119TH CONGRESS
2D SESSION

S. _____

To amend title XIX of the Social Security Act to require coverage of, and expand access to, home and community-based services under the Medicaid program; to award grants for the creation, recruitment, training and education, retention, and advancement of the direct care workforce and to award grants to support family caregivers; and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. LUJÁN introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend title XIX of the Social Security Act to require coverage of, and expand access to, home and community-based services under the Medicaid program; to award grants for the creation, recruitment, training and education, retention, and advancement of the direct care workforce and to award grants to support family caregivers; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''HCBS Access Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITIONS.

In this Act:

(1) DEMOGRAPHICS.—The term ''demographics'' means information relating to the races, ethnicities, genders, sexual orientations, gender iden-

tities, geographic locations, incomes, primary languages, types of service setting, and disability types represented within a particular group of individuals.

(2) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services.

TITLE I—REQUIRING AND EXPANDING ACCESS TO HCBS COVERAGE UNDER MEDICAID

SEC. 101. PURPOSE.

It is the purpose of this title to require coverage of home and community-based services (in this section referred to as ''HCBS'') under a State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for the following reasons:

(1) To eliminate waiting lists for HCBS, which delay access to necessary services and deny access to the promise of community inclusion guaranteed under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) for individuals with disabilities and older adults.

(2) To build on decades of progress in serving individuals with disabilities and older adults through access to HCBS.

(3) To fulfill the purposes of the Medicaid program to provide medical assistance for individuals whose income and resources are insufficient to meet the costs of necessary medical services, and to provide rehabilitation, long-term services and supports, and other services to help such individuals attain or retain capacity for independence or self-care.

(4) To ensure that individuals with all kinds of disabilities and with multiple disabilities, including intellectual disabilities, cognitive disabilities, developmental disabilities, behavioral health disabilities, physical disabilities, and substance use disorders, and older adults, receive the services they need to live in their communities.

(5) To streamline access to HCBS by eliminating the need for States to repeatedly apply for waivers of their respective State plans for medical assistance.

(6) To continue to increase the capacity of community services to ensure individuals with disabilities and older adults have high-quality, safe, and meaningful options to receive care in their community and are not at risk of unnecessary institutionalization.

(7) To act on the decades of research and practice that show that everyone, including individuals

with the most severe disabilities, can live in the community with the right services and supports.

(8) To eliminate the race, gender, sexual orientation, and gender identity disparities that exist in accessing information and HCBS and to prevent the unnecessary impoverishment and institutionalization of black and brown individuals with disabilities and older adults.

(9) To support over 63,000,000 unpaid family caregivers, who are disproportionately women and often providing complex services and supports to older adults and individuals with disabilities because of a lack of affordable services, workforce shortages, and other inefficiencies.

(10) To improve direct care quality and ensure access to services by improving workforce standards for the nearly 3,200,000 direct care workers, who are primarily women, people of color, and immigrants facing heightened risks of discrimination in employment, providing support to individuals with disabilities and older adults in their homes and communities.

SEC. 102. REQUIRING COVERAGE OF HOME AND COMMUNITY-BASED SERVICES UNDER THE MEDICAID PROGRAM.

(a) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—

(1) INCLUSION AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(A) in paragraph (31), by striking ''and'' at the end;

(B) by redesignating paragraph (32) as paragraph (33); and

(C) by inserting after paragraph (31) the following new paragraph:

''(32) home and community-based services (as defined in subsection (ll)); and''.

(2) HOME AND COMMUNITY-BASED SERVICES DEFINED.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(ll) HOME AND COMMUNITY-BASED SERVICES.—

''(1) IN GENERAL.—For purposes of this title, the term 'home and community-based services' means those services specified in paragraph (2) furnished to an eligible individual (as defined in paragraph (3)), based on an individualized assessment

(as described in paragraph (4)) and person-centered service plan (as described in paragraph (4)(D)) for such individual, in a setting that—

"(A) meets the qualities specified in paragraph (1) of section 441.710(a) of title 42, Code of Federal Regulations (or a successor regulation);

"(B) is not described in paragraph (2) of such section (or a successor regulation); and

"(C) meets such other qualities as the Secretary determines appropriate in line with recommendations for additional services made by the advisory panel described in paragraph (2)(B) of this subsection.

"(2) SERVICES SPECIFIED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the services specified in this paragraph are services described in any of paragraphs (7), (8), (13)(C), (19), (20), (22), (24), (29), and (33) of subsection (a) of this section or in any of subsections (c)(4)(B), (c)(5), (k)(1)(A), (k)(1)(B), or (k)(1)(D) of section 1915, including the following:

"(i) Supported employment and integrated day services.

"(ii) Personal assistance, including personal care attendants, direct support professionals, home health aides, private duty nursing, homemakers and chore assistance, and companionship services.

"(iii) Services that enhance independence, inclusion, and full participation in the broader community.

"(iv) Non-emergency, non-medical transportation services to facilitate community integration.

"(v) Respite services provided in the individual's home or broader community.

"(vi) Caregiver and family support services.

"(vii) Case management, including intensive case management, fiscal intermediary, and support brokerage services.

"(viii) Services that support person-centered planning and self-direction.

"(ix) Direct support services during acute hospitalizations.

"(x) Necessary medical and nursing services not otherwise covered that are necessary in order for the individual to remain

in their home and community, including hospice services.

"(xi) Home and community-based intensive behavioral health and crisis intervention services.

"(xii) Peer support services.

"(xiii) Housing support, including transitional housing or transitional support services for individuals who are unhoused, and wrap-around services.

"(xiv) Necessary home modifications and assistive technology, including those that substitute for human assistance.

"(xv) Transition services to support an individual who is transitioning from an institutional setting to the community, including appropriate services for individuals who are unhoused or at risk of becoming unhoused, and including such transition services provided while the individual resides in an institution.

"(xvi) Nutrition services.

"(xvii) Assisted living services.

"(xviii) Any other service approved by the Secretary, pursuant to the rec-

ommendation of the advisory panel convened under subparagraph (B).

''(B) SPECIFICATION OF RECOMMENDED SERVICES.—

''(i) IN GENERAL.—Not later than 6 months after the date of the enactment of this subparagraph, and not less frequently than once every 5 years thereafter, the Secretary shall appoint an advisory panel for purposes of recommending additional services which may be included as home and community-based services under this paragraph.

''(ii) COMPOSITION.—

''(I) SELECTION.—The advisory panel shall be comprised of not less than 50 members and include representatives of the following categories, with the majority of all members being selected from the categories described in items (aa), (bb), and (cc):

''(aa) Individuals with disabilities receiving home and community-based services under this

title and individuals with disabilities in need of such services, including those with physical disabilities, behavioral health disabilities, or intellectual or developmental disabilities, and including older adults, that are representative of multiple States, geographical locations, races, ethnicities, and other demographic factors.

''(bb) Beneficiary-led disability rights organizations.

''(cc) Disability-led organizations.

''(dd) Disabled veterans organizations.

''(ee) Disability organizations representing families.

''(ff) Organizations serving individuals with disabilities, including intellectual or developmental disabilities.

''(gg) Organizations serving older adults.

"(hh) Direct care workers and the labor organizations that represent such workers.

"(ii) The Protection and Advocacy System.

"(jj) The Centers for Independent Living.

"(kk) Health care providers.

"(ll) The National Association of Medicaid Directors.

"(mm) The National Association of State Directors of Developmental Disabilities Services.

"(nn) The National Association of State Mental Health Program Directors.

"(oo) Advancing States.

"(pp) The Centers for Medicare & Medicaid Services.

"(qq) The Administration for Community Living of the Department of Health and Human Services.

"(rr) Members of federally recognized tribes and tribally-led organizations.

"(ss) Other relevant Federal, State, and local home and community-based service systems, as determined by the Secretary.

"(II) REQUIREMENT FOR PROPORTIONATE REPRESENTATION.—The Secretary shall seek to ensure proportionate representation among each category described in items (dd) through (ss) of subclause (I) in convening the advisory panel.

"(iii) DUTIES.—

"(I) IN GENERAL.—Not later than 2 years after an advisory panel is convened under clause (i), the advisory panel shall submit to the Secretary and to Congress a report recommending additional services which may be included as home and community-based services under this paragraph with the goal of increasing community integration and self-deter-

mination for individuals with disabilities receiving such services.

