

109TH CONGRESS  
1ST SESSION

# S. 1602

To amend title XIX of the Social Security Act to require States to disregard benefits paid under long-term care insurance for purposes of determining medicaid eligibility, to expand long-term care insurance partnerships between States and insurers, to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, the use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs, to establish home and community-based services as an optional medicaid benefit, and for other purposes.

---

## IN THE SENATE OF THE UNITED STATES

JULY 29, 2005

Mr. GRASSLEY (for himself, Mr. BAYH, and Mrs. CLINTON) introduced the following bill; which was read twice and referred to the Committee on Finance

---

## A BILL

To amend title XIX of the Social Security Act to require States to disregard benefits paid under long-term care insurance for purposes of determining medicaid eligibility, to expand long-term care insurance partnerships between States and insurers, to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, the use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs, to establish home and community-

based services as an optional medicaid benefit, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
 5 “Improving Long-Term Care Choices Act of 2005”.

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

Sec. 1. Short title; table of contents.  
 Sec. 2. Findings.

TITLE I—LONG-TERM CARE INSURANCE

Subtitle A—Consumer Protections

Sec. 101. Disregard of benefits paid under long-term care insurance for pur-  
 poses of determining medicaid eligibility.  
 Sec. 102. Additional consumer protections for long-term care insurance.  
 Sec. 103. Expansion of State long-term care partnerships.  
 Sec. 104. National clearinghouse for long-term care information.

Subtitle B—Amendments to the Internal Revenue Code of 1986

Sec. 121. Treatment of premiums on qualified long-term care insurance con-  
 tracts.  
 Sec. 122. Credit for taxpayers with long-term care needs.  
 Sec. 123. Treatment of exchanges of long-term care insurance contracts.

TITLE II—MEDICAID HOME AND COMMUNITY-BASED SERVICES  
 OPTIONAL BENEFIT

Sec. 201. Medicaid home and community-based services optional benefit.

TITLE III—INTEGRATED ACUTE AND LONG-TERM CARE  
 SERVICES FOR DUALY ELIGIBLE INDIVIDUALS.

Sec. 301. Removal of barriers to integrated acute and long-term care services  
 for dually eligible individuals.

TITLE IV—EFFECTIVE DATE

Sec. 401. Effective date.

8 **SEC. 2. FINDINGS.**

9 Congress finds that—

1           (1) The Medicaid program is designed to assist  
2           low-income individuals with few resources obtain  
3           health care, including long-term care.

4           (2) The average daily cost of a private room in  
5           a nursing home in the United States is more than  
6           \$70,000 per year, with an average length of stay of  
7           2.4 years.

8           (3) Many individuals deplete their savings and  
9           resources paying for long-term care or qualifying for  
10          Medicaid in order to receive that care.

11          (4) Encouraging individuals to purchase private  
12          long-term care insurance that meets minimum Fed-  
13          eral standards would help ensure that Medicaid is  
14          able to continue to offer long-term care to low-in-  
15          come individuals who cannot afford that insurance.

16          (5) Requiring consumer protections and stand-  
17          ards for long-term care insurance will help ensure  
18          that Federal, State, and individual resources are  
19          used to purchase high-quality long-term care cov-  
20          erage that meets individual needs.

21          (6) In 1999, the United States Supreme Court,  
22          in *Olmstead v. L.C.* (527 U.S. 581) held that the  
23          medically unnecessary institutionalization of individ-  
24          uals with disabilities constitutes discrimination in

1 violation of the provisions of the Americans with  
2 Disabilities Act of 1990 (ADA).

3 (7) The Olmstead decision has had the effect of  
4 broadening State efforts to revise their Medicaid  
5 plans to develop alternatives to institutional care,  
6 but certain limitations in Medicaid's structure con-  
7 strain these efforts, in particular, the lack of certain  
8 coverage and benefit options related to community  
9 care, which in turn force States to rely on a more  
10 cumbersome Federal waiver process.

11 (8) Based on preliminary 2002 data, total Med-  
12 icaid expenditures for that year for long-term care  
13 services were \$92,800,000,000 (\$66,100,000,000 for  
14 services in institutions and \$26,700,000,000 for  
15 services provided in home and community-based set-  
16 tings).

17 (9) Nationally, only 33 percent of public long-  
18 term care spending is spent for home and commu-  
19 nity-based services and supports. Among the elderly,  
20 over 84 percent of long-term care funding is spent  
21 for nursing facility and other institutional care.

22 (10) In order to live independently, individuals  
23 with disabilities need access to home and commu-  
24 nity-based services and supports.

1           (11) Most Americans would prefer to receive  
2           long-term care services in their homes and commu-  
3           nities.

4           (12) States are currently operating a com-  
5           plicated system of over 261 different home and com-  
6           munity-based waivers.

7           (13) There is a need to build upon the progress  
8           made by the New Freedom Initiative, which was an-  
9           nounced in 2001, and is a continuing nationwide ef-  
10          fort to remove barriers to community living for peo-  
11          ple of all ages with disabilities and long-term ill-  
12          nesses.

## 13           **TITLE I—LONG-TERM CARE** 14           **INSURANCE**

### 15           **Subtitle A—Consumer Protections**

#### 16           **SEC. 101. DISREGARD OF BENEFITS PAID UNDER LONG-** 17           **TERM CARE INSURANCE FOR PURPOSES OF** 18           **DETERMINING MEDICAID ELIGIBILITY.**

19           (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
20           1902(a) of the Social Security Act (42 U.S.C. 1396a(a))  
21           is amended—

22           (1) in paragraph (66), by striking “and” at the  
23           end;

24           (2) in paragraph (67), by striking the period at  
25           the end and inserting “; and”; and

1           (3) by inserting after paragraph (67), the fol-  
 2       lowing:

3           “(68) provide that, with respect to benefits (in-  
 4       cluding assigned benefits) paid under any insurance  
 5       contract for coverage of qualified long-term care  
 6       services (as defined in in section 7702B(c) of the In-  
 7       ternal Revenue Code of 1986), the State does not  
 8       treat such benefits as income for purposes of deter-  
 9       mining an individual’s eligibility for medical assist-  
 10      ance under the State plan.”.

11       (b) CONSUMER EDUCATION.—Not later than Janu-  
 12      ary 1, 2009, the Secretary of Health and Human Services  
 13      shall establish a program for educating consumers regard-  
 14      ing—

15           (1) the advisability of obtaining a qualified  
 16      long-term care insurance contract (as defined in sec-  
 17      tion 7702B(b) of the Internal Revenue Code of  
 18      1986); and

19           (2) the potential interaction between coverage  
 20      under such an insurance contract and coverage of  
 21      long-term care under Federal and State health in-  
 22      surance programs, (including under a long-term care  
 23      partnership under section 1917(b)(1)(C)(ii) of the  
 24      Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)).

