AMENDMENT TO H.R. _____
OFFERED BY M__. ___________

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Dialysis PATIENTS
3 Demonstration Act of 2016" or the "Dialysis Patient Ac-
4 cess To Integrated-care, Empowerment, Nephrologists,
5 Treatment, and Services Demonstration Act of 2016".

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

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

12 "DEMONSTRATION PROGRAM TO PROVIDE INTEGRATED
13 CARE FOR MEDICARE BENEFICIARIES WITH END-
14 STAGE RENAL DISEASE

15 "SEC. 1866F. (a) ESTABLISHMENT.—

16 "(1) IN GENERAL.—The Secretary shall con-
17 duct under this section the ESRD Integrated Care
18 Demonstration Program (in this section referred to
19 as the 'Program') which is voluntary for patients

1 and providers to assess the effects of alternative care
2 delivery models on patient care improvements under
3 this title for Program-eligible beneficiaries (as de-
4 fined in paragraph (2)). Under the Program, eligible
5 participating providers (as defined in such para-
6 graph) may form an ESRD Integrated Care Organi-
7 zation (in this section referred to as an 'Organiza-
8 tion'). An Organization shall integrate care and
9 serve as the medical home for Program-eligible bene-
10 ficiaries.

11 ''(2) DEFINITIONS.—In this section:

12 ''(A) ELIGIBLE PARTICIPATING PRO-
13 VIDER.—The term 'eligible participating pro-
14 vider' means the following:

15 ''(i) A facility certified as a renal di-
16 alysis facility under this title.

17 ''(ii) A dialysis organization that owns
18 one or more of such facilities described in
19 clause (i).

20 ''(iii) A nephrologist or nephrology
21 practice.

22 ''(iv) Any other physician group prac-
23 tice or a group of affiliated physicians.

24 ''(B) ELIGIBLE PARTICIPATING PART-
25 NER.—The term 'eligible participating partner'

1 means, with respect to an Organization, the fol-
2 lowing:
3 "(i) A Medicare Advantage plan de-
4 scribed in section 1851(a)(2) or a Medi-
5 care Advantage organization offering such
6 a plan.
7 "(ii) A prescription drug plan (as de-
8 fined in section 1860D–41(a)(14)).
9 "(iii) A medicaid managed care orga-
10 nization (as defined in section 1903(m)).
11 "(iv) An entity able to bear risk as
12 deemed by a State and that chooses to
13 bear risk as a condition of partnership in
14 such organization.
15 "(v) A third party-administrator orga-
16 nization.
17 "(C) PROGRAM-ELIGIBLE BENEFICIARY.—
18 The term 'Program-eligible beneficiary' means,
19 with respect to an Organization offering an
20 ESRD Integrated Care Model, an individual en-
21 titled to benefits under part A and enrolled
22 under part B who—
23 "(i) is 18 years of age or older;
24 "(ii) is identified by the Secretary or
25 the Organization as receiving renal dialysis

1 services under the original medicare fee-
2 for-service program under parts A and B;
3 ''(iii) resides in the service area of
4 such Organization;
5 ''(iv) receives renal dialysis services
6 primarily from a facility that participates
7 in such Organization; and
8 ''(v) has not received a successful kid-
9 ney transplant.
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')—
15 "(I) shall cover all benefits under
16 parts A and B (other than hospice
17 care) and include benefits for transi-
18 tion (including education) into pallia-
19 tive care; and
20 "(II) may, through a partnership
21 or other agreement with an MA–PD
22 plan under part C or prescription
23 drug plan under part D, cover all pre-
24 scription drug benefits under such
25 part D.

1 "(ii) TREATMENT OF SAVINGS.—
2 "(I) IN GENERAL.—Any Organi-
3 zation offering an ESRD Integrated
4 Care Model shall provide for the re-
5 turn under subclause (IV) to a Pro-
6 gram-eligible beneficiary enrolled in
7 the Organization of the amount, if
8 any, by which the payment amount
9 described in subclause (III) with re-
10 spect to the Program-eligible bene-
11 ficiary for a year exceeds the revenue
12 amount described in subclause (II)
13 with respect to the Program-eligible
14 beneficiary for the year.
15 "(II) REVENUE AMOUNT DE-
16 SCRIBED.—The revenue 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 Organiza-
22 tion's estimated average revenue re-
23 quirements, including administrative
24 costs and return on investment, for
25 the Organization to provide the bene-