''(II) CONSIDERATIONS.—In developing recommendations, the advisory panel shall consider—

''(aa) available data on coverage gaps of needed home and community-based services, including compliance reporting required by section 441.311(d) of title 42, Code of Federal Regulations;

''(bb) new technology or innovations that could promote access to home and community-based services for individuals with disabilities and older adults;

''(cc) relevant data based on the latest Home and Community-Based Services Quality Measure Set established and updated by the Secretary pursuant to section 441.312 of title 42, Code of Federal Regulations; and

''(dd) other relevant research, data, or information that

will help inform the adoption of home and community-based services for individuals with disabilities and older adults.

''(iv) IMPLEMENTATION OF RECOMMENDED ADDITIONAL SERVICES.—

''(I) IN GENERAL.—The Secretary shall consider the recommendations made in a report submitted by the advisory panel pursuant to clause (iii)(I), and review any other relevant information, to identify additional services as home and community-based services pursuant to subparagraph (A)(xviii).

''(II) CONSIDERATIONS.—In determining which recommendations of the advisory panel to implement, the Secretary shall consider—

''(aa) available data on coverage gaps of needed home and community-based services, including compliance reporting required by section 411.311(d) of title 42, Code of Federal Regulations;

"(bb) new technology or innovations that could promote access to home and community-based services for individuals with disabilities;

"(cc) relevant data based on the latest Home and Community-Based Services Quality Measure Set established and updated by the Secretary pursuant to section 441.312 of title 42, Code of Federal Regulations;

"(dd) public comment about additional home and community-based services obtained through the public notice and comment process described in subclause (III); and

"(ee) other relevant research, data, or information that will help inform the adoption of home and community-based services for individuals with disabilities.

"(III) NOTICE AND COMMENT.—Not later than 1 year after an advisory panel is convened under clause (i), the Secretary shall establish a process for public notice and comment, including public hearings, sufficient to ensure a meaningful level of public input.

"(IV) NOTIFICATION TO STATE MEDICAID DIRECTORS.—Not later than 1 year after the conclusion of the notice and comment process established by the Secretary pursuant to subclause (III), the Secretary shall issue a State Medicaid Director Letter to notify States of any additional home and community-based services approved by the Secretary for purposes of subparagraph (A)(xviii).

"(C) PRIVATE DUTY NURSING DEFINED.—For purposes of this paragraph, the term 'private duty nursing' means nursing services that are sufficient to meet the needs of an individual who requires more individualized and continuous care than is available from a visiting nurse

or routinely provided by the nursing staff of a hospital or skilled nursing facility, and includes services provided to an individual in the individual's own home by a registered nurse or licensed practical nurse under the direction of a physician.

''(3) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'eligible individual' means—

''(i) an individual who is determined, on an annual basis or on a longer basis specified by the State, by a health care provider approved by the State under a process described in subparagraph (C) to have a functional impairment (as defined in subparagraph (B)) (not taking into account any items or services, or any other ameliorative measures, furnished to such individual to mitigate such impairment) that is expected to last at least 90 days;

''(ii) during the period that ends on the day before the first day of the first calendar quarter beginning on or after the date that is 5 years after the date of the

enactment of this subsection, an individual who, as of such date of enactment, is receiving or has been determined to be eligible for home and community-based services under this title (or under a waiver or State plan option in effect under section 1915 or 1115, provided that the individual continues to meet any level of care requirement applicable under such waiver or State plan option); or

''(iii) an individual who is eligible under the State plan or a waiver of such plan and is under the age of 21.

''(B) FUNCTIONAL IMPAIRMENT.—For purposes of subparagraph (A)(i), the term 'functional impairment' means, with respect to an individual, the inability of such individual to perform, without assistance—

''(i) 2 or more activities of daily living (as described in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986);

''(ii) 2 or more instrumental activities of daily living (as defined for purposes of section 1915(k)(1)(A)); or

"(iii) 1 activity of daily living (as so described) and 1 instrumental activity of daily living (as so defined).

"(C) HEALTH CARE PROVIDER STATE APPROVAL.—For purposes of subparagraph (A)(i), a process described in this subparagraph is a process established by the State to approve a health care provider to make a determination of functional impairment in accordance with such standards as the Secretary may prescribe.

"(4) INDIVIDUALIZED ASSESSMENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), an individualized assessment described in this paragraph is an independent assessment, with respect to an eligible individual—

"(i) to determine a necessary level of services and supports to be provided, consistent with the individual's physical and health condition, including any functional impairments;

"(ii) to identify needed medical and non-medical services and supports;

"(iii) to inform development of a person-centered care plan (as described in subparagraph (D)) for the individual;

"(iv) that includes each of the elements described in clauses (ii) through (v) of section 1915(i)(1)(F); and

"(v) that occurs not later than 30 days after such individual is determined to be an eligible individual.

"(B) REASSESSMENTS.—An individualized assessment shall be conducted at least once every 12 months, and as needed when the individual's support needs or circumstances change significantly, and an individual's person-centered service plan shall be revised as necessary to reflect the results of the most recent individualized assessment.

"(C) PRESUMPTION.—The individualized assessment described in subparagraph (A) shall be conducted with the presumption—

"(i) that each eligible individual, regardless of type or level of disability or service need, can be served in the individual's own home and community; and

"(ii) at the option of the individual, that services may be self-directed (as defined in section 1915(i)(1)(G)(iii)(II)).

"(D) PERSON-CENTERED CARE PLAN.—For purposes of subparagraph (A)(iii), a person-centered care plan described in this subparagraph is a written plan with respect to an individual that is developed in accordance with, and meets the requirements of, paragraphs (1) through (3) of section 441.301(c) of title 42, Code of Federal Regulations.

"(E) STANDARDS.—An individualized assessment shall be conducted in accordance with standards specified by the Secretary to—

"(i) safeguard against conflicts of interest;

"(ii) specify qualifications for who may perform any such assessment;

"(iii) ensure transparency in the conducting of any such assessment, including ensuring the provision of the results of the assessment and, in plain language, any information necessary to interpret the methodology and results of the assessment;

"(iv) ensure that the methodology used in any such assessment is sound and evidence-based;

"(v) require such methodology to be made available on the public website of the State and tested for reliability and validity by an independent evaluator;

"(vi) require assessment tools to include language assistance services and compliance with Federal non-discrimination requirements, including—

"(I) the availability of such assessments in the individual's primary language or with a qualified interpreter;

"(II) accessibility for individuals who are blind or have low-vision;

"(III) accessibility for deaf and hard-of-hearing individuals; and

"(IV) accessibility for individuals who cannot rely on speech to communicate; and

"(vii) ensure that any services and supports necessary for community integration are identified, involve professionals

knowledgeable about the range of services and supports available in the community, and allow individuals getting assessed to present their own independent evidence of the appropriateness of an integrated setting.''.

(b) MANDATORY BENEFIT.—

(1) IN GENERAL.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (30)'' and inserting ''(30), and (32)''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is 5 years after the date of enactment of this Act.

(c) ENSURING COVERAGE OF HCBS FOR ALL MEDICAID-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(D) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended—

(1) by inserting ''(i)'' after ''(D)'';

(2) by adding ''and'' after the semicolon; and

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

"(ii) beginning on the first day of the first calendar quarter that begins on or after the date that is 5 years after the date of enactment of this clause (or at such earlier date as the State may elect) for the inclusion of home and community-based services (as defined in section 1905(ll)) for any individual who—

"(I) is eligible for medical assistance under the State plan (or waiver of such plan);

"(II) is an eligible individual (as defined in such section); and

"(III) elects to receive such services.".

(d) FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HOME AND COMMUNITY-BASED SERVICES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by subsection (a), is further amended—

(1) in subsection (b), by striking "and (ii)" and inserting "(ii), and (mm)"; and

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

''(mm) SPECIFIED FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HOME AND COMMUNITY-BASED SERVICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law and except as provided in paragraph (3), the Federal medical assistance percentage for amounts expended for medical assistance for home and community-based services (as defined in subsection (ll)), including any such services furnished under a waiver in effect under section 1915 or 1115, on or after the date of the enactment of this subsection shall be equal to 100 percent for any State that meets the requirements of paragraph (2).

''(2) ACCESS TO ESSENTIAL HOME AND COMMUNITY-BASED SERVICES.—As a condition of receiving the Federal medical assistance percentage described in paragraph (1), a State shall enhance, expand, or strengthen the level of and access to home and community-based services offered under the State plan under this title (or a waiver of such plan) as of the date of enactment of this subsection by doing each of the following:

''(A) Lowering or eliminating access barriers and disparities in access or utilization

identified in the implementation plan described in section 1902(zz).