1 **SEC. 102. ADDITIONAL CONSUMER PROTECTIONS FOR**  
 2 **LONG-TERM CARE INSURANCE.**

3 (a) ADDITIONAL PROTECTIONS APPLICABLE TO  
 4 LONG-TERM CARE INSURANCE.—Subparagraphs (A) and  
 5 (B) of section 7702B(g)(2) of the Internal Revenue Code  
 6 of 1986 (relating to requirements of model regulation and  
 7 Act) are amended to read as follows:

8 “(A) IN GENERAL.—The requirements of  
 9 this paragraph are met with respect to any con-  
 10 tract if such contract meets—

11 “(i) MODEL REGULATION.—The fol-  
 12 lowing requirements of the model regula-  
 13 tion:

14 “(I) Section 6A (relating to guar-  
 15 anteed renewal or noncancellability),  
 16 other than paragraph (5) thereof, and  
 17 the requirements of section 6B of the  
 18 model Act relating to such section 6A.

19 “(II) Section 6B (relating to pro-  
 20 hibitions on limitations and exclu-  
 21 sions) other than paragraph (7) there-  
 22 of.

23 “(III) Section 6C (relating to ex-  
 24 tension of benefits).

1 “(IV) Section 6D (relating to  
2 continuation or conversion of cov-  
3 erage).

4 “(V) Section 6E (relating to dis-  
5 continuance and replacement of poli-  
6 cies).

7 “(VI) Section 7 (relating to unin-  
8 tentional lapse).

9 “(VII) Section 8 (relating to dis-  
10 closure), other than sections 8F, 8G,  
11 8H, and 8I thereof.

12 “(VIII) Section 11 (relating to  
13 prohibitions against post-claims un-  
14 derwriting).

15 “(IX) Section 12 (relating to  
16 minimum standards).

17 “(X) Section 13 (relating to re-  
18 quirement to offer inflation protec-  
19 tion).

20 “(XI) Section 25 (relating to pro-  
21 hibition against preexisting conditions  
22 and probationary periods in replace-  
23 ment policies or certificates).

24 “(XII) The provisions of section  
25 26 relating to contingent nonforfeiture



1                   benefits, if the policyholder declines  
2                   the offer of a nonforfeiture provision  
3                   described in paragraph (4).

4                   “(ii) MODEL ACT.—The following re-  
5                   quirements of the model Act:

6                               “(I) Section 6C (relating to pre-  
7                               existing conditions).

8                               “(II) Section 6D (relating to  
9                               prior hospitalization).

10                              “(III) The provisions of section 8  
11                              relating to contingent nonforfeiture  
12                              benefits, if the policyholder declines  
13                              the offer of a nonforfeiture provision  
14                              described in paragraph (4).

15                   “(B) DEFINITIONS.—For purposes of this  
16                   paragraph—

17                              “(i) MODEL PROVISIONS.—The terms  
18                              ‘model regulation’ and ‘model Act’ mean  
19                              the long-term care insurance model regula-  
20                              tion, and the long-term care insurance  
21                              model Act, respectively, promulgated by  
22                              the National Association of Insurance  
23                              Commissioners (as adopted as of October  
24                              2000).

1           “(ii) COORDINATION.—Any provision  
 2           of the model regulation or model Act listed  
 3           under clause (i) or (ii) of subparagraph  
 4           (A) shall be treated as including any other  
 5           provision of such regulation or Act nec-  
 6           essary to implement the provision.

7           “(iii) DETERMINATION.—For pur-  
 8           poses of this section and section 4980C,  
 9           the determination of whether any require-  
 10          ment of a model regulation or the model  
 11          Act has been met shall be made by the  
 12          Secretary.”.

13          (b) EXCISE TAX.—Paragraph (1) of section  
 14          4980C(c) of the Internal Revenue Code of 1986 (relating  
 15          to requirements of model provisions) is amended to read  
 16          as follows:

17               “(1) REQUIREMENTS OF MODEL PROVISIONS.—

18               “(A) MODEL REGULATION.—The following  
 19               requirements of the model regulation must be  
 20               met:

21                   “(i) Section 9 (relating to required  
 22                   disclosure of rating practices to consumer).

23                   “(ii) Section 14 (relating to applica-  
 24                   tion forms and replacement coverage).

1 “(iii) Section 15 (relating to reporting  
2 requirements).

3 “(iv) Section 22 (relating to filing re-  
4 quirements for marketing).

5 “(v) Section 23 (relating to standards  
6 for marketing), including inaccurate com-  
7 pletion of medical histories, other than  
8 paragraphs (1), (6), and (9) of section  
9 23C.

10 “(vi) Section 24 (relating to suit-  
11 ability).

12 “(vii) Section 29 (relating to standard  
13 format outline of coverage).

14 “(viii) Section 30 (relating to require-  
15 ment to deliver shopper’s guide).

16 The requirements referred to in clause (vi) shall  
17 not include those portions of the personal work-  
18 sheet described in Appendix B relating to con-  
19 sumer protection requirements not imposed by  
20 section 4980C or 7702B.

21 “(B) MODEL ACT.—The following require-  
22 ments of the model Act must be met:

23 “(i) Section 6F (relating to right to  
24 return).

1 “(ii) Section 6G (relating to outline of  
2 coverage).

3 “(iii) Section 6H (relating to require-  
4 ments for certificates under group plans).

5 “(iv) Section 6J (relating to policy  
6 summary).

7 “(v) Section 6K (relating to monthly  
8 reports on accelerated death benefits).

9 “(vi) Section 7 (relating to incontest-  
10 ability period).

11 “(C) DEFINITIONS.—For purposes of this  
12 paragraph, the terms ‘model regulation’ and  
13 ‘model Act’ have the meanings given such terms  
14 by section 7702B(g)(2)(B).”.

15 (C) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to policies issued more than 1 year  
17 after the date of enactment of this Act.

18 **SEC. 103. EXPANSION OF STATE LONG-TERM CARE PART-**  
19 **NERSHIPS.**

20 (a) IN GENERAL.—Section 1917(b)(1)(C)(ii) of the  
21 Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) is  
22 amended to read as follows:

23 “(ii) Clause (i) shall not apply in the case of an  
24 individual who received medical assistance under—

1           “(I) a Qualified State Long-Term Care In-  
 2           surance Partnership (as defined in paragraph  
 3           (6)); or

4           “(II) under a State plan of a State  
 5           which—

6                   “(aa) had a State plan amendment  
 7                   approved as of May 14, 1993, which pro-  
 8                   vided for the disregard of any assets or re-  
 9                   sources to the extent that payments are  
 10                  made under a long-term care insurance  
 11                  policy or because an individual has received  
 12                  (or is entitled to receive) benefits under a  
 13                  long-term care insurance policy; and

14                   “(bb) has a State plan amendment  
 15                   which satisfies the requirements of sub-  
 16                   paragraphs (B) through (F) of paragraph  
 17                   (6).”.

18           (b) SATISFACTION OF MINIMUM FEDERAL STAND-  
 19           ARDS, TAX-QUALIFICATIONS, INFLATION PROTECTION,  
 20           AND OTHER REQUIREMENTS FOR LONG-TERM CARE IN-  
 21           SURANCE PARTNERSHIPS.—Section 1917(e) of the Social  
 22           Security Act (42 U.S.C. 1396p(e)) is amended by insert-  
 23           ing at the end the following:

24                   “(6) The term ‘Qualified State Long-Term  
 25           Care Insurance Partnership’ means a State with an

1 approved State plan amendment that provides for  
2 the following:

3 “(A) The disregard of any assets or re-  
4 sources in an amount equal to the amount of  
5 payments made to, or on behalf of, an indi-  
6 vidual who is a beneficiary under any long-term  
7 care insurance policy (including a certificate  
8 issued under a group insurance contract) sold  
9 under such plan amendment.

