

115TH CONGRESS
1ST SESSION

H. R. 4143

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

OCTOBER 26, 2017

Mr. SMITH of Missouri (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

A BILL

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 Patient Access
5 To Integrated-care, Empowerment, Nephrologists, Treat-
6 ment, and Services Demonstration Act of 2017” or the
7 “Dialysis PATIENTS Demonstration Act of 2017”.

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

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

7 “DEMONSTRATION PROGRAM TO PROVIDE INTEGRATED
8 CARE FOR MEDICARE BENEFICIARIES WITH END-
9 STAGE RENAL DISEASE

10 “SEC. 1866F. (a) ESTABLISHMENT.—

11 “(1) IN GENERAL.—The Secretary shall con-
12 duct under this section the ESRD Integrated Care
13 Demonstration Program (in this section referred to
14 as the ‘Program’) which is voluntary for patients
15 and providers to assess the effects of alternative care
16 delivery models and payment methodologies on pa-
17 tient care improvements under this title for Pro-
18 gram-eligible beneficiaries (as defined in paragraph
19 (2)). Under the Program—

20 “(A) Program-eligible beneficiaries shall be
21 considered enrolled under the original Medicare
22 fee-for-service program under parts A and B;

23 “(B) eligible participating providers (as de-
24 fined in such paragraph) may form an ESRD
25 Integrated Care Organization (in this section
26 referred to as an ‘Organization’); and

1 “(C) an Organization shall integrate care
2 and serve as the medical home under the origi-
3 nal medicare fee-for-service program under
4 parts A and B for Program-eligible bene-
5 ficiaries.

6 “(2) DEFINITIONS.—In this section:

7 “(A) ELIGIBLE PARTICIPATING PRO-
8 VIDER.—The term ‘eligible participating pro-
9 vider’ means the following:

10 “(i) A facility certified as a renal di-
11 alysis facility under this title.

12 “(ii) A dialysis organization that owns
13 one or more of such facilities described in
14 clause (i).

15 “(iii) A nephrologist or nephrology
16 practice.

17 “(iv) Any other physician group prac-
18 tice or a group of affiliated physicians or
19 providers.

20 “(B) ELIGIBLE PARTICIPATING PART-
21 NER.—The term ‘eligible participating partner’
22 means, with respect to an Organization, the fol-
23 lowing:

24 “(i) A Medicare Advantage plan de-
25 scribed in section 1851(a)(2) or a Medi-

1 care Advantage organization offering such
2 a plan.

3 “(ii) A prescription drug plan (as de-
4 fined in section 1860D–41(a)(14)).

5 “(iii) A medicaid managed care orga-
6 nization (as defined in section 1903(m)).

7 “(iv) An entity that is able to bear
8 risk as deemed by a State, including public
9 medical educational institutions experi-
10 enced in the care of patients receiving di-
11 alysis, and that chooses to bear risk as a
12 condition of partnership in such organiza-
13 tion.

14 “(v) A third-party administrator orga-
15 nization.

16 “(C) PROGRAM-ELIGIBLE BENEFICIARY.—
17 The term ‘Program-eligible beneficiary’ means,
18 with respect to an Organization offering an
19 ESRD Integrated Care Model, an individual en-
20 titled to benefits under part A and enrolled
21 under part B who—

22 “(i) is identified by the Secretary or
23 the Organization as receiving renal dialysis
24 services under the original medicare fee-
25 for-service program under parts A and B;

1 “(ii) resides in the service area of
2 such Organization;

3 “(iii) receives renal dialysis services
4 primarily from a facility that participates
5 in such Organization;

6 “(iv) has not received a successful
7 kidney transplant; and

8 “(v) has experienced a failed trans-
9 plant.

10 “(b) ESRD INTEGRATED CARE ORGANIZATION ELI-
11 GIBILITY REQUIREMENTS.—

12 “(1) ORGANIZATIONS.—

13 “(A) IN GENERAL.—One or more eligible
14 participating providers may establish an Orga-
15 nization or may enter into, subject to subpara-
16 graph (B), one or more partnership, ownership,
17 or co-ownership agreements with one or more
18 eligible participating partners to establish an
19 Organization.

20 “(B) LIMITATION ON NUMBER OF AGREE-
21 MENTS.—The Secretary may specify a limita-
22 tion on the number of Organizations in which
23 an eligible participating partner may participate
24 under agreements described in subparagraph
25 (A).

1 “(2) ESRD INTEGRATED CARE MODEL.—

2 “(A) BENEFITS REQUIREMENTS.—

3 “(i) IN GENERAL.—Subject to clause
4 (iii), an Organization shall offer at least
5 one ESRD Integrated Care Model that is
6 an open network model (as described in
7 subparagraph (B)(i)) in each of its service
8 areas and may offer one or more ESRD
9 Integrated Care Models that is a preferred
10 network model (as described in subpara-
11 graph (B)(ii)) in each of its service areas.
12 For purposes of this section an ESRD In-
13 tegrated Care Model (in this section re-
14 ferred to as the ‘Model’), subject to sub-
15 section (f)(3)(B)—

16 “(I) shall cover all benefits under
17 parts A and B (other than hospice
18 care) and include benefits for transi-
19 tion (particularly including education)
20 into transplantation, palliative care, or
21 hospice; and

22 “(II) may, through a partnership
23 or other agreement with an MA–PD
24 plan under part C or prescription
25 drug plan under part D, cover all pre-

1 scription drug benefits under such
2 part D.

