Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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New House Build Back Better Legislation Would Make Long-Lasting Medicaid Improvements

By Jennifer Sullivan, Anna Bailey, Jennifer Wagner, and Judith Solomon

In addition to creating a pathway to coverage for more than 2 million people in the Medicaid coverage gap,[1] the House Build Back Better legislation would strengthen Medicaid and Children's Health Insurance Program (CHIP) coverage for parents and children, people leaving jails and prisons, and people with disabilities and older people who need home- and community-based services (HCBS). The policies in the bill would help narrow racial and ethnic inequities in coverage and access to health services. Many of the provisions would also be permanent, cementing long-lasting structural improvements that will increase continuity of care so that people can access the health services they need even as they navigate changing life circumstances.

Build Back Better would:

- Ensure all pregnant people enrolled in Medicaid and CHIP can maintain coverage for 12 months after the end of their pregnancy and create a new state option to better coordinate their care;
- Ensure all children and youth enrolled in Medicaid and CHIP can stay enrolled for 12 months at a time to reduce the risk that they will experience gaps in coverage or lose coverage altogether;
- Make CHIP (currently funded through September 30, 2027) permanent so that it doesn't require periodic reauthorization by Congress;
- Make the Express Lane Eligibility option, which allows states to take various steps to streamline enrollment and eligibility renewals for children in Medicaid and CHIP and is due to expire September 30, 2027, permanent;
- Increase access to and improve the quality of Medicaid HCBS and increase pay, training, and career pathways for direct care workers;
- Make permanent both 1) the successful Money Follows the Person program, which helps people move from institutional settings to the community, and 2) the rules that ensure people

[1] For more on this provision of the legislation, see Judith Solomon and Tara Straw, "Build Back Better Increases Health Coverage and Makes It More Affordable," CBPP, October 29, 2021, https://www.cbpp.org/research/health/build-back-better-increases-health-coverage-and-makes-it-more-affordable.

can maintain some financial resources when their spouse is receiving HCBS covered by Medicaid (both provisions are set to expire September 30, 2023);

- Provide Medicaid coverage of health care services for people 30 days prior to leaving jail or prison, which could help connect them to the care they will need in the community and reduce their risk of returning to jail or prison due to unmet health care needs;
- Make the mobile crisis services state option (which was created by the American Rescue Plan Act, begins April 1, 2022, and will be available through March 31, 2027) permanent, so that more states will deploy specialized teams to respond to mental health and substance use emergencies;
- Permanently increase federal Medicaid funds for Puerto Rico and other territories so they have more adequate funds to maintain their programs, though the measures fall short of ensuring parity between the territory and state Medicaid programs.

12 Months of Postpartum Coverage Would Improve Maternal Health

The proposed legislation would require that *all* states cover pregnant people enrolled in Medicaid and CHIP for 12 months following the end of a pregnancy. This change would be permanent and would take effect one year after the bill is enacted. Currently, states are required to provide just 60 days of postpartum coverage. In states that have expanded Medicaid under the Affordable Care Act (ACA), people with incomes up to 138 percent of the federal poverty line remain eligible for Medicaid after their postpartum period ends. However, people with incomes above that threshold can become uninsured when the Medicaid postpartum period ends or can be forced to navigate changing insurance by enrolling in marketplace coverage at a time when disruptions in coverage and changes in providers can be particularly harmful.

And currently, in states that have *not* expanded Medicaid, people with much lower incomes lose Medicaid 60 days after giving birth, and those with incomes below the poverty line have no affordable pathway to coverage, because they are not eligible for subsidized coverage in the ACA marketplaces.[2] While Build Back Better would provide a pathway to coverage in non-expansion states, 12-month postpartum coverage is still critical because it means that people who have recently given birth will not be forced to navigate a change in insurance and, potentially, providers.

The American Rescue Plan, enacted in March, created a temporary option — which starts in April 2022 and is available for five years — for states to offer 12 months of postpartum coverage in Medicaid or CHIP. However, only about half the states have passed legislation or taken other steps to take advantage of this option, and some are using section 1115 demonstration authority to extend coverage for less than 12 months or, in the case of Missouri, to limit it to people with substance use disorders.[3]

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[2] Build Back Better would allow adults with income up to 138 percent of poverty in states that have not expanded Medicaid to enroll in a plan through the ACA marketplace. However, ensuring people who give birth can retain Medicaid for 12 months postpartum would negate the need to navigate a transition from Medicaid to marketplace coverage during this critical period, easing unnecessary complications that can come with coverage transitions, such as adjusting to different provider networks and benefit packages.

