114TH CONGRESS
2D SESSION

H. R. 5942

To amend title XVIII of the Social Security Act to establish a demonstration program to provide integrated care for Medicare beneficiaries with end-stage renal disease, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 7, 2016

Mr. YOUNG of Indiana (for himself, Mr. BLUMENAUER, Mrs. MCMORRIS RODGERS, and Mr. CÁRDENAS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to establish a demonstration program to provide integrated care for Medicare beneficiaries with end-stage renal disease, 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.**

4 This Act may be cited as the "Dialysis PATIENTS
5 Demonstration Act of 2016" or the "Dialysis Patient Ac-

1 cess To Integrated-care, Empowerment, Nephrologists,
2 Treatment, and Services Demonstration Act of 2016''.

3 **SEC. 2. DEMONSTRATION PROGRAM TO PROVIDE INTE-**
4 **GRATED CARE FOR MEDICARE BENE-**
5 **FICIARIES WITH END-STAGE RENAL DISEASE.**

6 (a) IN GENERAL.—Title XVIII of the Social Security
7 Act is amended by inserting after section 1866E the fol-
8 lowing new section:

9 ''DEMONSTRATION PROGRAM TO PROVIDE INTEGRATED
10 CARE FOR MEDICARE BENEFICIARIES WITH END-
11 STAGE RENAL DISEASE

12 ''SEC. 1866F. (a) ESTABLISHMENT.—

13 ''(1) IN GENERAL.—The Secretary shall con-
14 duct under this section the ESRD Integrated Care
15 Demonstration Program (in this section referred to
16 as the 'Program') which is voluntary for patients
17 and providers to assess the effects of alternative care
18 delivery models on patient care improvements under
19 this title for Program-eligible beneficiaries (as de-
20 fined in paragraph (2)). Under the Program, eligible
21 participating providers (as defined in such para-
22 graph) may form an ESRD Integrated Care Organi-
23 zation (in this section referred to as an 'Organiza-
24 tion'). An Organization shall integrate care and
25 serve as the medical home for Program-eligible bene-
26 ficiaries.

1 ''(2) DEFINITIONS.—In this section:
2 ''(A) ELIGIBLE PARTICIPATING PRO-
3 VIDER.—The term 'eligible participating pro-
4 vider' means the following:
5 ''(i) A facility certified as a renal di-
6 alysis facility under this title.
7 ''(ii) A dialysis organization that owns
8 one or more of such facilities described in
9 clause (i).
10 ''(iii) A nephrologist or nephrology
11 practice.
12 ''(iv) Any other physician group prac-
13 tice or a group of affiliated physicians.
14 ''(B) ELIGIBLE PARTICIPATING PART-
15 NER.—The term 'eligible participating partner'
16 means, with respect to an Organization, the fol-
17 lowing:
18 ''(i) A Medicare Advantage plan de-
19 scribed in section 1851(a)(2) or a Medi-
20 care Advantage organization offering such
21 a plan.
22 ''(ii) A prescription drug plan (as de-
23 fined in section 1860D–41(a)(14)).
24 ''(iii) A medicaid managed care orga-
25 nization (as defined in section 1903(m)).

1 "(iv) An entity able to bear risk as
2 deemed by a State and that chooses to
3 bear risk as a condition of partnership in
4 such organization.
5 "(v) A third party-administrator orga-
6 nization.
7 "(C) PROGRAM-ELIGIBLE BENEFICIARY.—
8 The term 'Program-eligible beneficiary' means,
9 with respect to an Organization offering an
10 ESRD Integrated Care Model, an individual en-
11 titled to benefits under part A and enrolled
12 under part B who—
13 "(i) is 18 years of age or older;
14 "(ii) is identified by the Secretary or
15 the Organization as receiving renal dialysis
16 services under the original medicare fee-
17 for-service program under parts A and B;
18 "(iii) resides in the service area of
19 such Organization;
20 "(iv) receives renal dialysis services
21 primarily from a facility that participates
22 in such Organization; and
23 "(v) has not received a successful kid-
24 ney transplant.

1 "(b) ESRD INTEGRATED CARE ORGANIZATION ELI-
2 GIBILITY REQUIREMENTS.—
3 "(1) ORGANIZATIONS.—
4 "(A) IN GENERAL.—One or more eligible
5 participating providers may establish an Orga-
6 nization or may enter into, subject to subpara-
7 graph (B), one or more partnership, ownership,
8 or co-ownership agreements with one or more
9 eligible participating partners to establish an
10 Organization.
11 "(B) LIMITATION ON NUMBER OF AGREE-
12 MENTS.—The Secretary may specify a limita-
13 tion on the number of Organizations in which
14 an eligible participating partner may participate
15 under agreements described in subparagraph
16 (A).
17 "(2) ESRD INTEGRATED CARE MODEL.—
18 "(A) BENEFITS REQUIREMENTS.—
19 "(i) IN GENERAL.—Subject to clause
20 (iii), an Organization shall offer at least
21 one ESRD Integrated Care Model that is
22 an open network model (as described in
23 subparagraph (B)(i)) in each of its service
24 areas and may offer one or more ESRD
25 Integrated Care Models that is a preferred