3 “(ii) TREATMENT OF SAVINGS.—

4 “(I) IN GENERAL.—Any Organi-
5 zation offering an ESRD Integrated
6 Care Model shall provide for the re-
7 turn under subclause (IV) to a Pro-
8 gram-eligible beneficiary enrolled in
9 the Organization of the amount, if
10 any, by which the payment amount
11 described in subclause (III) with re-
12 spect to the Program-eligible bene-
13 ficiary for a year exceeds the revenue
14 amount described in subclause (II)
15 with respect to the Program-eligible
16 beneficiary for the year.

17 “(II) REVENUE AMOUNT DE-
18 SCRIBED.—The revenue amount de-
19 scribed in this subclause, with respect
20 to an Organization offering an ESRD
21 Integrated Care Model and a Pro-
22 gram-eligible beneficiary enrolled in
23 such Organization, is the Organiza-
24 tion’s estimated average revenue re-
25 quirements, including administrative

1 costs and return on investment, for
2 the Organization to provide the bene-
3 fits described in clause (i) under the
4 Model for the Program-eligible bene-
5 ficiary for the year.

6 “(III) PAYMENT AMOUNT DE-
7 SCRIBED.—The payment amount de-
8 scribed in this subclause, with respect
9 to an Organization offering an ESRD
10 Integrated Care Model and a Pro-
11 gram-eligible beneficiary enrolled in
12 such Organization, is the payment
13 amount to the Organization under
14 subsection (f)(1) made with respect to
15 the Program-eligible beneficiary for
16 the year.

17 “(IV) MEANS OF RETURNING
18 SAVINGS TO PROGRAM-ELIGIBLE
19 BENEFICIARIES ENROLLED IN ORGA-
20 NIZATIONS.—An Organization shall
21 return the amount under subclause (I)
22 to a Program-eligible beneficiary en-
23 rolled in the Organization in a man-
24 ner specified by the Organization,
25 which may include, as applicable, cost-

1 sharing lower than otherwise applica-
2 ble, benefits not covered under the
3 original medicare fee-for-service pro-
4 gram (including preventive services re-
5 lated to chronic kidney disease and
6 education surrounding the importance
7 of transplantation), or financial incen-
8 tives (such as reduced cost sharing)
9 for Program-eligible beneficiaries en-
10 rolled in the Organization to promote
11 the delivery of high-value and efficient
12 care and services.

13 “(iii) BENEFIT REQUIREMENTS FOR
14 DUAL ELIGIBLES.—In the case of a Pro-
15 gram-eligible beneficiary who is eligible for
16 benefits under this title and title XIX, an
17 Organization, in accordance with an agree-
18 ment entered into under subsection
19 (f)(4)—

20 “(I) may be responsible for pro-
21 viding, or arranging for the provision
22 of, all benefits (other than long-term
23 services and supports) for which the
24 Program-eligible beneficiary is eligible
25 for under the State Medicaid program

1 under title XIX in which the Pro-
2 gram-eligible beneficiary is enrolled;
3 and

4 “(II) may elect to provide, or ar-
5 range for the provision of, long-term
6 services and supports available to the
7 Program-eligible beneficiary under the
8 State Medicaid program, including
9 services related to the transition into
10 palliative care or hospice.

11 “(B) REQUIREMENTS FOR OPEN NETWORK
12 AND PREFERRED NETWORK MODELS.—

13 “(i) OPEN NETWORK MODEL.—Under
14 an ESRD Integrated Care Model offered
15 by an Organization that is an open net-
16 work model, the Organization shall—

17 “(I) allow Program-eligible bene-
18 ficiaries to receive such covered bene-
19 fits from any provider of services or
20 supplier regardless of whether such
21 provider is within the network assem-
22 bled under clause (ii)(I);

23 “(II) pay any Medicare-certified
24 provider or supplier that is not within
25 the network assembled under sub-

1 clause (I) for such covered benefits an
2 amount equal to the amount the pro-
3 vider or supplier would otherwise re-
4 ceive under this title; and

5 “(III) not apply any additional
6 premium or cost sharing requirements
7 for such covered benefits in addition
8 to premium or cost sharing require-
9 ments, respectively, that would be ap-
10 plicable under part A or part B for
11 such benefits.

