IssueBrief

MACPAC

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Implementation of the American Rescue Plan Act: Section 9817, Additional Support for Medicaid Home- and Community-Based Services during the COVID–19 Emergency

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2), through a temporary increase in the federal medical assistance percentage (FMAP) of 10 percentage points, provided state Medicaid programs with the largest infusion of one-time federal funding for home- and community-based services (HCBS) in recent history. This funding was intended to support states in providing Medicaid HCBS during the COVID-19 public health emergency (PHE) by reinvesting it in their HCBS programs. Based on state spending plans submitted to the Centers for Medicare & Medicaid Services (CMS), as of the quarter ending December 31, 2023, states planned to spend an estimated $37.1 billion in state and federal funds for state-driven HCBS reinvestment activities (CMS 2024a).

Since ARPA was enacted in March of 2021, MACPAC monitored state efforts to spend the federal funds and worked to understand state experiences with implementation, particularly given the size of the investment and the timeline states had in which to spend it. MACPAC's monitoring approach included interviews with officials from CMS, states, and other stakeholders, as well as document reviews. MACPAC staff completed an initial review of state spending plans and narratives in 46 states in August 2021, shortly after the deadline by which states were required to submit them. In 2023, MACPAC staff reviewed the first and second quarter fiscal year (FY) 2023 spending plans and narratives for all 50 states and the District of Columbia for select initiatives that were relevant to MACPAC work, such as efforts to support the direct care workforce. Organizations such as ADvancing States and CMS have undertaken comprehensive and quantitative tracking activities and have published materials summarizing state activities and dollars spent (ADvancing States 2023, CMS 2024a, 2024c). MACPAC did not set out to duplicate those efforts and instead focused on convening experts to discuss ARPA implementation as it was happening. MACPAC convened two expert panels during the course of the ARPA implementation period in January 2023 and January 2024. Panelists explained how states used the ARPA funds and managed the implementation process. Panelists included officials from four states, two policy experts, and a CMS official.[1]

Through our work, MACPAC identified the following key themes:

- **Section 9817 of ARPA provided additional federal funding through a temporary FMAP increase for Medicaid HCBS. The legislation did not include instructions to CMS or establish a timeline for the agency to issue needed operational guidance to states. CMS had limited time to develop guidance and disseminate it to states.** CMS's role in administering the provision included activities such as crafting guidance for states, reviewing state spending plans and narratives, supporting state implementation, and summarizing data on how states were spending the additional federal funding for the public. Necessary processes such as having states submit a spending plan for CMS review had to be newly established since parameters were not set forth in the legislation. Because of the time constraints, some states submitted a draft spending plan by the initial deadline and then made changes after the fact, which led to additional burden on CMS having to review updated versions. In addition, Congress did not appropriate additional funding for CMS to administer Section 9817.
- **States had limited time to design a comprehensive plan for spending the new federal funding.** States had to submit their initial spending plans within a couple months of receipt of CMS guidance. This short

timeframe made it challenging for states to draft comprehensive spending plans or to complete the research necessary to effectively launch new initiatives aimed at combating persistent HCBS policy challenges such as the nationwide shortage of direct care workers (DCWs). It also increased administrative burden for states and CMS by constraining the time they had to update, review, and approve changes to spending plans throughout the implementation period.

- **Many states could not spend the money in the time allotted and requested multiple extensions.** States had to plan, implement, and, in some cases, evaluate their initiatives within a three-year implementation period from late 2021 to early 2025. This was challenging for a number of reasons, including misalignment with state legislative cycles, limited state staff capacity to take on new responsibilities including additional administrative responsibilities, and the time needed to complete certain activities associated with an effort of this magnitude, such as letting contracts, drafting and approving state plan amendments, and consulting with CMS. As a result, half of states requested additional time beyond the March 2025 deadline to fully expend their ARPA funds.
- **Provisions for evaluating the results of the investment in HCBS were not included in the legislation.** Evaluations are important tools for states to demonstrate the effects of a policy intervention and may be used to justify a long-term investment to the state legislature, even after federal funding increases expire. They are also useful tools for the Congress to evaluate the effectiveness of federal policy interventions. In this instance, Congress did not establish a requirement for states or for CMS to evaluate ARPA activities. Some states chose to include evaluation activities in their spending plans but the short timeframe to conduct them was generally not conducive to robust evaluations. In addition, state staff had limited bandwidth to incorporate additional evaluation responsibilities.
- **States planned to sustain some activities financed through the increased FMAP for HCBS after the funding expires.** State spending plans contained a mix of funding for one-time activities and long-term activities that states plan to sustain following the expiration of ARPA funding. The most common activities that states chose to sustain are those that support the direct care workforce.