''(B) Using a program to ensure that an individual is not denied services based on the fact that the individual contacts the wrong entity (commonly referred to as a 'No Wrong Door Program'), providing presumptive eligibility for home and community-based services, and improving home and community-based services counseling and education programs.

''(C) Providing supports to family caregivers, which shall include providing respite care and may include providing such services as caregiver assessments, peer supports, access to assistive technology, or paid family caregiving.

''(D) Adopting processes to ensure that payments for home and community-based services (including any payment to a direct care worker who delivers such services) are sufficient to ensure that care and services are available to the extent described in the implementation plan described in section 1902(zz). In carrying out this subparagraph, the State shall review and update payment rates for home and community-based services at least every 2 years, with an

emphasis on ensuring that rates are adequate to recruit and retain a sufficient workforce to ensure access to the full set of services for eligible individuals as determined under subsection (ll) and through a transparent process involving meaningful input from stakeholders, including recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates.

''(E) Developing a process to ensure that increases in payment rates for home and community-based services are—

''(i) at a minimum, proportionately passed through to direct care workers and in a manner that is determined with input from the stakeholders described in subparagraph (D); and

''(ii) incorporated into payment rates for home and community-based services provided under this title by a managed care entity (as defined in section 1932(a)(1)(B)) or a prepaid inpatient health plan or prepaid ambulatory health

plan, as such terms are defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation), under a contract with the State.

''(F) Updating, developing, and adopting qualification standards and training opportunities for the continuum of providers of home and community-based services, including programs for independent providers of such services and agency direct care workers, as well as unique programs and resources for family caregivers.

''(G) Establishing an entity to strengthen the infrastructure supporting the delivery of home and community-based services under consumer-directed models of care in accordance with the requirements of subsection (nn).

''(3) EXCEPTION.—The Federal medical assistance percentage applicable to medical assistance for home and community-based services furnished to an individual who is only eligible for medical assistance under a State plan or waiver on the basis of section 1902(a)(10)(A)(ii)(XXIV) shall be determined without regard to this subsection.

''(4) ADMINISTRATIVE COSTS.—Notwithstanding the per centum specified in section

1903(a)(7), with respect to amounts expended for the first 4 fiscal quarters during which this subsection is implemented and each of the succeeding 16 fiscal quarters, for administrative costs for expanding and enhancing home and community-based services, including for enhancing the Medicaid data and technology infrastructure, modifying rate setting processes, adopting, using, and reporting quality measures, adopting or improving training programs for direct care workers and family caregivers, and adopting, carrying out, or enhancing programs that register qualified direct care workers or connect beneficiaries to qualified direct care workers under subsection (nn), such per centum shall be 80 percent.

''(nn) HCBS INFRASTRUCTURE TO SUPPORT SELF-DIRECTED CARE MODELS FOR THE DELIVERY OF SERVICES.—For the purposes of paragraph (2)(G) of subsection (mm), the requirements of this subsection, with respect to a State and fiscal quarter, are that the State establishes, directly or by contract with 1 or more non-profit entities, a program to support self-directed models for the delivery of services for the performance of each of the following functions:

''(1) Registering qualified direct care workers and assisting beneficiaries in finding direct care workers to furnish home and community-based services.

''(2) Undertaking activities to recruit and train independent providers to enable beneficiaries to direct their own care, including by providing or coordinating training for beneficiaries on self-directed care.

''(3) Ensuring the safety of, and supporting the quality of, care provided to beneficiaries, such as by conducting background checks and addressing complaints reported by recipients of home and community-based services.

''(4) Facilitating coordination between State and local agencies and direct care workers for matters of public health, training opportunities, changes in program requirements, workplace health and safety, or related matters.

''(5) Supporting beneficiary hiring of independent providers of home and community-based services through an agency with choice or similar model, including by processing applicable tax information, collecting and processing timesheets, submit-

ting claims, and processing payments to such providers.

''(6) To the extent a State permits beneficiaries to hire a family member or individual with whom they have an existing relationship to provide home and community-based services, providing support to beneficiaries who wish to hire a caregiver who is a family member or individual with whom they have an existing relationship, such as by facilitating enrollment of such family member or individual as a provider of home and community-based services under the State plan or a waiver of such plan.

''(7) Ensuring that program policies and procedures allow for cooperation with labor organizations that bargain on behalf of direct care workers in the case of a State in which the direct care workers in the State have elected to join, or form, such a labor organization, or, in the case of a State in which such workers have not joined or formed such a labor organization, are neutral with regard to such workers joining or forming such a labor organization.''.

(e) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) in section 1905(a), in the matter preceding the first numbered paragraph—

(i) in each of clauses (xvi) and (xviii), by moving the left margin 2 ems to the left; and

(ii) in clause (xvii), by inserting ''or who are described in section 1902(a)(10)(D)'' after ''a State plan amendment under such subsection''; and

(B) in section 1943(b)(5), by striking ''the State'' and all that follows through the period at the end and inserting ''a determination be conducted on an annual basis (or on such longer basis as specified by the State) in accordance with section 1905(ll) for purposes of providing home and community-based services under the State plan (or waiver of such plan).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is 5 years after the date of enactment of this Act.

SEC. 103. MEDICAID ELIGIBILITY MODIFICATIONS.

Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) in paragraph (10)—

(i) in subparagraph (A)(i)—

(I) in subclause (VIII), by striking ''; or'' and inserting a semicolon;

(II) in subclause (IX)(dd), by striking the semicolon at the end and inserting ''; or''; and

(III) by inserting after subclause (IX) the following new subclause:

''(X) beginning with the first calendar quarter that begins on or after the date that is 5 years after the date of enactment of this subclause (or such earlier date as the State may elect), who are eligible individuals described in section 1905(ll)(3)(A) and are not described in a previous subclause of this clause and whose income does not exceed the greater of—

''(aa) 150 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

"(bb) 300 percent of the supplemental security income benefit rate established by section 1611(b)(1);"; and

(ii) in subparagraph (A)(ii)—

(I) in subclause (XXII), by striking "; or" and inserting a semicolon;

(II) in subclause (XXIII), by striking the semicolon at the end and inserting "; or"; and

(III) by inserting after subclause (XXIII) the following new subclause:

"(XXIV) who are eligible individuals who would be described in clause (i)(X) but for the fact that their income exceeds the income levels established under such clause but is less than such income level as the State may establish for purposes of this subclause;"; and

(B) by amending paragraph (34) to read as follows:

"(34) provides that in the case of an individual eligible for home and community-based services (as described in section 1905(ll)(3)(A)), such services

will be made available and furnished in or after the third month before the month in which such individual made application (or application was made on behalf of such individual in the case of a deceased individual) for such services if such individual was (or upon application would have been) eligible for such services at the time such services were furnished and, that if services are provided through a service plan or any similar document, including services provided under the authority of any provision of section 1115 or 1915, such services shall be available pursuant to this subsection without regard to whether the service plan or similar document was developed before or after the services were provided;''; and

(2) in subsection (xx)(9)(A)(ii)—

(A) in subclause (VIII), by striking ''or'' at the end;

(B) in subclause (IX), by striking the period and inserting ''; or''; and

(C) by adding at the end the following new subclause:

''(X) who is described in subclause (X) of subsection (a)(10)(A)(i)

or subclause (XXIV) of subsection (a)(10)(A)(ii).''.

SEC. 104. HOME AND COMMUNITY-BASED SERVICES IMPLEMENTATION PLAN.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) in paragraph (89), by striking ''and'' at the end;

(B) in paragraph (90)(C), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (90) the following new paragraph:

''(91) provide that, prior to the beginning of the first calendar quarter beginning on or after the date that is 5 years after the date of the enactment of this paragraph (or such earlier date at the State may elect), the State shall submit to the Secretary the implementation plan described in subsection (zz).''; and

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

''(zz) IMPLEMENTATION PLAN.—For purposes of subsection (a)(91), an implementation plan described in

this subsection is a plan developed by a State that includes the following:

''(1) An explanation of how the State will operationalize the definition of an eligible individual under section 1905(ll), including the process for any determination specified in paragraph (3)(A)(i) of such section.

''(2) A description of the characteristics of the State's direct care workforce that provides home and community-based services, including the number of workers, the average and range of direct care worker wages or service payments, the health and other workplace benefits provided to direct care workers, turnover and vacancy rates, and an explanation of the State's plan to ensure a stable and high quality workforce and that compensation for individuals furnishing home and community-based services is sufficient to ensure an appropriate supply of workers to provide services to all eligible individuals and plans to identify and address any additional workforce issues.

