Subtitle D—Transitioning From Medicaid FMAP Increase Requirements

SEC. 5131. TRANSITIONING FROM MEDICAID FMAP INcREASE REQUIREMENTS.

(a) IN GENERAL .—Section 6008 of the Families First Coronavirus Response Act (42 U.S.C. 1396d note) is amended—
(1) in subsection (a)—
(A) by striking ‘‘Subject to subsection (b)’’ and inserting the following:
‘‘(1) TEMPORARY FMAP INCREASE .—Subject to subsections (b) and (f)’’;
(B) by striking ‘‘the last day of the calendar quarter in which the last day of such emergency period occurs’’ and inserting ‘‘December 31, 2023’’;
(C) by striking ‘‘6.2 percentage points’’ and inserting ‘‘the applicable number of per centage points for the quarter (as determined in paragraph (2))’’; and
(D) by adding at the end the following new paragraph:
‘‘(2) APPLICABLE NUMBER OF PERCENTAGE POINTS .—For purposes of paragraph (1), the applicable number of percentage points for a calendar quarter is the following:
‘‘(A) For each calendar quarter that occurs during the portion of the period described in paragraph (1) that ends on March 31, 2023, 6.2 percentage points.
‘‘(B) For the calendar quarter that begins on April 1, 2023, and ends on June 30, 2023, 5 percentage points.
‘‘(C) For the calendar quarter that begins on July 1, 2023, and ends on September 30, 2023, 2.5 percentage points.
‘‘(D) For the calendar quarter that begins on October 1, 2023, and ends on December 31, 2023, 1.5 percentage points.’’;
(2) in subsection (b)—
(A) in the matter preceding paragraph (1), by striking ‘‘subsection (a)’’ and inserting ‘‘subsection (a)(1)’’;
(B) in paragraph (2), by striking ‘‘, with respect to an individual enrolled under such plan (or waiver),’’; and
(C) in paragraph (3)—
(i) by striking ‘‘as of the date of enactment of this section’’ and inserting ‘‘as of March 18, 2020,’’;
(ii) by striking ‘‘such date of enactment’’ and inserting ‘‘March 18, 2020,’’;
(iii) by striking ‘‘the last day of the month in which the emergency period described in subsection (a) ends’’ and inserting ‘‘March 31, 2023,’’; and
(iv) by striking ‘‘the end of the month in which such emergency period ends’’ and inserting ‘‘March 31, 2023,’’;
(3) by redesignating the subsection (d) added by section 11 of division X of the Consolidated Appropriations Act, 2021 (Public Law 116–260) as subsection (e); and
(4) by adding at the end the following new subsections:
‘‘(f) ELIGIBILITY REDETERMINATIONS DURING TRANSITION PERIOD .—
‘‘(1) IN GENERAL .— For each calendar quarter occurring during the portion of the period described in subsection (a)(1) that begins on April 1, 2023, and ends on December 31, 2023 (such portion to be referred to in this subsection as the ‘transition period’), if a State described in

such subsection satisfies the conditions of subsection (b) and paragraph (2) of this subsection, the State shall receive the increase to the Federal medical assistance percentage of the State applicable under subsection (a). Nothing in this subsection shall be construed as prohibiting a State, following the expiration of the condition described in paragraph (3) of subsection (b), from initiating renewals, post-enrollment verifications, and redeterminations over a 12-month period for all individuals who are enrolled in such plan (or waiver) as of April 1, 2023.
‘‘(2) CONDITIONS FOR FMAP INCREASE DURING TRANSITION PERIOD .—The conditions of this paragraph with respect to a State and the transition period are the following:
‘‘(A) COMPLIANCE WITH FEDERAL REQUIREMENTS .—The State conducts eligibility redeterminations under title XIX of the Social Security Act in accordance with all Federal requirements applicable to such redeterminations, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act (42 U.S.C. 1396a(e)(14)(A)) or other alternative processes and procedures approved by the Secretary of Health and Human Services.
‘‘(B) MAINTENANCE OF UP - TO - DATE CONTACT INFORMATION .—The State, using the National Change of Address Database Maintained by the United States Postal Service, State health and human services agencies, or other reliable sources of contact information, attempts to ensure that it has up-to-date contact information (including a mailing address, phone number, and email address) for each individual for whom the State conducts an eligibility redetermination.
‘‘(C) REQUIREMENT TO ATTEMPT TO CONTACT BENEFICIARIES PRIOR TO DISENROLLMENT .—The State does not disenroll from the State plan or waiver any individual who is determined ineligible for medical assistance under the State plan or waiver pursuant to such a redetermination on the basis of returned mail unless the State first undertakes a good faith effort to contact the individual using more than one modality.
‘‘(g) APPLICABLE QUARTERS .—A State that ceases to meet the requirements of subsection (b) or (f) (as applicable) shall not qualify for the increase described in subsection (a) in the Federal medical assistance percentage for such State for the calendar quarter in which the State ceases to meet such requirements.’’.

