117TH CONGRESS
2D SESSION

S. _____

To establish a Dual Eligible Quality Care Fund to provide grants to State Medicaid programs to improve their capacity to ensure the provision of quality integrated care for dual eligible beneficiaries.

IN THE SENATE OF THE UNITED STATES

Mr. SCOTT of South Carolina introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To establish a Dual Eligible Quality Care Fund to provide grants to State Medicaid programs to improve their capacity to ensure the provision of quality integrated care for dual eligible beneficiaries.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Supporting Care for Dual Eligibles Act''.

SEC. 2. IMPROVING MEDICAID'S CAPACITY TO PROTECT DUAL ELIGIBLE BENEFICIARIES.

(a) ESTABLISHMENT OF DUAL ELIGIBLE QUALITY CARE FUND.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a fund to be known as the ''Dual Eligible Quality Care Fund''.

(2) ESTABLISHMENT WITHIN FEDERAL COORDINATED HEALTH CARE OFFICE.—The Dual Eligible Quality Care Fund shall be established within, and administered by the Director of, the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b).

(3) FUNDING.—There is appropriated to the Dual Eligible Quality Care Fund for fiscal year 2022 $100,000,000,to remain available until expended.

(b) PURPOSE.—The purpose of the Dual Eligible Quality Care Fund is to provide timely, targeted assistance in the way of grants to State Medicaid programs to improve their capacity to ensure the provision of quality integrated care for dual eligible beneficiaries.

(c) ALLOWABLE USES OF GRANT FUNDS.—A State Medicaid program may use amounts received under a grant from the Dual Eligible Quality Care Fund to improve its capacity to provide quality integrated care for dual eligible beneficiaries through any of the following:

(1) Recruiting and paying workers with needed subject matter knowledge, skills, or capabilities.

(2) Actuarial support for rate development and analysis and development or purchase of risk adjustment tools.

(3) Information technology system changes, including changes that—

(A) improve member enrollments;

(B) improve encounter data collection and analysis;

(C) improve the ability of State Medicaid programs to develop customized data management tools (such as queries and dashboards);

(D) improve compliance with Federal reporting requirements;

(E) enhance financial analysis;

(F) improve quality reporting and monitoring;

(G) improve modifications to capitation payments;

(H) transfer eligibility and enrollment data between systems;

(I) improve the grievances and appeals process; and

(J) improve interaction with Medicare data and related systems.

(4) Providing support for dual eligible beneficiaries during enrollment processes, assistance to dual eligible beneficiaries evaluating their enrollment choices, informational materials to dual eligible beneficiaries and those assisting with decision support, and coordination with Medicare enrollment processes.

(5) Monitoring and oversight of efforts undertaken by State Medicaid using grant funds, including measuring the level of participation by stakeholders and dual eligible beneficiaries.

(6) Quality measurement and State evaluation activities, development and deployment of survey tools, and costs of accessing, transferring, and analyzing data.

(7) Develop knowledge and understanding within the State Medicaid agency of the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(8) Supporting and improving Medicare initiatives, including new initiatives and existing or past initiatives such as the Financial Alignment Initiative for Medicare-Medicaid Enrollees demonstration projects conducted under section 1115A of the Social Security Act (42 U.S.C. 1315a).

(d) AWARDING GRANTS.—

(1) IN GENERAL.—A State Medicaid program that wishes to receive a grant under this section from the Dual Eligible Quality Care Fund shall submit an application to the Director of the Federal Coordinated Health Care Office (referred to in this subsection as the ''Director''), in such form and manner as the Director shall specify. The Director may award a grant under this section to any State, without regard to the State's existing capacity to provide quality integrated care for dual eligible beneficiaries.

(2) APPLICATION REQUIREMENTS.—An application for a grant under this section shall include an identification of the uses of funds described in subsection (c) for which the State Medicaid program will use the grant funds.

(3) METHODOLOGY FOR DISBURSING FUNDS.—

(A) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Director shall issue guidance establishing a clear and equitable methodology for awarding grants to State Medicaid programs under this section.