''(3) A list of any home and community-based services provided under the State Medicaid plan (including any waiver of such plan) as of the date of enactment of this subsection, including a breakdown

of use of such services by demographics (as defined in section 2 of the HCBS Access Act), compared to such services that are required under the amendments made by section 102 of such Act, and a description of numerical goals to increase access to such services that have barriers to access for populations in need of such services.

''(4) A description of how the State will incorporate existing State disability and aging agencies into the new unified provision of home and community-based services and how such State will ensure that such services address all functional impairments.

''(5) A plan for carrying out outreach and education activities with respect to the availability of such services through appropriate entities, including a program to ensure that an individual is not denied such services based on the fact that the individual contacts the wrong entity (commonly referred to as a 'No Wrong Door Program').

''(6) A plan for how such services will be coordinated with other relevant State agencies, such as housing, transportation, child welfare, food and income security, and employment agencies.

''(7) A State with federally recognized Indian tribes, Indian health programs, or urban Indian health organizations shall include a process to consult with the Indian tribes and seek advice from Indian health programs and urban Indian health organizations in the State.

''(8) A description of how the State will build capacity prior to the implementation of the requirements described in subclause (X) of subsection (a)(10)(A)(i) and subclause (XXIV) of subsection (a)(10)(A)(ii) to ensure that such services are available to every eligible individual under the State Medicaid program, how the State will ensure an adequate provider network to provide access to and choice of provider, and how the State will ensure that such services are provided in a setting that meets the requirements specified in paragraph (1) of section 1905(ll), as added by section 102 of the HCBS Access Act.

''(9) A plan for how the State will prioritize individuals who have already met eligibility requirements but are on waiting lists to receive home and community-based services and ensure those individuals do not experience an increase in the amount of time they will wait to receive such services.

''(10) In the case of a State that utilizes an alternative benefit plan, a description of how the State will ensure that all individuals who are eligible individuals (as defined in section 1905(ll)) are appropriately identified as medically frail and exempted from such plan.

''(11) How the State will coordinate eligibility for such services with other disability eligibility programs, such as disability buy-in programs.

''(12) Data and milestone requirements to ensure community integration, including such requirements with respect to utilization of such services by demographics (as defined in section 2 of the HCBS Access Act).

''(13) A description of how the State will evaluate and address disparities based on age, disability, race, ethnicity, sexual orientation, gender identity, and geographic equity.''.

(b) FMAP INCREASE.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

(1) in subparagraph (F)(ii), by striking ''plus'' at the end and inserting ''and''; and

(2) by inserting after subparagraph (F)(ii) the following new subparagraph:

''(G) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of developing the implementation plan described in section 1902(zz); and''.

SEC. 105. QUALITY OF SERVICES.

(a) IN GENERAL.—

(1) DEVELOPMENT OF METRICS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with State Medicaid Directors, shall develop standardized, State-level metrics regarding access to, and satisfaction with, providers, including primary care and specialist providers, with respect to individuals who are enrolled in a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan), broken down by demographics (as defined in section 2) and any other category determined appropriate by the Secretary.

(B) INCLUSIONS.—The metrics developed under subparagraph (A) shall include metrics on the total number of individuals enrolled in

the State plan or under a waiver of such plan during a fiscal year that required the level of care provided in a nursing facility, intermediate care facility for individuals with intellectual disabilities, institution for mental disease, or other similarly restrictive or institutional setting.

(2) PROCESS.—The Secretary shall develop the metrics described in paragraph (1) through a public process, which shall provide opportunities for stakeholders to participate.

(b) UPDATING METRICS.—The Secretary, in consultation with the Deputy Administrator and Director for the Center for Medicaid and CHIP Services and State Medicaid Directors, shall update the metrics developed under subsection (a) not less than once every 3 years.

(c) STATE IMPLEMENTATION FUNDING.—The Secretary may award funds, from the amount appropriated under subsection (d), to States for the purpose of implementing the metrics developed under this section.

(d) APPROPRIATION.—There is appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $200,000,000 for fiscal year 2027, to remain available until expended, for the purpose of carrying out this section.

SEC. 106. REPORTS; TECHNICAL ASSISTANCE; OTHER ADMINISTRATIVE REQUIREMENTS.

(a) REPORTS.—The Secretary shall submit to the Committee on Finance of the Senate, the Committee on Health, Education, Labor, and Pensions of the Senate, the Special Committee on Aging of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Education and Workforce of the House of Representatives the following reports relating to the home and community-based services implementation plan established under section 104:

(1) INTERIM REPORT.—Not later than 2 years after the date of enactment of this Act, a report that describes—

(A) State efforts to develop their home and community-based services implementation plans as described in section 1902(zz) of the Social Security Act (42 U.S.C. 1396a(zz)) (as added by section 104); and

(B) the funds awarded to States for any administrative costs associated with the development of such implementation plans.

(2) FIRST IMPLEMENTATION REPORT.—Not later than 4 years after the date of enactment of this Act, a report that includes the following:

(A) A description of the home and community-based services implementation plans approved by the Secretary under section 1902(zz) of the Social Security Act (42 U.S.C. 1396a(zz)) (as added by section 104).

(B) A description of the national landscape with respect to gaps in coverage of home and community-based services, disparities in access to such services, utilization of such services, and barriers to accessing such services.

(C) A description of the national landscape with respect to the direct care workforce that provides home and community-based services, including with respect to compensation, benefits, and challenges to the availability of such workers.

(3) SUBSEQUENT REPORTS.—Not later than 7 years after the date of enactment of this Act, and every 3 years thereafter, a report that includes the following:

(A) The number of States awarded funding, and the funds awarded to such States, to develop an implementation plan described in section 1902(zz) of the Social Security Act (42 U.S.C. 1396a(zz)) (as added by section 104).

(B) A summary of the progress being made by such States with respect to strengthening and expanding access to home and community-based services and the direct care workforce that provides such services and meeting the benchmarks for demonstrating improvements required under section 1905(ll)(5) of the Social Security Act (as added by section 102).

(C) A summary of outcomes related to home and community-based services core quality measures and beneficiary and family caregiver surveys.

(D) A summary of the challenges and best practices reported by States in expanding access to home and community-based services and supporting and expanding the direct care workforce that provides such services.

(b) TECHNICAL ASSISTANCE; GUIDANCE; REGULATIONS.—The Secretary shall provide States awarded funding to develop an implementation plan described in section 1902(zz) of the Social Security Act (42 U.S.C. 1396a(zz)) (as added by section 104) with technical assistance related to carrying out the home and community-based services implementation plans approved by the Secretary under such section and meeting the requirements and bench-

marks for demonstrating improvements required under section 1905(mm) of the Social Security Act (as added by section 102) and shall issue such guidance or regulations as necessary to carry out this title and the amendments made by this title, including guidance specifying how States shall assess and track the availability of home and community-based services over time.

(c) RECOMMENDATIONS TO GUIDE HCBS IMPLEMENTATION.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary, in coordination with the Secretary of Labor and the Administrator of the Centers for Medicare & Medicaid Services, shall issue recommendations regarding how the Federal Government and States can strengthen the direct care workforce that provides home and community-based services, including with respect to how the Federal Government should classify the direct care workforce, how such Administrator and State Medicaid programs can enforce and support the provision of competitive wages and benefits across the direct care workforce, including for workers with particular skills or expertise, and how State Medicaid programs can support training opportunities and other related efforts that support the

provision of quality home and community-based services.

(2) STAKEHOLDER CONSULTATION.—

(A) IN GENERAL.—In developing the recommendations required under paragraph (1), the Secretary shall ensure that such recommendations are informed by consultation with recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, educational agencies, and aging, disability, and workforce advocates.

(B) CONSULTATION WITH CURRENT AND POTENTIAL HCBS BENEFICIARIES AND FAMILY CAREGIVERS.—In consulting with stakeholders under subparagraph (A), the Secretary shall—

(i) hold at least 1 meeting solely with current and potential recipients of home and community-based services and family caregivers of such recipients for the purpose of developing the recommendations required under paragraph (1); and

(ii) seek to achieve parity in terms of the level of participation in the development of such recommendations between—

(I) current and potential recipients of home and community-based services and family caregivers of such recipients; and

(II) other categories of stakeholder described in subparagraph (A).