1 network model (as described in subpara-
2 graph (B)(ii)) in each of its service areas.
3 For purposes of this section an ESRD In-
4 tegrated Care Model (in this section re-
5 ferred to as the 'Model')—
6 ''(I) shall cover all benefits under
7 parts A and B (other than hospice
8 care) and include benefits for transi-
9 tion (including education) into pallia-
10 tive care; and
11 ''(II) may, through a partnership
12 or other agreement with an MA–PD
13 plan under part C or prescription
14 drug plan under part D, cover all pre-
15 scription drug benefits under such
16 part D.
17 ''(ii) TREATMENT OF SAVINGS.—
18 ''(I) IN GENERAL.—Any Organi-
19 zation offering an ESRD Integrated
20 Care Model shall provide for the re-
21 turn under subclause (IV) to a Pro-
22 gram-eligible beneficiary enrolled in
23 the Organization of the amount, if
24 any, by which the payment amount
25 described in subclause (III) with re-

1 spect to the Program-eligible beneficiary for a year exceeds the revenue amount described in subclause (II) with respect to the Program-eligible beneficiary for the year.

6 "(II) REVENUE AMOUNT DESCRIBED.—The revenue amount described in this subclause, with respect to an Organization offering an ESRD Integrated Care Model and a Program-eligible beneficiary enrolled in such Organization, is the Organization's estimated average revenue requirements, including administrative costs and return on investment, for the Organization to provide the benefits described in clause (i) under the Model for the Program-eligible beneficiary for the year.

20 "(III) PAYMENT AMOUNT DESCRIBED.—The payment amount described in this subclause, with respect to an Organization offering an ESRD Integrated Care Model and a Program-eligible beneficiary enrolled in

1 such Organization, is the payment
2 amount to the Organization under
3 subsection (f)(1) made with respect to
4 the Program-eligible beneficiary for
5 the year.

6 "(IV) MEANS OF RETURNING
7 SAVINGS TO PROGRAM-ELIGIBLE
8 BENEFICIARIES ENROLLED IN ORGA-
9 NIZATIONS.—An Organization shall
10 return the amount under subclause (I)
11 to a Program-eligible beneficiary en-
12 rolled in the Organization in a man-
13 ner specified by the Organization,
14 which may include cost-sharing lower
15 than otherwise applicable, benefits not
16 covered under the original medicare
17 fee-for-service program, or financial
18 incentives (such as reduced cost shar-
19 ing) for Program-eligible beneficiaries
20 enrolled in the Organization to pro-
21 mote the delivery of high-value and ef-
22 ficient care and services.

23 "(iii) BENEFIT REQUIREMENTS FOR
24 DUAL ELIGIBLES.—In the case of a Pro-
25 gram-eligible beneficiary who is eligible for

1 benefits under this title and title XIX, an
2 Organization, in accordance with an agree-
3 ment entered into under subsection
4 (f)(4)—

5 ''(I) may be responsible for pro-
6 viding, or arranging for the provision
7 of, all benefits (other than long-term
8 services and supports) for which the
9 Program-eligible beneficiary is eligible
10 for under the State Medicaid program
11 under title XIX in which the Pro-
12 gram-eligible beneficiary is enrolled;
13 and

14 ''(II) may elect to provide, or ar-
15 range for the provision of, long-term
16 services and supports available to the
17 Program-eligible beneficiary under the
18 State Medicaid program.

19 ''(B) REQUIREMENTS FOR OPEN NETWORK
20 AND PREFERRED NETWORK MODELS.—

21 ''(i) OPEN NETWORK MODEL.—Under
22 an ESRD Integrated Care Model offered
23 by an Organization that is an open net-
24 work model, the Organization shall—

1 "(I) allow Program-eligible bene-
2 ficiaries to receive such covered bene-
3 fits from any provider of services or
4 supplier regardless of whether such
5 provider is within the network assem-
6 bled under subclause (I);
7 "(II) pay any Medicare-certified
8 provider or supplier that is not within
9 the network assembled under sub-
10 clause (I) for such covered benefits an
11 amount equal to the amount the pro-
12 vider or supplier would otherwise re-
13 ceive under this title; and
14 "(III) not apply any additional
15 premium or cost sharing requirements
16 for such covered benefits in addition
17 to premium or cost sharing require-
18 ments, respectively, that would be ap-
19 plicable under part A or part B for
20 such benefits.
21 "(ii) PREFERRED NETWORK
22 MODEL.—Under an ESRD Integrated
23 Care Model offered by an Organization
24 that is a preferred network model, the Or-
25 ganization—