Background

In 2021, Congress enacted ARPA which included a number of provisions related to the PHE. Section 9817 of the legislation is specific to Medicaid HCBS and provided one-time federal funding through a temporary increase in the FMAP for state Medicaid programs to support the provision of HCBS during the PHE (Appendix A). It increased the FMAP by 10 percentage points for certain HCBS expenditures occurring during the one-year period from April 1, 2021 through March 31, 2022. This included the following services: home health care services provided under Section 1905(a)(7); personal care services provided under Section 1905(a)(24); Program of All-Inclusive Care for the Elderly services under Section 1905(a)(26); HCBS provided under Section 1915(b), (c), (i), (j), and (k) authorities; case management services under Section 1905(a)(19) and 1915(g); rehabilitative services provided under Section 1905(a)(13); and any other services specified by the Secretary of the U.S. Department of Health and Human Services. Unlike previous, temporary FMAP increases designed to reduce state Medicaid spending, this FMAP increase generated a new source of spending for states to use for the specific purpose of improving their HCBS programs.

To receive the increased FMAP, states had to use the federal funds to “supplement, not supplant,” their level of state funding for HCBS in effect as of April 1, 2021. They were required to use the federal funding to implement or supplement the implementation of certain activities, specifically “one or more activities to enhance, expand, or strengthen” Medicaid HCBS (CRS 2021). States used the additional funds generated from the one-year period of increased FMAP to reinvest into their HCBS programs.

ARPA did not specify how the policies that ultimately guided implementation should be developed or how states should operationalize the increased funding under Section 9817, with the exception of allowing the Secretary of HHS to specify services, other than those explicitly included in the legislation, that could be considered HCBS for

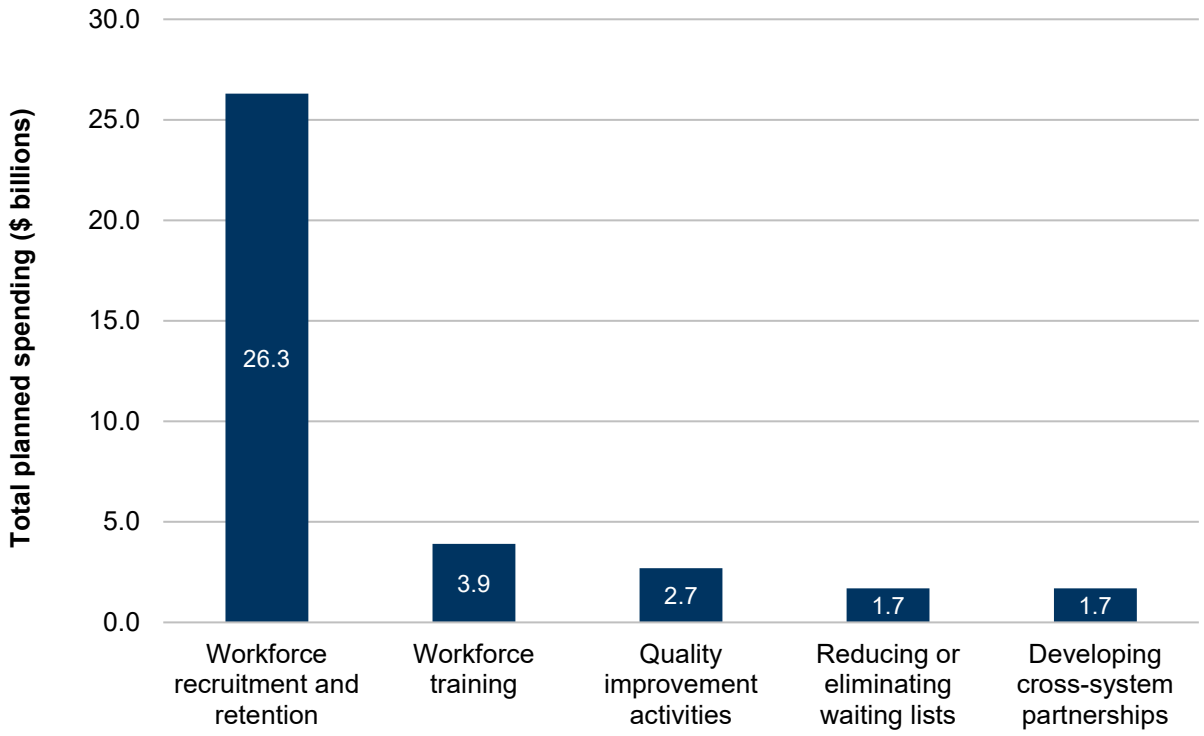
purposes of the enhanced funding. The legislation did not establish parameters around spending timelines or reporting requirements for states using the reinvestment funds. It also did not appropriate additional funds for CMS to implement the law. Activities CMS undertook to implement Section 9817 included developing guidance, reviewing spending plans and narratives, overseeing state activities, and producing public reports.