12 “(ii) PREFERRED NETWORK
13 MODEL.—Under an ESRD Integrated
14 Care Model offered by an Organization
15 that is a preferred network model, the Or-
16 ganization—

17 “(I) shall assemble a network of
18 providers of services and suppliers
19 identified by the Organization and
20 confirmed by the Secretary as includ-
21 ing providers of services and suppliers
22 with significant expertise in caring for
23 individuals with end-stage renal dis-
24 ease through which Program-eligible
25 beneficiaries shall receive covered ben-

1 efits as described in subparagraph (A)
2 that are required to be covered under
3 the Model;

4 “(II) shall provide for payment
5 for items and services furnished by
6 providers of services and suppliers
7 within such network to Program-eli-
8 gible beneficiaries enrolled in such Or-
9 ganization in accordance with pay-
10 ment rates determined pursuant to an
11 agreement entered into between the
12 Organization and such providers of
13 services and suppliers and shall pro-
14 vide for payment for items and serv-
15 ices furnished by providers of services
16 and suppliers not within such network
17 to such beneficiaries so enrolled in ac-
18 cordance that would be determined
19 under section 1853(a)(1)(H);

20 “(III) may apply premium and
21 cost-sharing requirements, in addition
22 to premium or cost-sharing require-
23 ments, respectively, that would be ap-
24 plicable under part B, for benefits in

1 addition to those required to be cov-
2 ered under the Model; and

3 “(IV) shall apply network stand-
4 ards as defined by the Secretary.

5 “(iii) PROMOTING ACCESS TO HIGH-
6 QUALITY PROVIDERS.—An Organization
7 offering an ESRD Integrated Care Model
8 may develop and implement performance-
9 based incentives for providers of services
10 and suppliers to promote delivery of high
11 quality and efficient care. Such incentives
12 shall be based on clinical measures and
13 non-clinical measures, such as with respect
14 to notification of patient discharge from a
15 hospital, patient education (such as with
16 respect to treatment options, including
17 chronic kidney disease maintenance, and
18 nutrition), and the interoperability of elec-
19 tronic health records developed by an Or-
20 ganization according to requirements and
21 standards specified by the Secretary pursu-
22 ant to subparagraph (C).

23 “(iv) APPLICATION OF MEDICARE AD-
24 VANTAGE REQUIREMENT WITH RESPECT
25 TO MEDICARE SERVICES FURNISHED BY

1 OUT-OF-NETWORK PROVIDERS AND SUP-
2 PLIERS.—

3 “(I) IN GENERAL.—Section
4 1852(k)(1) (relating to limitations on
5 balance billing against MA organiza-
6 tions for noncontract physicians and
7 other entities with respect to services
8 covered under this title) shall apply to
9 Organizations, Program-eligible bene-
10 ficiaries enrolled in such Organiza-
11 tions, and physicians and other enti-
12 ties that do not have a contract or
13 other agreement with the Organiza-
14 tion establishing payment amounts for
15 services furnished to such a bene-
16 ficiary in the same manner as such
17 section applies to MA organizations,
18 individuals enrolled with such organi-
19 zations, and physicians and other en-
20 tities referred to in such section.

21 “(II) REFERENCE FOR ADDI-
22 TIONAL PROVISION.—For the provi-
23 sion relating to limitations on balance
24 billing against Organizations for serv-
25 ices covered under this title furnished

1 by noncontract providers of services
2 and suppliers, see section
3 1866(a)(1)(O).

4 “(C) QUALITY AND REPORTING REQUIRE-
5 MENTS.—

6 “(i) CLINICAL MEASURES.—Under the
7 Program, the Secretary shall—

8 “(I) require each participating
9 Organization to submit to the Sec-
10 retary data on clinical measures con-
11 sistent with those measures submitted
12 by organizations participating in the
13 Comprehensive ESRD Care Initiative
14 operated by the Center for Medicare
15 and Medicaid Innovation as of Octo-
16 ber 1, 2016, to assess the quality of
17 care provided;

18 “(II) establish requirements for
19 participating Organizations to report
20 to the Secretary, in a form and man-
21 ner specified by the Secretary, infor-
22 mation on such measures; and

23 “(III) establish quality perform-
24 ance standards on such measures to
25 assess the quality of care.

1 “(ii) REQUIREMENT FOR STAKE-
2 HOLDER INPUT.—In developing require-
3 ments and standards under subclauses (II)
4 and (III) of clause (i), the Secretary shall
5 request and consider input from a stake-
6 holder board, at least one nephrologist,
7 other suppliers and providers of services,
8 renal dialysis facilities, and beneficiary ad-
9 vocates.

10 “(iii) ADDITIONAL ASSESSMENTS AND
11 REPORTING REQUIREMENTS.—The Sec-
12 retary shall assess the extent to which an
13 Organization delivers integrated and pa-
14 tient-centered care through analysis of in-
15 formation obtained from Program-eligible
16 beneficiaries enrolled in the Organization
17 through surveys, such as the In-Center
18 Hemodialysis Consumer Assessment of
19 Healthcare Providers and Systems.

