

114TH CONGRESS
2D SESSION

S. 3090

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 SENATE OF THE UNITED STATES

JUNE 23, 2016

Mr. HELLER (for himself and Mr. NELSON) introduced the following bill;
which was read twice and referred to the Committee on Finance

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 PATIENT
5 Demonstration Act of 2016” or the “Patient Access To
6 Integrated-care, Empowerment, Nephrologists and Treat-
7 ment Demonstration Act of 2016”.

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

4 Title XVIII of the Social Security Act is amended by
 5 inserting after section 1866E the following new section:

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

9 “SEC. 1866F. (a) ESTABLISHMENT.—

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

24 “(2) DEFINITIONS.—In this section:

“(A) ELIGIBLE PARTICIPATING PROVIDER.—The term ‘eligible participating provider’ means the following:

“(i) A facility certified as a renal dialysis facility under this title.

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

“(iii) A nephrologist or nephrology practice.

“(iv) Any other physician group practice or a group of affiliated physicians.

“(B) ELIGIBLE PARTICIPATING PARTNER.—The term ‘eligible participating partner’ means the following:

“(i) A Medicare Advantage plan described in section 1851(a)(2) or a Medicare Advantage organization offering such a plan.

“(ii) A prescription drug plan (as defined in section 1860D–41(a)(14)).

“(iii) A medicaid managed care organization (as defined in section 1903(m)).

“(iv) An entity able to bear risk as deemed by a State.

1 “(v) A third party-administrator orga-
2 nization.

3 “(C) PROGRAM-ELIGIBLE BENEFICIARY.—
4 The term ‘Program-eligible beneficiary’ means,
5 with respect to an Organization offering an
6 ESRD Integrated Care Model, an individual en-
7 titled to benefits under part A and enrolled
8 under part B who—

9 “(i) is 18 years of age or older;

10 “(ii) is identified by the Secretary or
11 the Organization as receiving renal dialysis
12 services under the original medicare fee-
13 for-service program under parts A and B;

14 “(iii) resides in the service area of
15 such Organization;

16 “(iv) receives renal dialysis services
17 primarily from a facility that participates
18 in such Organization; and

19 “(v) has not received a successful kid-
20 ney transplant.

21 “(b) ESRD INTEGRATED CARE ORGANIZATION ELI-
22 GIBILITY REQUIREMENTS.—

23 “(1) ORGANIZATIONS.—

24 “(A) IN GENERAL.—One or more eligible
25 participating providers may establish an Orga-

nization or may enter into, subject to subparagraph (B), one or more partnership, ownership, or co-ownership agreements with one or more eligible participating partners to establish an Organization.

“(B) LIMITATION ON NUMBER OF AGREEMENTS.—The Secretary may specify a limitation on the number of Organizations in which an eligible participating partner may participate under agreements described in subparagraph (A).

“(2) ESRD INTEGRATED CARE MODEL.—

“(A) BENEFITS REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause (iii), an Organization shall offer at least one ESRD Integrated Care Model that is an open network model (as described in subparagraph (B)(i)) in each of its service areas and may offer one or more ESRD Integrated Care Models that is a preferred network model (as described in subparagraph (B)(ii)) in each of its service areas. For purposes of this section an ESRD Integrated Care Model (in this section referred to as the ‘Model’)—

1 “(I) shall cover all benefits under
 2 parts A and B (other than hospice
 3 care) and include benefits for transi-
 4 tion (including education) into pallia-
 5 tive care; and

6 “(II) may, through a partnership
 7 or other agreement with an MA-PD
 8 plan under part C or prescription
 9 drug plan under part D, cover all pre-
 10 scription drug benefits under such
 11 part D.