1 “(I) shall assemble a network of
2 providers of services and suppliers
3 identified by the Organization and
4 confirmed by the Secretary as includ-
5 ing providers of services and suppliers
6 with significant expertise in caring for
7 individuals with end-stage renal dis-
8 ease through which Program-eligible
9 beneficiaries shall receive covered ben-
10 efits as described in subparagraph (A)
11 that are required to be covered under
12 the Model;

13 “(II) shall provide for payment
14 for items and services furnished by
15 providers of services and suppliers
16 within such network to Program-eligi-
17 ble beneficiaries enrolled in such Or-
18 ganization in accordance with pay-
19 ment rates determined pursuant to an
20 agreement entered into between the
21 Organization and such providers of
22 services and suppliers and shall pro-
23 vide for payment for items and serv-
24 ices furnished by providers of services
25 and suppliers not within such network

1 to such beneficiaries so enrolled in ac-
2 cordance that would be determined
3 under section 1853(a)(1)(H);
4 “(III) may apply premium and
5 cost-sharing requirements, in addition
6 to premium or cost-sharing require-
7 ments, respectively, that would be ap-
8 plicable under part B, for benefits in
9 addition to those required to be cov-
10 ered under the Model; and
11 “(IV) shall apply network stand-
12 ards as defined by the Secretary.
13 “(iii) PROMOTING ACCESS TO HIGH-
14 QUALITY PROVIDERS.—An Organization
15 offering an ESRD Integrated Care Model
16 may develop and implement performance-
17 based incentives for providers of services
18 and suppliers to promote delivery of high
19 quality and efficient care. Such incentives
20 shall be based on clinical measures and
21 non-clinical measures, such as with respect
22 to notification of patient discharge from a
23 hospital, patient education (such as with
24 respect to treatment options and nutri-
25 tion), and the interoperability of electronic

1 health records developed by an Organiza-
2 tion according to requirements and stand-
3 ards specified by the Secretary pursuant to
4 subparagraph (C).

5 "(iv) APPLICATION OF MEDICARE AD-
6 VANTAGE REQUIREMENT WITH RESPECT
7 TO MEDICARE SERVICES FURNISHED BY
8 OUT-OF-NETWORK PROVIDERS AND SUP-
9 PLIERS.—

10 "(I) IN GENERAL.—Section
11 1852(k)(1) (relating to limitations on
12 balance billing against MA organiza-
13 tions for noncontract physicians and
14 other entities with respect to services
15 covered under this title) shall apply to
16 Organizations, Program-eligible bene-
17 ficiaries enrolled in such Organiza-
18 tions, and physicians and other enti-
19 ties that do not have a contract or
20 other agreement with the Organiza-
21 tion establishing payment amounts for
22 services furnished to such a bene-
23 ficiary in the same manner as such
24 section applies to MA organizations,
25 individuals enrolled with such organi-

1 zations, and physicians and other en-
2 tities referred to in such section.
3 "(II) REFERENCE FOR ADDI-
4 TIONAL PROVISION.—For the provi-
5 sion relating to limitations on balance
6 billing against Organizations for serv-
7 ices covered under this title furnished
8 by noncontract providers of services
9 and suppliers, see section
10 1866(a)(1)(O).
11 "(C) QUALITY AND REPORTING REQUIRE-
12 MENTS.—
13 "(i) CLINICAL MEASURES.—Under the
14 Program, the Secretary shall—
15 "(I) require each participating
16 Organization to submit to the Sec-
17 retary data on clinical measures con-
18 sistent with those measures submitted
19 by organizations participating in the
20 Comprehensive ESRD Care Initiative
21 operated by the Center for Medicare
22 and Medicaid Innovation as of Octo-
23 ber 1, 2016, to assess the quality of
24 care provided;

1 "(II) establish requirements for
2 participating Organizations to report
3 to the Secretary, in a form and man-
4 ner specified by the Secretary, infor-
5 mation on such measures; and
6 "(III) establish quality perform-
7 ance standards on such measures to
8 assess the quality of care.
9 "(ii) REQUIREMENT FOR STAKE-
10 HOLDER INPUT.—In developing require-
11 ments and standards under subclauses (II)
12 and (III) of clause (i), the Secretary shall
13 request and consider input from a stake-
14 holder board, at least one nephrologist,
15 other suppliers and providers of services,
16 renal dialysis facilities, and beneficiary ad-
17 vocates, and respond in writing to such
18 input.
19 "(iii) ADDITIONAL ASSESSMENTS AND
20 REPORTING REQUIREMENTS.—The Sec-
21 retary shall assess the extent to which an
22 Organization delivers integrated and pa-
23 tient-centered care through analysis of in-
24 formation obtained from Program-eligible
25 beneficiaries enrolled in the Organization