20 “(D) REQUIREMENTS FOR ESRD INTE-
21 GRATED CARE STRATEGY.—

22 “(i) IN GENERAL.—An Organization
23 seeking a contract under this section to
24 offer one or more ESRD Integrated Care
25 Models must develop and submit for the

1 Secretary’s approval, subject to clauses (ii)
2 and (iii), an ESRD Integrated Care Strat-
3 egy.

4 “(ii) ESRD INTEGRATED CARE
5 STRATEGY.—In assessing an ESRD Inte-
6 grated Care Strategy under clause (i), the
7 Secretary shall consider the extent to
8 which the Strategy includes elements, such
9 as the following:

10 “(I) Interdisciplinary care teams
11 led by at least one nephrologist, and
12 comprised of registered nurses, social
13 workers, renal dialysis facility man-
14 agers, and other representatives from
15 alternative settings described in sub-
16 clause (VIII).

17 “(II) A decision process for care
18 plans and care management that in-
19 cludes the nephrologist and other
20 practitioners responsible for direct de-
21 livery of care to Program-eligible
22 beneficiaries enrolled in the Organiza-
23 tion involved.

24 “(III) Health risk and other as-
25 sessments to determine the physical,

1 psychosocial, nutrition, language, cul-
2 tural, and other needs of Program-eli-
3 gible beneficiaries enrolled in the Or-
4 ganization involved.

5 “(IV) Development and at least
6 annual updating of individualized care
7 plans that incorporate at least the
8 medical, social, and functional needs,
9 preferences, and care goals of Pro-
10 gram-eligible beneficiaries enrolled in
11 the Organization.

12 “(V) Coordination and delivery of
13 non-clinical services, such as transpor-
14 tation, aimed at improving the adher-
15 ence of Program-eligible beneficiaries
16 enrolled in the Organization with care
17 recommendations.

18 “(VI) Services, such as trans-
19 plant evaluation, palliative care, eval-
20 uation for hospice eligibility, and vas-
21 cular access care.

22 “(VII) In the case of an indi-
23 vidual who, while enrolled in the Or-
24 ganization, receives confirmation that
25 a kidney transplant is imminent, the

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

6 “(VIII) 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 “(IX) Use of patient reminder
16 systems.

17 “(X) Education programs for pa-
18 tients, families, and caregivers.

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

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

1 “(XIII) Co-location of providers
2 and services.

3 “(XIV) Use of a demonstrated
4 capacity to share electronic health
5 record information across sites of
6 care.

7 “(XV) 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 “(XVI) Defined protocols to fa-
14 cilitate the transition of pediatric pa-
15 tients into adult end stage renal dis-
16 ease care, developed in conjunction
17 with the pediatric nephrology commu-
18 nity.

19 “(XVII) Other services, strate-
20 gies, and approaches identified by the
21 Organization to improve care coordi-
22 nation and delivery.

23 “(iii) REQUIREMENTS.—The Sec-
24 retary may not approve an ESRD Inte-
25 grated Care Strategy of an Organization

1 unless under such Strategy the Organiza-
2 tion—

3 “(I) provides services to Pro-
4 gram-eligible beneficiaries enrolled in
5 the Organization through a com-
6 prehensive, multidisciplinary health
7 and social services delivery system
8 which integrates acute and long-term
9 care services pursuant to regulations;

10 “(II) specifies the covered items
11 and services that will not be provided
12 directly by the Organization, and to
13 arrange for delivery of those items
14 and services through contracts meet-
15 ing the requirements of regulations;
16 and

17 “(III) establishes a governing
18 body that—

19 “(aa) consists of representa-
20 tion from each eligible partici-
21 pating provider of such Organiza-
22 tion;

23 “(bb) includes at least one
24 nephrologist who may be affili-
25 ated with a participating provider

1 in the preferred network, at least
2 one nephrologist in the open net-
3 work, and at least one beneficiary
4 advocate; and

5 “(cc) has responsibility for
6 the oversight of the activities of
7 the Organization.

8 “(3) REQUIREMENT FOR CAPITAL RESERVES.—

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

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

22 “(i) is licensed as a risk-bearing entity
23 or deemed by a State as able to bear risk;
24 and

1 “(ii) chooses to bear risk as a condi-
2 tion of partnership in such Organization.

3 “(4) BENEFICIARY PROTECTIONS.—

4 “(A) SEAMLESS ACCESS TO CARE.—The
5 Secretary shall establish processes and take
6 steps as necessary, including educating Medi-
7 care-certified providers and suppliers about the
8 Program, to ensure that Program-eligible bene-
9 ficiaries assigned into an open network model
10 or who elect into a preferred network model of-
11 fered by an Organization experience no interrup-
12 tion of access to Medicare-certified providers or
13 suppliers furnishing items or services to such
14 beneficiary immediately before such assignment
15 or election and for purposes of receipt of such
16 items or services. Assignment into an open net-
17 work model or election into a preferred network
18 model under the Program shall in no way be
19 construed as affecting a Program-eligible bene-
20 ficiary’s ability to receive covered benefits from
21 any Medicare-certified provider or supplier as
22 described in subsection (b)(2)(A).