12 “(ii) TREATMENT OF SAVINGS.—

13 “(I) IN GENERAL.—Any Organi-
 14 zation offering an ESRD Integrated
 15 Care Model shall provide for the re-
 16 turn under subclause (IV) to a Pro-
 17 gram-eligible beneficiary enrolled in
 18 the Organization of the amount, if
 19 any, by which the payment amount
 20 described in subclause (III) with re-
 21 spect to the Program-eligible bene-
 22 ficiary for a year exceeds the revenue
 23 amount described in subclause (II)
 24 with respect to the Program-eligible
 25 beneficiary for the year.

1 “(II) REVENUE AMOUNT DE-
2 SCRIBED.—The revenue amount de-
3 scribed in this subclause, with respect
4 to an Organization offering an ESRD
5 Integrated Care Model and a Pro-
6 gram-eligible beneficiary enrolled in
7 such Organization, is the Organiza-
8 tion’s estimated average revenue re-
9 quirements, including administrative
10 costs and return on investment, for
11 the Organization to provide the bene-
12 fits described in clause (i) under the
13 Model for the Program-eligible bene-
14 ficiary for the year.

15 “(III) PAYMENT AMOUNT DE-
16 SCRIBED.—The payment amount de-
17 scribed in this subclause, with respect
18 to an Organization offering an ESRD
19 Integrated Care Model and a Pro-
20 gram-eligible beneficiary enrolled in
21 such Organization, is the payment
22 amount to the Organization under
23 subsection (f)(1) made with respect to
24 the Program-eligible beneficiary for
25 the year.

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

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

“(I) may be responsible for providing, or arranging for the provision of, all benefits (other than long-term services and supports) for which the Program-eligible beneficiary is eligible for under the State Medicaid program under title XIX in which the Program-eligible beneficiary is enrolled; and

“(II) may elect to provide, or arrange for the provision of, long-term services and supports available to the Program-eligible beneficiary under the State Medicaid program.

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

“(i) OPEN NETWORK MODEL.—Under an ESRD Integrated Care Model offered by an Organization that is an open network model, the Organization shall—

“(I) allow Program-eligible beneficiaries to receive such covered benefits from any provider of services or supplier regardless of whether such

1 provider is within the network assem-
 2 bled under subclause (I);

3 “(II) pay any Medicare-certified
 4 provider or supplier that is not within
 5 the network assembled under sub-
 6 clause (I) for such covered benefits an
 7 amount equal to the amount the pro-
 8 vider or supplier would otherwise re-
 9 ceive under this title; and

10 “(III) not apply any additional
 11 premium or cost sharing requirements
 12 for such covered benefits in addition
 13 to premium or cost sharing require-
 14 ments, respectively, that would be ap-
 15 plicable under part A or part B for
 16 such benefits.

17 “(ii) PREFERRED NETWORK
 18 MODEL.—Under an ESRD Integrated
 19 Care Model offered by an Organization
 20 that is a preferred network model, the Or-
 21 ganization—

22 “(I) shall assemble a network of
 23 providers of services and suppliers
 24 identified by the Organization and
 25 confirmed by the Secretary as includ-

1 ing providers of services and suppliers
2 with significant expertise in caring for
3 individuals with end-stage renal dis-
4 ease through which Program-eligible
5 beneficiaries shall receive covered ben-
6 efits as described in subparagraph (A)
7 that are required to be covered under
8 the Model;

9 “(II) may apply premium and
10 cost-sharing requirements, in addition
11 to premium or cost-sharing require-
12 ments, respectively, that would be ap-
13 plicable under part B, for benefits in
14 addition to those required to be cov-
15 ered under the Model; and

16 “(III) shall apply network stand-
17 ards as defined by the Secretary.

18 “(iii) PROMOTING ACCESS TO HIGH
19 QUALITY PROVIDERS.—An Organization
20 offering an ESRD Integrated Care Model
21 may develop and implement performance-
22 based incentives for providers of services
23 and suppliers to promote delivery of high
24 quality and efficient care. Such incentives
25 shall be based on clinical measures and

1 non-clinical measures, such as with respect
2 to notification of patient discharge from a
3 hospital, patient education (such as with
4 respect to treatment options and nutri-
5 tion), and the interoperability of electronic
6 health records developed by an Organiza-
7 tion according to requirements and stand-
8 ards specified by the Secretary pursuant to
9 subparagraph (C).