10 “(B) A requirement that the State will  
11 treat benefits paid under any long-term care in-  
12 surance policy (including a certificate issued  
13 under a group insurance contract) sold under a  
14 plan amendment of a State that maintains a  
15 Qualified Long-Term Care Insurance Partner-  
16 ship or is described in subsection  
17 (b)(1)(C)(ii)(II) the same as the State treats  
18 benefits paid under such a policy sold under the  
19 State’s plan amendment.

20 “(C) A requirement that any long-term  
21 care insurance policy (including a certificate  
22 issued under a group insurance contract) sold  
23 under such plan amendment be a qualified long-  
24 term care insurance contract within the mean-

1           ing of section 7702B(b) of the Internal Revenue  
2           Code of 1986.

3           “(D) A requirement that any such policy  
4           sold under the State plan amendment shall pro-  
5           vide for compound annual inflation protection.

6           “(E) A requirement that any individual  
7           who sells such a policy receive training, and  
8           demonstrate evidence of an understanding of,  
9           the policy and how the policy relates to other  
10          public and private coverage of long-term care.

11          “(F) A requirement that the issuer of any  
12          such policy report—

13                 “(i) to the Secretary, such informa-  
14                 tion or data as the Secretary may require;  
15                 and

16                 “(ii) to the State, the information or  
17                 data reported to the Secretary (if any), the  
18                 information or data required under the  
19                 minimum reporting requirements developed  
20                 under section 103(c)(1)(B) of the Improv-  
21                 ing Long-Term Care Choices Act of 2005,  
22                 and such additional information or data as  
23                 the State may require.

24          For purposes of applying this paragraph, if a long-  
25          term care insurance policy is exchanged for another

1       such policy, the date coverage became effective  
 2       under the first policy shall determine when coverage  
 3       first becomes effective.”.

4       (c) DEVELOPMENT OF RECIPROCITY AND UNIFORM  
 5 DATA STANDARDS.—

6           (1) IN GENERAL.—Not later than 1 year after  
 7       the date of enactment of this Act, the Secretary of  
 8       Health and Human Services, in consultation with  
 9       the National Association of Insurance Commis-  
 10      sioners, issuers of long-term care insurance policies,  
 11      States with experience with long-term care insurance  
 12      partnership plans, and other States shall develop the  
 13      following standards:

14           (A) RECIPROCITY.—Standards for ensur-  
 15      ing that long-term care insurance policies  
 16      issued under a State long-term care insurance  
 17      partnership under section 1917(b)(1)(C)(ii) of  
 18      the Social Security Act (42 U.S.C.  
 19      1396p(b)(1)(C)(ii)) (as amended by subsection  
 20      (a)) are portable to other States with such a  
 21      partnership.

22           (B) MINIMUM REPORTING REQUIRE-  
 23      MENTS.—Standards for minimum reporting re-  
 24      quirements for issuers of long-term care insur-  
 25      ance policies under such State long-term care



1 insurance partnerships that shall specify the  
2 data and information that each such issuer  
3 shall report to the State with which it has such  
4 a partnership. The requirements developed in  
5 accordance with this subparagraph shall specify  
6 the type and format of the data and informa-  
7 tion to be reported and the frequency with  
8 which such reports are to be made.

9 (2) STATE REPORTING REQUIREMENTS.—Noth-  
10 ing in paragraph (1)(B) shall be construed as pro-  
11 hibiting a State from requiring an issuer of a long-  
12 term care insurance policy sold in the State (regard-  
13 less of whether the policy is issued under a State  
14 long-term care insurance partnership under section  
15 1917(b)(1)(C)(ii) of the Social Security Act) to re-  
16 quire the issuer to report information or data to the  
17 State that is in addition to the information or data  
18 required under the minimum reporting requirements  
19 developed under that paragraph.

20 (d) ANNUAL REPORTS TO CONGRESS.—The Sec-  
21 retary of Health and Human Services shall annually re-  
22 port to Congress on the long-term care insurance partner-  
23 ships established in accordance with section  
24 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C.  
25 1396p(b)(1)(C)(ii))). Such reports shall include analyses

1 of the extent to which such partnerships expand or limit  
 2 access of individuals to long-term care and the impact of  
 3 such partnerships on Federal and State expenditures  
 4 under the medicare and medicaid programs.

5 **SEC. 104. NATIONAL CLEARINGHOUSE FOR LONG-TERM**  
 6 **CARE INFORMATION.**

7 (a) ESTABLISHMENT.—The Secretary of Health and  
 8 Human Services shall establish, by grant, contract, or  
 9 interagency agreement, a National Clearinghouse for  
 10 Long-Term Care Information.

11 (b) DUTIES.—The National Clearinghouse for Long-  
 12 Term Care Information shall—

13 (1) educate consumers regarding the extent to  
 14 which Federal and State health insurance programs  
 15 provide coverage for long-term care and options for  
 16 financing long-term care;

17 (2) establish mechanisms for assisting con-  
 18 sumers with the decisionmaking process for deter-  
 19 mining whether to purchase a long-term care insur-  
 20 ance policy or pursue other options for financing  
 21 long-term care; and

22 (3) establish an Internet website that allows  
 23 consumers to compare qualified long-term care in-  
 24 surance contracts (as defined in section 7702B(b) of  
 25 the Internal Revenue Code of 1986) with respect to

1 price, benefits provided, historical data on premium  
 2 increases, and other information that would help a  
 3 consumer determine whether such a policy would  
 4 meet their needs.

5 (c) AUTHORIZATION OF APPROPRIATIONS.—There  
 6 are authorized to be appropriated for purposes of carrying  
 7 out this section, such sums as may be necessary for fiscal  
 8 year 2006 and each fiscal year thereafter.

## 9 **Subtitle B—Amendments to the** 10 **Internal Revenue Code of 1986**

### 11 **SEC. 121. TREATMENT OF PREMIUMS ON QUALIFIED LONG-** 12 **TERM CARE INSURANCE CONTRACTS.**

13 (a) IN GENERAL.—Part VII of subchapter B of chap-  
 14 ter 1 of the Internal Revenue Code of 1986 (relating to  
 15 additional itemized deductions) is amended by redesign-  
 16 ating section 224 as section 225 and by inserting after  
 17 section 223 the following new section:

### 18 **“SEC. 224. PREMIUMS ON QUALIFIED LONG-TERM CARE IN-** 19 **SURANCE CONTRACTS.**

20 “(a) IN GENERAL.—In the case of an individual,  
 21 there shall be allowed as a deduction an amount equal to  
 22 the applicable percentage of the amount of eligible long-  
 23 term care premiums (as defined in section 213(d)(10))  
 24 paid during the taxable year for coverage for the taxpayer  
 25 and the taxpayer’s spouse and dependents under a quali-

1 fied long-term care insurance contract (as defined in sec-  
 2 tion 7702B(b)).