[3] Wisconsin plans to extend coverage for 90 days and Georgia and Texas for six months. Maine will begin with six months and ramp up to 12 months by July 2023. Missouri provides a limited benefit package focused on behavioral health treatment services and only makes services available to people with substance use disorders. See Kaiser Family

Medicaid plays a key role in financing prenatal and postpartum care. In 2019, Medicaid paid for more than 42 percent of all births in the United States, 65 percent of births to Black mothers, and more than 59 percent of births to Hispanic mothers.[4] Medicaid coverage significantly improves pregnancy-related health outcomes by increasing access to care — particularly during the postpartum period, research shows.[5] Postpartum health coverage is particularly important because life-threatening conditions during and in the 12 months after pregnancy are distressingly common in the United States. People with low incomes and people of color — especially Black people and American Indians and Alaska Natives — are disproportionately likely to face these conditions.[6] Ensuring that all pregnant people enrolled in Medicaid can get a full year of postpartum coverage is an evidence-based strategy to improve maternal and child health and reduce disparities that have driven this country's Black maternal health crisis.

The Build Back Better legislation would also create a new Medicaid maternal health home state option. States that take up the option could create coordinated "health homes" to deliver comprehensive, individualized care to pregnant and postpartum people. Health homes are a delivery system reform model designed to help improve health outcomes for beneficiaries with complex medical conditions by providing person-centered, team-based care. Like health homes more broadly, the maternal health home model aims to improve health outcomes by improving coordination among primary, specialty, and hospital care as well as other social support services. States that adopt the option would receive a 15 percentage-point increase in their federal matching rate (or FMAP) for payments to maternal health teams during the first two years the option is in place. Similar models have shown promising results, reducing preterm births, cesarean sections, and low birthweight births.[7] This option is another important tool for reducing racial disparities in maternal health outcomes and addressing the black maternal mortality crisis.

Continuous Coverage for Children Would Reduce Unnecessary Coverage Gaps

Under the Build Back Better legislation, all states would permanently be required to provide 12 months of continuous eligibility to children enrolled in Medicaid and CHIP, a change from what is now a state option, which 23 states have adopted for children enrolled in Medicaid and 25 states have adopted for children enrolled in CHIP.[8] States that do not already have a continuous coverage requirement would have a year to implement the policy.

Foundation, "Medicaid Postpartum Coverage Extension Tracker," November 1, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[4] Joyce A. Martin, Brady E. Hamilton, and Michelle J.K. Osterman, "Births in the United States, 2019," Centers for Disease Control and Prevention, NCHS Data Brief No. 387, October 2020, https://www.cdc.gov/nchs/data/databriefs/db387-H.pdf.

[5] Centers for Medicare & Medicaid Services, "Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health," December 2020, https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf.

[6] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," CBPP, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

[7] Laurie Zephyrin *et al.*, "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity," Commonwealth Fund, March 4, 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity.

[8] Kaiser Family Foundation, "State Adoption of 12-Month Continuous Eligibility for Children's Medicaid and CHIP," as of January 1, 2020, https://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip.

While coverage for all children is authorized for 12 months upon approval of their application or renewal, they may lose benefits during that period if their families experience an income change or don't respond to a notice from the Medicaid agency. Keeping children enrolled for the full 12 months increases continuity of care and reduces administrative costs.[9]

Income volatility is particularly common for low-income households. One study tracked low- and moderate-income households over a year and found that on average, their income fell more than 25 percent below average for 2.5 months of the year, and their income rose more than 25 percent above average for 2.6 months.[10] Another study found the majority of individuals in the bottom income quintile experienced more than a 30 percent month-to-month change in total income.[11] These fluctuations often raise family income above the eligibility threshold for some months of the year, putting them at risk of losing Medicaid even though their income remains low and may soon drop below the eligibility threshold.