1 through surveys, such as the In-Center
2 Hemodialysis Consumer Assessment of
3 Healthcare Providers and Systems.
4 ‘‘(D) REQUIREMENTS FOR ESRD INTE-
5 GRATED CARE STRATEGY.—
6 ‘‘(i) IN GENERAL.—An Organization
7 seeking a contract under this section to
8 offer one or more ESRD Integrated Care
9 Models must develop and submit for the
10 Secretary’s approval, subject to clauses (ii)
11 and (iii), an ESRD Integrated Care Strat-
12 egy.
13 ‘‘(ii) ESRD INTEGRATED CARE
14 STRATEGY.—In assessing an ESRD Inte-
15 grated Care Strategy under clause (i), the
16 Secretary shall consider the extent to
17 which the Strategy includes elements, such
18 as the following:
19 ‘‘(I) Interdisciplinary care teams
20 led by at least one nephrologist, and
21 comprised of registered nurses, social
22 workers, renal dialysis facility man-
23 agers, and other representatives from
24 alternative settings described in sub-
25 clause (VI).

1 "(II) Health risk and other as-
2 sessments to determine the physical,
3 psychosocial, nutrition, language, cul-
4 tural, and other needs of Program-eli-
5 gible beneficiaries enrolled in the Or-
6 ganization involved.
7 "(III) Development and at least
8 annual updating of individualized care
9 plans that incorporate at least the
10 medical, social, and functional needs,
11 preferences, and care goals of Pro-
12 gram-eligible beneficiaries enrolled in
13 the Organization.
14 "(IV) Coordination and delivery
15 of non-clinical services, such as trans-
16 portation, aimed at improving the ad-
17 herence of Program-eligible bene-
18 ficiaries enrolled in the Organization
19 with care recommendations.
20 "(V) Services, such as transplant
21 evaluation and vascular access care.
22 "(VI) In the case of an individual
23 who, while enrolled in the Organiza-
24 tion, receives confirmation that a kid-
25 ney transplant is imminent, the provi-

1 sion by an interdisciplinary care team
2 described in subclause (I) of coun-
3 seling services to such individual on
4 preparation for and potential chal-
5 lenges surrounding such transplant.

6 "(VII) Delivery of benefits and
7 services in alternative settings, such
8 as the home of the Program-eligible
9 beneficiary enrolled in the Organiza-
10 tion, in coordination with the provider
11 or other appropriate stakeholder in-
12 volved in such delivery serving on an
13 interdisciplinary care team described
14 in subclause (I).

15 "(VIII) Use of patient reminder
16 systems.

17 "(IX) Education programs for
18 patients, families, and caregivers.

19 "(X) Use of health care advice
20 resources, such as nurse advice lines.

21 "(XI) Use of team-based health
22 care delivery models that provide com-
23 prehensive and continuous medical
24 care, such as medical homes.

1 "(XII) Co-location of providers
2 and services.
3 "(XIII) Use of a demonstrated
4 capacity to share electronic health
5 record information across sites of
6 care.
7 "(XIV) Use of programs to pro-
8 mote better adherence to rec-
9 ommended treatment regimens by in-
10 dividuals, including by addressing bar-
11 riers to access to care by such individ-
12 uals.
13 "(XV) Other services, strategies,
14 and approaches identified by the Or-
15 ganization to improve care coordina-
16 tion and delivery.
17 "(iii) REQUIREMENTS.—The Sec-
18 retary may not approve an ESRD Inte-
19 grated Care Strategy of an Organization
20 unless under such Strategy the Organiza-
21 tion—
22 "(I) provides services to Pro-
23 gram-eligible beneficiaries enrolled in
24 the Organization through a com-
25 prehensive, multidisciplinary health

1 and social services delivery system
2 which integrates acute and long-term
3 care services pursuant to regulations;
4 and

5 ‘‘(II) specifies the covered items
6 and services that will not be provided
7 directly by the Organization, and to
8 arrange for delivery of those items
9 and services through contracts meet-
10 ing the requirements of regulations.

11 ‘‘(3) REQUIREMENT FOR CAPITAL RESERVES.—

12 ‘‘(A) IN GENERAL.—The Secretary shall
13 enter into contracts under this section only with
14 Organizations that demonstrate sufficient cap-
15 ital reserves, measured as a percentage of
16 capitated payments and consistent with require-
17 ments established by the State in which the Or-
18 ganization operates.

19 ‘‘(B) ALTERNATIVE MECHANISM TO DEM-
20 ONSTRATE CAPACITY TO BEAR RISK.—An Orga-
21 nization shall be considered to meet the require-
22 ment in subparagraph (A) if the Organization
23 includes at least one eligible participating pro-
24 vider or eligible participating partner that—

1 "(i) is licensed as a risk-bearing entity
2 or deemed by a State as able to bear risk;
3 and

4 "(ii) chooses to bear risk as a condi-
5 tion of partnership in such Organization.