1 fits described in clause (i) under the
2 Model for the Program-eligible bene-
3 ficiary for the year.
4 "(III) PAYMENT AMOUNT DE-
5 SCRIBED.—The payment amount de-
6 scribed in this subclause, with respect
7 to an Organization offering an ESRD
8 Integrated Care Model and a Pro-
9 gram-eligible beneficiary enrolled in
10 such Organization, is the payment
11 amount to the Organization under
12 subsection (f)(1) made with respect to
13 the Program-eligible beneficiary for
14 the year.
15 "(IV) MEANS OF RETURNING
16 SAVINGS TO PROGRAM-ELIGIBLE
17 BENEFICIARIES ENROLLED IN ORGA-
18 NIZATIONS.—An Organization shall
19 return the amount under subclause (I)
20 to a Program-eligible beneficiary en-
21 rolled in the Organization in a man-
22 ner specified by the Organization,
23 which may include cost-sharing lower
24 than otherwise applicable, benefits not
25 covered under the original medicare

1 fee-for-service program, or financial
2 incentives (such as reduced cost shar-
3 ing) for Program-eligible beneficiaries
4 enrolled in the Organization to pro-
5 mote the delivery of high-value and ef-
6 ficient care and services.
7 "(iii) BENEFIT REQUIREMENTS FOR
8 DUAL ELIGIBLES.—In the case of a Pro-
9 gram-eligible beneficiary who is eligible for
10 benefits under this title and title XIX, an
11 Organization, in accordance with an agree-
12 ment entered into under subsection
13 (f)(4)—
14 "(I) may be responsible for pro-
15 viding, or arranging for the provision
16 of, all benefits (other than long-term
17 services and supports) for which the
18 Program-eligible beneficiary is eligible
19 for under the State Medicaid program
20 under title XIX in which the Pro-
21 gram-eligible beneficiary is enrolled;
22 and
23 "(II) may elect to provide, or ar-
24 range for the provision of, long-term
25 services and supports available to the

1 Program-eligible beneficiary under the
2 State Medicaid program.
3 “(B) REQUIREMENTS FOR OPEN NETWORK
4 AND PREFERRED NETWORK MODELS.—
5 “(i) OPEN NETWORK MODEL.—Under
6 an ESRD Integrated Care Model offered
7 by an Organization that is an open net-
8 work model, the Organization shall—
9 “(I) allow Program-eligible bene-
10 ficiaries to receive such covered bene-
11 fits from any provider of services or
12 supplier regardless of whether such
13 provider is within the network assem-
14 bled under subclause (I);
15 “(II) pay any Medicare-certified
16 provider or supplier that is not within
17 the network assembled under sub-
18 clause (I) for such covered benefits an
19 amount equal to the amount the pro-
20 vider or supplier would otherwise re-
21 ceive under this title; and
22 “(III) not apply any additional
23 premium or cost sharing requirements
24 for such covered benefits in addition
25 to premium or cost sharing require-

1 ments, respectively, that would be ap-
2 plicable under part A or part B for
3 such benefits.
4 "(ii) PREFERRED NETWORK
5 MODEL.—Under an ESRD Integrated
6 Care Model offered by an Organization
7 that is a preferred network model, the Or-
8 ganization—
9 "(I) shall assemble a network of
10 providers of services and suppliers
11 identified by the Organization and
12 confirmed by the Secretary as includ-
13 ing providers of services and suppliers
14 with significant expertise in caring for
15 individuals with end-stage renal dis-
16 ease through which Program-eligible
17 beneficiaries shall receive covered ben-
18 efits as described in subparagraph (A)
19 that are required to be covered under
20 the Model;
21 "(II) shall provide for payment
22 for items and services furnished by
23 providers of services and suppliers
24 within such network to Program-eligi-
25 ble beneficiaries enrolled in such Or-

1 ganization in accordance with pay-
2 ment rates determined pursuant to an
3 agreement entered into between the
4 Organization and such providers of
5 services and suppliers and shall pro-
6 vide for payment for items and serv-
7 ices furnished by providers of services
8 and suppliers not within such network
9 to such beneficiaries so enrolled in ac-
10 cordance that would be determined
11 under section 1853(a)(1)(H);
12 "(III) may apply premium and
13 cost-sharing requirements, in addition
14 to premium or cost-sharing require-
15 ments, respectively, that would be ap-
16 plicable under part B, for benefits in
17 addition to those required to be cov-
18 ered under the Model; and
19 "(IV) shall apply network stand-
20 ards as defined by the Secretary.
21 "(iii) PROMOTING ACCESS TO HIGH-
22 QUALITY PROVIDERS.—An Organization
23 offering an ESRD Integrated Care Model
24 may develop and implement performance-
25 based incentives for providers of services