All 50 states and the District of Columbia received federal funding under the increased FMAP established in Section 9817. States relied on CMS for guidance on using the reinvestment funds reflected in two State Medicaid Director (SMD) letters, the first on May 13, 2021 and the second on June 3, 2022 (CMS 2022, 2021).

In those SMD letters, CMS laid out new requirements it developed following enactment of the law. CMS required states to submit spending plans to the agency for approval to include details on how they would spend their ARPA funding. In addition, CMS required states to submit quarterly spending reports and semi-annual narratives on their progress toward meeting their spending goals. Many states struggled to spend the reinvestment funds in the time allotted. CMS originally gave states until March 31, 2024 to spend the increased FMAP earned during the one-year period but extended that deadline by a year in the June 2022 SMD letter, based on feedback from states (CMS 2022). States continued to request extensions. CMS subsequently granted additional extensions past the March 2025 deadline to 24 states, with the longest extension approved through September 30, 2026 (CMS 2025).[2]

CMS guidance emphasized that states should use ARPA funds on activities that enhance, expand, or strengthen HCBS, such as by providing new or additional services; building No Wrong Door systems in which state and local agencies coordinate to create a simplified process for beneficiaries to access information, determine their eligibility, and provide one-on-one counseling on LTSS options; streamlining application and enrollment processes; and expanding provider capacity (CMS 2021a, MACPAC 2023). According to CMS's review of state spending under ARPA as of the quarter ending December 31, 2023, across all 50 states and the District of Columbia, more than 1,400 activities were proposed (CMS 2024a). The most common types of activities included workforce recruitment and retention, workforce training, quality improvement, reducing or eliminating HCBS waiting lists, and developing cross-system partnerships (Figure 1).[3] Other activities focused on family caregiver training, respite, and support; addressing social determinants of health and promoting equity; and expanding the use of technology (CMS 2024a).

FIGURE 1. Total National Planned ARPA Spending by Most Common Activity Type, as of the Quarter Ending December 31, 2023



Notes: ARPA is American Rescue Plan Act of 2021 (P.L. 117-2). These figures include federal and state spending. The total does not add to $37.1 billion because these categories represent just the top five most common activity types. Other activities not listed include family caregiver training, respite, and support; addressing social determinants of health and promoting equity; and expanding the use of technology.

Source: CMS 2024a.

Implementation Considerations Identified through Monitoring

A number of implementation considerations emerged during the period in which CMS and states implemented Section 9817. The implementation period roughly spanned the years from 2021 to 2025, although some states expended all their funds in 2023 or 2024 while other states are financing HCBS activities with ARPA funding through 2026 (CMS 2024b). Our findings are grouped into three areas: timing constraints, lack of advance planning or requirements for evaluations, and an interest from states in sustaining their investments by making some initiatives permanent.