3 “(b) APPLICABLE PERCENTAGE.—For purposes of  
 4 subsection (a), the applicable percentage shall be deter-  
 5 mined in accordance with the following table:

<b>“For taxable years beginning in calendar year—</b>	<b>The ap- plicable percent- age is—</b>
2005, 2006, or 2007 .....	25
2008 .....	35
2009 .....	65
2010 or thereafter .....	100.

6 “(c) COORDINATION WITH OTHER DEDUCTIONS.—  
 7 Any amount paid by a taxpayer for any qualified long-  
 8 term care insurance contract to which subsection (a) ap-  
 9 plies shall not be taken into account in computing the  
 10 amount allowable to the taxpayer as a deduction under  
 11 section 162(l) or 213(a).”.

12 (b) LONG-TERM CARE INSURANCE PERMITTED TO  
 13 BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE  
 14 SPENDING ARRANGEMENTS.—

15 (1) CAFETERIA PLANS.—The last sentence of  
 16 section 125(f) of such Code (defining qualified bene-  
 17 fits) is amended by inserting before the period at the  
 18 end “; except that such term shall include the pay-  
 19 ment of premiums for any qualified long-term care  
 20 insurance contract (as defined in section 7702B) to  
 21 the extent the amount of such payment does not ex-

ceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract”.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—

Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c) and redesignating subsection (d) as subsection (c).

(c) CONFORMING AMENDMENTS.—

(1) Section 62(a) of such Code is amended by inserting before the last sentence at the end the following new paragraph:

“(21) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 224.”.

(2) Sections 223(b)(4)(B), 223(d)(4)(C), 223(f)(3)(B), 3231(e)(11), 3306(b)(18), 3401(a)(22), 4973(g)(1), and 4973(g)(2)(B)(i) of such Code are each amended by striking “section 106(d)” and inserting “section 106(c)”.

(3) Section 6041 of such Code is amended—

(A) in subsection (f)(1) by striking “(as defined in section 106(c)(2))”, and

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

1       “(h) FLEXIBLE SPENDING ARRANGEMENT DE-  
 2 FINED.—For purposes of this section, a flexible spending  
 3 arrangement is a benefit program which provides employ-  
 4 ees with coverage under which—

5               “(1) specified incurred expenses may be reim-  
 6 bursed (subject to reimbursement maximums and  
 7 other reasonable conditions), and

8               “(2) the maximum amount of reimbursement  
 9 which is reasonably available to a participant for  
 10 such coverage is less than 500 percent of the value  
 11 of such coverage.

12 In the case of an insured plan, the maximum amount rea-  
 13 sonably available shall be determined on the basis of the  
 14 underlying coverage.”.

15               (4) The table of sections for part VII of sub-  
 16 chapter B of chapter 1 of such Code is amended by  
 17 striking the last item and inserting the following  
 18 new items:

“Sec. 224. Premiums on qualified long-term care insurance contracts.

“Sec. 225. Cross reference.”.

19       (d) EFFECTIVE DATES.—

20               (1) IN GENERAL.—Except as provided in para-  
 21 graph (2), the amendments made by this section  
 22 shall apply to taxable years beginning after Decem-  
 23 ber 31, 2005.

1           (2) CAFETERIA PLANS AND FLEXIBLE SPEND-  
 2           ING ARRANGEMENTS.—The amendments made by  
 3           subsection (b) shall apply to taxable years beginning  
 4           after December 31, 2007.

5 **SEC. 122. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE**  
 6 **NEEDS.**

7           (a) IN GENERAL.—Subpart A of part IV of sub-  
 8           chapter A of chapter 1 of the Internal Revenue Code of  
 9           1986 (relating to nonrefundable personal credits), as  
 10          amended by the Energy Tax Incentives Act of 2005, is  
 11          amended by inserting after section 25D the following new  
 12          section:

13 **“SEC. 25E. CREDIT FOR TAXPAYERS WITH LONG-TERM**  
 14 **CARE NEEDS.**

15          “(a) ALLOWANCE OF CREDIT.—

16               “(1) IN GENERAL.—There shall be allowed as a  
 17               credit against the tax imposed by this chapter for  
 18               the taxable year an amount equal to the applicable  
 19               credit amount multiplied by the number of applica-  
 20               ble individuals with respect to whom the taxpayer is  
 21               an eligible caregiver for the taxable year.

22               “(2) APPLICABLE CREDIT AMOUNT.—For pur-  
 23               poses of paragraph (1), the applicable credit amount  
 24               shall be determined in accordance with the following  
 25               table:

<b>“For taxable years beginning in calendar year—</b>	<b>The ap- plicable credit amount is—</b>
2005 .....	\$1,000
2006 .....	1,500
2007 .....	2,000
2008 .....	2,500
2009 or thereafter .....	3,000.

1       “(b) LIMITATION BASED ON ADJUSTED GROSS IN-  
2 COME.—

3               “(1) IN GENERAL.—The amount of the credit  
4 allowable under subsection (a) shall be reduced (but  
5 not below zero) by \$100 for each \$1,000 (or fraction  
6 thereof) by which the taxpayer’s modified adjusted  
7 gross income exceeds the threshold amount. For  
8 purposes of the preceding sentence, the term ‘modi-  
9 fied adjusted gross income’ means adjusted gross in-  
10 come increased by any amount excluded from gross  
11 income under section 911, 931, or 933.

12               “(2) THRESHOLD AMOUNT.—For purposes of  
13 paragraph (1), the term ‘threshold amount’ means—

14                       “(A) \$150,000 in the case of a joint re-  
15 turn, and

16                       “(B) \$75,000 in any other case.

17               “(3) INDEXING.—In the case of any taxable  
18 year beginning in a calendar year after 2005, each  
19 dollar amount contained in paragraph (2) shall be  
20 increased by an amount equal to the product of—

21                       “(A) such dollar amount, and



1           “(B) the medical care cost adjustment de-  
 2           termined under section 213(d)(10)(B)(ii) for  
 3           the calendar year in which the taxable year be-  
 4           gins, determined by substituting ‘August 2004’  
 5           for ‘August 1996’ in subclause (II) thereof.

6           If any increase determined under the preceding sen-  
 7           tence is not a multiple of \$50, such increase shall  
 8           be rounded to the next lowest multiple of \$50.

9           “(c) DEFINITIONS.—For purposes of this section—

10           “(1) APPLICABLE INDIVIDUAL.—

11           “(A) IN GENERAL.—The term ‘applicable  
 12           individual’ means, with respect to any taxable  
 13           year, any individual who has been certified, be-  
 14           fore the due date for filing the return of tax for  
 15           the taxable year (without extensions), by a phy-  
 16           sician (as defined in section 1861(r)(1) of the  
 17           Social Security Act) as being an individual with  
 18           long-term care needs described in subparagraph  
 19           (B) for a period—

20           “(i) which is at least 180 consecutive  
 21           days, and

22           “(ii) a portion of which occurs within  
 23           the taxable year.

24           Notwithstanding the preceding sentence, a cer-  
 25           tification shall not be treated as valid unless it

1 is made within the 39½ month period ending  
2 on such due date (or such other period as the  
3 Secretary prescribes).