6 "(4) BENEFICIARY PROTECTIONS.—

7 "(A) CONTINUITY OF CARE.—To provide
8 for continuity of care, each contract entered
9 into with an Organization under this section
10 shall provide for a transition period during
11 which a Program-eligible beneficiary who is
12 first enrolled in the Organization or who elects
13 to opt out of the Program or otherwise disenroll
14 from the Organization maintains access to eligi-
15 ble participating providers furnishing items or
16 services to such beneficiary immediately before
17 such enrollment or election for purposes of re-
18 ceipt of such items or services. Payment for
19 such items or services covered under this title
20 furnished to such Program-eligible beneficiary
21 during such transition period shall be made in
22 accordance with this title and in such amounts
23 as would otherwise be determined for such
24 items and services provided to such a bene-
25 ficiary not enrolled under the Program.

1 “(B) ANTIDISCRIMINATION.—Each con-
2 tract entered into with an Organization under
3 this section shall provide that each eligible par-
4 ticipating provider of such Organization may
5 not deny, limit, or condition the furnishing of
6 services, or affect the quality of services fur-
7 nished, under this title to Program-eligible
8 beneficiaries on whether or not such a bene-
9 ficiary is enrolled with the Organization.

10 “(C) QUALITY ASSURANCE; PATIENT SAFE-
11 GUARDS.—Each contract entered into with an
12 Organization under this section shall require
13 that such Organization have in effect at a min-
14 imum—

15 “(i) a written plan of quality assur-
16 ance and improvement, and procedures im-
17 plementing such plan, in accordance with
18 regulations; and

19 “(ii) written safeguards of the rights
20 of Program-eligible beneficiaries enrolled in
21 the Organization (including a patient bill
22 of rights and procedures for grievances
23 and appeals) in accordance with regula-
24 tions and with other requirements of this

1 title and Federal and State law that are
2 designed for the protection of patients.
3 "(D) OVERSIGHT.—The Secretary shall
4 oversee the marketing and assignment practices
5 of each Organization entering into a contract
6 under this section as part of the approval proc-
7 ess of Organizations under this section.
8 "(5) NON-APPLICATION OF CERTAIN PROVI-
9 SIONS OF LAW.—For purposes of sections 162(m)(6)
10 and 414(m) of the Internal Revenue Code of 1986
11 and section 9010 of the Patient Protection and Af-
12 fordable Care Act (26 U.S.C. 4001 note prec.), in
13 the case of an eligible participating provider that es-
14 tablishes an Organization or that enters into a part-
15 nership, ownership, or co-ownership agreement to es-
16 tablish an Organization, or an Organization with a
17 contract under this section, risk-based payments in
18 exchange for providing medical care shall not be con-
19 sidered premiums for health insurance coverage.
20 "(6) TREATMENT AS MEDICARE ADVANCED AL-
21 TERNATIVE PAYMENT MODEL.—Alternative care de-
22 livery models under the Program shall be treated
23 under this title as an advanced alternative payment
24 model.
25 "(c) PROGRAM OPERATION AND SCOPE.—

1 "(1) IN GENERAL.—Not later than 6 months
2 after the date of enactment of this section, the Sec-
3 retary shall establish a process through which an
4 Organization can apply to offer one or more ESRD
5 Integrated Care Models. Such application shall in-
6 clude information on at least the following:
7 "(A) The estimated average revenue
8 amount described in subsection (b)(2)(A)(ii)(II)
9 for the Organization to deliver benefits de-
10 scribed in subsection (b)(2)(A).
11 "(B) Any benefits offered by the Organiza-
12 tion beyond those described in such subsection.
13 "(C) A listing of network providers of serv-
14 ices and supplier.
15 "(D) Information on the expertise of net-
16 work providers of services and suppliers in serv-
17 ing ESRD patients.
18 "(E) A description of the ESRD Inte-
19 grated Care Strategy of the Organization de-
20 scribed in subsection (b)(2)(D).
21 "(2) PROGRAM INITIATION.—The Secretary
22 shall initiate the Program such that Organizations
23 begin serving Program-eligible beneficiaries not later
24 than January 1, 2018.

1 "(3) CONTRACT AWARD AND PERIOD.—The
2 Secretary shall enter into contracts for an initial pe-
3 riod of not less than 5 years with all Organizations
4 that meet Program requirements.

5 "(4) ALLOWANCE FOR LARGER SERVICE AREAS
6 AND EXPANSION OF SERVICE AREAS.—Organizations
7 shall demonstrate in their application that the pro-
8 posed service area has the capacity to serve Pro-
9 gram-eligible beneficiaries through an adequate pro-
10 vider network and is reflective of the communities in
11 which beneficiaries live, work, and obtain health care
12 services.

