

118TH CONGRESS
1ST SESSION

S. _____

To provide States with support to establish integrated care programs for individuals who are dually eligible for Medicare and Medicaid, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide States with support to establish integrated care programs for individuals who are dually eligible for Medicare and Medicaid, 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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “_____ Act of _____”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—STATE INTEGRATED CARE PROGRAMS FOR DUAL
ELIGIBLE INDIVIDUALS

Sec. 101. State implementation.

“TITLE XXII—STATE INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE INDIVIDUALS

“Sec. 2201. Definitions.

“Sec. 2202. State selection of program models, development, and implementation.

“Sec. 2203. Enrollment in integrated care plans.

“Sec. 2204. Plan requirements and payments.

“Sec. 2205. Data collection and reporting.

“Sec. 2206. State ombudsman.

“Sec. 2207. Funding.

“Sec. 2208. Federal administration through the Federal Coordinated Health Care Office.

Sec. 102. Conforming amendments relating to Federal Coordinated Health Care Office responsibilities.

Sec. 103. Additional conforming amendments.

TITLE II—IMPROVING ELIGIBILITY DETERMINATIONS, ENROLLMENT PROCESSES, AND QUALITY OF CARE FOR DUAL ELIGIBLE INDIVIDUALS

Sec. 201. Development of new risk adjustment payment model.

Sec. 202. Identifying opportunities for State coordination with respect to eligibility determinations.

Sec. 203. Alignment of bidding, reporting, and other dates and deadlines for integrated care plans.

Sec. 204. Grants to State and local community organizations for outreach and enrollment.

Sec. 205. Application of model standards to information requirements for integrated care plans.

Sec. 206. Enrollment through independent brokers.

Sec. 207. Reducing threshold for look-alike D-SNP plans under Medicare Advantage.

Sec. 208. Uniform prohibition on enrollment in an integrated plan with a rating of less than 3 stars.

Sec. 209. Requiring regulate update of provider directories.

Sec. 210. Additional responsibilities for the Federal Coordinated Health Care Office with respect to integrated care plans under Medicaid and Medicare.

Sec. 211. Review of hospital quality star rating system.

Sec. 212. Requirement for FCHCO and State Medicaid agencies to develop maximum staffing ratios for care coordinators.

TITLE III—ADMINISTRATION

Sec. 301. Alignment of billing codes under titles XVIII, XIX, and XXII.

Sec. 302. Requiring Accountable Care organizations to have a State Medicaid agency contract.

TITLE IV—PACE

Sec. 401. Requiring States to offer PACE program services to eligible individuals.

Sec. 402. Enrollment of PACE beneficiaries at any time.

Sec. 403. Extending eligibility for PACE to medicare-eligible individuals under the age of 55.

Sec. 404. Removal of quarterly restrictions for submission of a new pace organization application, and removal quarterly restrictions for applications in a new service area.

Sec. 405. Cost outlier protection for new PACE providers.

Sec. 406. Ensuring Medicare-only PACE program enrollees have a choice of prescription drug plans under Medicare part D.

1 **TITLE I—STATE INTEGRATED**
2 **CARE PROGRAMS FOR DUAL**
3 **ELIGIBLE INDIVIDUALS**

4 **SEC. 101. STATE IMPLEMENTATION.**

5 The Social Security Act is amended by adding at the
6 end the following new title:

7 **“TITLE XXII—STATE INTE-**
8 **GRATED CARE PROGRAMS**
9 **FOR DUAL ELIGIBLE INDIVID-**
10 **UALS**

11 **“SEC. 2201. DEFINITIONS.**

12 “In this title:

13 “(1) DIRECTOR.—The term ‘Director’ means
14 the Director of the Federal Coordinated Health Care
15 Office of the Centers for Medicare & Medicaid Serv-
16 ices.

17 “(2) DUAL ELIGIBLE.—The term ‘dual eligible
18 individual’ means an individual who is entitled to, or
19 enrolled for, benefits under part A of title XVIII, or
20 enrolled for benefits under part B of title XVIII,
21 and is eligible for medical assistance under a State

1 plan under title XIX or under a waiver of such plan.
2 Such term includes a full-benefit dual eligible indi-
3 vidual and a Medicare Savings Program eligible indi-
4 vidual.

5 “(3) FULL-BENEFIT DUAL ELIGIBLE INDI-
6 VIDUAL.—The term ‘full-benefit dual eligible indi-
7 vidual’ has the meaning given such term in section
8 1935(e)(6) but without the application of subpara-
9 graph (A)(i) of such section.

10 “(4) INTEGRATED CARE PLAN.—The term ‘in-
11 tegrated care plan’ means an entity or organization
12 that provides fully integrated care, or partially inte-
13 grated care for a dual eligible individual in accord-
14 ance with the requirements of this title and related
15 Federal and State regulations.

16 “(5) MEDICARE SAVINGS PROGRAM ELIGIBLE
17 INDIVIDUAL.—The term ‘Medicare Savings Program
18 eligible individual’ means an individual who is eligi-
19 ble for the low-income subsidy program under sec-
20 tion 1860D–14, the Medicare Savings Program (as
21 defined in section 1144(c)(7)), or both.

22 **“SEC. 2202. STATE SELECTION OF PROGRAM MODELS, DE-**
23 **VELOPMENT, AND IMPLEMENTATION.**

24 “(a) STATE SELECTION OF PROGRAM MODELS.—
25 Not later than 1 year after the date on which the Director

1 first publishes the range of program models for providing
2 integrated care for dual eligible individuals required by
3 section 2602(d)(9) of the Patient Protection and Afford-
4 able Care Act, each State shall select from such published
5 models, and shall work with the Director to implement
6 such models in the State in accordance with the require-
7 ments of this title—

8 “(1) a program model to provide comprehen-
9 sive, fully integrated care for full-benefit dual eligi-
10 ble individuals; and

11 “(2) a program model to provide partially inte-
12 grated care for Medicare Savings Program eligible
13 individuals.

14 “(b) **TIMING.**—Each State shall work with the Direc-
15 tor to implement the models selected by the State under
16 subsection (a) so that, to the extent practicable, the State
17 may begin to enroll dual eligible individuals in the pro-
18 gram models selected during the 4th year that occurs after
19 the year in which the State makes such selection and, by
20 the end of such 4th year, the models are fully implemented
21 and operated in accordance with the requirements of this
22 title and related Federal and State regulations.

23 “(c) **ADJUSTMENT AUTHORITY.**—The Director may
24 modify the timing required by subsections (a) and (b) as

1 appropriate to account for the particular needs or cir-
2 cumstances of a State.

3 “(d) IMPLEMENTATION COUNCIL.—

4 “(1) IN GENERAL.—A State shall establish an
5 implementation council in accordance with such re-
6 quirements as the Secretary shall establish. The
7 members of the council shall include representatives
8 of a wide range of stakeholders relevant to the provi-
9 sion of integrated care for dual eligible individuals.

10 “(2) DUTIES.—The implementation counsel
11 shall provide advice and counsel to the State with re-
12 spect to the implementation of the models selected
13 by the State under subsection (a).