4 “(B) INDIVIDUALS WITH LONG-TERM CARE  
5 NEEDS.—An individual is described in this sub-  
6 paragraph if the individual meets any of the fol-  
7 lowing requirements:

8 “(i) The individual is at least 6 years  
9 of age and—

10 “(I) is unable to perform (with-  
11 out substantial assistance from an-  
12 other individual) at least 3 activities  
13 of daily living (as defined in section  
14 7702B(c)(2)(B)) due to a loss of  
15 functional capacity, or

16 “(II) requires substantial super-  
17 vision to protect such individual from  
18 threats to health and safety due to se-  
19 vere cognitive impairment and is un-  
20 able to perform, without reminding or  
21 cuing assistance, at least 1 activity of  
22 daily living (as so defined) or to the  
23 extent provided in regulations pre-  
24 scribed by the Secretary (in consulta-  
25 tion with the Secretary of Health and

1 Human Services), is unable to engage  
 2 in age appropriate activities.

3 “(ii) The individual is at least 2 but  
 4 not 6 years of age and is unable due to a  
 5 loss of functional capacity to perform  
 6 (without substantial assistance from an-  
 7 other individual) at least 2 of the following  
 8 activities: eating, transferring, or mobility.

9 “(iii) The individual is under 2 years  
 10 of age and requires specific durable med-  
 11 ical equipment by reason of a severe health  
 12 condition or requires a skilled practitioner  
 13 trained to address the individual’s condi-  
 14 tion to be available if the individual’s par-  
 15 ents or guardians are absent.

16 “(2) ELIGIBLE CAREGIVER.—

17 “(A) IN GENERAL.—A taxpayer shall be  
 18 treated as an eligible caregiver for any taxable  
 19 year with respect to the following individuals:

20 “(i) The taxpayer.

21 “(ii) The taxpayer’s spouse.

22 “(iii) An individual with respect to  
 23 whom the taxpayer is allowed a deduction  
 24 under section 151(c) for the taxable year.

“(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional standard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

“(v) An individual who would be described in clause (iii) for the taxable year if—

“(I) the requirements of clause (iv) are met with respect to the individual, and

“(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test under subsection (c)(1)(D) or (d)(1)(C) of section 152.

“(B) RESIDENCY TEST.—The requirements of this subparagraph are met if an individual has as his principal place of abode the home of the taxpayer and—

1 “(i) in the case of an individual who  
 2 is an ancestor or descendant of the tax-  
 3 payer or the taxpayer’s spouse, is a mem-  
 4 ber of the taxpayer’s household for over  
 5 half the taxable year, or

6 “(ii) in the case of any other indi-  
 7 vidual, is a member of the taxpayer’s  
 8 household for the entire taxable year.

9 “(C) SPECIAL RULES WHERE MORE THAN  
 10 1 ELIGIBLE CAREGIVER.—

11 “(i) IN GENERAL.—If more than 1 in-  
 12 dividual is an eligible caregiver with re-  
 13 spect to the same applicable individual for  
 14 taxable years ending with or within the  
 15 same calendar year, a taxpayer shall be  
 16 treated as the eligible caregiver if each  
 17 such individual (other than the taxpayer)  
 18 files a written declaration (in such form  
 19 and manner as the Secretary may pre-  
 20 scribe) that such individual will not claim  
 21 such applicable individual for the credit  
 22 under this section.

23 “(ii) NO AGREEMENT.—If each indi-  
 24 vidual required under clause (i) to file a  
 25 written declaration under clause (i) does

1 not do so, the individual with the highest  
 2 adjusted gross income shall be treated as  
 3 the eligible caregiver.

4 “(iii) MARRIED INDIVIDUALS FILING  
 5 SEPARATELY.—In the case of married indi-  
 6 viduals filing separately, the determination  
 7 under this subparagraph as to whether the  
 8 husband or wife is the eligible caregiver  
 9 shall be made under the rules of clause (ii)  
 10 (whether or not one of them has filed a  
 11 written declaration under clause (i)).

12 “(d) IDENTIFICATION REQUIREMENT.—No credit  
 13 shall be allowed under this section to a taxpayer with re-  
 14 spect to any applicable individual unless the taxpayer in-  
 15 cludes the name and taxpayer identification number of  
 16 such individual, and the identification number of the phy-  
 17 sician certifying such individual, on the return of tax for  
 18 the taxable year.

19 “(e) TAXABLE YEAR MUST BE FULL TAXABLE  
 20 YEAR.—Except in the case of a taxable year closed by rea-  
 21 son of the death of the taxpayer, no credit shall be allow-  
 22 able under this section in the case of a taxable year cov-  
 23 ering a period of less than 12 months.”.

24 (b) CONFORMING AMENDMENTS.—

1           (1) Section 6213(g)(2) of such Code is amend-  
 2       ed by striking “and” at the end of subparagraph  
 3       (L), by striking the period at the end of subpara-  
 4       graph (M) and inserting “, and”, and by inserting  
 5       after subparagraph (M) the following new subpara-  
 6       graph:

7                   “(N) an omission of a correct TIN or phy-  
 8       sician identification required under section  
 9       25E(d) (relating to credit for taxpayers with  
 10      long-term care needs) to be included on a re-  
 11      turn.”.

12           (2) The table of sections for subpart A of part  
 13      IV of subchapter A of chapter 1 of such Code is  
 14      amended by inserting after the item relating to sec-  
 15      tion 25D the following new item:

“Sec. 25E. Credit for taxpayers with long-term care needs.”.

16           (c) EFFECTIVE DATE.—The amendments made by  
 17      this section shall apply to taxable years beginning after  
 18      December 31, 2005.

19      **SEC. 123. TREATMENT OF EXCHANGES OF LONG-TERM**  
 20                   **CARE INSURANCE CONTRACTS.**

21           (a) IN GENERAL.—Subsection (a) of section 1035 of  
 22      the Internal Revenue Code of 1986 (relating to exchanges  
 23      of insurance policies) is amended by striking the period  
 24      at the end of paragraph (3) and inserting “; or” and by  
 25      adding at the end the following new paragraph:

1           “(4) a qualified long-term care insurance con-  
 2           tract for another qualified long-term care insurance  
 3           contract.”.

4           (b) QUALIFIED LONG-TERM CARE INSURANCE CON-  
 5           TRACT.—Subsection (b) of section 1035 of such Code (re-  
 6           lating to definitions) is amended by adding at the end the  
 7           following new paragraph:

8           “(4) QUALIFIED LONG-TERM CARE INSURANCE  
 9           CONTRACT.—The term ‘qualified long-term care in-  
 10          surance contract’ means—

11                   “(A) any qualified long-term care insur-  
 12                   ance contract (as defined in section 7702B),  
 13                   and

14                   “(B) any contract which is treated as such  
 15                   by section 321(f)(2) of the Health Insurance  
 16                   Portability and Accountability Act of 1996.”.

17          (c) EFFECTIVE DATE.—

18           (1) IN GENERAL.—The amendments made by  
 19           this section shall apply to exchanges after December  
 20           31, 1997.