1 and suppliers to promote delivery of high
2 quality and efficient care. Such incentives
3 shall be based on clinical measures and
4 non-clinical measures, such as with respect
5 to notification of patient discharge from a
6 hospital, patient education (such as with
7 respect to treatment options and nutri-
8 tion), and the interoperability of electronic
9 health records developed by an Organiza-
10 tion according to requirements and stand-
11 ards specified by the Secretary pursuant to
12 subparagraph (C).
13 "(iv) APPLICATION OF MEDICARE AD-
14 VANTAGE REQUIREMENT WITH RESPECT
15 TO MEDICARE SERVICES FURNISHED BY
16 OUT-OF-NETWORK PROVIDERS AND SUP-
17 PLIERS.—
18 "(I) IN GENERAL.—Section
19 1852(k)(1) (relating to limitations on
20 balance billing against MA organiza-
21 tions for noncontract physicians and
22 other entities with respect to services
23 covered under this title) shall apply to
24 Organizations, Program-eligible bene-
25 ficiaries enrolled in such Organiza-

1 tions, and physicians and other enti-
2 ties that do not have a contract or
3 other agreement with the Organiza-
4 tion establishing payment amounts for
5 services furnished to such a bene-
6 ficiary in the same manner as such
7 section applies to MA organizations,
8 individuals enrolled with such organi-
9 zations, and physicians and other en-
10 tities referred to in such section.
11 "(II) REFERENCE FOR ADDI-
12 TIONAL PROVISION.—For the provi-
13 sion relating to limitations on balance
14 billing against Organizations for serv-
15 ices covered under this title furnished
16 by noncontract providers of services
17 and suppliers, see section
18 1866(a)(1)(O).
19 "(C) QUALITY AND REPORTING REQUIRE-
20 MENTS.—
21 "(i) CLINICAL MEASURES.—Under the
22 Program, the Secretary shall—
23 "(I) require each participating
24 Organization to submit to the Sec-
25 retary data on clinical measures con-

1 sistent with those measures submitted
2 by organizations participating in the
3 Comprehensive ESRD Care Initiative
4 operated by the Center for Medicare
5 and Medicaid Innovation as of Octo-
6 ber 1, 2016, to assess the quality of
7 care provided;

8 "(II) establish requirements for
9 participating Organizations to report
10 to the Secretary, in a form and man-
11 ner specified by the Secretary, infor-
12 mation on such measures; and

13 "(III) establish quality perform-
14 ance standards on such measures to
15 assess the quality of care.

16 "(ii) REQUIREMENT FOR STAKE-
17 HOLDER INPUT.—In developing require-
18 ments and standards under subclauses (II)
19 and (III) of clause (i), the Secretary shall
20 request and consider input from a stake-
21 holder board, at least one nephrologist,
22 other suppliers and providers of services,
23 renal dialysis facilities, and beneficiary ad-
24 vocates, and respond in writing to such
25 input.

1 "(iii) ADDITIONAL ASSESSMENTS AND
2 REPORTING REQUIREMENTS.—The Sec-
3 retary shall assess the extent to which an
4 Organization delivers integrated and pa-
5 tient-centered care through analysis of in-
6 formation obtained from Program-eligible
7 beneficiaries enrolled in the Organization
8 through surveys, such as the In-Center
9 Hemodialysis Consumer Assessment of
10 Healthcare Providers and Systems.
11 "(D) REQUIREMENTS FOR ESRD INTE-
12 GRATED CARE STRATEGY.—
13 "(i) IN GENERAL.—An Organization
14 seeking a contract under this section to
15 offer one or more ESRD Integrated Care
16 Models must develop and submit for the
17 Secretary's approval, subject to clauses (ii)
18 and (iii), an ESRD Integrated Care Strat-
19 egy.
20 "(ii) ESRD INTEGRATED CARE
21 STRATEGY.—In assessing an ESRD Inte-
22 grated Care Strategy under clause (i), the
23 Secretary shall consider the extent to
24 which the Strategy includes elements, such
25 as the following:

1 "(I) Interdisciplinary care teams
2 led by at least one nephrologist, and
3 comprised of registered nurses, social
4 workers, renal dialysis facility man-
5 agers, and other representatives from
6 alternative settings described in sub-
7 clause (VI).