13 "(5) CONTRACT TERMINATION AND SUSPEN-
14 SION.—

15 "(A) IN GENERAL.—The Secretary may
16 terminate a contract with an Organization
17 under this section if the Secretary determines
18 that an Organization has failed to meet quality
19 requirements described in subsection (b) or
20 (e)(2)(C)(iii) or violates other terms of the con-
21 tract.

22 "(B) INSUFFICIENT BENEFICIARY PARTICI-
23 PATION.—The Secretary shall, in the case of an
24 Organization with a contract under this section
25 with respect to which, for any period of at least

1 30 consecutive days during a year for which
2 such contract applies, fewer than 50 percent of
3 the total number of Program-eligible bene-
4 ficiaries served by the Organization receive ben-
5 efits through the Organization under this sec-
6 tion—

7 "(i) suspend such contract for the re-
8 mainder of such year; and

9 "(ii) provide for the Organization to
10 return any prospective payments made to
11 the Organization under this section for
12 items and services not provided pursuant
13 to clause (i).

14 "(C) REMEDY AND APPEALS PROCESS.—
15 Prior to the Secretary terminating or sus-
16 pending a contract with an Organization under
17 this section, the Secretary shall afford such Or-
18 ganization sufficient opportunity to remedy any
19 contract violations and appeal a contract termi-
20 nation.

21 "(D) PROGRAM-ELIGIBLE BENEFICIARY
22 NOTICE AT TIME OF CONTRACT TERMI-
23 NATION.—Each contract under this section with
24 an Organization shall require the Organization
25 to provide (and pay for) written notice in ad-

vance of the contract's termination or suspension, as well as a description of alternatives for obtaining benefits under this title, to each Program-eligible beneficiary assigned to or who elected to receive benefits through the Organization under this section.

"(6) PROGRAM EXPANSION.—The Secretary may, through rulemaking, expand the duration and scope of the Program under this section, to the extent determined appropriate by the Secretary, if—

"(A) the Secretary determines that such expansion is expected to—

"(i) reduce spending under this title without reducing the quality of patient care; or

"(ii) improve the quality of patient care without increasing spending under this title;

"(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under this title; and

"(C) the Secretary determines that such expansion would not deny or limit the coverage

1 or provision of benefits under this title for ap-
2 plicable individuals.

3 ''(d) IDENTIFICATION OF PROGRAM-ELIGIBLE BENE-
4 FICIARIES.—The Secretary shall establish a process for
5 the initial and ongoing identification of Program-eligible
6 beneficiaries.

7 ''(e) PROGRAM-ELIGIBLE BENEFICIARIES ASSIGNED
8 INTO AN ESRD INTEGRATED CARE ORGANIZATION OPEN
9 NETWORK MODEL.—

10 ''(1) ASSIGNMENT.—

11 ''(A) IN GENERAL.—Under the Program,
12 subject to the succeeding provisions of this
13 paragraph, the Secretary shall, upon the Sec-
14 retary identifying a beneficiary as a Program-
15 eligible beneficiary, assign all such Program-eli-
16 gible beneficiary to an open network model of-
17 fered by an Organization that includes the di-
18 alysis facility at which the Program-eligible ben-
19 eficiary primarily receives renal dialysis serv-
20 ices.

21 ''(B) PROGRAM-ELIGIBLE BENEFICIARY
22 NOTIFICATION OF ASSIGNMENT.—

23 ''(i) IN GENERAL.—Upon assignment
24 of a Program-eligible beneficiary to an Or-
25 ganization, the Secretary shall provide to

1 the Organization written notification of
2 such assignment of such Program-eligible
3 beneficiary and not later than 15 business
4 days after the date of receipt of such noti-
5 fication, the Organization shall provide
6 written notice of such assignment to the
7 Program-eligible beneficiary.

8 "(ii) OPT-OUT PERIOD AND CHANGES
9 UPON INITIAL ASSIGNMENT.—The Sec-
10 retary shall provide for a 75-day period be-
11 ginning on the date on which the assign-
12 ment of a Program-eligible beneficiary into
13 an open network model offered by an Or-
14 ganization becomes effective during which
15 a Program-eligible beneficiary may—

16 "(I) opt out of the Program;

17 "(II) make a one-time change of
18 assignment into an open network
19 model offered by a different Organiza-
20 tion; or

21 "(III) elect a preferred network
22 model offered by the same or different
23 Organization.