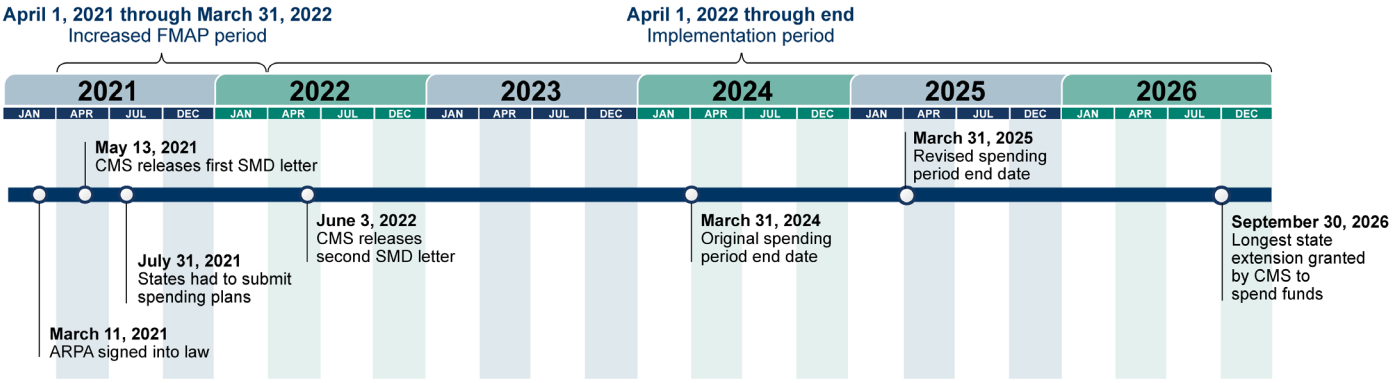
The following findings on timing, sustainability, and program evaluation draw from MACPAC's two expert panels in January 2023 and in January 2024, informational interviews with ADvancing States and CMS, and a white paper titled "Efforts to Evaluate the Impact of ARPA HCBS Investments" published in January 2024 by the ARPA HCBS Technical Assistance Collective, which is made up of ADvancing States, Halperin Health Policy Solutions, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), Riverstone Health

Advisors, and Brian Burwell (Halperin & Jacobs 2024). The white paper is based on a survey conducted in February 2023 that 24 states responded to as well as 3 focus groups conducted in the spring of 2023 with a total of 14 individuals from 9 states.

Timing

Most stakeholders discussed issues around timing and in a variety of contexts. We heard that stakeholders needed more time to plan effectively for an infusion of federal Medicaid funding of this magnitude, and to engage in related implementation activities. CMS and state Medicaid programs had less than one year following enactment of the law to do so. The ARPA provision allowed for flexibility in the areas of state investment; neither CMS nor states anticipated an infusion of federal funding for ARPA-related activities and many needed time to establish a considered process to develop their ARPA spending plans. States needed to create detailed spending plans by the end of the one-year period of the increased FMAP on March 31, 2022, at which point states began receiving the additional federal funding. CMS issued guidance to states within two months of enactment of the legislation. States drafted detailed plans for spending the reinvestment funds within four months, just two months after receiving CMS guidance (Figure 2).

FIGURE 2. ARPA Timeline



Notes: ARPA is American Rescue Plan Act of 2021 (P.L. 117-2).

Source: MACPAC and CMS 2024a.

Spending plan development. ARPA was signed into law on March 11, 2021, CMS issued its first guidance document on May 13, 2021, and states submitted their initial spending plans by July 31, 2021 (Halperin & Jacobs 2024, CMS 2021).[4] This short timeframe was challenging for states to draft comprehensive plans, and many plans included initiatives that states had not fully fleshed out (Halperin & Jacobs 2024). As state officials and experts noted, they had limited time to consult with their governor's offices, legislatures, providers, beneficiaries, and other stakeholders. These stakeholders may have had competing priorities, which required states to make decisions about what activities to prioritize. In many cases, state officials needed legislative approval for their ARPA initiatives since the Medicaid agency was obligating state financial resources. The sequencing of the spending plan deadlines with state legislative calendars meant that some plans included placeholder initiatives that did not receive necessary state legislative approval. States that already had strategic plans, multi-sector plans on aging, rate studies, or other such "shovel-ready" projects were better positioned to include more complex initiatives or to add more initiatives to their plans (Halperin & Jacobs 2024). In other places, however, states designed initiatives without much initial stakeholder input.