14 **“SEC. 2203. ENROLLMENT IN INTEGRATED CARE PLANS.**

15 **【“(a) PASSIVE ENROLLMENT; OPT-OUT PER-**
16 **MITTED.—】**

17 **【“(1) IN GENERAL.—Notwithstanding para-**
18 **graph (1), (10)(B), or (23)(A) of section 1902(a),**
19 **but subject to the succeeding provisions of this sec-**
20 **tion and title, a State shall require a dual eligible in-**
21 **dividual to enroll with an integrated care plan as a**
22 **condition of receiving medical assistance under a**
23 **State plan under title XIX or under a waiver of such**
24 **plan (and, with respect to assistance furnished by or**
25 **under arrangements with such integrated care plan,**

1 to receive such assistance through the integrated
2 care plan), so long as the integrated care plan and
3 the contract with the State meet the applicable re-
4 quirements of this title.】

5 【“(2) NOTICE REQUIREMENTS.—A State shall
6 notify a dual eligible individual that the individual
7 shall be enrolled with an integrated care plan under
8 a contract with the State at least 60 days (90 days,
9 in the case of the first time the individual is pro-
10 vided such notice) prior to the effective date of such
11 enrollment. Notice provided to a dual eligible indi-
12 vidual under this paragraph shall include the fol-
13 lowing:】

14 【“(A) The name and contact information
15 for the integrated care plan and whether the
16 plan provides fully or partially integrated care.】

17 【“(B) The date on which the enrollment
18 takes effect and, if applicable, whether the
19 State has elected the option for a 12-month.】

20 【“(C) A summary of the benefits to be
21 provided by the plan.】

22 【“(D) Information regarding the provider
23 network of the plan.】

24 【“(E) Information regarding how the dual
25 eligible individual may elect to opt-out of enroll-

1 ment with the plan within 60 days (90 days, in
2 the case of the first time the individual is pro-
3 vided such notice).】

4 【“(3) CHOICE OF COVERAGE REQUIRED.—A
5 State shall not passively enroll a dual eligible indi-
6 vidual in a fully integrated care plan or a partially
7 integrated care plan (as applicable) unless—】

8 【“(A) the individual may choose from at
9 least 2 such plans with a quality rating under
10 section 1853(o)(4) (or, at the discretion of the
11 Secretary, an equivalent rating system) of 3
12 stars or higher based on the most recent data
13 available; and】

14 【“(B) the individual’s primary care physi-
15 cian is an in-network, participating provider for
16 the plan.】

17 【“(4) VOLUNTARY ENROLLMENT PER-
18 MITTED.—A State may offer a dual eligible indi-
19 vidual the option to enroll in a fully integrated care
20 plan or a partially integrated care plan (as applica-
21 ble) without regard to meeting the requirements of
22 subparagraph (A) or (B) of paragraph (3).】

23 【“(5) STATE OPTION FOR CONTINUOUS ELIGI-
24 BILITY AND ENROLLMENT.—A State may elect for a
25 dual eligible individual who is determined to be eligi-

1 ble for medical assistance under the State plan
2 under title XIX or under a waiver of such plan and
3 who is enrolled with an integrated care plan under
4 a contract with the State to remain eligible for med-
5 ical assistance and enrolled with such plan until the
6 earlier of—】

7 【“(A) the end of the 12-month beginning
8 on the date of such determination; or】

9 【“(B) the date that such individual ceases
10 to be a resident of such State.】

11 “(b) CHANGE OF ENROLLMENT.—A State shall per-
12 mit a dual eligible individual to change enrollment in an
13 integrated care plan—

14 “(1) in the case of a full-benefit dual eligible in-
15 dividual, on a monthly basis if the individual is elect-
16 ing to enroll in another fully integrated care plan;
17 and

18 “(2) in the case of any dual eligible indi-
19 vidual—

20 “(A) during the general enrollment period
21 applicable under section 1837, if the individual
22 is electing to disenroll from an integrated care
23 plan and not enroll in another integrated care
24 plan; and

1 “(B) during the 60-day period beginning
2 on the date the individual receives notice from
3 the State that the individual has been deter-
4 mined to no longer be eligible for treatment as
5 a full-benefit dual eligible individual or as a
6 Medicare Savings Program eligible individual
7 (as applicable), if the individual is electing to
8 change enrollment from a fully integrated care
9 plan to a partially integrated care plan (if eligi-
10 ble) or is not eligible to enroll in any fully or
11 partially integrated care plan.

12 “(c) CONTACT BY PLAN CARE COORDINATOR PER-
13 MITTED PRIOR TO EFFECTIVE DATE OF ENROLLMENT.—
14 A care coordinator for an integrated care plan may contact
15 a dual eligible individual who has been passively enrolled
16 in the plan prior to the effective date of the enrollment.

17 **“SEC. 2204. PLAN REQUIREMENTS AND PAYMENTS.**

18 “(a) IN GENERAL.—A contract between a State and
19 an offeror of an integrated care plan shall not be consid-
20 ered to meet the requirements of this title unless the plan
21 and the contract provisions comply with the following re-
22 quirements:

23 “(1) FULLY INTEGRATED CARE PLANS.—An of-
24 feror of an integrated care plan that provides com-

1 preprehensive, fully integrated care for full-benefit dual
2 eligible individuals shall—

3 “(A) offer a partially integrated care plan
4 for Medicare Savings Program eligible individ-
5 uals that includes the provider network for the
6 fully integrated care plan; and

7 “(B) automatically transfer the enrollment
8 of any individual who was a full-benefit dual eli-
9 gible individual enrolled in the fully integrated
10 care plan to such partially integrated care plan
11 at the end of the 60-day period that begins on
12 the date on which the plan receives notice from
13 the State that the individual has been deter-
14 mined to no longer be eligible for treatment as
15 a full-benefit dual eligible individual.

16 “(2) FULLY AND PARTIALLY INTEGRATED CARE
17 PLANS.—An offeror of an integrated care plan
18 shall—

19 “(A) permit a dual eligible individual who
20 changes enrollment to another integrated care
21 plan for which the individual’s primary care
22 provider is not a participating, in-network pro-
23 vider, or who disenrolls from an integrated care
24 plan and does not enroll in another integrated
25 care plan, a 30-day grace period during which

1 the individual may continue to be treated by
2 their primary care provider and any such treat-
3 ment shall be considered to be in-network treat-
4 ment by the plan;

5 “(B) administer a health risk assessment
6 to each dual eligible individual enrolled with the
7 plan within 90 days of the effective date of the
8 individual’s enrollment and shall affirm no
9 changes in the information provided at least
10 every 12 months thereafter, in accordance with
11 the requirements of subsection (c);

12 “(C) provide benefits for a dual eligible in-
13 dividual under a comprehensive care plan in ac-
14 cordance with the requirements of subsections
15 (d) and (f); and

16 “(D) assign a care coordinator to each
17 dual eligible individual enrolled with the plan in
18 accordance with the requirements of subsection
19 (e).