8 "(II) Health risk and other as-
9 sessments to determine the physical,
10 psychosocial, nutrition, language, cul-
11 tural, and other needs of Program-eli-
12 gible beneficiaries enrolled in the Or-
13 ganization involved.

14 "(III) Development and at least
15 annual updating of individualized care
16 plans that incorporate at least the
17 medical, social, and functional needs,
18 preferences, and care goals of Pro-
19 gram-eligible beneficiaries enrolled in
20 the Organization.

21 "(IV) Coordination and delivery
22 of non-clinical services, such as trans-
23 portation, aimed at improving the ad-
24 herence of Program-eligible bene-

1 ficiaries enrolled in the Organization
2 with care recommendations.
3 ''(V) Services, such as transplant
4 evaluation and vascular access care.
5 ''(VI) In the case of an individual
6 who, while enrolled in the Organiza-
7 tion, receives confirmation that a kid-
8 ney transplant is imminent, the provi-
9 sion by an interdisciplinary care team
10 described in subclause (I) of coun-
11 seling services to such individual on
12 preparation for and potential chal-
13 lenges surrounding such transplant.
14 ''(VII) Delivery of benefits and
15 services in alternative settings, such
16 as the home of the Program-eligible
17 beneficiary enrolled in the Organiza-
18 tion, in coordination with the provider
19 or other appropriate stakeholder in-
20 volved in such delivery serving on an
21 interdisciplinary care team described
22 in subclause (I).
23 ''(VIII) Use of patient reminder
24 systems.

1 “(IX) Education programs for
2 patients, families, and caregivers.
3 “(X) Use of health care advice
4 resources, such as nurse advice lines.
5 “(XI) Use of team-based health
6 care delivery models that provide com-
7 prehensive and continuous medical
8 care, such as medical homes.
9 “(XII) Co-location of providers
10 and services.
11 “(XIII) Use of a demonstrated
12 capacity to share electronic health
13 record information across sites of
14 care.
15 “(XIV) Use of programs to pro-
16 mote better adherence to rec-
17 ommended treatment regimens by in-
18 dividuals, including by addressing bar-
19 riers to access to care by such individ-
20 uals.
21 “(XV) Other services, strategies,
22 and approaches identified by the Or-
23 ganization to improve care coordina-
24 tion and delivery.

1 "(iii) REQUIREMENTS.—The Sec-
2 retary may not approve an ESRD Inte-
3 grated Care Strategy of an Organization
4 unless under such Strategy the Organiza-
5 tion—
6 "(I) provides services to Pro-
7 gram-eligible beneficiaries enrolled in
8 the Organization through a com-
9 prehensive, multidisciplinary health
10 and social services delivery system
11 which integrates acute and long-term
12 care services pursuant to regulations;
13 and
14 "(II) specifies the covered items
15 and services that will not be provided
16 directly by the Organization, and to
17 arrange for delivery of those items
18 and services through contracts meet-
19 ing the requirements of regulations.
20 "(3) REQUIREMENT FOR CAPITAL RESERVES.—
21 "(A) IN GENERAL.—The Secretary shall
22 enter into contracts under this section only with
23 Organizations that demonstrate sufficient cap-
24 ital reserves, measured as a percentage of
25 capitated payments and consistent with require-

1 ments established by the State in which the Or-
2 ganization operates.
3 "(B) ALTERNATIVE MECHANISM TO DEM-
4 ONSTRATE CAPACITY TO BEAR RISK.—An Orga-
5 nization shall be considered to meet the require-
6 ment in subparagraph (A) if the Organization
7 includes at least one eligible participating pro-
8 vider or eligible participating partner that—
9 "(i) is licensed as a risk-bearing entity
10 or deemed by a State as able to bear risk;
11 and
12 "(ii) chooses to bear risk as a condi-
13 tion of partnership in such Organization.
14 "(4) BENEFICIARY PROTECTIONS.—
15 "(A) CONTINUITY OF CARE.—To provide
16 for continuity of care, each contract entered
17 into with an Organization under this section
18 shall provide for a transition period during
19 which a Program-eligible beneficiary who is
20 first enrolled in the Organization or who elects
21 to opt out of the Program or otherwise disenroll
22 from the Organization maintains access to eligi-
23 ble participating providers furnishing items or
24 services to such beneficiary immediately before
25 such enrollment or election for purposes of re-

1 ceipt of such items or services. Payment for
2 such items or services covered under this title
3 furnished to such Program-eligible beneficiary
4 during such transition period shall be made in
5 accordance with this title and in such amounts
6 as would otherwise be determined for such
7 items and services provided to such a bene-
8 ficiary not enrolled under the Program.