24 "(C) ADDITIONAL OPT-IN POPULATION.—
25 An individual who, without application of clause

1 (iv) of subsection (a)(2)(C), would be treated as
2 a Program-eligible beneficiary, may elect to en-
3 roll in an Organization under the Program
4 under this section if such individual agrees to
5 receive renal dialysis services primarily from a
6 facility that participates in such Organization.
7 For purposes of this section (other than sub-
8 paragraphs (A) and (B) of this paragraph,
9 paragraph (2), and subsection (d)), an indi-
10 vidual making an election pursuant to the pre-
11 vious sentence shall be treated as a Program-el-
12 igible beneficiary.

13 "(D) DEEMED RE-ENROLLMENT.—A Pro-
14 gram-eligible beneficiary assigned under this
15 paragraph to an ESRD Integrated Care Model
16 offered by an Organization with respect to a
17 year is deemed, unless the individual elects oth-
18 erwise under this paragraph, to have elected to
19 continue such assignment with respect to the
20 subsequent year.

21 "(E) ADDITIONAL OPPORTUNITY TO OPT
22 OUT OR ELECT DIFFERENT MODEL OR ORGANI-
23 ZATION.—On the date that is one year after the
24 effective date of the initial assignment of a Pro-
25 gram-eligible beneficiary to an open network

1 model offered by an Organization (and annually
2 thereafter), a Program-eligible beneficiary shall
3 be given the opportunity to—

4 “(i) opt out of the Program;

5 “(ii) make a one-time change of as-
6 signment into an open network model of-
7 fered by a different Organization; or

8 “(iii) elect a preferred network model
9 offered by the same or different Organiza-
10 tion.

11 “(F) CHANGE IN PRINCIPAL DIAGNOSIS
12 OPT OUT.—In addition to any other period dur-
13 ing which a Program-eligible beneficiary may,
14 pursuant to this paragraph, opt out of the Pro-
15 gram, in the case of a Program-eligible bene-
16 ficiary who, after assignment under this para-
17 graph, is diagnosed with a principal diagnosis
18 (as defined by the Secretary) other than end-
19 stage renal disease, such individual shall be
20 given the opportunity to opt out of the Program
21 during such period as specified by the Sec-
22 retary.

23 “(G) SPECIAL ELECTION PERIODS.—The
24 Secretary shall offer Program-eligible bene-

1 ficiaries special election periods consistent with
2 those described in section 1851(e)(4).
3 "(2) PROGRAM-ELIGIBLE BENEFICIARY NOTIFI-
4 CATION.—
5 "(A) IN GENERAL.—The Secretary shall
6 notify Program-eligible beneficiaries about the
7 Program under this section and provide them
8 with information about receiving benefits under
9 this title through an Organization.
10 "(B) REQUIREMENTS.—Notwithstanding
11 any other provision of law, subject to subpara-
12 graph (C), such notification shall allow for eligi-
13 ble participating providers that are part of an
14 Organization to—
15 "(i) inform Program-eligible bene-
16 ficiaries about the Program;
17 "(ii) distribute Program materials to
18 Program-eligible beneficiaries; and
19 "(iii) assist Program-eligible bene-
20 ficiaries in assessing the options of such
21 beneficiaries under the Program.
22 "(C) LIMITATION ON UNSOLICITED MAR-
23 KETING.—
24 "(i) IN GENERAL.—Under the Pro-
25 gram, an eligible participating provider

1 may not provide marketing information or
2 materials, including information, materials,
3 and assistance described in subparagraph
4 (B), to a Program-eligible beneficiary un-
5 less the Program-eligible beneficiary re-
6 quests such marketing information or ma-
7 terials.

8 "(ii) EXCEPTION FOR PROVIDERS
9 TREATING BENEFICIARIES.—An eligible
10 participating provider that is part of an
11 Organization may provide information, ma-
12 terials, and assistance described in sub-
13 paragraph (B) to a Program-eligible bene-
14 ficiary, without prior request of such bene-
15 ficiary, if such beneficiary is receiving
16 renal dialysis services from such provider.

17 "(iii) PARITY IN MARKETING.—In any
18 case that an Organization participates in
19 any form of marketing, such form of mar-
20 keting shall be the same for all Program-
21 eligible beneficiaries to which, pursuant to
22 clause (ii), the Organization may provide
23 information, materials, and assistance de-
24 scribed in such clause.

1 "(3) PROGRAM-ELIGIBLE BENEFICIARY APPEAL
2 RIGHTS.—Program-eligible beneficiaries enrolled in
3 an Organization shall have the same right to appeal
4 any denial of benefits under this title as such a Pro-
5 gram-eligible beneficiary would have under this title
6 if such Program-eligible beneficiary were not so en-
7 rolled.

8 "(f) PAYMENT.—

9 "(1) IN GENERAL.—For each Program-eligible
10 beneficiary receiving care through an Organization,
11 the Secretary shall make a monthly capitated pay-
12 ment in accordance with payment rates that would
13 be determined under section 1853(a)(1)(H), as ad-
14 justed pursuant to paragraph (2).