20 “(b) DISREGARD OF CERTAIN DISENROLLMENT
21 DATA FOR RATINGS PURPOSES.—The disenrollment of a
22 dual eligible individual from an integrated care plan who
23 was passively enrolled in the plan under section 2203, or
24 disenrolled from a fully integrated care plan after the 60-
25 day period required under subsection (a)(1)(B), shall be

1 disregarded for purposes of any data used for rating of
2 the plan.

3 “(c) HEALTH RISK ASSESSMENT.—An offeror of an
4 integrated care plan shall administer a health risk assess-
5 ment to each dual eligible individual enrolled with the plan
6 using the standardized health risk assessment question-
7 naire developed by the Director under section 2602(d)(11)
8 of the Patient Protection and Affordable Care Act and in
9 accordance with such additional requirements as the State
10 may establish. An integrated care plan may rely on the
11 results of a previously administered health risk assessment
12 of a dual eligible individual if such results are accessible
13 to the plan and the dual eligible individual affirms no
14 changes in the information previously provided.

15 “(d) BENEFITS.—

16 “(1) IN GENERAL.—An integrated care plan
17 shall provide benefits under the plan in accordance
18 with requirements established by the Director and
19 the State, and which shall include the following:

20 “(A) Clinical health services.

21 “(B) Behavioral health services.

22 “(C) Long-term services and supports.

23 “(2) CARVE-OUT EXCEPTIONS.—

24 “(A) IN GENERAL.—The Director may
25 permit a State and integrated care plan to sep-

1 arately contract for the provision of services or
2 supports required under paragraph (1) but only
3 if the State demonstrates to the Director that—

4 “(i) the level of care provided for a
5 dual eligible individual under the separate
6 contract with respect to such services or
7 supports is not less than the level of care
8 that would be provided without the excep-
9 tion; and

10 “(ii) the dual eligible individual will
11 not be subject to any unreasonable admin-
12 istrative requirements to access the serv-
13 ices or supports.

14 “(B) PREFERRED CONTRACTORS.—A State
15 shall give preference to entering into separate
16 contracts for the provision of services or sup-
17 ports required under paragraph (1) with offers
18 of fully integrated care plans under contract
19 with the State.

20 “(3) SUPPLEMENTAL BENEFITS.—An inte-
21 grated care plan may provide customized, supple-
22 mental benefits to a dual eligible individual enrolled
23 with the plan, including supplemental health care
24 benefits described in section 1852(a)(3), other pri-
25 marily health-related benefits offered by Medicare

1 Advantage plans and benefits permitted by the Sec-
2 retary to be offered as Special Supplemental Bene-
3 fits for the Chronically Ill (SSBCI), without regard
4 to whether the dual eligible individual has requisite
5 condition or diagnosis, so long as the plan dem-
6 onstrates to the Director and the State that the of-
7 fering of such benefits has a positive impact on pa-
8 tient health.

9 “(e) CARE COORDINATOR REQUIREMENTS.—A care
10 coordinator assigned to a dual eligible individual enrolled
11 in an integrated care plan shall—

12 “(1) serve as the single point of contact be-
13 tween the individual and the plan;

14 “(2) be responsible for helping the individual
15 and their caregivers and family make benefit and
16 service decisions;

17 “(3) design a beneficiary-focused comprehensive
18 care plan for the individual that meets the require-
19 ments of subsection (f); and

20 “(4) connect and coordinate acute, subacute,
21 social, primary, and specialty care for the individual
22 and the provision of long-term services and supports
23 for the individual.

1 “(f) COMPREHENSIVE CARE PLAN REQUIRE-
2 MENTS.—The comprehensive care plan for a dual eligible
3 individual shall be—

4 “(1) designed to address the totality of the indi-
5 viduals’ medical, functional, behavioral, social, and
6 caregiving needs and goals, and to the extent prac-
7 ticable, to apply to multiple years;

8 “(2) be based on the health risk assessment of
9 the individual required by subsection (c);

10 “(3) be implemented by an interdisciplinary
11 care team that includes relevant specialists to ensure
12 access to all aspects of care that are required for the
13 individual;

14 “(4) be approved by the individual (or by an
15 authorized caregiver or guardian) prior to implemen-
16 tation; and

17 “(5) be reviewed at least annually and within
18 30 days of a major health event, such as hospitaliza-
19 tion or an emergency room visit.

20 “(g) AUTHORITY TO APPLY FRAILTY ADJUSTMENT
21 FACTOR TO PLAN PAYMENTS.—A contract between a
22 State and integrated care plan under this title may apply
23 a frailty adjustment factor with respect to dual eligible
24 individuals enrolled in the plan in the same manner as
25 is permitted under section 1853(a)(1)(B)(iv), but without

1 regard to requiring the plan to demonstrate enrollment of
2 a high concentration of frail individuals.

3 **“SEC. 2205. DATA COLLECTION AND REPORTING.**

4 “(a) ANNUAL COLLECTION AND REPORTING BY
5 STATES AND INTEGRATED CARE PLANS.—Each State
6 and integrated care plans annually shall collect and report
7 information and data to the Director in accordance with
8 the requirements of this section and guidance and regula-
9 tions issued under section 2602(d)(17) of the Patient Pro-
10 tection and Affordable Care Act that includes data col-
11 lected by such plans with respect to a plan year regarding
12 age, gender, disability (including specific disability
13 statuses required to be reported by the Director), smoking
14 status, mobility, employment status, education, race and
15 ethnicity, and zip code, of dual eligible individuals enrolled
16 in the plan.

17 “(b) COLLECTION AND REPORTING OF ADDITIONAL
18 DATA AND INFORMATION PERMITTED.—A State may re-
19 quire an integrated care plan under contract with the
20 State to collect and report to the State additional data
21 and information.

22 **【“SEC. 2206. STATE OMBUDSMAN.**

23 【“(a) IN GENERAL.—Each State shall establish and
24 operate an Office of the Ombudsman for Integrated Care
25 Programs for Dual Eligible Individuals (in this section re-

1 ferred to as the ‘Office’). The Office may operate inde-
2 pendent of, or in connection with, the State agency respon-
3 sible for administering the Medicaid program under title
4 XIX.】

5 【“(b) OMBUDSMAN.—The Office shall be headed by
6 an individual, to be known as the State Integrated Care
7 for Dual Eligible Individuals Ombudsman, who shall be
8 selected from among individuals with expertise in and ex-
9 perience with integrated care models for dual eligible indi-
10 viduals, the Medicare program under title XVIII, and the
11 Medicaid program under title XIX. The Ombudsman shall
12 be responsible for the management, including the fiscal
13 management, of the Office.】

14 【“(c) REQUIREMENTS.—】

15 【“(1) IN GENERAL.—The primary responsi-
16 bility of the Office shall be to provide support and
17 feedback for dual eligible individuals enrolled in inte-
18 grated care plans under this title and caregivers or
19 family members of such individuals who need assist-
20 ance.】

21 【“(2) MINIMUM STAFFING RATIO.—The Office
22 shall have a minimum staffing ratio of 1 employee
23 for every 2,000 full-benefit dual eligible individuals
24 in the State.】