23 “(B) CONTINUITY OF CARE.—To provide
24 for continuity of care, each contract entered
25 into with an Organization under this section

1 shall provide for a transition period during
2 which a Program-eligible beneficiary who is
3 first enrolled in the Organization or who elects
4 to opt out of the Program or otherwise disenroll
5 from the Organization maintains access to eligi-
6 ble participating providers furnishing items or
7 services to such beneficiary immediately before
8 such enrollment or election for purposes of re-
9 ceipt of such items or services. Payment for
10 such items or services covered under this title
11 furnished to such Program-eligible beneficiary
12 during such transition period shall be made in
13 accordance with this title and in such amounts
14 as would otherwise be determined for such
15 items and services provided to such a bene-
16 ficiary not enrolled under the Program.

17 “(C) ANTIDISCRIMINATION.—Each con-
18 tract entered into with an Organization under
19 this section shall provide that each eligible par-
20 ticipating provider of such Organization may
21 not deny, limit, or condition the furnishing of
22 services, or affect the quality of services fur-
23 nished, under this title to Program-eligible
24 beneficiaries on whether or not such a bene-
25 ficiary is enrolled with the Organization.

1 “(D) QUALITY ASSURANCE; PATIENT
2 SAFEGUARDS.—Each contract entered into with
3 an Organization under this section shall require
4 that such Organization have in effect at a min-
5 imum—

6 “(i) a written plan of quality assur-
7 ance and improvement, and procedures im-
8 plementing such plan, in accordance with
9 regulations; and

10 “(ii) written safeguards of the rights
11 of Program-eligible beneficiaries enrolled in
12 the Organization (including a patient bill
13 of rights and procedures for grievances
14 and appeals) in accordance with regula-
15 tions and with other requirements of this
16 title and Federal and State law that are
17 designed for the protection of patients.

18 “(E) OVERSIGHT.—The Secretary shall
19 oversee the marketing and assignment practices
20 of each Organization entering into a contract
21 under this section as part of the approval and
22 renewal processes of Organizations under this
23 section.

24 “(5) NON-APPLICATION OF CERTAIN PROVI-
25 SIONS OF LAW.—For purposes of sections 162(m)(6)

1 and 414(m) of the Internal Revenue Code of 1986
2 and section 9010 of the Patient Protection and Af-
3 fordable Care Act (26 U.S.C. 4001 note prec.), in
4 the case of an eligible participating provider that es-
5 tablishes an Organization or that enters into a part-
6 nership, ownership, or co-ownership agreement to es-
7 tablish an Organization, or an Organization with a
8 contract under this section, risk-based payments in
9 exchange for providing medical care shall not be con-
10 sidered premiums for health insurance coverage.

11 “(6) TREATMENT AS MEDICARE ADVANCED AL-
12 TERNATIVE PAYMENT MODEL.—Alternative care de-
13 livery models under the Program shall be treated
14 under this title as an advanced alternative payment
15 model.

16 “(c) PROGRAM OPERATION AND SCOPE.—

17 “(1) IN GENERAL.—Not later than one year
18 after the date of enactment of this section, the Sec-
19 retary shall establish a process through which an
20 Organization can apply to offer one or more ESRD
21 Integrated Care Models. Such application shall in-
22 clude information on at least the following:

23 “(A) The estimated average revenue
24 amount described in subsection (b)(2)(A)(ii)(II)

1 for the Organization to deliver benefits de-
2 scribed in subsection (b)(2)(A).

3 “(B) Any benefits offered by the Organiza-
4 tion beyond those described in such subsection.

5 “(C) A listing of network providers of serv-
6 ices and supplier.

7 “(D) Information on the expertise of net-
8 work providers of services and suppliers in serv-
9 ing ESRD patients.

10 “(E) A description of the ESRD Inte-
11 grated Care Strategy of the Organization de-
12 scribed in subsection (b)(2)(D).

13 “(2) PROGRAM INITIATION.—The Secretary
14 shall initiate the Program such that Organizations
15 begin serving Program-eligible beneficiaries not later
16 than January 1, 2018.

17 “(3) CONTRACT AWARD AND PERIOD.—The
18 Secretary shall enter into contracts for an initial pe-
19 riod of not less than 5 years with all Organizations
20 that meet Program requirements.

21 “(4) ALLOWANCE FOR LARGER SERVICE AREAS
22 AND EXPANSION OF SERVICE AREAS.—Organizations
23 shall demonstrate in their application that the pro-
24 posed service area has the capacity to serve Pro-
25 gram-eligible beneficiaries through an adequate pro-

1 vider network and is reflective of the communities in
2 which beneficiaries live, work, and obtain health care
3 services.

4 “(5) CONTRACT TERMINATION AND SUSPEN-
5 SION.—

6 “(A) IN GENERAL.—The Secretary may
7 terminate a contract with an Organization
8 under this section if the Secretary determines
9 that an Organization has failed to meet quality
10 requirements described in subsection (b) or
11 (e)(2)(C)(iii) or violates other terms of the con-
12 tract.