(d) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for purposes of carrying out this section, $10,000,000 for fiscal year 2027, to remain available until expended.

SEC. 107. QUALITY MEASUREMENT AND IMPROVEMENT.

(a) DEVELOPMENT AND PUBLICATION OF CORE AND SUPPLEMENTAL SETS OF HCBS QUALITY MEASURES.—

(1) IN GENERAL.—The Secretary shall identify and publish a core set and supplemental set of home and community-based services quality measures for use by State Medicaid programs, health plans and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) REGULAR REVIEWS AND UPDATES.—The Secretary shall review and update the core set and supplemental set of home and community-based services quality measures published under paragraph (1) not less frequently than annually.

(3) REQUIREMENTS.—

(A) INTERAGENCY COLLABORATION; STAKEHOLDER INPUT.—In developing the core set and supplemental set of home and community-based services quality measures under paragraph (1), and subsequently reviewing and updating such core and supplemental sets, the Secretary shall—

(i) collaborate with subagency heads determined appropriate by the Secretary; and

(ii) ensure that such core and supplemental sets are informed by input from stakeholders, including recipients of home and community-based services, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates, with the goal that at least half of such

input is from current and potential recipients of home and community-based services and family caregivers.

(B) REFLECTIVE OF FULL ARRAY OF SERVICES.—Such core set and supplemental set of home and community-based services quality measures shall—

(i) reflect the full array of home and community-based services and recipients of such services, including adults and children; and

(ii) include—

(I) outcomes-based measures;

(II) measures of availability of services;

(III) measures of provider capacity and availability;

(IV) measures related to person-centered care;

(V) measures specific to self-directed care;

(VI) measures related to transitions to and from institutional care;

(VII) beneficiary and family caregiver surveys; and

(VIII) measures related to outcomes by race and ethnicity, language, sex, gender identity, geography, and other demographic factors to track and reduce health disparities.

(C) DEMOGRAPHICS.—Such core set and supplemental set of home and community-based services quality measures shall allow for the collection of data that is disaggregated by demographics (as defined in section 2 and including any additional category determined by the Secretary).

(4) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for purposes of carrying out this subsection, $10,000,000 for fiscal year 2027, to remain available until expended.

(b) STATE ADOPTION AND REPORTS.—

(1) IN GENERAL.—Not later than 2 years after the date on which the Secretary publishes the core set and supplemental set of home and community-based services quality measures under subsection (a)(1), and annually thereafter, each State Medicaid program shall use such core and supplemental sets (or an alternative set of quality measures approved

by the Secretary) to report information to the Secretary regarding the quality of home and community-based services provided under such program.

(2) PROCESS.—The information required under paragraph (1) shall be reported using a standardized format and procedures established by the Secretary. Such procedures shall allow a State Medicaid program to report such information separately or as part of the annual reports required under sections 1139A(c) and 1139B(d) of the Social Security Act (42 U.S.C. 1320b–9a, 1320b–9b).

(3) PUBLICATION OF QUALITY MEASURES.—Each State Medicaid program shall annually make the information reported to the Secretary under paragraph (1) available to the public.

(4) INCREASED FEDERAL MATCHING RATE FOR ADOPTION AND REPORTING.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)), as amended by section 104(b), is amended—

(A) in subparagraph (H)(ii), by striking ''plus'' after the semicolon and inserting ''and''; and

(B) by inserting after subparagraph (H)(ii) the following new subparagraph:

''(I) 80 percent of so much of the sums expended during such quarter as are attributable to the reporting of information regarding the quality of home and community-based services in accordance with section 107(b) of the HCBS Access Act; plus''.

(c) OMBUDSMAN.—Each State shall establish a home and community-based services ombudsman office that—

(1) operates independently from the State Medicaid agency and managed care entities;

(2) provides direct assistance to beneficiaries and their families with respect to accessing home and community-based services; and

(3) identifies and reports systemic problems to State officials, the public, and the Secretary with respect to the provision of or access to home and community-based services.

SEC. 108. MAKING PERMANENT THE EXTENDED PROTECTION UNDER MEDICAID FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

(a) IN GENERAL.—Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''(at the option of the State) is described

in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is an eligible individual (as defined in section 1905(ll)(3))''.

(b) CONFORMING AMENDMENT.—Section 2404 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396r–5 note) is amended by striking ''September 30, 2027'' and inserting ''the date of enactment of the HCBS Access Act''.

SEC. 109. PERMANENT EXTENSION OF MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

Section 6071(h)(1)(L) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended by striking ''each of fiscal years 2024 through 2027'' and inserting ''fiscal year 2024 and each fiscal year thereafter''.

SEC. 110. LIENS, ADJUSTMENTS, AND RECOVERIES FOR MEDICAL ASSISTANCE.

(a) LIENS.—Section 1917(a) of the Social Security Act (42 U.S.C. 1396p(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking ''plan, except—'' and inserting ''plan, except, subject to paragraph (4)—''; and

(B) in subparagraph (B), by striking ''in the case of'' and inserting ''with respect to liens

imposed before the date of the enactment of the HCBS Access Act, in the case of''; and

(2) by adding at the end the following:

''(4) Notwithstanding any preceding provision of this subsection, not later than 90 days after the date of the enactment of this paragraph, a State shall—

''(A) withdraw any lien imposed under paragraph (1)(B) that is in effect as of such date; and

''(B) notify each individual (or legal representative of such individual (or of such individual's estate)) subject to such a lien so withdrawn of the withdrawal of such lien.''.

(b) ADJUSTMENTS AND RECOVERIES.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1), by striking ''except that'' and inserting ''except that, subject to paragraph (6),''; and

(2) by adding at the end the following:

''(6) Notwithstanding any preceding provision of this subsection, no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be initiated, maintained, or collected on or after the date of the enactment of this paragraph. Not later than 90 days after such date, a State shall—

''(A) withdraw any lien in effect as of such date with respect to such medical assistance correctly paid; and

''(B) notify each individual (or legal representative of such individual (or of such individual's estate)) subject to such a lien so withdrawn of the withdrawal of such lien and the prohibition on adjustment or recovery under this paragraph.''.

SEC. 111. HCBS PROVIDER TAX.

Section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) is amended—

(1) in paragraph (7)(A)—

(A) by redesignating clause (ix) as clause (x); and

(B) by inserting after clause (viii) the following new clause:

''(ix) home and community-based services.''; and

(2) in paragraph (4)(C)(ii), by inserting ''for a class of health care items and services other than the class described in paragraph (7)(A)(ix),'' after ''2026,''.

SEC. 112. MEDICARE AMENDMENT.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114) is amended by striking ''or

subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section'' and inserting '', section 1915, 1115A, or under a State plan amendment''.

TITLE II—RECOGNIZING THE ROLE OF DIRECT SUPPORT PROFESSIONALS

SEC. 201. FINDINGS.

Congress finds the following:

(1) Direct support professionals play a critical role in the care provided to children and adults with intellectual and developmental disabilities.

(2) Providers of home and community-based services are experiencing difficulty hiring and retaining direct support professionals, with a national turnover rate of 39 percent as identified in a 2023 study by the National Core Indicators.

(3) High turnover rates can lead to instability for individuals receiving services, and this may result in individuals not receiving enough personalized care to help them reach their goals for independent living.

(4) A discrete occupational category for direct support professionals will help States and the Federal Government—

(A) better interpret the shortage in the labor market of direct support professionals; and

(B) collect data on the high turnover rate of direct support professionals.

(5) The Standard Occupational Classification system is designed and maintained solely for statistical purposes, and is used by Federal statistical agencies to classify workers and jobs into occupational categories for the purpose of collecting, calculating, analyzing, or disseminating data.

(6) Occupations in the Standard Occupational Classification system are classified based on work performed and, in some cases, on the skills, education, or training needed to perform the work.

(7) Establishing a discrete occupational category for direct support professionals will—

(A) correct an inaccurate representation in the Standard Occupational Classification system;

(B) recognize these professionals for the critical and often times overlooked work that they perform for the disabled community, which work is different than the work of a home health aide or a personal care aide; and

(C) better align the Standard Occupational Classification system with related classification systems.

SEC. 202. REVISION OF STANDARD OCCUPATIONAL CLASSIFICATION SYSTEM.

(a) IN GENERAL.—The Director of the Office of Management and Budget (in this Act referred to as the ''Director'') shall, as part of the first revision process of the Standard Occupational Classification system occurring after the date of enactment of this Act, consider establishing a separate code for direct support professionals as a subset of healthcare support occupations.