10 “(C) QUALITY AND REPORTING REQUIRE-
11 MENTS.—

12 “(i) CLINICAL MEASURES.—Under the
13 Program, the Secretary shall—

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

24 “(II) establish requirements for
25 participating Organizations to report

1 to the Secretary, in a form and man-
2 ner specified by the Secretary, infor-
3 mation on such measures; and

4 “(III) establish quality perform-
5 ance standards on such measures to
6 assess the quality of care.

7 “(ii) REQUIREMENT FOR STAKE-
8 HOLDER INPUT.—In developing require-
9 ments and standards under subclauses (II)
10 and (III) of clause (i), the Secretary shall
11 request and consider input from a stake-
12 holder board, at least one nephrologist,
13 other suppliers and providers of services,
14 renal dialysis facilities, and beneficiary ad-
15 vocates, and respond in writing to such
16 input.

17 “(iii) ADDITIONAL ASSESSMENTS AND
18 REPORTING REQUIREMENTS.—The Sec-
19 retary shall assess the extent to which an
20 Organization delivers integrated and pa-
21 tient-centered care through analysis of in-
22 formation obtained from Program-eligible
23 beneficiaries enrolled in the Organization
24 through surveys, such as the In-Center

1 Hemodialysis Consumer Assessment of
2 Healthcare Providers and Systems.

3 “(D) REQUIREMENTS FOR ESRD INTE-
4 GRATED CARE STRATEGY.—

5 “(i) IN GENERAL.—An Organization
6 seeking a contract under this section to
7 offer one or more ESRD Integrated Care
8 Models must develop and submit for the
9 Secretary’s approval, subject to clause (ii),
10 an ESRD Integrated Care Strategy.

11 “(ii) ESRD INTEGRATED CARE
12 STRATEGY.—In assessing an ESRD Inte-
13 grated Care Strategy under clause (i), the
14 Secretary shall consider the extent to
15 which the Strategy includes elements, such
16 as the following:

17 “(I) Interdisciplinary care teams
18 led by at least one nephrologist, and
19 comprised of registered nurses, social
20 workers, renal dialysis facility man-
21 agers, and other representatives from
22 alternative settings described in sub-
23 clause (VI).

24 “(II) 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 “(III) 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 “(IV) Coordination and delivery
13 of non-clinical services, such as trans-
14 portation, aimed at improving the ad-
15 herence of Program-eligible bene-
16 ficiaries enrolled in the Organization
17 with care recommendations.

18 “(V) Services, such as transplant
19 evaluation and vascular access care.

20 “(VI) In the case of an individ-
21 uals who, while enrolled in the Orga-
22 nization, receives confirmation that a
23 kidney transplant is imminent, the
24 provision by an interdisciplinary care
25 team described in subclause (I) of

1 counseling services to such individual
2 on preparation for and potential chal-
3 lenges surrounding such transplant.

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

13 “(VIII) Use of patient reminder
14 systems.

15 “(IX) Education programs for
16 patients, families, and caregivers.

17 “(X) Use of health care advice
18 resources, such as nurse advice lines.

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

23 “(XII) Co-location of providers
24 and services.

1 “(XIII) Use of a demonstrated
2 capacity to share electronic health
3 record information across sites of
4 care.

5 “(XIV) Use of programs to pro-
6 mote better adherence to rec-
7 ommended treatment regimens by in-
8 dividuals, including by addressing bar-
9 riers to access to care by such individ-
10 uals.

11 “(XV) Other services, strategies,
12 and approaches identified by the Or-
13 ganization to improve care coordina-
14 tion and delivery.