9 "(B) ANTIDISCRIMINATION.—Each con-
10 tract entered into with an Organization under
11 this section shall provide that each eligible par-
12 ticipating provider of such Organization may
13 not deny, limit, or condition the furnishing of
14 services, or affect the quality of services fur-
15 nished, under this title to Program-eligible
16 beneficiaries on whether or not such a bene-
17 ficiary is enrolled with the Organization.

18 "(C) QUALITY ASSURANCE; PATIENT SAFE-
19 GUARDS.—Each contract entered into with an
20 Organization under this section shall require
21 that such Organization have in effect at a min-
22 imum—

23 "(i) a written plan of quality assur-
24 ance and improvement, and procedures im-

1 plementing such plan, in accordance with
2 regulations; and
3 "(ii) written safeguards of the rights
4 of Program-eligible beneficiaries enrolled in
5 the Organization (including a patient bill
6 of rights and procedures for grievances
7 and appeals) in accordance with regula-
8 tions and with other requirements of this
9 title and Federal and State law that are
10 designed for the protection of patients.
11 "(D) OVERSIGHT.—The Secretary shall
12 oversee the marketing and assignment practices
13 of each Organization entering into a contract
14 under this section as part of the approval and
15 renewal process of Organizations under this
16 section.
17 "(5) NON-APPLICATION OF CERTAIN PROVI-
18 SIONS OF LAW.—For purposes of sections 162(m)(6)
19 and 414(m) of the Internal Revenue Code of 1986
20 and section 9010 of the Patient Protection and Af-
21 fordable Care Act (26 U.S.C. 4001 note prec.), in
22 the case of an eligible participating provider that es-
23 tablishes an Organization or that enters into a part-
24 nership, ownership, or co-ownership agreement to es-
25 tablish an Organization, or an Organization with a

1 contract under this section, risk-based payments in
2 exchange for providing medical care shall not be con-
3 sidered premiums for health insurance coverage.

4 "(6) TREATMENT AS MEDICARE ADVANCED AL-
5 TERNATIVE PAYMENT MODEL.—Alternative care de-
6 livery models under the Program shall be treated
7 under this title as an advanced alternative payment
8 model.

9 "(c) PROGRAM OPERATION AND SCOPE.—

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

16 "(A) The estimated average revenue
17 amount described in subsection (b)(2)(A)(ii)(II)
18 for the Organization to deliver benefits de-
19 scribed in subsection (b)(2)(A).

20 "(B) Any benefits offered by the Organiza-
21 tion beyond those described in such subsection.

22 "(C) A listing of network providers of serv-
23 ices and supplier.

1 "(D) Information on the expertise of net-
2 work providers of services and suppliers in serv-
3 ing ESRD patients.
4 "(E) A description of the ESRD Inte-
5 grated Care Strategy of the Organization de-
6 scribed in subsection (b)(2)(D).
7 "(2) PROGRAM INITIATION.—The Secretary
8 shall initiate the Program such that Organizations
9 begin serving Program-eligible beneficiaries not later
10 than January 1, 2018.
11 "(3) CONTRACT AWARD AND PERIOD.—The
12 Secretary shall enter into contracts for an initial pe-
13 riod of not less than 5 years with all Organizations
14 that meet Program requirements.
15 "(4) 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 "(5) CONTRACT TERMINATION AND SUSPEN-
24 SION.—

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

8 "(B) INSUFFICIENT BENEFICIARY PARTICI-
9 PATION.—The Secretary shall, in the case of an
10 Organization with a contract under this section
11 with respect to which, for any period of at least
12 30 consecutive days during a year for which
13 such contract applies, fewer than 50 percent of
14 the total number of Program-eligible bene-
15 ficiaries served by the Organization receive ben-
16 efits through the Organization under this sec-
17 tion—

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

20 "(ii) provide for the Organization to
21 return any prospective payments made to
22 the Organization under this section for
23 items and services not provided pursuant
24 to clause (i).