CMS guidance and approval. CMS staff, similar to state staff, worked under compressed timelines to issue guidance and approve states' spending plans. CMS issued guidance within two months of ARPA's enactment.

CMS guidance outlined what qualified for the increased FMAP. For example, the guidance states that administrative activities are not eligible for the increased FMAP, such as Medicaid administrative claiming for state No Wrong Door systems and state long-term care ombudsman programs (CMS 2021). Then, CMS staff had to review and approve all states' spending plans, which included iterative discussions with states to understand initiatives and ensure they adhered to certain requirements such as the maintenance of effort (MOE) requirements. CMS MOE requirements for states included: 1) not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021; 2) preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and 3) maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021 (CMS 2021). For some states, CMS's interpretation of the MOE requirements prevented them from enacting certain changes, such as updating assessment tools or rate methodologies. It also impacted some states decisions about timing, such as if they wanted to take the additional year.

The timelines limited CMS's capacity to streamline operations, which could have made submission, review, and evaluation of state spending plans more efficient. CMS permitted states to make changes to their spending plans after receiving initial approval and many states did so multiple times. The initial plans sometimes changed to accommodate factors that could not be considered at the outset because of time constraints, such as obtaining legislative approval or establishing a plan to collect data to evaluate the effectiveness of a particular initiative. Those changes required discussions with CMS. CMS officials noted that with more time, they could have created standardized reporting templates for states. States formatted their spending and narrative reports differently, which slowed down CMS review and made summarizing across all states challenging.

Implementation. States generally had three years to spend their ARPA funds, from 2022 through 2025. This included planning, implementing, and, in some cases, evaluating initiatives. Some states hired additional staff, which prompted considerations regarding status (e.g., permanent employees or contractors) and timelines for hiring (e.g., time to post jobs, interview, and onboard new state staff; modifying existing contracts; or develop new solicitations). As one state official noted, contracting is usually a more expensive but time efficient option. In Colorado, for example, the state official noted that hiring more programmatic staff and developing budgets and project plans took about one year. This left them with two years for both the implementation and evaluation; limiting the number of initiatives that they could evaluate in the short timeframe. In retrospect, Colorado speculated that more administrative staff could have supplemented program staff to better support program design and evaluation. Finally, during the implementation period, states had to account for time to complete documents like waiver and state plan amendments and receive CMS approval, particularly as states sought to make some disaster flexibilities permanent.

Execution. As noted above, half of states needed additional time beyond March 2025 to fully expend all of their ARPA funds. States requested extensions for a variety of reasons. Some states invested in upfront planning, engaging stakeholders, and waiting for legislative approval, which then delayed the implementation of activities. States also made changes to their plans at different points throughout the implementation period because they realized aspects of their plans were not feasible or because they received different legislative direction that caused them to change course. Some activities, such as information technology or other infrastructure investments, needed longer timeframes to be completed. As of July 2025, CMS officials noted that most states with extensions only had one or two activities that were not yet completed; the majority of initiatives were complete and funds were expended.

Evaluations

As noted above, states and the federal government can use evaluations to understand the effectiveness of their investments and policy interventions. Existing federal vehicles for state policy interventions, such as Section 1115 demonstration authority, include requirements to conduct evaluations and report the findings to CMS (MACPAC 2019). The ARPA funding enacted in Section 9817 is the largest investment of new federal funding in HCBS that states have received recently (Burwell et al. 2022). While Section 9817 did not include a requirement to evaluate

activities funded through the legislation, some states chose to conduct evaluations to gauge the effectiveness of their ARPA activities, and financed them through their ARPA spending plans.

As of March 2023, 24 states had program evaluation efforts planned (ADvancing States 2023). We reviewed a number of spending plans specifically for evaluation activities and found that many states had plans to evaluate pilot programs or a subset of activities included in their ARPA plans. Few states intended to evaluate their entire ARPA spending plans (Halperin & Jacobs 2024). In 2022, the U.S. General Services Administration (GSA) announced a multi-year contract with the American Institutes for Research to conduct a national evaluation examining ARPA's role in "advancing equitable outcomes", which will include the Section 9817 HCBS funding as one of many programs being evaluated. A report is anticipated in 2026 (OES 2022). In December 2024, the Office of Evaluation Services at GSA published a notice and request for comments to the Federal Register on a plan for data collection for the national evaluation (OES 2024).