25 【“(d) FUNDING.—】

1 【“(1) INITIAL FUNDING.—During the first 2
2 years of the Office’s operation, the Secretary shall
3 pay the State 【\$_____】 for each such year for ex-
4 penditures necessary to establish and operate the
5 Office from amounts appropriated under section
6 2207(b).】

7 【“(2) SUBSEQUENT FUNDING.—Beginning with
8 the 3rd year of the Office’s operation, expenditures
9 necessary to operate the Office shall be considered,
10 for purposes of section 1903(a)(7), to be necessary
11 for the proper and efficient administration of the
12 State plan under title XIX and reimbursed in ac-
13 cordance with that section.】

14 **“SEC. 2207. FUNDING.**

15 “(a) PAYMENTS TO STATES.—From the sums appro-
16 priated under subsection (b), the Secretary shall pay to
17 each State for each calendar year (beginning January 1
18 of the first full calendar year in which this title is imple-
19 mented in the State), an amount equal to the sum of the
20 following:

21 “(1) PAYMENTS TO INTEGRATED CARE PLANS
22 UNDER CONTRACT WITH THE STATE.—An amount
23 equal to 【_____】 of the amount expended by the
24 State for the quarter for making payments to inte-

1 grated care plans under contract with the State
2 under this title.

3 “(2) SHARED SAVINGS COMPONENT.—The
4 shared savings payment applicable to the State and
5 the quarter, as determined in accordance with sec-
6 tion 2602(d)(16) of the Patient Protection and Af-
7 fordable Care Act.

8 “(3) GENERAL ADMINISTRATIVE EXPENSES.—
9 An amount equal to [____] percent of the amount
10 expended by State for the quarter for administrative
11 expenses to carry out this title, other than data col-
12 lection and reporting under section 2205, and sub-
13 ject to section 2207(d)(1).

14 “(4) DATA COLLECTION AND REPORTING.—An
15 amount equal to [____] percent of the amount ex-
16 pended by State for the quarter for data collection
17 and reporting expenses under section 2205.

18 “(b) APPROPRIATION.—There is appropriated, out of
19 any money in the Treasury not otherwise appropriated,
20 such amounts as may be required to provide payments to
21 States under this section, reduced by any amounts made
22 available from the Medicare trust funds under subsection
23 (c).

24 “(c) RELATION TO MEDICARE TRUST FUNDS.—
25 There shall be made available for application under this

1 title from the Federal Hospital Insurance Trust Fund
2 (under section 1817) and from the Federal Supplementary
3 Medical Insurance Trust Fund (under section 1841) (and
4 from the Medicare Prescription Drug Account (under sec-
5 tion 1860D–16) within such Trust Fund) such amounts
6 as the Secretary determines appropriate, taking into ac-
7 count the reductions in payments from such Trust Funds
8 and Account that are attributable to the enrollment of
9 dual eligible individuals in integrated care plans under this
10 title.

11 “(d) RELATION TO OTHER PAYMENTS.—Payments
12 provided under this section to a State are in addition to
13 payments provided under other provisions of this title.

14 **“SEC. 2208. FEDERAL ADMINISTRATION THROUGH THE**
15 **FEDERAL COORDINATED HEALTH CARE OF-**
16 **FICE.**

17 “(a) IN GENERAL.—The Director shall have primary
18 authority for implementing and carrying out responsibil-
19 ities of the Federal Government under this title.

20 “(b) APPROPRIATIONS.—There are hereby appro-
21 priated, out of any funds in the Treasury not otherwise
22 appropriated, for the first fiscal year that begins after the
23 date of enactment of this title, and for each fiscal year
24 thereafter, such sums as are necessary to carry out this

1 title and paragraphs (9) through (23) of section 2602(d)
2 of the Patient Protection and Affordable Care Act.

3 “(c) DIRECT-HIRE AUTHORITY.—In carrying out
4 this title, the Director shall have direct-hire authority to
5 the extent required to implement and administer this title
6 on a timely basis.”.

7 **SEC. 102. CONFORMING AMENDMENTS RELATING TO FED-**
8 **ERAL COORDINATED HEALTH CARE OFFICE**
9 **RESPONSIBILITIES.**

10 (a) DEVELOPMENT AND PUBLICATION OF INTE-
11 GRATED CARE PROGRAM MODELS.—Section 2602(d) of
12 the Patient Protection and Affordable Care Act (42
13 U.S.C. 1315b(d)) is amended by adding at the end the
14 following new paragraph:

15 “(9) To develop and, not later than 180 days
16 after the date of enactment of this paragraph, pub-
17 lish, a range of program models for providing inte-
18 grated care for dual eligible individuals from which
19 States shall select to develop and administer full and
20 partial integrated care programs for dual eligible in-
21 dividuals, in accordance with title XXII of the Social
22 Security Act. The program models developed and
23 published under this paragraph shall include—

24 “(A) models for providing comprehensive,
25 fully integrated care for dual eligible individuals

1 who are full-benefit dual eligible individuals (as
2 defined in section 1935(c)(6) of the Social Se-
3 curity Act but without the application of sub-
4 paragraph (A)(i) of such section); and

5 “(B) models for providing partially inte-
6 grated care for dual eligible individuals who are
7 not full-benefit dual eligible individuals but who
8 are eligible for the low-income subsidy program
9 under section 1860D–14, the Medicare Savings
10 Program (as defined in section 1144(c)(7)), or
11 both, that includes supplemental benefits.”.

12 (b) UNIFIED APPEALS PROCESS.—Section 2602(d)
13 of the Patient Protection and Affordable Care Act (42
14 U.S.C. 1315b(d)), as previously amended by this section,
15 is further amended by adding at the end the following new
16 paragraph:

17 “(10) To develop and, not later than 1 year
18 after the date of enactment of this paragraph, pub-
19 lish a unified administrative appeals process for
20 State integrated care programs for dual eligible indi-
21 viduals under title XXII of the Social Security Act
22 to use in lieu of other administrative appeals proc-
23 esses involving Medicare and Medicaid.”.

24 (c) HEALTH RISK ASSESSMENT.—Section 2602(d) of
25 the Patient Protection and Affordable Care Act (42

1 U.S.C. 1315b(d)), as previously amended by this section,
2 is further amended by adding at the end the following new
3 paragraph:

4 “(11) To develop a standardized health risk as-
5 sessment questionnaire for dual eligible individuals
6 that collects standard demographic data and infor-
7 mation relating to food insecurity, access to trans-
8 portation, internet access, utility difficulty, inter-
9 personal safety, and housing instability.”.

10 (d) SUPPLEMENTAL BENEFITS STANDARDS AND RE-
11 PORTING REQUIREMENTS.—Section 2602(d) of the Pa-
12 tient Protection and Affordable Care Act (42 U.S.C.
13 1315b(d)), as previously amended by this section, is fur-
14 ther amended by adding at the end the following new para-
15 graph:

16 “(12) To establish standards for reporting by
17 States and integrated care plans under title XXII
18 information relating to the offering and provision of
19 supplemental benefits under section 2204(d)(3) of
20 the Social Security Act, including data relating to
21 enrollment, utilization, and outcomes, to annually
22 publish a report regarding the offering and utiliza-
23 tion of such benefits, and to study and report to the
24 Secretary on whether to cap the actuarial dollar

1 value allowed for such benefits under titles XVIII,
2 XIX, and XXII.”.

