

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.

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## 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 bene-  
2           ficiary for a year exceeds the revenue  
3           amount described in subclause (II)  
4           with respect to the Program-eligible  
5           beneficiary for the year.

6           “(II) REVENUE AMOUNT DE-  
7           SCRIBED.—The revenue 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 Organiza-  
13          tion’s estimated average revenue re-  
14          quirements, including administrative  
15          costs and return on investment, for  
16          the Organization to provide the bene-  
17          fits described in clause (i) under the  
18          Model for the Program-eligible bene-  
19          ficiary for the year.

20          “(III) PAYMENT AMOUNT DE-  
21          SCRIBED.—The payment amount de-  
22          scribed in this subclause, with respect  
23          to an Organization offering an ESRD  
24          Integrated Care Model and a Pro-  
25          gram-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-eli-  
17 gible 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 pro-  
7 cess 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-

1 vance of the contract’s termination or suspen-  
2 sion, as well as a description of alternatives for  
3 obtaining benefits under this title, to each Pro-  
4 gram-eligible beneficiary assigned to or who  
5 elected to receive benefits through the Organi-  
6 zation under this section.

7 “(6) PROGRAM EXPANSION.—The Secretary  
8 may, through rulemaking, expand the duration and  
9 scope of the Program under this section, to the ex-  
10 tent determined appropriate by the Secretary, if—

11 “(A) the Secretary determines that such  
12 expansion is expected to—

13 “(i) reduce spending under this title  
14 without reducing the quality of patient  
15 care; or

16 “(ii) improve the quality of patient  
17 care without increasing spending under  
18 this title;

19 “(B) the Chief Actuary of the Centers for  
20 Medicare & Medicaid Services certifies that  
21 such expansion would reduce (or would not re-  
22 sult in any increase in) net program spending  
23 under this title; and

24 “(C) the Secretary determines that such  
25 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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