Medicaid agencies also match enrollee information against other data sources, flag cases with discrepancies, and mail a notice to enrollees requiring information — such as a pay stub or letter from their employer — to verify their ongoing eligibility. Many families don't receive these notices because of issues with the mail or because they have moved, are unable to gather the required documentation, or don't respond. Children then lose coverage, even though many remain eligible for Medicaid.

Gaps in coverage resulting from income volatility, missed notices, and paperwork requirements lead to higher health care costs due to skipped medications, fewer screenings, or delayed care.[12] Further, many individuals who lose coverage reapply, increasing administrative costs. The uninsured rate among children had been rising before the continuous coverage requirement associated with the COVID-19 public health emergency took effect in 2020.[13] In states that have adopted continuous eligibility for children, children are less likely to experience gaps in coverage.[14] Making continuous eligibility mandatory would extend the benefits of this policy to all children covered by Medicaid or CHIP.

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[9] Jennifer Wagner and Judith Solomon, "Continuous Eligibility Keeps People Insured and Reduces Costs," CBPP, May 4, 2021, https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs.

[10] Anthony Hannagan and Jonathan Morduch, "Income Gains and Month-to-Month Income Volatility: Household evidence from the US Financial Diaries," U.S. Financial Diaries, March 16, 2015, https://www.usfinancialdiaries.org/paper-1/.

[11] JPMorgan Chase & Co., "Paychecks, Paydays, and the Online Platform Economy," February 2016, https://www.jpmorganchase.com/institute/research/labor-markets/report-paychecks-paydays-and-the-online-platform-economy.

[12] Sarah Sugar *et al.*, "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, April 12, 2021, https://aspe.hhs.gov/reports/medicaid-churning-continuity-care.

[13] Jesse Cross-Call, "Children's Uninsured Rate Rose for Second Straight Year in 2018," CBPP, October 30, 2019, https://www.cbpp.org/blog/childrens-uninsured-rate-rose-for-second-straight-year-in-2018.

[14] Medicaid and CHIP Payment and Access Commission, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," October 2021, https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

Other Medicaid and CHIP Provisions Would Provide Stability for Children's Coverage

In addition to the policies described above, the legislation would make two other important policies permanent:

- **CHIP:** For more than 20 years, CHIP has provided coverage to children in families with incomes too high to qualify for Medicaid but too low to afford private coverage. The program covered more than 9 million children in 2020.[15] Although CHIP, like Medicaid, is financed jointly by the federal government and states, unlike Medicaid, the federal portion of CHIP is a block grant, which requires periodic reauthorization. Making CHIP permanent will provide predictability for states and stable coverage for the families who depend on it. CHIP is currently funded through September 30, 2027.
- **Express Lane Eligibility (ELE):** ELE allows Medicaid and CHIP agencies to rely on income findings from another program to determine eligibility for or renew children's coverage — even when that program's methodology for determining income and household size differs. Build Back Better would make ELE, which has been effective in streamlining and simplifying enrollment and renewal for children, permanent beyond its current September 30, 2027 expiration date.

Increased Federal Funding Would Improve Quality of and Access to Home- and Community-Based Services, Support Transitions to Community

The Build Back Better legislation creates a financial incentive for states to improve the quality of and increase access to Medicaid HCBS, which are optional services that states don't have to cover. First, states could apply to receive planning grants from the Department of Health and Human Services (HHS) to develop comprehensive HCBS improvement plans. After the HHS Secretary approves a state's plan, the state would get a 6 percentage-point increase in its FMAP for Medicaid HCBS. In addition, states would get an 80 percent FMAP for administrative costs associated with implementing the plan, significantly greater than the regular 50 percent FMAP for state administrative costs.[16] To qualify for these financial incentives, states must meet certain requirements:

- **Maintenance of effort (MOE).** States must generally maintain HCBS eligibility levels and processes; amount, duration, and scope of HCBS; and HCBS payment rates at least as generous as those in place as of the date the state is awarded a planning grant.[17]
- **Enhanced access to services.** States must adopt policies to do all of the following to enhance or expand access to HBCS: reduce barriers to accessing HCBS; provide coverage for personal care services; adopt "no wrong door" and other policies to streamline HCBS

[15] Centers for Medicare & Medicaid Services, Federal Fiscal Year (FFY) 2020 Statistical Enrollment Data System (SEDS) Reporting, June 23, 2021, https://www.medicaid.gov/chip/downloads/fy-2020-childrens-enrollment-report.pdf.