3 (e) CARE COORDINATOR REQUIREMENTS.—Section
4 2602(d) of the Patient Protection and Affordable Care Act
5 (42 U.S.C. 1315b(d)), as previously amended by this sec-
6 tion, is further amended by adding at the end the following
7 new paragraphs:

8 “(13) To establish a formula based on patient
9 chronic conditions, activities of daily living stand-
10 ards, geographic, and such other factors as the Di-
11 rector determines are necessary for States and inte-
12 grated care plans to use to determine the maximum
13 staffing ratio for assigning care coordinators to dual
14 eligible individuals enrolled with integrated care
15 plans under title XXII.

16 “(14) To develop online training and profes-
17 sional development materials relating to the statu-
18 tory and administrative requirements for providing
19 integrated care for care coordinators for dual eligible
20 individuals enrolled with integrated care plans under
21 title XXI.”.

22 (f) ADMINISTRATION AND OVERSIGHT OF INTE-
23 GRATED CARE PLANS FOR DUAL ELIGIBLE INDIVID-
24 UALS.—Section 2602(d) of the Patient Protection and Af-
25 fordable Care Act (42 U.S.C. 1315b(d)), as previously

1 amended by this section, is further amended by adding
2 at the end the following new paragraphs:

3 “(15) To develop and issue guidance and regu-
4 lations related to the alignment of policy and oper-
5 ational process under the Medicare program under
6 title XVIII and the Medicaid program under title
7 XIX, necessary for implementation, administration,
8 and oversight of integrated care plans for dual eligi-
9 ble individuals under title XXII.

10 “(16) To administer and provide oversight of
11 integrated care plans for dual eligible individuals
12 under title XXII, including with respect to the fol-
13 lowing:

14 “(A) Development and application of an
15 integrated medical loss ratio for such plans, in
16 lieu of compliance with separate medical loss
17 ratio requirements under titles XVIII and XIX.

18 “(B) Establishment and application of net-
19 work adequacy standards for such plans that—

20 “(i) apply only with respect to such
21 plans;

22 “(ii) allow the Director to waive com-
23 pliance with such standards for integrated
24 care plans that cannot meet the require-
25 ments in certain areas, but must operate

1 statewide to meet a States' selective con-
2 tracting requirements; and

3 “(iii) allow the Director to consider
4 flexibilities to support innovative models
5 that do not rely on traditional time and
6 distance standards, such as the use of tele-
7 health.

8 **【“(C) With respect to fully integrated care**
9 **plans under title XXII, establishment and ap-**
10 **plication of targeted, streamlined model-of-care**
11 **requirements for such plans that include an in-**
12 **tegrated audit process, with shared responsibil-**
13 **ities between the Director and States, and that**
14 **requires the Director to share the results of**
15 **such audits with State Medicaid programs. To**
16 **the extent practicable, such requirements also**
17 **shall be designed to be integrated with model of**
18 **care requirements applicable to Medicaid man-**
19 **aged care organizations.】**

20 “(17) To develop contract management teams,
21 consisting of representatives from integrated care
22 plans with contracts with States under title XXII,
23 State agencies responsible for administering the
24 State plan under title XIX or a waiver of such, and
25 the Federal Coordinated Health Care Office, to over-

1 see compliance and performance of integrated care
2 plans under title XXII.

3 “(18) To develop and implement a shared sav-
4 ings payment for States to receive a share of savings
5 to Federal spending in the Medicaid program estab-
6 lished under title XIX as a result of the implementa-
7 tion and operation of integrated care plans for dual
8 eligible individuals under title XXII.

9 [“(19) To develop a new star rating system for
10 integrated care plans for dual eligible individuals
11 under title XXII that rates the performance of each
12 plan type separately, with State-specific measures
13 and tied to single contracts, instead of the collective
14 performance of all of the offeror’s plans under con-
15 tract with the State under that title, that include
16 measures which directly reflect enrollee satisfaction,
17 and that awards higher star ratings to plans based
18 on their ability to retain enrollees.”.]

19 (g) DATA COLLECTION AND REPORTING.—Section
20 2602(d) of the Patient Protection and Affordable Care Act
21 (42 U.S.C. 1315b(d)) is further amended by adding at the
22 end the following new paragraph:

23 “(20) To establish data and information collec-
24 tion and reporting requirements for States and inte-
25 grated care plans under section 2205, including re-

1 quired reporting of specific disability statuses and
2 safeguards to protect patient privacy, and to annual
3 publish not later than April of any year, the data
4 and information collected and reported to the Direc-
5 tor under such section for the preceding year.”.

6 **[(h) QUALITY MEASURES.—**Section 2602(d) of the
7 Patient Protection and Affordable Care Act (42 U.S.C.
8 1315b(d)), as previously amended by this section, is fur-
9 ther amended by adding at the end the following new para-
10 graph: **]**

11 **[(“(21) To develop quality measures for the**
12 population of dual eligible individuals that are de-
13 signed to be uniformly implemented across all plat-
14 forms and health benefits plans that provide inte-
15 grated care for such individuals under title XXII of
16 the Social Security Act. Such measures shall include
17 measures relating to patient satisfaction, quality of
18 life, rates of emergency room use, institutionaliza-
19 tion for long-term care, hospital admission and read-
20 mission rates, and medication errors. The Director
21 shall regularly review and update such measures as
22 necessary and may develop outcome-based quality
23 measures for determining payments to health bene-
24 fits plans that provide integrated care for dual eligi-

1 ble individuals under title XXII of the Social Secu-
2 rity Act.”.]

3 (i) BEST PRACTICES.—Section 2602(d) of the Pa-
4 tient Protection and Affordable Care Act (42 U.S.C.
5 1315b(d)), as previously amended by this section, is fur-
6 ther amended by adding at the end the following new para-
7 graph:

8 “(22) To not less than annually publish best
9 practices under title XXII for States and integrated
10 care plans, including with respect to improving out-
11 reach to beneficiaries, improving comprehensive care
12 plans and health risk assessments for dual eligible
13 individuals, and developing a workforce that provides
14 culturally intelligent and respectful care.”.

15 (j) TRAINING PROGRAMS.—Section 2602(d) of the
16 Patient Protection and Affordable Care Act (42 U.S.C.
17 1315b(d)), as previously amended by this section, is fur-
18 ther amended by adding at the end the following new para-
19 graph:

20 “(23) To develop training programs related to
21 integrated care plans under title XXII for—

22 “(A) providers of care, services, and sup-
23 ports under such plans with respect to issues
24 such as coordination of benefits, data sharing

1 barriers, quality ratings, and provider incen-
2 tives;

3 “(B) State employees to increase Medicare
4 expertise at State agencies responsible for ad-
5 ministering Medicaid plans and waivers and
6 contracting with integrated care plans under
7 title XXII; and

8 “(C) insurance brokers and local coun-
9 selors who help enroll individuals in Medicare,
10 Medicaid, and integrated care plans under title
11 XXII.”.