13 “(B) INSUFFICIENT BENEFICIARY PARTICI-
14 PATION.—The Secretary shall, in the case of an
15 Organization with a contract under this section
16 with respect to which, for any period of at least
17 30 consecutive days during a year for which
18 such contract applies, fewer than 50 percent of
19 the total number of Program-eligible bene-
20 ficiaries served by the Organization receive ben-
21 efits through the Organization under this sec-
22 tion—

23 “(i) suspend such contract for the re-
24 mainder of such year; and

1 “(ii) provide for the Organization to
2 return any prospective payments made to
3 the Organization under this section for
4 items and services not provided pursuant
5 to clause (i).

6 “(C) REMEDY AND APPEALS PROCESS.—
7 Prior to the Secretary terminating or sus-
8 pending a contract with an Organization under
9 this section, the Secretary shall afford such Or-
10 ganization sufficient opportunity to remedy any
11 contract violations and appeal a contract termi-
12 nation.

13 “(D) PROGRAM-ELIGIBLE BENEFICIARY
14 NOTICE AT TIME OF CONTRACT TERMI-
15 NATION.—Each contract under this section with
16 an Organization shall require the Organization
17 to provide (and pay for) written notice in ad-
18 vance of the contract’s termination or suspen-
19 sion, as well as a description of alternatives for
20 obtaining benefits under this title, to each Pro-
21 gram-eligible beneficiary assigned to or who
22 elected to receive benefits through the Organi-
23 zation under this section.

24 “(6) PROGRAM EXPANSION.—The Secretary
25 may, through rulemaking, expand the duration and

1 scope of the Program under this section, to the ex-
2 tent determined appropriate by the Secretary, if—

3 “(A) the Secretary determines that such
4 expansion is expected to—

5 “(i) reduce spending under this title
6 without reducing the quality of patient
7 care; or

8 “(ii) improve the quality of patient
9 care without increasing spending under
10 this title;

11 “(B) the Chief Actuary of the Centers for
12 Medicare & Medicaid Services certifies that
13 such expansion would reduce (or would not re-
14 sult in any increase in) net program spending
15 under this title; and

16 “(C) the Secretary determines that such
17 expansion would not deny or limit the coverage
18 or provision of benefits under this title for ap-
19 plicable individuals.

20 “(7) STUDY.—The Secretary shall conduct a
21 study on an appropriate payment adjustor under the
22 Program to ensure there are not disincentives in
23 under the payment method under the Program from
24 providing proper transplant evaluations.

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

5 “(e) PROGRAM-ELIGIBLE BENEFICIARIES ASSIGNED
6 INTO AN ESRD INTEGRATED CARE ORGANIZATION OPEN
7 NETWORK MODEL.—

8 “(1) ASSIGNMENT.—

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

19 “(B) PROGRAM-ELIGIBLE BENEFICIARY
20 NOTIFICATION OF ASSIGNMENT.—

21 “(i) IN GENERAL.—Upon assignment
22 of a Program-eligible beneficiary to an Or-
23 ganization, the Secretary shall provide to
24 the Organization written notification of
25 such assignment of such Program-eligible

1 beneficiary and not later than 15 business
2 days after the date of receipt of such noti-
3 fication, the Organization shall provide
4 written notice to the Program-eligible ben-
5 eficiary—

6 “(I) of such assignment; and

7 “(II) including education regard-
8 ing the importance of transplantation
9 as the best health outcome, as well as
10 the minimum health requirements for
11 transplant eligibility before and dur-
12 ing dialysis treatment.

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

21 “(I) opt out of the Program;

22 “(II) make a one-time change of
23 assignment into an open network
24 model offered by a different Organiza-
25 tion; or

1 “(III) elect a preferred network
2 model offered by the same or different
3 Organization.

4 “(C) ADDITIONAL OPT-IN POPULATION IN
5 CASE OF BENEFICIARY RELOCATION OR
6 CHOICE.—An individual who, without applica-
7 tion of clause (iv) of subsection (a)(2)(C),
8 would be treated as a Program-eligible bene-
9 ficiary, may elect to enroll in an Organization
10 under the Program under this section if such
11 individual agrees to receive renal dialysis serv-
12 ices primarily from a facility that participates
13 in such Organization. For purposes of this sec-
14 tion (other than subparagraphs (A) and (B) of
15 this paragraph, paragraph (2), and subsection
16 (d)), an individual making an election pursuant
17 to the previous sentence shall be treated as a
18 Program-eligible beneficiary.

19 “(D) DEEMED RE-ENROLLMENT.—A Pro-
20 gram-eligible beneficiary assigned under this
21 paragraph to an ESRD Integrated Care Model
22 offered by an Organization with respect to a
23 year is deemed, unless the individual elects oth-
24 erwise under this paragraph, to have elected to

1 continue such assignment with respect to the
2 subsequent year.