21           (2) WAIVER OF LIMITATIONS.—If the credit or  
 22           refund of any overpayment of tax with respect to a  
 23           taxable year ending before the date of the enactment  
 24           of this Act resulting from the application of section  
 25           1035(a)(4) of the Internal Revenue Code of 1986, as



1 added by this section, is prevented at any time by  
 2 the operation of any law or rule of law (including res  
 3 judicata), such credit or refund may nevertheless be  
 4 allowed or made if the claim therefor is filed before  
 5 the close of the 1-year period beginning on the date  
 6 of the enactment of this Act.

7 **TITLE II—MEDICAID HOME AND**  
 8 **COMMUNITY-BASED SERV-**  
 9 **ICES OPTIONAL BENEFIT**

10 **SEC. 201. MEDICAID HOME AND COMMUNITY-BASED SERV-**  
 11 **ICES OPTIONAL BENEFIT.**

12 (a) HOME AND COMMUNITY-BASED SERVICES AS AN  
 13 OPTIONAL BENEFIT FOR INDIVIDUALS ELIGIBLE FOR  
 14 MEDICAL ASSISTANCE.—Title XIX of the Social Security  
 15 Act (42 U.S.C. 1396 et seq.) is amended—

16 (1) in section 1905(a)—

17 (A) in paragraph (27), by striking “and”  
 18 at the end;

19 (B) by redesignating paragraph (28) as  
 20 paragraph (29); and

21 (C) by inserting after paragraph (27), the  
 22 following:

23 “(28) subject to section 1930A, such home and  
 24 community-based services (as defined in subsections  
 25 (c)(4)(B) and (d)(5)(C)(i) of section 1915 (not in-

1 including payment for room and board but including,  
 2 in the case of services described in section  
 3 1915(c)(4)(B), any other services requested by a  
 4 State and approved by the Secretary under such sec-  
 5 tion)) as the State shall specify in a State plan  
 6 amendment; and”; and

7 (2) by inserting after section 1930, the fol-  
 8 lowing:

9 “HOME AND COMMUNITY-BASED SERVICES

10 “SEC. 1930A. (a) IN GENERAL.—A State may pro-  
 11 vide through a State plan amendment for the provision  
 12 of such home and community-based services under section  
 13 1905(a)(28) as the State shall specify for individuals eligi-  
 14 ble for medical assistance under the State plan (without  
 15 determining that but for the provision of such services the  
 16 individuals would require the level of care provided in a  
 17 hospital or a nursing facility or intermediate care facility  
 18 for the mentally retarded), but only if the State meets the  
 19 following requirements:

20 “(1) NEEDS-BASED CRITERIA FOR ELIGIBILITY  
 21 FOR, AND RECEIPT OF, HOME AND COMMUNITY-  
 22 BASED SERVICES.—The State establishes needs-  
 23 based criteria for determining an individual’s eligi-  
 24 bility under the State plan for medical assistance for  
 25 such home and community-based services, and if the  
 26 individual is eligible for such services, the specific

1 home and community-based services that the indi-  
 2 vidual will receive.

3 “(2) ESTABLISHMENT OF MORE STRINGENT  
 4 NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITU-  
 5 TIONALIZED CARE.—The State establishes needs-  
 6 based criteria for determining whether an individual  
 7 requires the level of care provided in a hospital, a  
 8 nursing facility, or an intermediate care facility for  
 9 the mentally retarded under the State plan or under  
 10 any waiver of such plan that are more stringent  
 11 than the needs-based criteria established under para-  
 12 graph (1) for determining eligibility for home and  
 13 community-based services.

14 “(3) PROJECTION OF NUMBER OF INDIVIDUALS  
 15 TO BE PROVIDED HOME AND COMMUNITY-BASED  
 16 SERVICES.—The State submits to the Secretary, in  
 17 such form and manner, and upon such frequency as  
 18 the Secretary shall specify, the projected number of  
 19 individuals to be provided home and community-  
 20 based services.

21 “(4) CRITERIA BASED ON INDIVIDUAL ASSESS-  
 22 MENT.—

23 “(A) IN GENERAL.—The criteria estab-  
 24 lished by the State for purposes of paragraphs  
 25 (1) and (2) requires an assessment of an indi-

vidual’s support needs and capabilities, and may take into account the inability of the individual to perform 1 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

“(B) ADJUSTMENT AUTHORITY.—The State plan amendment provides for modification of the criteria established under paragraph (1) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of paragraph (3), but only if—

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

“(ii) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to

1 be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

2 “(iii) after the effective date of such modification, the State applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under paragraph (2).

3 “(5) INDEPENDENT EVALUATION AND ASSESSMENT.—

4 “(A) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in paragraphs (1) and (2).

5 “(B) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State

1 uses an independent assessment, based on the  
2 needs of the individual to—

3 “(i) determine a necessary level of  
4 services and supports to be provided, con-  
5 sistent with an individual’s physical and  
6 mental capacity,

7 “(ii) prevent the provision of unneces-  
8 sary or inappropriate care; and

9 “(iii) establish an individualized care  
10 plan for the individual in accordance with  
11 paragraph (7).

12 “(6) ASSESSMENT.—The independent assess-  
13 ment required under paragraph (5)(B) shall include  
14 the following:

15 “(A) An objective evaluation of an individ-  
16 ual’s inability of the individual to perform 1 or  
17 more activities of daily living (as defined in sec-  
18 tion 7702B(c)(2)(B) of the Internal Revenue  
19 Code of 1986) or the need for significant assist-  
20 ance to perform such activities, and of the indi-  
21 vidual’s ability to engage in major life activities  
22 such as walking, seeing, hearing, breathing,  
23 speaking, working, performing manual tasks,  
24 learning, thinking, concentrating, interacting

1 with others, sleeping, and any other appropriate  
2 activities.

3 “(B) A face-to-face evaluation of the indi-  
4 vidual by an individual trained in the assess-  
5 ment and evaluation of individuals whose phys-  
6 ical or mental conditions trigger a potential  
7 need for home and community-based services.

8 “(C) Where appropriate, consultation with  
9 the individual’s family, spouse, guardian, or  
10 other responsible individual.

11 “(D) Consultation with appropriate treat-  
12 ing and consulting health and support profes-  
13 sionals caring for the individual.

14 “(E) An examination of the individual’s  
15 relevant history, medical records, and care and  
16 support needs, guided by best practices and re-  
17 search on effective strategies that result in im-  
18 proved health and quality of life outcomes.

19 “(F) If the State offers individuals the op-  
20 tion to self-direct the purchase of, or control the  
21 receipt of, home and community-based service,  
22 an evaluation of the ability of the individual or  
23 the individual’s representative to self-direct the  
24 purchase of, or control the receipt of, such serv-  
25 ices if the individual so elects.

1 “(7) INDIVIDUALIZED CARE PLAN.—

2 “(A) IN GENERAL.—In the case of an indi-  
3 vidual who is determined to be eligible for home  
4 and community-based services, the State uses  
5 the independent assessment required under  
6 paragraph (5)(B) to establish a written individ-  
7 ualized care plan for the individual.