15 “(3) DIALYSIS FACILITY OWNERSHIP REQUIRE-
16 MENT.—The Secretary shall enter into contracts
17 under this section only with Organizations that have
18 at least one eligible participating provider with an
19 ownership interest in a renal dialysis facility in the
20 Organization’s service area.

21 “(4) REQUIREMENT FOR CAPITAL RESERVES.—

22 “(A) IN GENERAL.—The Secretary shall
23 enter into contracts under this section only with
24 Organizations that demonstrate sufficient cap-
25 ital reserves, measured as a percentage of

1 capitated payments and consistent with require-
 2 ments established by the State in which the Or-
 3 ganization operates.

4 “(B) ALTERNATIVE MECHANISM TO DEM-
 5 ONSTRATE CAPACITY TO BEAR RISK.—An Orga-
 6 nization shall be considered to meet the require-
 7 ment in subparagraph (A) if the Organization
 8 includes at least one eligible participating pro-
 9 vider or eligible participating partner that is li-
 10 censed as a risk-bearing entity or deemed by a
 11 State as able to bear risk.

12 “(5) NON-APPLICATION OF CERTAIN PROVI-
 13 SIONS OF LAW.—For purposes of sections 162(m)(6)
 14 and 414(m) of the Internal Revenue Code of 1986
 15 and section 9010 of the Patient Protection and Af-
 16 fordable Care Act (26 U.S.C. 4001 note prec.), in
 17 the case of an eligible participating provider that es-
 18 tablishes an Organization or that enters into a part-
 19 nership, ownership, or co-ownership agreement to es-
 20 tablish an Organization, or an Organization with a
 21 contract under this section, risk-based payments in
 22 exchange for providing medical care shall not be con-
 23 sidered premiums for health insurance coverage.

24 “(6) TREATMENT AS MEDICARE ADVANCED AL-
 25 TERNATIVE PAYMENT MODEL.—Alternative care de-

1 livery models under the Program shall be treated
2 under this title as an advanced alternative payment
3 model.

4 “(c) PROGRAM OPERATION AND SCOPE.—

5 “(1) IN GENERAL.—Not later than 6 months
6 after the date of enactment of this section, the Sec-
7 retary shall establish a process through which an
8 Organization can apply to offer one or more ESRD
9 Integrated Care Models. Such application shall in-
10 clude information on at least the following:

11 “(A) The estimated average revenue
12 amount described in subsection (b)(2)(A)(ii)(II)
13 for the Organization to deliver benefits de-
14 scribed in subsection (b)(2)(A).

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

17 “(C) A listing of network providers of serv-
18 ices and supplier.

19 “(D) Information on the expertise of net-
20 work providers of services and suppliers in serv-
21 ing ESRD patients.

22 “(E) A description of the ESRD Inte-
23 grated Care Strategy of the Organization de-
24 scribed in subsection (b)(2)(D).

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

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

9 “(4) PROGRAM EXPANSION.—The Secretary
10 may expand the duration and scope of the Program
11 under this section, to the extent determined appro-
12 priate by the Secretary, if the Secretary determines
13 that such expansion will result in improved quality
14 of care under the Medicare program under this title.

15 “(5) ALLOWANCE FOR LARGER SERVICE AREAS
16 AND EXPANSION OF SERVICE AREAS.—Organizations
17 shall demonstrate in their application that the pro-
18 posed service area has the capacity to serve Pro-
19 gram-eligible beneficiaries through an adequate pro-
20 vider network and is reflective of the communities in
21 which beneficiaries live, work, and obtain health care
22 services.

23 “(6) CONTRACT TERMINATION.—

24 “(A) IN GENERAL.—The Secretary may
25 terminate a contract with an Organization

1 under this section if the Secretary determines
2 that an Organization has failed to meet quality
3 requirements described in subsection (b) or vio-
4 lates other terms of the contract.