(b) REPORTING AND ENFORCEMENT AND CORRECTIVE ACTION .—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:
‘‘(tt) REQUIREMENTS RELATING TO TRANSITION FROM FAMILIES FIRST CORONAVIRUS RESPONSE ACT FMAP INCREASE REQUIREMENTS ; ENFORCEMENT AND CORRECTIVE ACTION .—
‘‘(1) REPORTING REQUIREMENTS .—For each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, each State shall submit to the Secretary, on a timely basis, a report, that the Secretary shall make publicly available, on the activities of the State relating to eligibility redeterminations conducted during such period, and which include, with respect to the month for which the report is submitted, the following information:
‘‘(A) The number of eligibility renewals initiated, beneficiaries renewed on a total and ex parte basis, and individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was terminated.

‘‘(B) The number of individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was so terminated for procedural reasons.
‘‘(C) Where applicable, the number of individuals who were enrolled in a State child health plan or waiver in the form described in paragraph (1) of section 2101(a).
‘‘(D) Unless the Administrator of the Centers for Medicare & Medicaid Services reports such information on behalf of the State:
‘‘(i) In a State with a Federal or State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this title or title XXI are not integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—
‘‘(I) the number of individuals whose accounts were received via secure electronic transfer by the Federal or State American Health Benefit Exchange, or a basic health program established under section 1331 of the Patient Protection and Affordable Care Act;
‘‘(II) the number of individuals identified in subclause (I) who were determined eligible for a qualified health plan, as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act, or (if applicable) the basic health program established under section 1331 of such Act; and
‘‘(III) the number of individuals identified in subclause (II) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).
‘‘(ii) In a State with a State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this title or title XXI are integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—
‘‘(I) the number of individuals who were determined eligible for a qualified health plan, as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act, or (if applicable) the basic health program established under section 1331 of such Act; and
‘‘(II) the number of individuals identified in subclause (I) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).
‘‘(E) The total call center volume, average wait times, and average abandonment rate (as determined by the Secretary) for each call center of the State agency responsible for administering the State plan under this title (or a waiver of such plan) during such month.
‘‘(F) Such other information related to eligibility redeterminations and renewals during the period described in paragraph (1), as identified by the Secretary.
‘‘(2) ENFORCEMENT AND CORRECTIVE ACTION .—
‘‘(A) IN GENERAL .—For each fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, if a State does not satisfy the requirements of paragraph (1), the Federal medical assistance percentage determined for the State for the quarter under section 1905(b) shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such

period for which the State has failed to satisfy such requirements.
‘‘(B) CORRECTIVE ACTION PLAN ; ADDITIONAL AUTHORITY .—
‘‘(i) IN GENERAL .—The Secretary may assess a State’s compliance with all Federal requirements applicable to eligibility redeterminations and the reporting requirements described in paragraph (1), and, if the Secretary determines that a State did not comply with any such requirements during the period that begins on April 1, 2023, and ends on June 30, 2024, the Secretary may require the State to submit and implement a corrective action plan in accordance with clause (ii).
‘‘(ii) CORRECTIVE ACTION PLAN .—A State that receives a written notice from the Secretary that the Secretary has determined that the State is not in compliance with a requirement described in clause (i) shall—
‘‘(I) not later than 14 days after receiving such notice, submit a corrective action plan to the Secretary;
‘‘(II) not later than 21 days after the date on which such corrective action plan is submitted to the Secretary, receive approval for the plan from the Secretary; and
‘‘(III) begin implementation of such corrective action plan not later than 14 days after such approval.
‘‘(iii) EFFECT OF FAILURE TO SUBMIT OR IMPLEMENT A CORRECTIVE ACTION PLAN .—If a State fails to submit or implement an approved corrective action plan in accordance with clause (ii), the Secretary may, in addition to any reduction applied under subparagraph (A) to the Federal medical assistance percentage determined for the State and any other remedy available to the Secretary for the purpose of carrying out this title, require the State to suspend making all or some terminations of eligibility for medical assistance from the State plan under this title (including any waiver of such plan) that are for procedural reasons until the State takes appropriate corrective action, as determined by the Secretary, and may impose a civil money penalty of not more than $100,000 for each day a State is not in compliance.’’.

(c) EFFECTIVE D ATE .—The amendments made by this section take effect on April 1, 2023.