15 "(2) APPLICATION OF HEALTH STATUS RISK
16 ADJUSTMENT METHODOLOGY.—The Secretary shall
17 adjust the payment amount to an Organization
18 under this subsection in the same manner in which
19 the payment amount to a Medicare Advantage plan
20 is adjusted under section 1853(a)(1)(C).

21 "(3) PAYMENT FOR PART D BENEFITS.—In the
22 case where an Organization elects to offer part D
23 prescription drug coverage under the Program under
24 this section, payments to the Organization for such
25 benefits provided to Program-eligible beneficiaries by

1 the Organization shall be made in the same manner
2 and amounts as those payments would be made in
3 the case of an organization with a contract under
4 such part.

5 ''(4) AGREEMENT WITH STATE MEDICAID
6 AGENCY.—In the event of an Organization that
7 elects to cover benefits under title XIX for Program-
8 eligible beneficiaries eligible for benefits under this
9 title and title XIX such Organization shall enter into
10 an agreement with the State Medicaid agency to
11 provide benefits, or arrange for benefits to be pro-
12 vided, for which such beneficiaries are entitled to re-
13 ceive medical assistance under title XIX and to re-
14 ceive payment from the State for providing or ar-
15 ranging for the provision of such benefits.

16 ''(5) AFFIRMATION OF STATE OBLIGATIONS TO
17 PAY PREMIUM AND COST-SHARING AMOUNTS.—

18 ''(A) IN GENERAL.—A State shall continue
19 to make medical assistance under the State
20 plan under title XIX available in the amount
21 described in subparagraph (B) for the duration
22 of the Program for cost-sharing (as defined in
23 section 1905(p)(3)) under this title for qualified
24 medicare beneficiaries described in section
25 1905(p)(1) and other individuals who are Pro-

1 gram-eligible beneficiaries enrolled in an Orga-
2 nization and entitled to medical assistance for
3 premiums and such cost-sharing under the
4 State plan under title XIX.

5 "(B) AMOUNTS MADE AVAILABLE FOR
6 COST-SHARING.—For purposes of subparagraph
7 (A):

8 "(i) IN GENERAL.—Subject to clause
9 (ii), the amount of medical assistance de-
10 scribed in this clause to be made available
11 for cost-sharing pursuant to subparagraph
12 (A) for an individual described in such
13 subparagraph entitled to medical assist-
14 ance for such cost-sharing under a State
15 plan under title XIX shall be equal to the
16 amount of medical assistance that would
17 be made available under such State plan as
18 in effect as of January 1, 2016.

19 "(ii) AMOUNTS IN THE CASE OF A
20 STATE THAT INCREASES PAYMENTS FOR
21 COST-SHARING.—If a State increases the
22 amount of medical assistance made avail-
23 able under the State plan under title XIX
24 for cost-sharing described in subparagraph
25 (A) after such date, such increased

1 amounts shall be made available under
2 subparagraph (A) for the remaining dura-
3 tion of the Program.
4 "(g) WAIVER AUTHORITY.—
5 "(1) IN GENERAL.—In order to carry out the
6 Program under this section, the Secretary shall
7 waive those requirements waived under section 1899
8 and may waive such additional requirements con-
9 sistent with those waived under programs adminis-
10 tered through the Center for Medicare and Medicaid
11 Innovation as may be necessary.
12 "(2) NOTICE OF WAIVERS.—Not later than 3
13 months after the date of enactment of this section,
14 the Secretary shall publish a notice of waivers that
15 will apply in connection with the Program. The no-
16 tice shall include the specific conditions that an Or-
17 ganization must meet to qualify for each waiver, and
18 commentary explaining the waiver requirements.".
19 (b) CONFORMING AMENDMENT RELATING TO BAL-
20 ANCED BILLING.—Section 1866(a)(1)(O) of the Social Se-
21 curity Act (42 U.S.C. 1395cc(a)(1)(O)) is amended—
22 (1) by inserting "with an ESRD Integrated
23 Care Organization under section 1866F," after
24 "with a PACE provider under section 1894 or
25 1934,";

1 (2) by inserting "or ESRD Integrated Care Or-
2 ganization" after "in the case of a PACE provider";
3 (3) by striking "or PACE program eligible indi-
4 viduals enrolled with the PACE provider" and in-
5 serting ", Program-eligible beneficiaries enrolled in
6 the ESRD Integrated Care Organization, or PACE
7 program eligible individuals enrolled with the PACE
8 provider"; and
9 (4) by inserting "(or in the case of a Program-
10 eligible beneficiary enrolled in the ESRD Integrated
11 Care Organization, the amounts that would be made
12 in accordance with payment rates that would be de-
13 termined under section 1853(a)(1)(H))" after "the
14 amounts that would be made".

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