(b) REPORT TO CONGRESS.—If the Director decides not to establish the separate code for direct support professionals described in subsection (a), the Director shall, not later than 30 days after the Director announces in the Federal Register the final decision of the revision process described in such subsection, submit to the Committee on Homeland Security and Governmental Affairs of the Senate and the Committee on Education and the Workforce of the House of Representatives a report explaining why such separate code was not established.

TITLE III—SUPPORT FOR THE DIRECT CARE WORKFORCE

SEC. 301. DEFINITIONS.

In this title:

(1) APPRENTICESHIP PROGRAM.—The term ''apprenticeship program'' means an apprenticeship program registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act''; 50 Stat. 664, chapter 663; 29 U.S.C. 50 et seq.), including any requirement, standard, or rule promulgated under such Act.

(2) COMMUNITY COLLEGE.—The term ''community college'' means a public institution of higher education at which the highest degree that is predominantly awarded to students is an associate's degree, including Tribal Colleges or Universities receiving grants under section 316 of the Higher Education Act of 1965 (20 U.S.C. 1059c) that offer a 2-year program for completion of such degree and State public institutions of higher education that offer such a 2-year program.

(3) DIRECT CARE PROFESSIONAL.—The term ''direct care professional''—

(A) means an individual who, in exchange for compensation, provides services to a person

with a disability or an older adult that promote the independence of such person or adult, including—

(i) services that enhance the independence and community inclusion for such person or adult, including traveling with such person or individual or attending and assisting such person or adult while visiting friends and family, shopping, or socializing;

(ii) services such as coaching and supporting such person or adult in communicating needs, achieving self-expression, pursuing personal goals, living independently, and participating actively in employment or voluntary roles in the community;

(iii) services such as providing assistance with activities of daily living (such as feeding, bathing, toileting, and ambulation) and with tasks such as meal preparation, shopping, light housekeeping, and laundry;

(iv) services that support such person or adult at home, work, or school, or in any other community setting; or

(v) services that promote health and wellness, including scheduling and taking such person or adult for or to health care appointments, communicating with health and allied health professionals administering medications, implementing health and behavioral health interventions and treatment plans, and monitoring and recording health status and progress; and

(B) includes—

(i) a service provider supporting people with intellectual disabilities, developmental disabilities, or other disabilities;

(ii) a home and community-based services manager or direct support professional manager;

(iii) a self-directed care worker;

(iv) a personal care service worker;

(v) a direct care worker, as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p); or

(vi) any worker in another position or job related to the home care or direct care workforce, such as positions or jobs in respite care, palliative care, community sup-

port, or peer support, as determined by the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services and the Secretary of Labor.

(4) DIRECT CARE WORKFORCE.—The term ''direct care workforce'' means the broad workforce of direct care professionals.

(5) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity—

(A) that is—

(i) a State;

(ii) a labor organization, joint labor-management organization, or employer, of direct care professionals;

(iii) an organization or a nonprofit entity with experience in aging or disability, or in supporting the rights and interests of, training, or educating direct care professionals or family caregivers;

(iv) an Indian Tribe, Tribal organization, or Urban Indian organization;

(v) a community college or other institution of higher education; or

(vi) a consortium of entities listed in any of clauses (i) through (v);

(B) that agrees to include, as applicable with respect to the type of grant the entity is seeking under this title and the activities supported through such grant, older adults, people with disabilities, direct care professionals, and family caregivers, as advisors and trainers in such activities; and

(C) that agrees to consult with the State Medicaid agency of the State (or each State) served by the grant on the grant activities, to the extent that such agency (or each such agency) is not the eligible entity.

(6) EMPLOYER.—The terms ''employ'' and ''employer'' have the meanings given the terms in section 3 of the Fair Labor Standards Act of 1938 (29 U.S.C. 203).

(7) FAMILY CAREGIVER.—The term ''family caregiver'' has the meaning given such term in section 2 of the RAISE Family Caregivers Act (42 U.S.C. 3030s note) and includes paid and unpaid family caregivers.

(8) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ''Indian Tribe'' and ''Tribal organiza-

tion'' have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(9) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' means—

(A) an institution of higher education defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001); or

(B) an institution of higher education defined in section 102(a)(1)(B) of such Act (20 U.S.C. 1002(a)(1)(B)).

(10) OLDER ADULT.—The term ''older adult'' means an individual who is 60 years of age or older.

(11) PERSON WITH A DISABILITY.—The term ''person with a disability'' means an individual with a disability, as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

(12) PROJECT PARTICIPANT.—The term ''project participant'' means an individual participating in a project or activity assisted with a grant under this title, including (as applicable for the category of the grant) a direct care professional, or an individual seeking to be such a professional, or a family caregiver.

(13) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator for Community Living.

(14) SELF-DIRECTED CARE PROFESSIONAL.—The term ''self-directed care professional'' means a direct care professional who is employed by an individual who is an older adult, a person with a disability, or a representative of such older adult or person with a disability, and such older adult or person with a disability has the decisionmaking authority over certain supports and services provided by the direct care professional and takes direct responsibility to manage those supports and services.

(15) SUPPORTIVE SERVICES.—The term ''supportive services'' means services that are necessary to enable an individual to participate in activities assisted with a grant under this title, such as transportation, child care, dependent care, housing, workplace accommodations, employee benefits such as paid sick leave and child care, workplace health and safety protections, wages and overtime pay, and needs-related payments.

(16) URBAN INDIAN ORGANIZATION.—The term ''urban Indian organization'' has the meaning given

the term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(17) WORKFORCE INNOVATION AND OPPORTUNITY ACT TERMS.—The terms ''career pathway'', ''career planning'', ''in-demand industry sector or occupation'', ''individual with a barrier to employment'', ''local board'', ''on-the-job training'', ''recognized postsecondary credential'', ''region'', and ''State board'' have the meanings given such terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

(18) WORK-BASED LEARNING.—The term ''work-based learning'' has the meaning given the term in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2302).

SEC. 302. AUTHORITY TO ESTABLISH A TECHNICAL ASSISTANCE CENTER FOR BUILDING THE DIRECT CARE WORKFORCE.

(a) PROGRAM AUTHORIZED.—The Secretary shall, in consultation with the Secretary of Labor, the Secretary of Education, the Administrator of the Centers for Medicare & Medicaid Services, and the heads of other entities as necessary, establish a national technical assistance center (referred to in this section as the ''Center'') for—

(1) supporting direct care workforce creation, training and education, recruitment, retention, and advancement; and

(2) supporting family caregivers and activities of family caregivers as a critical part of the support team for older adults or people with disabilities.

(b) ADVISORY COUNCIL.—The Secretary shall establish an advisory council to provide recommendations to the Center with respect to the duties of the Center under this section and may engage individuals and entities described in paragraphs (3)(B), and (12), of section 304(b) (without regard to a specific project described in such paragraphs) for service on the advisory council.

(c) ACTIVITIES.—The Center may—

(1) develop recommendations for training and education curricula and programs for direct care professionals, which recommendations may include recommendations for curricula for higher education, postsecondary credentials, and programs with community colleges;

(2) develop learning and dissemination strategies to—

(A) engage States and other entities in activities supported by grants under this title and in use of related best practices; and

(B) distribute findings from activities supported by grants under this title;

(3) develop recommendations for training and education curricula and other strategies for supporting family caregivers;

(4) explore the national data gaps, workforce shortage areas, and data collection strategies for direct care professionals and make recommendations to the Director of the Office of Management and Budget for an occupation category in the Standard Occupational Classification system for direct care professionals as a health care support occupation;

(5) recommend career development and advancement opportunities for direct care professionals, which may include recommendations for occupational frameworks, national standards, recruitment campaigns, pre-apprenticeship and on-the-job training opportunities, apprenticeship programs, career ladders or pathways, specializations or certifications, or other activities; and

(6) develop strategies for assisting with reporting and evaluation of grant activities under section 305.

SEC. 303. AUTHORITY TO AWARD GRANTS.

(a) GRANTS.—

(1) IN GENERAL.—Not later than 12 months after the date of enactment of this title, the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, the Secretary of Labor, and the Secretary of Education, shall award grants described in paragraph (2) to eligible entities. A grant awarded under this section may be in more than 1 category described in such paragraph.