1 "(C) REMEDY AND APPEALS PROCESS.—
2 Prior to the Secretary terminating or sus-
3 pending a contract with an Organization under
4 this section, the Secretary shall afford such Or-
5 ganization sufficient opportunity to remedy any
6 contract violations and appeal a contract termi-
7 nation.
8 "(D) PROGRAM-ELIGIBLE BENEFICIARY
9 NOTICE AT TIME OF CONTRACT TERMI-
10 NATION.—Each contract under this section with
11 an Organization shall require the Organization
12 to provide (and pay for) written notice in ad-
13 vance of the contract's termination or suspen-
14 sion, as well as a description of alternatives for
15 obtaining benefits under this title, to each Pro-
16 gram-eligible beneficiary assigned to or who
17 elected to receive benefits through the Organi-
18 zation under this section.
19 "(6) PROGRAM EXPANSION.—The Secretary
20 may, through rulemaking, expand the duration and
21 scope of the Program under this section, to the ex-
22 tent determined appropriate by the Secretary, if—
23 "(A) the Secretary determines that such
24 expansion is expected to—

1 "(i) reduce spending under this title
2 without reducing the quality of patient
3 care; or
4 "(ii) improve the quality of patient
5 care without increasing spending under
6 this title;
7 "(B) the Chief Actuary of the Centers for
8 Medicare & Medicaid Services certifies that
9 such expansion would reduce (or would not re-
10 sult in any increase in) net program spending
11 under this title; and
12 "(C) the Secretary determines that such
13 expansion would not deny or limit the coverage
14 or provision of benefits under this title for ap-
15 plicable individuals.
16 "(d) IDENTIFICATION OF PROGRAM-ELIGIBLE BENE-
17 FICIARIES.—The Secretary shall establish a process for
18 the initial and ongoing identification of Program-eligible
19 beneficiaries.
20 "(e) PROGRAM-ELIGIBLE BENEFICIARIES ASSIGNED
21 INTO AN ESRD INTEGRATED CARE ORGANIZATION OPEN
22 NETWORK MODEL.—
23 "(1) ASSIGNMENT.—
24 "(A) IN GENERAL.—Under the Program,
25 subject to the succeeding provisions of this

1 paragraph, the Secretary shall, upon the Sec-
2 retary identifying a beneficiary as a Program-
3 eligible beneficiary, assign all such Program-eli-
4 gible beneficiary to an open network model of-
5 fered by an Organization that includes the di-
6 alysis facility at which the Program-eligible ben-
7 eficiary primarily receives renal dialysis serv-
8 ices.

9 "(B) PROGRAM-ELIGIBLE BENEFICIARY
10 NOTIFICATION OF ASSIGNMENT.—

11 "(i) IN GENERAL.—Upon assignment
12 of a Program-eligible beneficiary to an Or-
13 ganization, the Secretary shall provide to
14 the Organization written notification of
15 such assignment of such Program-eligible
16 beneficiary and not later than 15 business
17 days after the date of receipt of such noti-
18 fication, the Organization shall provide
19 written notice of such assignment to the
20 Program-eligible beneficiary.

21 "(ii) OPT–OUT PERIOD AND CHANGES
22 UPON INITIAL ASSIGNMENT.—The Sec-
23 retary shall provide for a 75-day period be-
24 ginning on the date on which the assign-
25 ment of a Program-eligible beneficiary into

1 an open network model offered by an Or-
2 ganization becomes effective during which
3 a Program-eligible beneficiary may—
4 "(I) opt out of the Program;
5 "(II) make a one-time change of
6 assignment into an open network
7 model offered by a different Organiza-
8 tion; or
9 "(III) elect a preferred network
10 model offered by the same or different
11 Organization.
12 "(C) ADDITIONAL OPT-IN POPULATION.—
13 An individual who, without application of clause
14 (iv) of subsection (a)(2)(C), would be treated as
15 a Program-eligible beneficiary, may elect to en-
16 roll in an Organization under the Program
17 under this section if such individual agrees to
18 receive renal dialysis services primarily from a
19 facility that participates in such Organization.
20 For purposes of this section (other than sub-
21 paragraphs (A) and (B) of this paragraph,
22 paragraph (2), and subsection (d), an individual
23 making an election pursuant to the previous
24 sentence shall be treated as a Program-eligible
25 beneficiary.