3 “(E) ADDITIONAL OPPORTUNITY TO OPT
4 OUT OR ELECT DIFFERENT MODEL OR ORGANI-
5 ZATION.—On the date that is one year after the
6 effective date of the initial assignment of a Pro-
7 gram-eligible beneficiary to an open network
8 model offered by an Organization (and annually
9 thereafter), a Program-eligible beneficiary shall
10 be given the opportunity to—

11 “(i) opt out of the Program;

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

15 “(iii) elect a preferred network model
16 offered by the same or different Organiza-
17 tion.

18 “(F) CHANGE IN PRINCIPAL DIAGNOSIS
19 OPT OUT.—In addition to any other period dur-
20 ing which a Program-eligible beneficiary may,
21 pursuant to this paragraph, opt out of the Pro-
22 gram, in the case of a Program-eligible bene-
23 ficiary who, after assignment under this para-
24 graph, is diagnosed with a principal diagnosis
25 (as defined by the Secretary) other than end-

1 stage renal disease, such individual shall be
2 given the opportunity to opt out of the Program
3 during such period as specified by the Sec-
4 retary.

5 “(G) SPECIAL ELECTION PERIODS.—The
6 Secretary shall offer Program-eligible bene-
7 ficiaries special election periods consistent with
8 those described in section 1851(e)(4).

9 “(2) PROGRAM-ELIGIBLE BENEFICIARY NOTIFI-
10 CATION.—

11 “(A) IN GENERAL.—The Secretary shall
12 notify Program-eligible beneficiaries about the
13 Program under this section and provide them
14 with information about receiving benefits under
15 this title through an Organization.

16 “(B) REQUIREMENTS.—Notwithstanding
17 any other provision of law, subject to subpara-
18 graph (C), such notification shall allow for eligi-
19 ble participating providers that are part of an
20 Organization to—

21 “(i) inform Program-eligible bene-
22 ficiaries about the Program;

23 “(ii) distribute Program materials to
24 Program-eligible beneficiaries; and

1 “(iii) assist Program-eligible bene-
2 ficiaries in assessing the options of such
3 beneficiaries under the Program.

4 “(C) LIMITATION ON UNSOLICITED MAR-
5 KETING.—

6 “(i) IN GENERAL.—Under the Pro-
7 gram, an eligible participating provider
8 may not provide marketing information or
9 materials, including information, materials,
10 and assistance described in subparagraph
11 (B), to a Program-eligible beneficiary un-
12 less the Program-eligible beneficiary re-
13 quests such marketing information or ma-
14 terials.

15 “(ii) EXCEPTION FOR PROVIDERS
16 TREATING BENEFICIARIES.—An eligible
17 participating provider that is part of an
18 Organization may provide information, ma-
19 terials, and assistance described in sub-
20 paragraph (B) to a Program-eligible bene-
21 ficiary, without prior request of such bene-
22 ficiary, if such beneficiary is receiving
23 renal dialysis services from such provider.

24 “(iii) PARITY IN MARKETING.—In any
25 case that an Organization participates in

1 any form of marketing, such form of mar-
2 keting shall be the same for all Program-
3 eligible beneficiaries to which, pursuant to
4 (ii), the Organization may provide informa-
5 tion, materials, and assistance described in
6 such clause.

7 “(3) PROGRAM-ELIGIBLE BENEFICIARY APPEAL
8 RIGHTS.—Program-eligible beneficiaries enrolled in
9 an Organization shall have the same right to appeal
10 any denial of benefits under this title as such a Pro-
11 gram-eligible beneficiary would have under this title
12 if such Program-eligible beneficiary were not so en-
13 rolled.

14 “(f) PAYMENT.—

15 “(1) IN GENERAL.—For each Program-eligible
16 beneficiary receiving care through an Organization,
17 the Secretary shall make a monthly capitated pay-
18 ment in accordance with payment rates that would
19 be determined under section 1853(a)(1)(H), as ad-
20 justed pursuant to paragraph (2).

21 “(2) APPLICATION OF HEALTH STATUS RISK
22 ADJUSTMENT METHODOLOGY.—The Secretary shall
23 adjust the payment amount to an Organization
24 under this subsection in the same manner in which

1 the payment amount to a Medicare Advantage plan
2 is adjusted under section 1853(a)(1)(C).

3 “(3) TREATMENT OF KIDNEY ACQUISITION
4 COSTS.—

5 “(A) EXCLUDING COSTS FOR KIDNEY AC-
6 QUISSIONS FROM MA BENCHMARK.—The Sec-
7 retary shall adjust the payment amount to an
8 Organization to exclude from such payment
9 amount the Secretary’s estimate of the stand-
10 ardized costs for payments for organ acquisi-
11 tions for kidney transplants in the area involved
12 for the year.