Panelists discussed the importance of evaluations in demonstrating the impact of new initiatives and measuring changes in outcomes as well as providing justification for sustaining policy interventions over the long term. They said that evaluations can be particularly helpful for obtaining legislative support and securing appropriations. Even interim evaluations can be useful to determine if changes need to be made to better achieve desired outcomes, or to identify if outcomes are not as expected and possibly pivot to other activities (Halperin & Jacobs 2024).

We found that state staff capacity was stretched to incorporate some evaluation responsibilities. Robust ARPA evaluations use third-party evaluators, such as contractors or public universities, but generally states used less formal methods and relied on state staff to run data and evaluate initiatives. All focus group states said they were overwhelmed and that state staff workloads increased as they worked to implement and evaluate initiatives (Halperin & Jacobs 2024).

Panelists and states also had concerns with the short timeframe to conduct evaluations. States that included evaluation activities in their spending plans had to complete those evaluations by the end of the spending period, meaning that some evaluations overlapped with the implementation period or covered a shorter period of time than originally envisioned. This also meant that in many states evaluation results did not align with state legislative and budgetary cycles, which may have affected the continuity of some programs if officials did not have the data or results to justify the continuation of activities to appropriators (Halperin & Jacobs 2024).

Other challenges that states experienced in designing their evaluations included issues with data availability and isolating the impact of ARPA-funded initiatives. Some states noted challenges with collecting baseline data or with having adequate data collection methods ready to go in the short timeframe before implementation. In addition, states varied in the degree to which they had established methods for collecting stakeholder feedback. Finally, in states with many initiatives targeting the same activity type, such as those targeting the direct care workforce shortage, states encountered difficulty in isolating the impact of each initiative (Halperin & Jacobs 2024).

Sustainability

CMS guidance notes that "states should explain how they intend to sustain such activities" in their narratives but does not provide specific parameters on how states should demonstrate sustainability (CMS 2021a). In 2023, we reviewed the state spending plans and narratives for the first and second quarters (Q1 and Q2) of FY 2023. Staff reviewed them for initiatives states planned to maintain after the ARPA funding expires. About two-thirds of all states (33) included detail on the sustainability of some or all of the initiatives included in their plans.

As noted by the CMS official on our January 2024 expert panel, states are sustaining about one-third of activities that bolster the direct care workforce, such as payment rate increases, worker registries, and training programs. For example, the Certified Direct Care Professional (CDCP) training and credentialing system offered in partnership between the Wisconsin Department of Health Services and the University of Wisconsin-Green Bay, launched in July 2023 and provides free training, up to $500 in bonuses, a CDCP credential, and an employer

registry to help people find jobs (WI DHS 2025, 2023). Many states also planned to maintain waiting list reductions. States used funding to increase their Section 1915(c) waiver capacity and worked with their state legislatures to maintain those enrollment increases long term. Finally, the CMS official noted that activities that required large upfront investments that states could finance through ARPA, like new or enhanced information systems, were more easily sustained than those that require ongoing funding.

Panelists expressed a strong desire to use the increased funding under Section 9817 to improve their HCBS infrastructure and make other lasting changes. This included more complicated and time-intensive initiatives such as reviewing and reforming Section 1915(c) waivers, investing in technology, adding additional waiver slots and reducing waiting lists, and adding specific services such as behavioral health services. Due to the time-limited nature of the ARPA funding and the ongoing PHE, however, state officials discussed how this meant that some funding went toward immediate relief while other funding was dedicated to longer term initiatives that ultimately required legislative approval. In particular, states wanted to get immediate relief to DCWs and used funds for initiatives like one-time bonuses.

Many noted that the one-time, time-limited nature of the ARPA funding had a big impact on sustainability. States vary widely in the size of their budgets and their ability to get support from legislatures and governors' offices, which affects the long-term funding of programs. State officials talked about potential funding cliffs and reluctance to make changes that would not be continued once the federal funding ran out, such as rate increases for DCWs or additional waiver slots. In Colorado, for example, the state increased DCW hourly wages from $12.41 to nearly $18 an hour, and state officials ensured they had long-term legislative support so that when the spending period ended workers would not see their wages reduced.