1 "(D) DEEMED RE-ENROLLMENT.—A Pro-
2 gram-eligible beneficiary assigned under this
3 paragraph to an ESRD Integrated Care Model
4 offered by an Organization with respect to a
5 year is deemed, unless the individual elects oth-
6 erwise under this paragraph, to have elected to
7 continue such assignment with respect to the
8 subsequent year.
9 "(E) ADDITIONAL OPPORTUNITY TO OPT
10 OUT OR ELECT DIFFERENT MODEL OR ORGANI-
11 ZATION.—On the date that is one year after the
12 effective date of the initial assignment of a Pro-
13 gram-eligible beneficiary to an open network
14 model offered by an Organization (and annually
15 thereafter), a Program-eligible beneficiary shall
16 be given the opportunity to—
17 "(i) opt out of the Program;
18 "(ii) make a one-time change of as-
19 signment into an open network model of-
20 fered by a different Organization; or
21 "(iii) elect a preferred network model
22 offered by the same or different Organiza-
23 tion.
24 "(F) CHANGE IN PRINCIPAL DIAGNOSIS
25 OPT OUT.—In addition to any other period dur-

ing which a Program-eligible beneficiary may, pursuant to this paragraph, opt out of the Program, in the case of a Program-eligible beneficiary who, after assignment under this paragraph, is diagnosed with a principal diagnosis (as defined by the Secretary) other than end-stage renal disease, such individual shall be given the opportunity to opt out of the Program during such period as specified by the Secretary.

"(G) SPECIAL ELECTION PERIODS.—The Secretary shall offer Program-eligible beneficiaries special election periods consistent with those described in section 1851(e)(4).

"(2) PROGRAM-ELIGIBLE BENEFICIARY NOTIFICATION.—

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

"(B) REQUIREMENTS.—Notwithstanding any other provision of law, subject to subparagraph (C), such notification shall allow for eligi-

1 ble participating providers that are part of an
2 Organization to—
3 "(i) inform Program-eligible bene-
4 ficiaries about the Program;
5 "(ii) distribute Program materials to
6 Program-eligible beneficiaries; and
7 "(iii) assist Program-eligible bene-
8 ficiaries in assessing the options of such
9 beneficiaries under the Program.
10 "(C) LIMITATION ON UNSOLICITED MAR-
11 KETING.—
12 "(i) IN GENERAL.—Under the Pro-
13 gram, an eligible participating provider
14 may not provide marketing information or
15 materials, including information, materials,
16 and assistance described in subparagraph
17 (B), to a Program-eligible beneficiary un-
18 less the Program-eligible beneficiary re-
19 quests such marketing information or ma-
20 terials.
21 "(ii) EXCEPTION FOR PROVIDERS
22 TREATING BENEFICIARIES.—An eligible
23 participating provider that is part of an
24 Organization may provide information, ma-
25 terials, and assistance described in sub-

1 paragraph (B) to a Program-eligible bene-
2 ficiary, without prior request of such bene-
3 ficiary, if such beneficiary is receiving
4 renal dialysis services from such provider.
5 ''(iii) PARITY IN MARKETING.—In any
6 case that an Organization participates in
7 any form of marketing, such form of mar-
8 keting shall be the same for all Program-
9 eligible beneficiaries to which, pursuant to
10 (ii), the Organization may provide informa-
11 tion, materials, and assistance described in
12 such clause.
13 ''(3) PROGRAM-ELIGIBLE BENEFICIARY APPEAL
14 RIGHTS.—Program-eligible beneficiaries enrolled in
15 an Organization shall have the same right to appeal
16 any denial of benefits under this title as such a Pro-
17 gram-eligible beneficiary would have under this title
18 if such Program-eligible beneficiary were not so en-
19 rolled.
20 ''(f) PAYMENT.—
21 ''(1) IN GENERAL.—For each Program-eligible
22 beneficiary receiving care through an Organization,
23 the Secretary shall make a monthly capitated pay-
24 ment in accordance with payment rates that would