12 **SEC. 103. ADDITIONAL CONFORMING AMENDMENTS.**

13 (a) DEFINITION OF STATE.—Section 1101(a)(1) of
14 the Social Security Act (42 U.S.C. 1301(a)(1)) is amend-
15 ed—

16 (1) by striking “XIX, and XXI” and inserting
17 “XIX, XXI, and XXII”; and

18 (2) by striking “XIX and XXI” and inserting
19 “XIX, XXI, and XXII”.

20 (b) MEDICARE ENROLLMENT.—Section 1851(a) of
21 the Social Security Act (42 U.S.C. 1395w–21(a)) is
22 amended by adding at the end the following new para-
23 graph:

24 “(4) ADDITIONAL ENROLLMENT OPTION FOR
25 DUAL ELIGIBLE INDIVIDUALS.—Dual eligible individ-

1 uals (as defined in section 2201) may also be eligible
2 to enroll in an integrated care plan under title
3 XXII.”.

4 (c) PREVENTING DUPLICATE PAYMENTS UNDER
5 MEDICAID.—Section 1903(i) of the Social Security Act
6 (42 U.S.C. 1396(i)) is amended—

7 (1) by striking “or” at the end of paragraph
8 (26);

9 (2) by striking the period at the end of para-
10 graph (27) and inserting “; or”;

11 (3) by inserting after paragraph (27) the fol-
12 lowing new paragraph:

13 “(28) with respect to any amount expended for
14 medical assistance for a dual eligible individual (as
15 defined in section 2201) enrolled in a integrated
16 care plan under title XXII, except specifically per-
17 mitted under such title.”; and

18 (4) in the third sentence, by striking “, and
19 (18)” and inserting “, (18), and (28)”.

1 **TITLE II—IMPROVING ELIGI-**
2 **BILITY DETERMINATIONS, EN-**
3 **ROLLMENT PROCESSES, AND**
4 **QUALITY OF CARE FOR DUAL**
5 **ELIGIBLE INDIVIDUALS**

6 **[SEC. 201. DEVELOPMENT OF NEW RISK ADJUSTMENT PAY-**
7 **MENT MODEL.**

8 Section 2602 of the Patient Protection and Afford-
9 able Care Act (42 U.S.C. 1315b) is amended by adding
10 at the end the following:】

11 **【“(g) RISK ADJUSTMENT PAYMENT MODEL FOR**
12 **PROVIDING HEALTH BENEFITS COVERAGE FOR DUAL**
13 **ELIGIBLE INDIVIDUALS.—**Not later than 1 year after the
14 date of enactment of this subsection, the Director shall
15 enter into a contract or other agreement with an inde-
16 pendent entity to develop a risk adjustment payment
17 model for dual eligible individuals that—】

18 **【“(1) is designed to be uniformly implemented**
19 **across all platforms and health benefits plans that**
20 **provide integrated care for such individuals under**
21 **title XXII of the Social Security Act;】**

22 **【“(2) includes factors based on the health sta-**
23 **tus of such individuals; and】**

24 **【“(3) allows plan payments to be made and up-**
25 **dated on a monthly basis.”.】**

1 **SEC. 202. IDENTIFYING OPPORTUNITIES FOR STATE CO-**
2 **ORDINATION WITH RESPECT TO ELIGIBILITY**
3 **DETERMINATIONS.**

4 Not later than 1 year after the date of enactment
5 of this Act, the Secretary of Health and Human Services,
6 in consultation with States, shall—

7 (1) review State processes for determining
8 whether an individual is a full-benefit dual individual
9 (as defined in section 1935(c)(6) of the Social Secu-
10 rity Act (42 U.S.C. 1396u–5(e)(6)) but without the
11 application of subparagraph (A)(i) of such section)
12 and whether an individual is eligible for the low-in-
13 come subsidy program under section 1860D–14 of
14 the Social Security Act (42 U.S.C. 1395w–114) and
15 the Medicare Savings Program (as defined in section
16 1144(c)(7) of such Act (42 U.S.C. 1320b–
17 14(c)(7))); and

18 (2) issue guidance for States that identifies op-
19 portunities for better coordination of such processes
20 among States.

21 **SEC. 203. ALIGNMENT OF BIDDING, REPORTING, AND**
22 **OTHER DATES AND DEADLINES FOR INTE-**
23 **GRATED CARE PLANS.**

24 Not later than 180 days after the date of enactment
25 of this Act, the Director of the Federal Coordinated
26 Health Care Office of the Centers for Medicare & Med-

1 icaid Services and the Administrator of the Centers for
2 Medicare & Medicaid Services shall—

3 (1) review bidding, reporting, and other signifi-
4 cant dates and deadlines applicable to integrated
5 care plans under the Medicare program, the Med-
6 icaid program, and State Integrated Care Programs
7 for Dual Eligible Individuals under XXII of the So-
8 cial Security Act; and

9 (2) identify such administrative and legislative
10 changes as are need to ensure that all such dates
11 and deadlines are aligned and consistent under all
12 such programs.

13 **SEC. 204. GRANTS TO STATE AND LOCAL COMMUNITY OR-**
14 **GANIZATIONS FOR OUTREACH AND ENROLL-**
15 **MENT.**

16 (a) IN GENERAL.—From the amounts appropriated
17 under subsection (c) for a fiscal year, the Secretary of
18 Health and Human Services (in this section referred to
19 as the “Secretary”) shall award grants to State and local
20 community organizations to conduct outreach and enroll-
21 ment efforts that are designed to increase the enrollment
22 dual eligible individuals (as defined in section 2201 of the
23 Social Security Act) in health benefits plans that provide
24 integrated care for such individuals under State Inte-

1 grated Care Programs for Dual Eligible Individuals estab-
2 lished under XXII of the Social Security Act.

3 (b) MODEL STANDARDS.—The Secretary, in con-
4 sultation with the Administrator of the Administration for
5 Community Living and States, shall develop and issue
6 model standards for outreach and education conducted by
7 State and local community organizations awarded grants
8 under this section that include the following:

9 (1) Information and education support is avail-
10 able for individuals in a range of languages, and on-
11 line, over the phone, and in person.

12 (2) Materials presented are easy to read, writ-
13 ten in as low a reading comprehension level as pos-
14 sible, and are in the proper language for the indi-
15 vidual involved.

16 (3) Information presented online is accessible
17 for individuals with disabilities.

18 (4) Information is presented in a manner that
19 takes into consideration the accessibility needs of the
20 individual, such as language access requirements
21 and the health literacy level of the individual.

22 (c) APPROPRIATION.—There is appropriated, out of
23 any money in the Treasury not otherwise appropriated,
24 for the first fiscal year that begins after the date of enact-

1 ment of this Act, and for each fiscal year thereafter,
2 **[\$_____]** to carry out this section.