[16] The increased FMAP for HCBS is available on an ongoing basis as long as states meet the criteria listed. The increased administrative match is only available through October 1, 2031.

[17] States can request approval from the Secretary of Health and Human Services to make changes that would violate the terms of the MOE if they can demonstrate that the changes would not result in: HCBS services that are less comprehensive or lower in amount, duration, and scope; fewer people receiving HCBS (overall or within specific eligibility groups); or higher cost sharing for HCBS.

eligibility and enrollment; expand access to behavioral health services; improve coordination between Medicaid HCBS programs and programs focused on employment, housing, and transportation; provide supports to family caregivers; and take other steps to expand Medicaid HCBS eligibility or benefits.

- **HCBS workforce improvements.** States must also adopt policies to ensure HCBS payment rates are sufficient to provide the care and services described in the state's implementation plan and update qualifications and training opportunities for direct care workers and family caregivers. They must also update and increase (as appropriate) payment rates for HCBS providers to support workforce recruitment and retention, and ensure that rate increases are appropriately passed through to direct care workers and reflected in payment rates for care delivered through managed care arrangements.
- **Reporting, oversight, and performance improvement benchmarks.** States must designate an independent HCBS ombudsman program, submit annual progress reports on their HCBS Improvement Plan to the HHS Secretary, and demonstrate increased availability of HCBS and an increased proportion of spending on long-term services and supports for HCBS relative to spending for institution-based care.

Build Back Better builds on the HCBS investments included in the American Rescue Plan, which made additional federal funding available (also through an FMAP increase) for one year beginning in April 2021 for states to bolster their efforts during the pandemic to help seniors and people with disabilities live safely in their homes and communities rather than in nursing homes or other congregate settings. This funding is helping states shore up HCBS and prevent an erosion of services that could undermine future efforts to expand HCBS to all people who need them.[18]

But even before the pandemic, people already encountered considerable barriers to accessing Medicaid HCBS, with over three-quarters of states reporting wait lists for some services, and widespread reports of workforce shortages and lack of affordable, community-based housing.[19] The HCBS provisions in Build Back Better would allow states to continue the critical work they are beginning with the Rescue Plan investments and make long-term, systemic changes to improve access to HCBS, including through unprecedented actions to bolster the direct care workforce, which is composed primarily of low-income women of color.[20]

The new legislation also would make the Money Follows the Person (MFP) program and Medicaid HCBS spousal impoverishment protections permanent. These important changes would reduce uncertainty and help more people receive services in their homes or communities.

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[18] Jennifer Sullivan, "States Are Using One-Time Funds to Improve Medicaid Home- and Community-Based Services, But Longer-Term Investments Are Needed," CBPP, September 23, 2021, https://www.cbpp.org/research/health/states-are-using-one-time-funds-to-improve-medicaid-home-and-community-based.

[19] MaryBeth Musumeci, "How Could $400 Billion New Federal Dollars Change Medicaid Home and Community-Based Services?" Kaiser Family Foundation, July 16, 2021, https://www.kff.org/medicaid/issue-brief/how-could-400-billion-new-federal-dollars-change-medicaid-home-and-community-based-services/.

[20] Tyler Cromer *et al.*, "Modernizing Long-Term Services And Supports And Valuing The Caregiver Workforce," Health Affairs Blog, April 13, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210409.424254/full/.