8 “(B) PLAN REQUIREMENTS.—The State  
9 ensures that the individualized care plan for an  
10 individual—

11 “(i) is developed—

12 “(I) in consultation with the indi-  
13 vidual, the individual’s treating physi-  
14 cian, health care or support profes-  
15 sional, or other appropriate individ-  
16 uals, as defined by the State, and,  
17 where appropriate the individual’s  
18 family, caregiver, or representative;  
19 and

20 “(II) taking into account the ex-  
21 tent of, and need for, any family or  
22 other supports for the individual;

23 “(ii) identifies the necessary home and  
24 community-based services to be furnished  
25 to the individual (or, if the individual elects



1 to self-direct the purchase of, or control  
 2 the receipt of, such services, funded for the  
 3 individual); and

4 “(iii) is reviewed at least annually and  
 5 as needed when there is a significant  
 6 change in the individual’s circumstances.

7 “(C) STATE OPTION TO OFFER ELECTION  
 8 FOR SELF-DIRECTED SERVICES.—

9 “(i) INDIVIDUAL CHOICE.—At the op-  
 10 tion of the State, the State may allow an  
 11 individual or the individual’s representative  
 12 to elect to receive self-directed home and  
 13 community-based services in a manner  
 14 which gives them the most control over  
 15 such services consistent with the individ-  
 16 ual’s abilities and the requirements of  
 17 clause (ii).

18 “(ii) SELF-DIRECTED SERVICES.—The  
 19 term ‘self-directed’ means, with respect to  
 20 the home and community-based services of-  
 21 fered under the State plan amendment,  
 22 such services for the individual which are  
 23 planned and purchased under the direction  
 24 and control of such individual or the indi-  
 25 vidual’s authorized representative, includ-

1 ing the amount, duration, scope, provider,  
2 and location of such services, under the  
3 State plan consistent with the following re-  
4 quirements:

5 “(I) ASSESSMENT.—There is an  
6 assessment of the needs, capabilities,  
7 and preferences of the individual with  
8 respect to such services.

9 “(II) SERVICE PLAN.—Based on  
10 such assessment, there is developed  
11 jointly with such individual or the in-  
12 dividual’s authorized representative a  
13 plan for such services for such indi-  
14 vidual that is approved by the State  
15 and that—

16 “(aa) specifies those services  
17 which the individual or the indi-  
18 vidual’s authorized representative  
19 would be responsible for direct-  
20 ing;

21 “(bb) identifies the methods  
22 by which the individual or the in-  
23 dividual’s authorized representa-  
24 tive will select, manage, and dis-  
25 miss providers of such services;

1           “(cc) specifies the role of  
2 family members and others whose  
3 participation is sought by the in-  
4 dividual or the individual’s au-  
5 thorized representative with re-  
6 spect to such services;

7           “(dd) is developed through a  
8 person-centered process that is  
9 directed by the individual or the  
10 individual’s authorized represent-  
11 ative, builds upon the individual’s  
12 capacity to engage in activities  
13 that promote community life and  
14 that respects the individual’s  
15 preferences, choices, and abilities,  
16 and involves families, friends,  
17 and professionals as desired or  
18 required by the individual or the  
19 individual’s authorized represent-  
20 ative;

21           “(ee) includes appropriate  
22 risk management techniques that  
23 recognize the roles and sharing of  
24 responsibilities in obtaining serv-  
25 ices in a self-directed manner and

1 assure the appropriateness of  
2 such plan based upon the re-  
3 sources and capabilities of the in-  
4 dividual or the individual's au-  
5 thorized representative; and

6 “(ff) may include an individ-  
7 ualized budget which identifies  
8 the dollar value of the services  
9 and supports under the control  
10 and direction of the individual or  
11 the individual's authorized rep-  
12 resentative.

13 “(III) BUDGET PROCESS.—With  
14 respect to individualized budgets de-  
15 scribed in subclause (II)(ff), the State  
16 plan amendment—

17 “(aa) describes the method  
18 for calculating the dollar values  
19 in such budgets based on reliable  
20 costs and service utilization;

21 “(bb) defines a process for  
22 making adjustments in such dol-  
23 lar values to reflect changes in  
24 individual assessments and serv-  
25 ice plans; and

1 “(cc) provides a procedure  
2 to evaluate expenditures under  
3 such budgets.

4 “(8) QUALITY ASSURANCE; CONFLICT OF IN-  
5 TEREST STANDARDS.—

6 “(A) QUALITY ASSURANCE.—The State en-  
7 sures that the provision of home and commu-  
8 nity-based services meets Federal and State  
9 guidelines for quality assurance.

10 “(B) CONFLICT OF INTEREST STAND-  
11 ARDS.—The State establishes standards for the  
12 conduct of the independent evaluation and the  
13 independent assessment to safeguard against  
14 conflicts of interest.

15 “(9) REDETERMINATIONS AND APPEALS.—The  
16 State allows for at least annual redeterminations of  
17 eligibility, and appeals in accordance with the fre-  
18 quency of, and manner in which, redeterminations  
19 and appeals of eligibility are made under the State  
20 plan.

21 “(10) PRESUMPTIVE ELIGIBILITY FOR ASSESS-  
22 MENT.—

23 “(A) IN GENERAL.—The State, at its op-  
24 tion, elects to provide for a period of presump-  
25 tive eligibility for an individual that is limited

1 to medical assistance for carrying out the inde-  
 2 pendent evaluation and assessment under para-  
 3 graph (5) to determine an individual's eligibility  
 4 for home and community-based services, and if  
 5 the individual is eligible for such services, the  
 6 specific home and community-based services  
 7 that the individual will receive.

8 “(B) APPLICATION OF EXISTING RULES.—

9 In the case of a State that makes such an elec-  
 10 tion, the State provides for a period of pre-  
 11 sumptive eligibility in the same manner as the  
 12 State may provide for such a period under sec-  
 13 tion 1920B (except that subsection (d)(2) of  
 14 that section is applied by substituting ‘section  
 15 1903’ for ‘clause (4) of the first sentence of  
 16 section 1905(b)’).

17 “(b) DEFINITION OF INDIVIDUAL’S REPRESENTA-

18 TIVE.—In this section, the term ‘individual’s representa-  
 19 tive’ means, with respect to an individual, a parent, a fam-  
 20 ily member, or a guardian of the individual, an advocate  
 21 for the individual, or any other individual who is author-  
 22 ized to represent the individual.

23 “(c) NO EFFECT ON 1915 OR 1115 WAIVERS.—

24 Nothing in this section shall be construed as effecting the  
 25 option of a State to offer home and community-based serv-

ices under a waiver under subsections (c) or (d) of section 1915 or under section 1115.”.

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of such Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by inserting “or (28)” after “(24)”.

(b) STATE OPTION TO EXPAND HOME AND COMMUNITY-BASED SERVICES TO ADDITIONAL AT-RISK INDIVIDUALS.—

(1) IN GENERAL.—Section 1930A of the Social Security Act (42 U.S.C. 1396d(y)) (as added by subsection (a)) is amended—

(A) by redesignating subsection (b) as subsection (c); and

(B) by inserting after subsection (a) the following:

“(b) HOME AND COMMUNITY-BASED SERVICES FOR AT-RISK INDIVIDUALS.—

“(1) IN GENERAL.—If a State elects to offer under the State plan medical assistance for home and community-based services in accordance with section 1905(a)(28) and subsection (a), the State may elect, subject to paragraph (3), to offer such services to an individual described in paragraph (2) who is determined on the basis of an independent

1 evaluation to meet the criteria established under  
 2 subsection (a)(1) for eligibility for, and receipt of,  
 3 such services.