3 **SEC. 205. APPLICATION OF MODEL STANDARDS TO INFOR-**
4 **MATION REQUIREMENTS FOR INTEGRATED**
5 **CARE PLANS.**

6 Not later than 1 year after the date of enactment
7 of this Act, the Director of the Federal Coordinated
8 Health Care Office of the Centers for Medicare & Med-
9 icaid Services and the Administrator of the Centers for
10 Medicare & Medicaid Services jointly shall issue guidance
11 or regulations requiring that any notice or informational
12 materials provided to a dual eligible individual (as defined
13 in section 2201 of the Social Security Act) by such Direc-
14 tor, Administrator, States, or health benefits plans that
15 provide integrated care for such individuals under the
16 Medicare program, the Medicaid program, or under State
17 Integrated Care Programs for Dual Eligible Individuals
18 established under XXII of the Social Security Act com-
19 plies with the model standards issued under section
20 204(b).

21 **SEC. 206. ENROLLMENT THROUGH INDEPENDENT BRO-**
22 **KERS.**

23 Not later than 1 year after the date of enactment
24 of this Act, the Director of the Federal Coordinated
25 Health Care Office of the Centers for Medicare & Med-

1 Medicaid Services and the Administrator of the Centers for
2 Medicare & Medicaid Services jointly shall issue guidance
3 or regulations providing that—

4 (1) a dual eligible individual (as defined in sec-
5 tion 2201 of the Social Security Act) may not be en-
6 rolled in a health benefits plan that provides inte-
7 grated care for such individual under XXII of the
8 Social Security Act through a broker unless the
9 broker is an independent broker (as defined under
10 such guidance or regulations);

11 (2) the commission an independent broker may
12 receive with respect to the enrollment of a dual eligi-
13 ble individual in any such health benefits plan is lim-
14 ited to the initial enrollment of the individual in any
15 such plan by such broker; and

16 (3) if a broker disenrolls a dual eligible indi-
17 vidual from any such health benefits plan that pro-
18 vides fully integrated care to a plan that provides
19 partial or no integrated care, the broker, in accord-
20 ance with the model standards issued under section
21 204(b), shall inform the individual—

22 (A) of the health benefits plan the indi-
23 vidual is being disenrolled from; and

24 (B) that the individual is being enrolled in
25 a health benefits plan that provides partial or

1 no integrated care and the potential implica-
2 tions of such disenrollment and enrollment on
3 the individual's care; and

4 **SEC. 207. REDUCING THRESHOLD FOR LOOK-ALIKE D-SNP**
5 **PLANS UNDER MEDICARE ADVANTAGE.**

6 For plan year 2025 and subsequent plan years, the
7 Secretary of Health and Human Services—

8 (1) shall implement section 422.514(d)(1)(ii) of
9 title 42, Code of Federal Regulations (or any suc-
10 cessor regulations) by substituting “50 percent” for
11 “80 percent”; and

12 (2) shall only count full-benefit dual eligible in-
13 dividuals (as defined in section 1935(c)(6) of the So-
14 cial Security Act (42 U.S.C. 1396u-5(c)(6))) for
15 purposes of applying the threshold under such sec-
16 tion.

17 **SEC. 208. UNIFORM PROHIBITION ON ENROLLMENT IN AN**
18 **INTEGRATED PLAN WITH A RATING OF LESS**
19 **THAN 3 STARS.**

20 Notwithstanding any other provision of law, a dual
21 eligible individual (as defined in section 2201 of the Social
22 Security Act) shall not be enrolled in a health benefits
23 plans that provides integrated care for such individual
24 under title XXII of the Social Security Act that has a
25 quality rating under section 1853(o)(4) of the Social Secu-

1 rity Act (42 U.S.C. 1395w-23(o)(4)) (or, at the discretion
2 of the Secretary, an equivalent rating system) of less than
3 3 stars based on the most recent data available.

4 **SEC. 209. REQUIRING REGULATE UPDATE OF PROVIDER DI-**
5 **RECTORIES.**

6 Not later than 1 year after the date of enactment
7 of this Act, the Director of the Federal Coordinated
8 Health Care Office of the Centers for Medicare & Med-
9 icaid Services and the Administrator of the Centers for
10 Medicare & Medicaid Services shall promulgate regula-
11 tions that—

12 (1) require Medicare Advantage plans under
13 part C of title XVIII of the Social Security Act (42
14 U.S.C. 1395w-21) and integrated care plans under
15 title XXII of such Act to regularly update provider
16 directories; and

17 (2) include a measure relating to provider direc-
18 tor currency rating on star rating systems for Medi-
19 care Advantage plans under section 1853(o) of the
20 Social Security Act (42 U.S.C. 1395w-23(o)) and
21 integrated care plans under title XXII of such Act.

1 **SEC. 210. ADDITIONAL RESPONSIBILITIES FOR THE FED-**
2 **ERAL COORDINATED HEALTH CARE OFFICE**
3 **WITH RESPECT TO INTEGRATED CARE PLANS**
4 **UNDER MEDICAID AND MEDICARE.**

5 Section 2602 of the Patient Protection and Afford-
6 able Care Act (42 U.S.C. 1315b), as amended by section
7 201, is further amended by adding at the end the fol-
8 lowing:

9 “(h) **ADDITIONAL RESPONSIBILITIES WITH RESPECT**
10 **TO INTEGRATED CARE PLANS UNDER MEDICAID AND**
11 **MEDICARE.—**

12 “(1) **OUTREACH TO MEDICAID PROVIDERS.—**

13 Not later than 180 days after the date of enactment
14 of this subsection, the Director, in consultation with
15 State Medicaid programs, shall develop outreach
16 plans for such programs to use to contact providers
17 of health benefits, services, or supports for dual eli-
18 gible individuals and provide information and edu-
19 cation regarding the State Integrated Care Pro-
20 grams for Dual Eligible Individuals established
21 under XXII of the Social Security Act, how such
22 program will operate in the State where such pro-
23 viders offer health benefits, services or supports for
24 such individuals, and the impact of such program on
25 such providers.

1 “(2) COLLECTION OF DATA ON QUALITY MEAS-
2 URES FROM INTEGRATED CARE PLANS UNDER MED-
3 ICAID AND MEDICARE.—

4 “(A) IN GENERAL.—Not later than 180
5 days after the date of enactment of this sub-
6 section, the Director, in consultation with the
7 Administrator of the Centers for Medicare &
8 Medicaid Services and State Medicaid pro-
9 grams, shall establish a plan for collecting data
10 on quality measures from health benefits plans
11 that provide integrated care for dual eligible in-
12 dividuals under Medicare or Medicaid. Such
13 data shall include, at a minimum, data relating
14 to provider network availability in both Medi-
15 care and Medicaid, providers in-network who
16 are accepting new Medicare and Medicaid pa-
17 tients, spending on supplemental benefits, and
18 claims denials.

19 “(B) AUTHORITY TO COLLECT ADDI-
20 TIONAL DATA AND INFORMATION; PUBLICA-
21 TION.—The Director may—

22 “(i) collect additional data and infor-
23 mation relating to the quality of care pro-
24 vided for dual eligible individuals by health
25 benefits plans that provide integrated care

1 for such individuals under Medicare or
2 Medicaid; and

3 “(ii) make the data and information
4 collected in accordance with this paragraph
5 publicly available.