(2) CATEGORIES OF GRANTS.—The categories of grants described in this paragraph are each of the following:

(A) DIRECT CARE PROFESSIONAL GRANTS.—Grants to eligible entities to create and carry out projects for the purposes of recruiting, retaining, or providing advancement opportunities for direct care professionals who are not described in subparagraph (B) or (C), including through education or training programs for such professionals or individuals seeking to become such professionals.

(B) DIRECT CARE PROFESSIONAL MANAGERS GRANTS.—Grants to eligible entities to create and carry out projects for the purposes of recruiting, retaining, or providing advance-

ment opportunities for direct care professionals who are managers or supervisory staff and who have coaching, training, managerial, supervisory, or other oversight responsibilities, including through education or training programs for such individuals professionals or individuals seeking to become such professionals.

(C) SELF-DIRECTED CARE PROFESSIONALS GRANTS.—Grants to eligible entities to create and carry out projects for the purposes of recruiting, retaining, or providing advancement opportunities for self-directed care professionals, including through education or training programs for such professionals or individuals seeking to become such professionals.

(D) FAMILY CAREGIVER GRANTS.—Grants to eligible entities to create and carry out projects for providing support to paid or unpaid family caregivers through educational, training, or other resources, including resources for caregiver self-care or educational or training resources for individuals newly in a caregiving role or seeking additional support in the role of a family caregiver.

(3) PROJECTS FOR ADVANCEMENT OPPORTUNITIES.—Not less than 30 percent of projects assisted with grants under this title shall be projects to provide career pathways that offer opportunities for professional development and advancement opportunities to direct care professionals.

(b) TREATMENT OF CONTINUATION ACTIVITIES.—An eligible entity that carries out activities described in subsection (a)(2) prior to receipt of a grant under this title may use such grant to continue carrying out such activities, and, if the entity uses such grant to continue such activities, the entity shall be treated as an eligible entity carrying out a project through a grant under this title and the activities shall be considered to be such a project.

SEC. 304. PROJECT PLANS.

(a) IN GENERAL.—An eligible entity seeking a grant under this title shall submit to the Secretary a project plan for each project to be developed and carried out (including activities to be continued as described in section 303(b)) with the grant at such time, in such manner, and containing such information as the Secretary may require.

(b) CONTENTS.—A project plan submitted by an eligible entity under subsection (a) shall include a description of information determined relevant by the Secretary

for purposes of the category of the grant and the activities to be carried out through the grant. Such information shall include (as applicable) each of the following:

(1) The demographics (as defined in section 2) of the population in the State or relevant geographic area, including a description of the populations likely to need long-term care services, such as people with disabilities and older adults.

(2) Projections of unmet need for services provided by direct care professionals based on enrollment waiting lists under home and community-based waivers under section 1115 of the Social Security Act (42 U.S.C. 1315) or section 1915 of such Act (42 U.S.C. 1396n) and other relevant data to the extent practicable and feasible, such as direct care workforce vacancy rates and crude separation rates, and the number of direct care professionals, including such professionals who are managers or supervisors, in the region.

(3) Information on an advisory committee to advise the eligible entity on activities to be carried out through the grant. Such advisory committee—

(A) may include entities listed in paragraph (12); and

(B) shall include—

(i) older adults or persons with a disability;

(ii) organizations representing the rights and interests of people receiving services by the direct care professionals or family caregivers targeted by the project;

(iii) individuals who are direct care professionals or family caregivers targeted by the project and organizations representing the rights and interests of direct care professionals or family caregivers;

(iv) as applicable, employers of individuals described in clause (iii) and labor organizations representing such individuals;

(v) representatives of the State Medicaid agency, the State agency defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002), the State developmental disabilities office, and the State behavioral health agency, in the State (or each State) to be served by the project; and

(vi) representatives reflecting diverse racial, cultural, ethnic, geographic, socio-

economic, and gender identity and sexual orientation perspectives.

(4) Information on current or projected job openings for, or relevant labor market information related to, the direct care professionals targeted by the project in the State or geographic area to be served by the project, and the geographic scope of the workforce to be served by the project.

(5) Information on specific efforts and strategies that the entity carrying out the project will undertake to reduce barriers to recruitment, retention, or advancement of the direct care professionals targeted by the project, including an assurance that such efforts will include—

(A) an assessment of the wages or other compensation or benefits necessary to recruit and retain the direct care professionals targeted by the project;

(B) a description of the project's projected compensation or benefits for the direct care professionals targeted by the project at the State or local level, including a comparison of such projected compensation or benefits to regional and national compensation or benefits and a description of how wages and benefits re-

ceived by project participants will be impacted by the participation in and completion of the project; and

(C) a description of the projected impact of workplace safety issues on the recruitment and retention of direct care professionals targeted by the project, and a description of the availability of personal protective equipment.

(6) In the case of a project offering an education or training program for direct care professionals, a description of such program (including how the core competencies identified by the Administrator of the Centers for Medicare & Medicaid Services will be incorporated, curricula, models, and standards used under the program, and any associated recognized postsecondary credentials for which the program provides preparation, as applicable), which shall include an assurance that such program will provide to each project participant in such program—

(A) relevant education or training regarding the rights of recipients of home and community-based services, including their rights to—

(i) receive services in integrated settings that provide access to the broader community;

(ii) exercise self-determination;

(iii) be free from all forms of abuse, neglect, or exploitation; and

(iv) person-centered planning and practices, including participation in planning activities;

(B) relevant education or training to ensure that each project participant has the necessary skills to recognize abuse and understand their obligations with regard to reporting and responding to abuse appropriately in accordance with relevant Federal and State law;

(C) relevant education or training regarding the provision of culturally competent and disability competent supports to recipients of services provided by the direct care professionals targeted by the project;

(D) an apprenticeship program, work-based learning, or on-the-job training opportunities;

(E) supervision or mentoring; and

(F) for any on-the-job training portion of the program, a progressively increasing, clearly defined schedule of wages to be paid to each such participant that—

(i) is consistent with skill gains or attainment of a recognized postsecondary credential described in the plan and received as a result of participation in or completion of such program; and

(ii) ensures the entry wage is not less than the greater of—

(I) the minimum wage required under section 6(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)); or

(II) the applicable wage required by other applicable Federal or State law, or a collective bargaining agreement.

(7) A description of any innovative models or processes, not described in another paragraph of this subsection, the eligible entity will implement to support the retention and career advancement of the direct care professionals targeted by the project.

(8) A description of the supportive services and benefits to be provided to the project participants in order to support the employment, retention, or career advancement of the direct care professionals targeted by the project.

(9) A description of how the eligible entity will make use of career planning to support the identification of advancement opportunities and career pathways for the direct care professionals in the State or geographic area to be served by the project.

(10) A description of how the eligible entity will collect and submit to the Secretary workforce data and outcomes of the project.

(11) A description of how the project—

(A) will—

(i) provide adequate and safe equipment and facilities for training and supervision, including a safe work environment free from discrimination, which may include the provision of personal protective equipment and other necessary equipment to prevent the spread of infectious disease among the direct care professionals targeted by the project and recipients of services provided by such professionals;

(ii) incorporate remote training and education opportunities or technology-supported opportunities;

(iii) for training and education curricula, incorporate evidenced-supported practices for adult learners and universal design for learning and ensure recipients of services provided by the direct care professionals or family caregivers targeted by the project participate in the development and implementation of such training and education curricula;

(iv) use outreach, recruitment, and retention strategies designed to reach and retain a diverse workforce;

(v) incorporate methods to monitor satisfaction with project activities for project participants and individuals receiving services from such participants;

(vi) incorporate evidence-supported practices for family caregiver engagement; and

(vii) incorporate core competencies identified by the Administrator of the Centers for Medicare & Medicaid Services; and

(B) may incorporate continuing education programs and specialty training, with a specific focus on—

(i) trauma-informed care;

(ii) behavioral health, including co-occurring behavioral health conditions and intellectual or developmental disabilities;

(iii) Alzheimer's and dementia care;

(iv) chronic disease management; or

(v) the use of supportive or assistive technology.

(12) A description of how the eligible entity will consult on the implementation of the project, or coordinate the project with, each of the following entities, to the extent that each such entity is not the eligible entity:

(A) The State Medicaid agency, State agency defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002), and the State developmental disabilities office for the State (or each State) to be served by the project.

(B) The local board and State board for each geographic area, or State, to be served by the project.

(C) In the case of a project that carries out an education or training program, a nonprofit organization with demonstrated experience in the development or delivery of curricula or coursework.