Summary

The ARPA funding increases represented the largest federal investment in HCBS in many years. States responded to the challenges of the PHE while also trying to determine how to best use the funds to make lasting changes to their HCBS programs. Due to tight timeframes, limited staff bandwidth to take on new responsibilities, and other constraints, many states had to modify their original ARPA spending plans. States struggled to spend the funding associated with the FMAP increase in the amount of time allotted and CMS approved multiple extensions, some of which are ongoing. States also faced challenges trying to evaluate their investments in real time which may have affected their ability to justify continuing certain activities, following expiration of federal funding.

Endnotes

[1] The January 2023 panelists were Kevin Bagley, Director, Medicaid & Long-Term Care, Nebraska Department of Health and Human Services; Heidi Hamilton, Acting Director of the Disability Services Division, Minnesota Department of Human Services; Elizabeth Matney, State Medicaid Director, Iowa Department of Health and Human Services; and Camille Dobson, Deputy Executive Director, ADvancing States. The January 2024 panelists were Jennifer Bowdoin, Director, Division of Community Systems Transformation, CMS; Bonnie Silva, Director, Office of Community Living, Colorado Department of Health Care Policy & Financing; and Alissa Halperin, Principal Consultant, Halperin Health Policy Solutions.

[2] This data is accurate as of July 24, 2025.

[3] For additional state-specific information, please see here for the state summaries released by CMS (CMS 2024c).

[4] States originally had 30 days to submit their spending plans but the deadline was extended from June 13 to July 31, 2021.

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APPENDIX A: Legislative Text of Section 9817 of ARPA

The following is a copy of the legislative text of Section 9817 of the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2).

SEC. 9817. ADDITIONAL SUPPORT FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES DURING THE COVID–19 EMERGENCY.

(a) INCREASED FMAP.—

(1) IN GENERAL.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) or section 1905(ff), in the case of a State that meets the HCBS program requirements under subsection (b), the Federal medical assistance percentage determined for the State under section 1905(b) of such Act (or, if applicable, under section 1905(ff)) and, if applicable, increased under subsection (y), (z), (aa), or (ii) of section 1905 of such Act (42 U.S.C. 1396d), section 1915(k) of such Act (42 U.S.C. 1396n(k)), or section 6008(a) of the Families First Coronavirus Response Act (Public Law 116– 127), shall be increased by 10 percentage points with respect to expenditures of the State under the State Medicaid program for home and community-based services (as defined in paragraph (2)(B)) that are provided during the HCBS program improvement period (as defined in paragraph (2)(A)). In no case may the application of the previous sentence result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percentage increase specified under the first sentence of this paragraph shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

(2) DEFINITIONS.—In this section:

A) HCBS PROGRAM IMPROVEMENT PERIOD.—The term ‘‘HCBS program improvement period’’ means, with respect to a State, the period—

(i) beginning on April 1, 2021; and

(ii) ending on March 31, 2022.

(B) HOME AND COMMUNITY-BASED SERVICES.—The term ‘‘home and community-based services’’ means any of the following:

(i) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(ii) Personal care services authorized under paragraph (24) of such section.

(iii) PACE services authorized under paragraph (26) of such section.

(iv) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and such services through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u–7).

(v) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such Act (42 U.S.C. 1396n(g)).

(vi) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13)).

(vii) Such other services specified by the Secretary of Health and Human Services.

(C) ELIGIBLE INDIVIDUAL.—The term ‘‘eligible individual’’ means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

(D) MEDICAID PROGRAM.—The term ‘‘Medicaid program’’ means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

(E) 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.).

(b) STATE REQUIREMENTS FOR FMAP INCREASE.—As conditions for receipt of the increase under subsection (a) to the Federal medical assistance percentage determined for a State, the State shall meet each of the following requirements (referred to in subsection (a) as the HCBS program requirements):

(1) SUPPLEMENT, NOT SUPPLANT.—The State shall use the Federal funds attributable to the increase under subsection (a) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021.

(2) REQUIRED IMPLEMENTATION OF CERTAIN ACTIVITIES.—The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program.