1 be determined under section 1853(a)(1)(H), as ad-
2 justed pursuant to paragraph (2).
3 "(2) APPLICATION OF HEALTH STATUS RISK
4 ADJUSTMENT METHODOLOGY.—The Secretary shall
5 adjust the payment amount to an Organization
6 under this subsection in the same manner in which
7 the payment amount to a Medicare Advantage plan
8 is adjusted under section 1853(a)(1)(C).
9 "(3) PAYMENT FOR PART D BENEFITS.—In the
10 case where an Organization elects to offer part D
11 prescription drug coverage under the Program under
12 this section, payments to the Organization for such
13 benefits provided to Program-eligible beneficiaries by
14 the Organization shall be made in the same manner
15 and amounts as those payments would be made in
16 the case of an organization with a contract under
17 such part.
18 "(4) AGREEMENT WITH STATE MEDICAID
19 AGENCY.—In the event of an Organization that
20 elects to cover benefits under title XIX for Program-
21 eligible beneficiaries eligible for benefits under this
22 title and title XIX such Organization shall enter into
23 an agreement with the State Medicaid agency to
24 provide benefits, or arrange for benefits to be pro-
25 vided, for which such beneficiaries are entitled to re-

1 ceive medical assistance under title XIX and to re-
2 ceive payment from the State for providing or ar-
3 ranging for the provision of such benefits.

4 "(5) AFFIRMATION OF STATE OBLIGATIONS TO
5 PAY PREMIUM AND COST-SHARING AMOUNTS.—

6 "(A) IN GENERAL.—A State shall continue
7 to make medical assistance under the State
8 plan under title XIX available in the amount
9 described in subparagraph (B) for the duration
10 of the Program for cost-sharing (as defined in
11 section 1905(p)(3)) under this title for qualified
12 medicare beneficiaries described in section
13 1905(p)(1) and other individuals who are Pro-
14 gram-eligible beneficiaries enrolled in an Orga-
15 nization and entitled to medical assistance for
16 premiums and such cost-sharing under the
17 State plan under title XIX.

18 "(B) AMOUNTS MADE AVAILABLE FOR
19 COST-SHARING.—For purposes of subparagraph
20 (A):

21 "(i) IN GENERAL.—Subject to clause
22 (ii), the amount of medical assistance de-
23 scribed in this clause to be made available
24 for cost-sharing pursuant to subparagraph
25 (A) for an individual described in such

1 subparagraph entitled to medical assist-
2 ance for such cost-sharing under a State
3 plan under title XIX shall be equal to the
4 amount of medical assistance that would
5 be made available under such State plan as
6 in effect as of January 1, 2016.

7 ''(ii) AMOUNTS IN THE CASE OF A
8 STATE THAT INCREASES PAYMENTS FOR
9 COST-SHARING.—If a State increases the
10 amount of medical assistance made avail-
11 able under the State plan under title XIX
12 for cost-sharing described in subparagraph
13 (A) after such date, such increased
14 amounts shall be made available under
15 subparagraph (A) for the remaining dura-
16 tion of the Program.

17 ''(g) WAIVER AUTHORITY.—

18 ''(1) IN GENERAL.—In order to carry out the
19 Program under this section, the Secretary shall
20 waive those requirements waived under section 1899
21 and may waive such additional requirements con-
22 sistent with those waived under programs adminis-
23 tered through the Center for Medicare and Medicaid
24 Innovation as may be necessary.

1 "(2) NOTICE OF WAIVERS.—Not later than 3
2 months after the date of enactment of this section,
3 the Secretary shall publish a notice of waivers that
4 will apply in connection with the Program. The no-
5 tice shall include the specific conditions that an Or-
6 ganization must meet to qualify for each waiver, and
7 commentary explaining the waiver requirements.".
8 (b) CONFORMING AMENDMENT RELATING TO BAL-
9 ANCED BILLING.—Section 1866(a)(1)(O) of the Social Se-
10 curity Act (42 U.S.C. 1395cc(a)(1)(O)) is amended—
11 (1) by inserting "with an ESRD Integrated
12 Care Organization under section 1866F," after
13 "with a PACE provider under section 1894 or
14 1934,";
15 (2) by inserting "or ESRD Integrated Care Or-
16 ganization" after "in the case of a PACE provider";
17 (3) by striking "or PACE program eligible indi-
18 viduals enrolled with the PACE provider" and in-
19 serting ", Program-eligible beneficiaries enrolled in
20 the ESRD Integrated Care Organization, or PACE
21 program eligible individuals enrolled with the PACE
22 provider"; and
23 (4) by inserting "(or in the case of a Program-
24 eligible beneficiary enrolled in the ESRD Integrated
25 Care Organization, the amounts that would be made

1 in accordance with payment rates that would be de-
2 termined under section 1853(a)(1)(H))'' after ''the
3 amounts that would be made''.