4 “(2) INDIVIDUAL DESCRIBED.—For purposes of  
 5 paragraph (1), an individual described in this para-  
 6 graph is an individual whose income (as determined  
 7 under section 1612, but without regard to subsection  
 8 (b) thereof) does not exceed such percent of the sup-  
 9 plemental security income benefit rate established by  
 10 section 1611(b)(1) as the State may establish (but  
 11 not to exceed 300 percent).

12 “(3) APPLICATION OF RULES FOR OFFERING  
 13 HOME AND COMMUNITY-BASED SERVICES AS AN OP-  
 14 TIONAL BENEFIT.—The requirements of subsection  
 15 (a) shall apply to the provision of home and commu-  
 16 nity-based services to eligible individuals under this  
 17 subsection.”.

18 (2) CONFORMING AMENDMENT.—Section  
 19 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is  
 20 amended in the matter preceding subparagraph (A),  
 21 by inserting “1930A(b)” after “1905(p)(1)”.

22 (c) QUALITY OF CARE MEASURES.—

23 (1) IN GENERAL.—The Secretary of Health and  
 24 Human Services (in this subsection referred to as  
 25 the “Secretary”), acting through the Director of the



1       Agency for Healthcare Research and Quality, shall  
2       consult with consumers, health and social service  
3       providers and other professionals knowledgeable  
4       about long-term care services and supports to de-  
5       velop program performance indicators, client func-  
6       tion indicators, and measures of client satisfaction  
7       with respect to home and community-based services  
8       offered under State medicaid programs (under a  
9       waiver approved under section 1115 or 1915 of the  
10      Social Security Act or under section 1930A of such  
11      Act (as added by subsections (a) and (b))).

12           (2) BEST PRACTICES.—The Secretary shall—

13               (A) use the indicators and measures devel-  
14               oped under paragraph (1) to assess such home  
15               and community-based services, the outcomes as-  
16               sociated with the receipt of such services (par-  
17               ticularly with respect to the health and welfare  
18               of the recipient of the services), and the overall  
19               system for providing home and community-  
20               based services under the medicaid program  
21               under title XIX of the Social Security Act; and

22               (B) make publicly available the best prac-  
23               tices identified through such assessment and a  
24               comparative analyses of the system features of  
25               each State.

1 **TITLE III—INTEGRATED ACUTE**  
 2 **AND LONG-TERM CARE SERV-**  
 3 **ICES FOR DUALY ELIGIBLE**  
 4 **INDIVIDUALS.**

5 **SEC. 301. REMOVAL OF BARRIERS TO INTEGRATED ACUTE**  
 6 **AND LONG-TERM CARE SERVICES FOR DU-**  
 7 **ALLY ELIGIBLE INDIVIDUALS.**

8 (a) REGULATIONS AND LEGISLATIVE RECOMMENDA-  
 9 TIONS.—Not later than January 1, 2007, the Secretary  
 10 of Health and Human Services, in consultation with direc-  
 11 tors of State medicaid programs under title XIX of the  
 12 Social Security Act, health care insurers, managed care  
 13 entities (as defined in section 1932(a)(1)(B) of the Social  
 14 Security Act (42 U.S.C. 1396u–2(a)(1)(B))), entities offer-  
 15 ing Medicare Advantage plans under part C of title XVIII  
 16 of such Act (42 U.S.C. 1395w–21 et seq.) (including spe-  
 17 cialized MA plans for special needs individuals (as defined  
 18 in section 1859(b)(6) of such Act), PACE providers (as  
 19 defined in section 1934(a)(3) of the Social Security Act  
 20 (42 U.S.C. 1396u–4(a)(3))), and representatives of individ-  
 21 uals who are dually eligible for the medicare and medicaid  
 22 programs, shall do the following:

23 (1) REMOVAL OF ADMINISTRATIVE BARRIERS  
 24 TO INTEGRATED CARE.—Issue regulations removing  
 25 administrative barriers under the medicare and med-

1       icaid programs that impede the offering of inte-  
 2       grated acute and long-term care services which com-  
 3       bine acute, home and community-based, nursing fa-  
 4       cility, and mental health services, and, to the extent  
 5       consistent with an enrollee’s coverage for such serv-  
 6       ices under part D of title XVIII of the Social Secu-  
 7       rity Act, coverage for prescribed drugs, into a single  
 8       model of care for individuals who are dually eligible  
 9       for such programs. Such regulations shall address  
 10      conflicting requirements under such programs for  
 11      managed care entities (as defined in section  
 12      1932(a)(1)(B) of the Social Security Act (42 U.S.C.  
 13      1396u–2(a)(1)(B)), entities offering Medicare Ad-  
 14      vantage plans under part C of title XVIII of such  
 15      Act (42 U.S.C. 1395w–21 et seq.) (including special-  
 16      ized MA plans for special needs individuals (as de-  
 17      fined in section 1859(b)(6) of such Act), and PACE  
 18      providers (as defined in section 1934(a)(3) of the  
 19      Social Security Act (42 U.S.C. 1396u–4(a)(3)) with  
 20      respect to identification cards, marketing require-  
 21      ments, and such other requirements as the Secretary  
 22      shall identify.

23           (2) SUBMISSION OF RECOMMENDATIONS FOR  
 24      REMOVAL OF STATUTORY BARRIERS TO INTEGRATED  
 25      CARE.—Submit to Congress recommendations for re-

1        removal of such statutory barriers to the offering of  
 2        such integrated services to individuals dually eligible  
 3        under the medicare and medicaid programs as the  
 4        Secretary shall identify.

5        (b) MEDPAC COMMENTS.—Not later than February  
 6        1, 2007, the Medicare Payment Advisory Commission  
 7        shall submit to Congress comments on the recommenda-  
 8        tions submitted by the Secretary of Health and Human  
 9        Services under subsection (a)(2).

## 10        **TITLE IV—EFFECTIVE DATE**

### 11        **SEC. 401. EFFECTIVE DATE.**

12        (a) IN GENERAL.—Except as otherwise provided in  
 13        this Act, this Act and the amendments made by this Act  
 14        take effect on October 1, 2005.

15        (b) EXTENSION OF EFFECTIVE DATE FOR STATE  
 16        LAW AMENDMENT.—In the case of a State plan under  
 17        title XIX of the Social Security Act which the Secretary  
 18        of Health and Human Services determines requires State  
 19        legislation in order for the plan to meet the additional re-  
 20        quirements imposed by the amendments made by a provi-  
 21        sion of this Act, the State plan shall not be regarded as  
 22        failing to comply with the requirements of this Act solely  
 23        on the basis of its failure to meet these additional require-  
 24        ments before the first day of the first calendar quarter  
 25        beginning after the close of the first regular session of the

1 State legislature that begins after the date of enactment  
2 of this Act. For purposes of the previous sentence, in the  
3 case of a State that has a 2-year legislative session, each  
4 year of the session shall be considered to be a separate  
5 regular session of the State legislature.

