

115TH CONGRESS  
1ST SESSION

# H. R. 4143

To establish a demonstration program to provide integrated care for Medicare beneficiaries with end-stage renal disease, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 26, 2017

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

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## A BILL

To establish a demonstration program to provide integrated care for Medicare beneficiaries with end-stage renal disease, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

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

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

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

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

10 “SEC. 1866F. (a) ESTABLISHMENT.—

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

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

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

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

6           “(2) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

1 care Advantage organization offering such  
2 a plan.

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

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

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

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

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

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

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

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

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

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

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

12                   “(1) ORGANIZATIONS.—

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

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

1           “(2) ESRD INTEGRATED CARE MODEL.—

2                   “(A) BENEFITS REQUIREMENTS.—

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

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

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

1           description drug benefits under such  
2           part D.

3           “(ii) TREATMENT OF SAVINGS.—

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

15 “(IX) Use of patient reminder  
16 systems.

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

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

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

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

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

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

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

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

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

1 unless under such Strategy the Organiza-  
2 tion—

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

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

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

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

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

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

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

8 “(3) REQUIREMENT FOR CAPITAL RESERVES.—

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

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

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

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

3                   “(4) BENEFICIARY PROTECTIONS.—

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

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

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

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



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

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

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

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

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

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

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

16 “(c) PROGRAM OPERATION AND SCOPE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8           “(1) ASSIGNMENT.—

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

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

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

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

6 “(I) of such assignment; and

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

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

21 “(I) opt out of the Program;

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



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

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

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

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

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

11 “(i) opt out of the Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14          “(f) PAYMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

7           “(g) WAIVER AUTHORITY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

○