- **Money Follows the Person:** The MFP demonstration is an optional program that provides states funding to help people transition out of institutions and receive services in the community. Since 2007, MFP has helped more than 100,000 Medicaid beneficiaries who need long-term services and supports transition from institutions back to their own homes and communities.[21] It was most recently extended through September 2023 as part of a 2021 spending bill, but state participation has waned in recent years due to uncertainty about future funding.[22] Making it permanent would provide the stability needed to ensure more people are able to successfully transition from institutions to home- and community-based settings.
- **Spousal impoverishment protections for HCBS:** When one member of a couple needs long-term services and supports, so-called spousal impoverishment protections mean that some of the couple's income and assets are assumed to be needed by their spouse and therefore are not considered when determining the amount the couple must contribute toward the cost of long-term services and supports. The ACA required states to extend spousal impoverishment protections to married couples receiving HCBS — as a way to ensure that differences in how a couple's income and assets were treated did not pressure families to choose institutional care over HCBS — but this provision expired in 2018. It has been temporarily extended several times since, and is currently set to expire September 30, 2023, but this has created uncertainty for couples; if the provision is not extended, some people could be forced to get care in a long-term care facility rather than at home.[23] Making spousal impoverishment protections permanent for those receiving HCBS is the best way to avoid disruption and confusion for beneficiaries and increased work for states, and to continue to address Medicaid's bias toward institutional care.

Providing Medicaid Coverage Would Bolster Efforts to Improve Continuity of Care for People Preparing to Leave Jail or Prison

The Build Back Better legislation would allow Medicaid to pay for health care services for people in jail or prison during their last 30 days of incarceration by partially lifting the statutory exclusion on Medicaid reimbursement for services provided to people who are incarcerated. Medicaid payments would be available for this population two years after the legislation's enactment, giving the Centers for Medicare & Medicaid Services and states time to prepare.

People in jail and prison have high rates of chronic physical and behavioral health conditions but often go without needed health care while incarcerated and return home without adequate access to

[21] Kristie Liao and Victoria Peebles, "Money Follows the Person: State Transitions as of December 31, 2019," Centers for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf.

[22] MaryBeth Musumeci, Priya Chidambaram, and Molly O'Malley Watts, "Medicaid's Money Follows the Person Program: State Progress and Uncertainty Pending Federal Funding Reauthorization," Kaiser Family Foundation, November 25, 2019, https://www.kff.org/medicaid/issue-brief/medicaids-money-follows-the-person-program-state-progress-and-uncertainty-pending-federal-funding-reauthorization/.

[23] Judith Solomon, "Married Couples With Medicaid Home- and Community-Based Services Could Lose Critical Protections," CBPP, March 13, 2019, https://www.cbpp.org/blog/married-couples-with-medicaid-home-and-community-based-services-could-lose-critical.

medications or care coordination.[24] Once home, health care often falls by the wayside as people face competing demands, including securing housing, finding work, filling prescriptions, connecting with family, and fulfilling court-ordered obligations. These gaps in care contribute to a litany of poor health outcomes[25] and compound the harmful effects of mass incarceration and the over-policing of people of color, particularly for Black and Hispanic people.[26]

Many states and localities have taken steps to enroll eligible people leaving jail or prison in Medicaid. While states should continue these steps, many people need help beyond enrollment to get care. One solution is "in-reach" services where case managers, clinicians, or peer support professionals visit people in jail or prison to help them prepare to return home.[27] In-reach services enable providers to assess people's health, establish rapport, develop an individualized care plan, and schedule future appointments. But these services are severely underfunded and underutilized.

The reentry provision would give states additional, reliable funding that they could use to expand in-reach and other care coordination services to connect people to community-based health and social service providers upon reentry. These services would be especially beneficial for people with significant behavioral health or chronic physical health conditions.

The services could also connect people to available housing and employment resources. People leaving incarceration report that finding work and housing are among their most urgent needs, making it difficult to prioritize their health care.[28] Stable employment and housing greatly improve people's chances of staying out of jail and prison, but people who were formerly incarcerated experience homelessness at nearly ten times the rate of the general public and face an unemployment rate of over 27 percent.[29]

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[24] Kamala Mallik-Kane and Christy A. Visher, "Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration," Urban Institute, February 2008, https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF.

[25] Laura M. Maruschak, Marcus Berzofsky, and Jennifer Unangst, "Medical Problems in State and Federal Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice, Bureau of Justice Statistics, https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.

[26] Wendy Sawyer and Peter Wagner, "Mass Incarceration: The Whole Pie 2020," Prison Policy Initiative, March 24, 2020, https://www.prisonpolicy.org/reports/pie2020.html; Wendy Sawyer, "Visualizing the Racial Disparities in Mass Incarceration," Prison Policy Initiative, July 27, 2020, https://www.prisonpolicy.org/blog/2020/07/27/disparities/.