5 “(B) REMEDY AND APPEALS PROCESS.—

6 Prior to the Secretary terminating a contract
7 with an Organization under this section, the
8 Secretary shall afford such Organization suffi-
9 cient opportunity to remedy any contract viola-
10 tions and appeal a contract termination.

11 “(C) PROGRAM-ELIGIBLE BENEFICIARY

12 NOTICE AT TIME OF CONTRACT TERMI-
13 NATION.—Each contract under this section with
14 an Organization shall require the Organization
15 to provide (and pay for) written notice in ad-
16 vance of the contract’s termination, as well as
17 a description of alternatives for obtaining bene-
18 fits under this title, to each Program-eligible
19 beneficiary assigned to or who elected to receive
20 benefits through the Organization under this
21 section.

22 “(d) IDENTIFICATION OF PROGRAM-ELIGIBLE BENE-

23 FICIARIES.—The Secretary shall establish a process for
24 the initial and ongoing identification of Program-eligible

1 beneficiaries that provides for the identification of Pro-
 2 gram-eligible beneficiaries by Organizations.

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

6 “(1) ASSIGNMENT.—

7 “(A) IN GENERAL.—Under the Program,
 8 subject to the succeeding provisions of this
 9 paragraph, the Secretary shall, upon the Sec-
 10 retary or an Organization identifying a bene-
 11 ficiary as a Program-eligible beneficiary, assign
 12 such Program-eligible beneficiary to an open
 13 network model offered by an Organization that
 14 includes the dialysis facility at which the Pro-
 15 gram-eligible beneficiary primarily receives
 16 renal dialysis services.

17 “(B) PROGRAM-ELIGIBLE BENEFICIARY
 18 NOTIFICATION OF ASSIGNMENT.—

19 “(i) IN GENERAL.—Upon assignment
 20 of a Program-eligible beneficiary to an Or-
 21 ganization, the Secretary shall provide to
 22 the Organization written notification of
 23 such assignment of such Program-eligible
 24 beneficiary and not later than 15 business
 25 days after the date of receipt of such noti-

1 fication, the Organization shall provide
 2 written notice of such assignment to the
 3 Program-eligible beneficiary.

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

12 “(I) opt out of the Program;

13 “(II) make a one-time change of
 14 assignment into an open network
 15 model offered by a different Organiza-
 16 tion; or

17 “(III) elect a preferred network
 18 model offered by the same or different
 19 Organization.

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

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

3 “(D) 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 “(E) 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 “(F) 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 “(3) PROGRAM-ELIGIBLE BENEFICIARY PRO-
 25 TECTIONS.—Program-eligible beneficiaries enrolled

1 in an Organization shall have the same right to ap-
2 peal any denial of benefits under this title as such
3 a Program-eligible beneficiary would have under this
4 title if such Program-eligible beneficiary were not so
5 enrolled.

6 “(f) PAYMENT.—

7 “(1) IN GENERAL.—For each Program-eligible
8 beneficiary receiving care through an Organization,
9 the Secretary shall make a monthly capitated pay-
10 ment equal to the amount that would be determined
11 under section 1853(a)(1)(H).

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

18 “(3) PAYMENT FOR PART D BENEFITS.—In the
19 case where an Organization elects to offer part D
20 prescription drug coverage under the Program under
21 this section, payments to the Organization for such
22 benefits provided to Program-eligible beneficiaries by
23 the Organization shall be made in the same manner
24 and amount as those payments would be made in

1 the case of an Organization with a contract under
2 such part.

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

14 “(5) AFFIRMATION OF STATE OBLIGATIONS TO
15 PAY PREMIUM AND COST-SHARING AMOUNTS.—

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

1 premiums and such cost-sharing under the
2 State plan under title XIX.

3 “(B) AMOUNTS MADE AVAILABLE FOR
4 COST-SHARING.—For purposes of subparagraph
5 (A):

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

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

1 subparagraph (A) for the remaining dura-
2 tion of the Program.

3 “(g) WAIVER AUTHORITY.—

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

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

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