(D) A nonprofit organization, which may be a labor organization, that fosters the professional development and collective engagement of the direct care professionals or family caregivers targeted by the project.

(E) Area agencies on aging, as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002).

(F) Centers for independent living, as described in part C of chapter 1 of title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796f et seq.).

(G) The State Council on Developmental Disabilities (as such term is used in subtitle B of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15021 et seq.)) for the State (or each State) to be served by the project.

(H) Aging and Disability Resource Centers (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)).

(I) A nonprofit State provider association that represents providers who employ the direct care professionals or family caregivers targeted by the project, where such an association exists.

(J) An entity that employs the direct care professionals or family caregivers targeted by the project.

(K) University Centers for Excellence in Developmental Disabilities Education, Research, and Service supported under subtitle D of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15061 et seq.).

(L) The State protection and advocacy system described in section 143 of such Act (42 U.S.C. 15043) of the State (or each State) to be served by the project.

(M) Direct care professionals or family caregivers targeted by the project, or workforce organizations for such professionals or caregivers as applicable, representing underserved communities.

(13) A description of how the eligible entity will consult throughout the project with—

(A) individuals employed or working as the direct care professionals or family caregivers targeted by the project;

(B) representatives of such professionals or caregivers;

(C) individuals assisted by such professionals or caregivers;

(D) the families of such professionals or caregivers; and

(E) individuals receiving education or training to become such professionals or caregivers.

(14) A description of outreach efforts to individuals for participation in such project, including targeted outreach efforts to—

(A) individuals who are recipients of assistance under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) or individuals who are eligible for such assistance; and

(B) individuals with barriers to employment.

(c) CONSIDERATIONS.—In selecting eligible entities to receive a grant under this title, the Secretary shall ensure—

(1) equitable geographic diversity, including by selecting recipients serving rural areas and selecting recipients serving urban areas; and

(2) that selected eligible entities will serve areas where the occupation of a direct care professional, or a related occupation, is an in-demand industry sector or occupation.

(d) USES OF FUNDS; SUPPLEMENT, NOT SUPPLANT.—

(1) USES OF FUNDS.—

(A) IN GENERAL.—Each eligible entity receiving a grant under this title shall use the funds of such grant to carry out at least 1 project described in section 303(a)(2).

(B) ADMINISTRATIVE COSTS.—Each eligible entity receiving a grant under this title shall not use more than 5 percent of the funds of such grant for costs associated with the administration of activities under this title.

(C) DIRECT SUPPORT.—Each eligible entity receiving a grant under this title shall use not less than 5 percent of the funds of such

grant to provide direct financial benefits or supportive services to project participants who are direct care professionals or paid or unpaid family caregivers to support the financial needs of such participants during the duration of the project activities.

(2) SUPPLEMENT, NOT SUPPLANT.—An eligible entity receiving a grant under this title shall use such grant only to supplement, and not supplant, the amount of government funds that, in the absence of such grant, would be available to address the recruitment, training and education, retention, and advancement of direct care professionals or provide support for family caregivers, in the State or geographic area served by the eligible entity.

(3) PROHIBITION.—No amounts made available under this title may be used for any activity that is subject to the reporting requirements set forth in section 203(a) of the Labor-Management Reporting and Disclosure Act of 1959 (29 U.S.C. 433(a)).

SEC. 305. EVALUATIONS AND REPORTS; TECHNICAL ASSISTANCE.

(a) REPORTING REQUIREMENTS BY GRANT RECIPIENTS.—

(1) IN GENERAL.—An eligible entity receiving a grant under this title shall cooperate with the Secretary and annually provide a report to the Secretary that includes any relevant data requested by the Secretary in a manner specified by the Secretary.

(2) CONTENTS.—The data requested by the Secretary for an annual report may include any of the following (as determined relevant by the Secretary with respect to the category of the grant and each project supported through the grant):

(A) The number of individuals and the demographics categories served by each project supported by the grant, including—

(i) the number of individuals recruited through each such project to be employed as a direct care professional;

(ii) the number of individuals who through each such project attained employment as a direct care professional; and

(iii) the number of individuals who enrolled in each such project and withdrew or were terminated from that project without completing training or attaining employment as a direct care professional.

(B) The number of family caregivers participating in an education or training program through each project supported by the grant.

(C) The number of project participants who through each such project participated in and completed—

(i) work-based learning;

(ii) on-the-job training;

(iii) an apprenticeship program; or

(iv) a professional development or mentoring program.

(D)(i) Other services, benefits, or supports (other than the services, benefits, or supports described in subparagraph (C)) provided through each such project to assist in the recruitment, retention, or advancement of direct care professionals (including through education or training for such professionals or individuals seeking to become such professionals);

(ii) the number of individuals who accessed such services, benefits, or supports; and

(iii) the impact of such services, benefits, or supports.

(E) The crude separation and vacancy rates of direct care professionals, and such

rates for those professionals who are managers or supervisors, in the geographic area for a number of years before the grant was awarded, as the number of years is determined by the Secretary, and annually thereafter for the duration of the grant period.

(F) How each project supported by the grant assessed satisfaction with respect to—

(i) project participants assisted by the project;

(ii) individuals receiving services delivered by project participants, including satisfaction regarding—

(I) any impact on the health or health outcomes of such individuals; and

(II) any impact on the ability of individuals to transition to or remain in the community in an environment that has the qualities established in section 441.301(c)(4) of title 42, Code of Federal Regulations (or successor regulations); and

(iii) employers of such project participants.

(G) The performance of the eligible entity with respect to the indicators of performance on unsubsidized employment, median earnings, credential attainment, measurable skill gains, and employer satisfaction.

(H) Any other information with respect to outcomes of the project as determined by the Secretary.

(b) ANNUAL REPORT TO CONGRESS BY SECRETARY.—Not later than 2 years after the date of enactment of this title, and each year thereafter until all projects supported through a grant under this title are completed, the Secretary shall prepare and submit to Congress an annual report on the progress of each project supported through a grant under this title and the activities of the technical assistance center established under section 302.

(c) GAO REPORT.—Not later than 1 year after the date on which all projects supported through a grant under this title are completed, the Comptroller General of the United States shall conduct a study and submit to Congress a report including—

(1) an assessment of how the technical assistance center established under section 302 and the projects supported through a grant under this title

assisted in the creation, recruitment, training and education, retention, and advancement of the direct care workforce or in providing support for family caregivers; and

(2) recommendations for such legislative or administrative actions needed for improving the assistance described in paragraph (1), as the Comptroller General determines appropriate.

(d) INDEPENDENT EVALUATIONS.—Not later than 6 months after the date of enactment of this title, the Secretary shall enter into a contract with an independent entity to provide independent evaluations of activities supported by grants under this title and activities of the technical assistance center established under section 302.

SEC. 306. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated—

(1) for the establishment and activities of the technical assistance center under section 302, $2,000,000 for each of fiscal years 2029 through 2030; and

(2) for grants under section 303, $1,000,000,000 for fiscal year 2029.

(b) AVAILABILITY.—Amounts made available under this title shall remain available through September 30, 2038.

TITLE IV—EVALUATION

SEC. 401. EVALUATION OF IMPACT ON ACCESS TO HCBS.

(a) NATIONAL SURVEY ON EXPANDED HCBS ACCESS.—The Administrator of the Centers for Medicare & Medicaid Services, in coordination with the National Academy of Medicine, shall, not later than 7 years after the date of enactment of this Act, conduct or contract for a national survey of States, direct care professionals, family caregivers, and providers and recipients of home and community-based services, to determine the effects of the implementation of this Act and the amendments made by this Act on—

(1) the availability and access to home and community-based services under the Medicaid program nationally and in each State;

(2) the capacity of the direct service workforce to provide home and community-based services and information on the demographics (as defined in section 2) of such workforce;

(3) the compensation and working conditions, including scheduling and benefits, of direct care workers;

(4) the economic effects on beneficiaries and on families with a member receiving home and community-based services through Medicaid;

(5) the availability of direct care workers and services for people needing long-term services and supports who are not Medicaid eligible;

(6) family caregivers; and

(7) recommendations for measures to further expand and enhance access home and community-based services.

(b) REPORT.—Not later than 9 years after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall publish a report containing the results of the survey conducted under subsection (a).

(c) AMERICAN COMMUNITY SURVEY ADDITION.—The Secretary of Commerce, acting through the Bureau of the Census, shall add to the American Community Survey a question designed to identify the need for long-term services and supports by residents of the United States.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as are necessary to carry out this section.