(B) METHODOLOGY REQUIREMENTS.—The methodology established by the Director under this paragraph shall, to the extent practical—

(i) ensure that grant funds are used in accordance with subsection (c);

(ii) provide that grants are awarded by the Director in a manner that is transparent and equitable to State Medicaid programs; and

(iii) provide that, in determining the grant amount to be awarded to a State Medicaid program, the Director shall take into consideration—

(I) the percentage of enrollees in the program who are dual eligible beneficiaries; and

(II) the total number of dual eligible beneficiaries enrolled in the program.

(C) LIMITATIONS.—The Director shall not award more than 1 grant under this section to any State Medicaid program, and in no case may the amount of a grant awarded under this section exceed $2,000,000.

(e) STATE PROGRAM REPORTING.—

(1) QUARTERLY REPORTING.—States receiving a grant under this section shall, in a form and manner specified by the Director of the Federal Coordinated Health Care Office (referred to in this subsection as the ''Director''), report no less frequently than once a quarter regarding the amount of grant funds spent by the State and how funds received from the grant are being used within the State.

(2) LONGITUDINAL REPORT.—States receiving a grant under this section shall, no later than 2 years after the receipt of such grant, submit to the Director and make available on a State website a report summarizing how the funds received under such grant were used. Such report shall include the following:

(A) An explanation of which uses of funds described in subsection (c) the grant funds supported.

(B) An assessment of each of the following:

(i) The manner in which the grant funds improved the State Medicaid program's capacity to provide quality integrated care for dual eligible beneficiaries.

(ii) The manner in which the grant funds improved the quality of care for dual eligible beneficiaries.

(iii) The manner in which the grant funds improved the integration and coordination of care for dual eligible beneficiaries.

(f) DEFINITIONS.—In this section:

(1) DUAL ELIGIBLE BENEFICIARY.—The term ''dual eligible beneficiary'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or enrolled for benefits under part B of such title, and is eligible for medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such a plan.

(2) QUALITY INTEGRATED CARE.—The term ''quality integrated care'' means the provision of

services provided under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and services provided under a State Medicaid program—

(A) through systems in which Medicaid and Medicare program administrative requirements, financing, benefits, or care delivery are aligned; and

(B) in a coordinated fashion, which may include coverage of such services through a single entity or coordinating entities.

(3) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such a plan.

SEC. 3. PAYMENT ERROR RATE MEASUREMENT (PERM) AUDIT REQUIREMENTS.

(a) BIENNIAL PERM AUDIT REQUIREMENT.—Beginning with fiscal year 2023, the Administrator shall conduct payment error rate measurement (''PERM'') audits of each State Medicaid program on a biennial basis.

(b) NOTIFICATION; IDENTIFICATION OF SOURCES OF IMPROPER PAYMENTS.—

(1) NOTIFICATION.—Not later than 6 months after the date of enactment of this Act, the Administrator shall notify the contractor conducting PERM audits of the Administrator's intent to modify contracts to require PERM audits not less than once every other year in each State.

(2) IDENTIFICATION OF SOURCES OF IMPROPER PAYMENTS.—The Administrator shall direct the contractor conducting PERM audits of State Medicaid programs to identify areas known to be sources of improper payments under such programs to identify program areas or components known to be sources of high-risk for improper payments under such programs.

(c) STATE MEDICAID DIRECTOR LETTER.—Not later than 12 months after the date of enactment of this Act, the Administrator shall issue a State Medicaid Director letter regarding State requirements under Federal law and regulations regarding avoiding and responding to improper payments under State Medicaid programs.

(d) STATE IMPROPER PAYMENT MITIGATION PLANS.—

(1) IN GENERAL.—Not later than January 1, 2023, each State Medicaid program shall submit to the Administrator a plan, which shall include specific actions and timeframes for taking such actions and achieving specified results, for mitigating improper payments under such program.

(2) PUBLICATION OF STATE PLANS.—The Administrator shall make State plans submitted under paragraph (1) available to the public.

(e) DEFINITIONS.—In this section:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Centers for Medicare & Medicaid Services.

(2) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such a plan.