[27] See National Reentry Resource Center, "Best Practices for Successful Reentry for People Who Have Opioid Addictions," November 2018, https://csgjusticecenter.org/wp-content/uploads/2020/01/Best-Practices-Successful-Reentry-Opioid-Addictions.pdf.

[28] Kamala Mallik-Kane, Ellen Paddock, and Jesse Jannetta, "Health Care after Incarceration: How Do Formerly Incarcerated Men Choose Where and When to Access Physical and Behavioral Health Services?" Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96386/health_care_after_incarceration.pdf.

[29] Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html; Lucius Couloute and Daniel Kopf, "Out of Prison & Out of Work: Unemployment among formerly incarcerated people," Prison Policy Institute, July 2018, https://www.prisonpolicy.org/reports/outofwork.html.

Legislation Would Make Medicaid Mobile Crisis Services a Permanent Option

The American Rescue Plan created a new, temporary option for states to cover mobile crisis intervention services in Medicaid. Mobile crisis teams help de-escalate behavioral health crises and connect people to community-based services, avoiding costly emergency department visits and hospitalizations.[30] Mobile crisis services may also prevent the arrest and incarceration of people with mental health and substance use disorders, who are disproportionately represented in the nation's jails and prisons and among fatal police shootings.

The Rescue Plan provided enhanced federal matching funds for three years to help states scale up mobile crisis services in Medicaid and reduce reliance on law enforcement to address mental health crises, but the option itself was only authorized for five years. Build Back Better would make the option permanently available, providing stability that could encourage more states to take it up.

Proposal Would Increase Federal Funds for the Territories

Build Back Better would permanently increase federal Medicaid funding for the five U.S. territories — American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands — to a level more in line with their needs. Current funding falls short of the funding for states' Medicaid programs in three ways, leading to inequitable treatment of territory residents:

- States receive open-ended federal funds that match a specified percentage of their expenditures for Medicaid-covered health services they provide to enrollees. The territories receive only fixed block grant funding each year, which falls short of covering the costs of health care for their residents.
- In states, the percentage of Medicaid costs that the federal government covers is based on a state's per capita income relative to the nation as a whole. But the territories draw down their federal block grant funds at a matching rate set in statute at 55 percent — well below what the rate would be if it were based on the territories' per capita incomes.
- The territories aren't subject to the same eligibility and benefit requirements as state programs, in large part because they aren't given the financial resources to meet them. They are allowed to set their own eligibility standards that aren't based on the federal poverty line, and most of the territories have income eligibility thresholds lower than those in the states. Not all the territories cover all the health services that the states must cover.

The inadequacy of the allotments and the inadequate federal matching rate has led to repeated time-limited tranches of supplemental funding to stave off draconian cuts the territories would have to make in eligibility, benefits, and provider payments. But temporary increases have not provided the stable and adequate funding the territories need to strengthen their programs and fully meet their residents' health care needs.

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[30] Substance Abuse and Mental Health Services Administration, "Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies," U.S. Department of Health and Human Services, 2014, https://www.nasmhpd.org/sites/default/files/SAMSHA%20Publication%20on%20Effectiveness%20%26%20Cost-Effectiveness%20of%2C%20and%20Funding%20Strategies%20for%2C%20Crisis%20Services%206-5-14_8.pdf.

Build Back Better would permanently increase the allotments, which would grow each year by the percentage increase in Medicaid spending to ensure that the allotments remain adequate over time. This is an important step toward parity in state and territory Medicaid programs, but territories would still receive fixed allotments rather than open-ended funding like states receive. In 2022, the statutory matching rate would rise to 76 percent for Puerto Rico and 83 percent for the other territories. Puerto Rico's matching rate would increase to 83 percent in 2023.

Block grant funding is inherently risky as it can fall short of need, and Congress should eventually provide open-ended federal funding to enable the territories to provide the same level of care that Medicaid enrollees receive in the states. But the stable, adequate funding, realistic growth factor, and increased matching rates in the Build Back Better legislation would minimize the risk that the territories will exhaust their block grants and would increase their ability to expand and improve their programs.