(1) IN GENERAL- The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

(2) FINAL REPORT- The Secretary shall make a final report to the President and Congress, not later than September 30, 2011, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

(3) FUNDING- From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2011, not more than \$1,100,000 per year shall be available to the Secretary to carry out this subsection.

(h) APPROPRIATIONS-

(1) IN GENERAL- There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section--

(A) \$250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;

(B) \$300,000,000 for fiscal year 2008;

(C) \$350,000,000 for fiscal year 2009;

(D) \$400,000,000 for fiscal year 2010; and

(E) \$450,000,000 for fiscal year 2011.

(2) AVAILABILITY- Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30, 2011.

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SEC. 6086. EXPANDED ACCESS TO HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY AND DISABLED.

(a) HOME AND COMMUNITY-BASED SERVICES AS AN OPTIONAL BENEFIT FOR ELDERLY AND DISABLED INDIVIDUALS- Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS-

(1) IN GENERAL- Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for

which the Secretary has the authority to approve a waiver and not including room and board or such other services requested by the State as the Secretary may approve) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

“(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES- The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

“(B) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE- The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

“(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES-

“(i) IN GENERAL- The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

“(ii) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS- A State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.

“(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT-

“(i) IN GENERAL- The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

`(ii) ADJUSTMENT AUTHORITY- The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if--

`(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

`(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services; and

`(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

`(E) INDEPENDENT EVALUATION AND ASSESSMENT-

`(i) ELIGIBILITY DETERMINATION- The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

`(ii) ASSESSMENT- In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to--

`(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

`(II) prevent the provision of unnecessary or inappropriate care; and

`(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

`(F) ASSESSMENT- The independent assessment required under subparagraph (E)(ii) shall include the following:

`(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in

section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

`(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

`(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

`(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

`(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

`(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

`(G) INDIVIDUALIZED CARE PLAN-

`(i) IN GENERAL- In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

`(ii) PLAN REQUIREMENTS- The State ensures that the individualized care plan for an individual--

`(I) is developed--

`(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

`(bb) taking into account the extent of, and need for, any family or other supports for the individual;

`(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

`(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

`(iii) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES-

`(I) INDIVIDUAL CHOICE- At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

`(II) SELF-DIRECTED SERVICES- The term 'self-directed' means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

`(aa) ASSESSMENT- There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

`(bb) SERVICE PLAN- Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

`(III) PLAN REQUIREMENTS- For purposes of subclause (II)(bb), the requirements of this subclause are that the plan--

`(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

`(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

`(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

`(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's

preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

`(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

`(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

`(IV) BUDGET PROCESS- With respect to individualized budgets described in subclause (III)(ff), the State plan amendment--

`(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

`(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

`(cc) provides a procedure to evaluate expenditures under such budgets.

`(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS-

`(i) QUALITY ASSURANCE- The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

`(ii) CONFLICT OF INTEREST STANDARDS- The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

`(I) REDETERMINATIONS AND APPEALS- The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

`(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT- The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the

individual is so eligible, the specific home and community-based services that the individual will receive.

`(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE- In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

`(3) NONAPPLICATION- A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

`(4) NO EFFECT ON OTHER WAIVER AUTHORITY- Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

`(5) CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION FOR MEDICAL ASSISTANCE PROVIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF STATE PLAN AMENDMENT- Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.'.

(b) QUALITY OF CARE MEASURES-

(1) IN GENERAL- The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

(2) BEST PRACTICES- The Secretary shall--

(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act; and
(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

(3) APPROPRIATION- Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, \$1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.

(c) EFFECTIVE DATE- The amendments made by subsections (a) and (b) take effect on January 1, 2007, and apply to expenditures for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act (as added by subsections (a) and (b)) on or after that date.

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SEC. 6087. OPTIONAL CHOICE OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES (CASH AND COUNSELING).

(a) Exemption From Certain Requirements- Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 6086(a), is amended by adding at the end the following new subsection:

`(j)(1) A State may provide, as `medical assistance', payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

`(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

`(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

`(B) The State will provide, with respect to individuals who--

`(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

`(ii) may require self-directed personal assistance services; and

`(iii) may be eligible for self-directed personal assistance services, an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

`(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

`(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

`(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

`(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

`(4)(A) For purposes of this subsection, the term 'self-directed personal assistance services' means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

`(B) At the election of the State--

`(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

`(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

`(5) For purpose of this section, the term 'approved self-directed services plan and budget' means, with respect to a participant, the establishment of a plan and

budget for the provision of self-directed personal assistance services, consistent with the following requirements:

`(A) SELF-DIRECTION- The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

`(B) ASSESSMENT OF NEEDS- There is an assessment of the needs, strengths, and preferences of the participants for such services.

`(C) SERVICE PLAN- A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that--

`(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

`(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

`(D) SERVICE BUDGET- A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

`(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT- There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

`(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).'

(b) Effective Date- The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2007.