13 “(B) FFS CONVERGE OF KIDNEY ACQUISSI-
14 TIONS.—An Organization shall provide all bene-
15 fits described in subclause (I) of subsection
16 (b)(2)(A)(i), except for kidney acquisition costs.
17 Payment for kidney acquisition costs covered
18 under this title furnished to a Program-eligible
19 beneficiary shall be made in accordance with
20 this title and in such amounts as would other-
21 wise be made and determined for such items
22 and services provided to such a beneficiary not
23 enrolled under the Program.

24 “(4) PAYMENT FOR PART D BENEFITS.—In the
25 case where an Organization elects to offer part D

1 prescription drug coverage under the Program under
2 this section, payments to the Organization for such
3 benefits provided to Program-eligible beneficiaries by
4 the Organization shall be made in the same manner
5 and amounts as those payments would be made in
6 the case of an organization with a contract under
7 such part.

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

19 “(6) AFFIRMATION OF STATE OBLIGATIONS TO
20 PAY PREMIUM AND COST-SHARING AMOUNTS.—

21 “(A) IN GENERAL.—A State shall continue
22 to make medical assistance under the State
23 plan under title XIX available in the amount
24 described in subparagraph (B) for the duration
25 of the Program for cost-sharing (as defined in

1 section 1905(p)(3)) under this title for qualified
2 medicare beneficiaries described in section
3 1905(p)(1) and other individuals who are Pro-
4 gram-eligible beneficiaries enrolled in an Orga-
5 nization and entitled to medical assistance for
6 premiums and such cost-sharing under the
7 State plan under title XIX.

8 “(B) AMOUNTS MADE AVAILABLE FOR
9 COST-SHARING.—For purposes of subparagraph
10 (A):

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

22 “(ii) AMOUNTS IN THE CASE OF A
23 STATE THAT INCREASES PAYMENTS FOR
24 COST-SHARING.—If a State increases the
25 amount of medical assistance made avail-

1 able under the State plan under title XIX
2 for cost-sharing described in subparagraph
3 (A) after such date, such increased
4 amounts shall be made available under
5 subparagraph (A) for the remaining dura-
6 tion of the Program.

7 “(g) WAIVER AUTHORITY.—

8 “(1) IN GENERAL.—In order to carry out the
9 Program under this section, the Secretary shall
10 waive those requirements waived under section 1899
11 and may waive such additional requirements con-
12 sistent with those waived under programs adminis-
13 tered through the Center for Medicare and Medicaid
14 Innovation as may be necessary.

15 “(2) NOTICE OF WAIVERS.—Not later than 3
16 months after the date of enactment of this section,
17 the Secretary shall publish a notice of waivers that
18 will apply in connection with the Program. The no-
19 tice shall include the specific conditions that an Or-
20 ganization must meet to qualify for each waiver, and
21 commentary explaining the waiver requirements.

22 “(h) REPORT.—Not later than December 31, 2024,
23 the Medicare Payment Advisory Commission shall submit
24 to Congress an interim report on the Program.”.

1 (b) CONFORMING AMENDMENT RELATING TO BAL-
2 ANCED BILLING.—Section 1866(a)(1)(O) of the Social Se-
3 curity Act (42 U.S.C. 1395cc(a)(1)(O)) is amended—

4 (1) by inserting “with an ESRD Integrated
5 Care Organization under section 1866F,” after
6 “with a PACE provider under section 1894 or
7 1934,”;

8 (2) by inserting “or ESRD Integrated Care Or-
9 ganization” after “in the case of a PACE provider”;

10 (3) by striking “or PACE program eligible indi-
11 viduals enrolled with the PACE provider” and in-
12 serting “, Program-eligible beneficiaries enrolled in
13 the ESRD Integrated Care Organization, or PACE
14 program eligible individuals enrolled with the PACE
15 provider”; and

16 (4) by inserting “(or in the case of a Program-
17 eligible beneficiary enrolled in the ESRD Integrated
18 Care Organization, the amounts that would be made
19 in accordance with payment rates that would be de-
20 termined under section 1853(a)(1)(H))” after “the
21 amounts that would be made”.

22 (c) EXTENSION OF GUARANTEED ISSUE RIGHTS
23 UNDER MEDIGAP.—

24 (1) IN GENERAL.—Section 1882(s)(3)(B) of the
25 Social Security Act (42 U.S.C. 1395ss(s)(3)(B)) is

1 amended by adding at the end the following new
2 clause:

3 “(vii) The individual is participating
4 in the demonstration program established
5 under section 1866F, regardless of the du-
6 ration of the individual’s participation in
7 the program and regardless of any pre-
8 vious enrollment in, or disenrollment from,
9 a medicare supplemental policy under this
10 section.”.

11 (2) NOTIFICATION.—The Secretary of Health
12 and Human Services shall develop a process to no-
13 tify (and shall notify) individuals described in clause
14 (vii) of section 1882(s)(3)(B) of the Social Security
15 Act (42 U.S.C. 1395ss(s)(3)(B)), as added by para-
16 graph (1), of their guaranteed issue rights under
17 such section.

○