6 “(3) DEVELOPMENT OF AN ALIGNED PROGRAM
7 FOR INSTITUTIONAL SPECIAL NEEDS PLANS UNDER
8 MEDICAID.—Not later than 180 days after the date
9 of enactment of this subsection, the Director, in con-
10 sultation with the Administrator of the Centers for
11 Medicare & Medicaid Services and State Medicaid
12 programs, shall developed an aligned program for of-
13 fering Institutional Special Needs Plans under Med-
14 icaid that has 1 entity financially responsible for
15 providing health benefits, services, and supports for
16 dual eligible individuals.

17 “(4) ASSESSMENT OF NEED FOR CRITERIA TO
18 REGULATE AND EXPAND UTILIZATION OF INSTITU-
19 TIONAL SPECIAL NEEDS PLANS.—Not later than 180
20 days after the date of enactment of this subsection,
21 the Director, in consultation with the Administrator
22 of the Centers for Medicare & Medicaid Services,
23 shall assess the adequacy of regulations and over-
24 sight of Institutional Special Needs Plan to deter-
25 mine whether new, or additional requirements should

1 be established to improve the utilization, perform-
2 ance, and oversight of such plans and how such
3 plans may be offered under State Integrated Care
4 Programs for Dual Eligible Individuals established
5 under XXII of the Social Security Act.”.

6 **SEC. 211. REVIEW OF HOSPITAL QUALITY STAR RATING**
7 **SYSTEM.**

8 Not later than 180 days after the date of enactment
9 of this Act, the Administrator of the Centers for Medicare
10 & Medicaid Services shall—

11 (1) review the hospital quality star rating sys-
12 tem under the Medicare program under title XVIII
13 of the Social Security Act (42 U.S.C. 1395 et seq.);
14 and

15 (2) identify such administrative and legislative
16 changes as are needed to ensure that sufficient in-
17 formation is collected under such system regarding
18 hospitals to effectively measure hospital quality.

19 **SEC. 212. REQUIREMENT FOR FCHCO AND STATE MEDICAID**
20 **AGENCIES TO DEVELOP MAXIMUM STAFFING**
21 **RATIOS FOR CARE COORDINATORS.**

22 (a) IN GENERAL.—The Director of the Federal Co-
23 ordinated Health Care Office, in consultation with State
24 Medicaid agencies, shall develop model Federal legislation
25 that would establish a process for determining a maximum

1 care coordinator-to-patient ratio. Such process shall take
2 into account the varying needs required by different cat-
3 egories of patients.

4 (b) SUBMISSION OF MODEL LEGISLATION.—Not
5 later than 180 days after the date of enactment of this
6 Act, the Director of the Federal Coordinated Health Care
7 Office shall submit the model legislation developed under
8 subsection (a) to—

9 (1) the Secretary of Health and Human Serv-
10 ices;

11 (2) the Committee on Finance of the Senate;
12 and

13 (3) the Committee on Energy and Commerce of
14 the House of Representatives.

15 **TITLE III—ADMINISTRATION**

16 **SEC. 301. ALIGNMENT OF BILLING CODES UNDER TITLES** 17 **XVIII, XIX, AND XXII.**

18 Not later than 180 days after the date of enactment
19 of this Act, the Director of the Federal Coordinated
20 Health Care Office of the Centers for Medicare & Med-
21 icaid Services and the Administrator of the Centers for
22 Medicare & Medicaid Services shall—

23 (1) review billing codes under the Medicare pro-
24 gram, the Medicaid program, and State Integrated

1 Care Programs for Dual Eligible Individuals under
2 XXII of the Social Security Act; and

3 (2) identify such administrative and legislative
4 changes as are need to ensure that all such billing
5 codes are aligned and consistent under all such pro-
6 grams.

7 **SEC. 302. REQUIRING ACCOUNTABLE CARE ORGANIZA-**
8 **TIONS TO HAVE A STATE MEDICAID AGENCY**
9 **CONTRACT.**

10 Section 1899(b)(2) of the Social Security Act (42
11 U.S.C. 1395jjj(b)(2)) is amended by adding at the end
12 the following new subparagraph:

13 “(J) The ACO shall have a contract with
14 the State Medicaid agency to provide benefits,
15 or arrange for benefits to be provided, for which
16 a Medicare fee-for-service beneficiary assigned
17 to the ACO is entitled to receive as medical as-
18 sistance under title XIX.”.

19 **[TITLE IV—PACE]**

20 **[SEC. 401. REQUIRING STATES TO OFFER PACE PROGRAM**
21 **SERVICES TO ELIGIBLE INDIVIDUALS.**

22 **[(a) IN GENERAL.—**Section 1934 of the Social Secu-
23 rity Act (42 U.S.C. 1396u-4) is amended—**]**

24 **[(1) in subsection (a)(1)—]**

1 **[(A) by striking “A State may elect to**
2 **provide” and inserting “A State shall provide”;**
3 **and]**

4 **[(B) by striking “A State may establish a**
5 **numerical limit on the number of individuals**
6 **who may be enrolled in a PACE program under**
7 **a PACE program agreement.”;]**

8 **[(2) in subsection (e)—]**

9 **[(A) in paragraph (1)—]**

10 **[(i) by striking “(A) IN GENERAL.—**
11 **The Secretary” and inserting “The Sec-**
12 **retary”; and]**

13 **[(ii) by striking subparagraph (B);]**

14 **[(B) in paragraph (2)(A)(ii) *[SLC: Advise***
15 ***on whether/how 1934(e)(2)(A)(ii) should be***
16 ***amended to remove State ability to impose addi-***
17 ***tional requirements on who is eligible for***
18 ***PACE.*]; and]**

19 **[(3) in subsection (h)(2)—]**

20 **[(A) by striking “(A) IN GENERAL.—Ex-**
21 **cept as provided under subparagraph (B), and”**
22 **and inserting “Except as provided under”;**
23 **and]**

24 **[(B) by striking subparagraph (B).]**

1 【(1) in the subparagraph header, by inserting
2 “ENROLLMENT OR”；】

3 【(2) by inserting “PACE program eligible indi-
4 viduals to enroll in a PACE program at any time
5 and” after “shall permit”； and】

6 【(3) by adding at the end the following sen-
7 tence: “The amount of any capitated payment made
8 to a PACE provider under subsection (d)(1) may be
9 adjusted to account for any PACE program eligible
10 individuals who enroll after the first day of a month
11 (with the amount of such payment adjustment being
12 proportional to the portion of such month for which
13 the individual is enrolled)”．】

14 【(b) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on the date that is 180 days
16 after the date of enactment of this Act．】

17 **【SEC. 403. EXTENDING ELIGIBILITY FOR PACE TO MEDI-**
18 **CARE-ELIGIBLE INDIVIDUALS UNDER THE**
19 **AGE OF 55.**

20 【(a) IN GENERAL.—Sections 1894(a)(5)(A) and
21 1934(a)(5)(A) of the Social Security Act (42 U.S.C.
22 1395eee(a)(5), 1396u-4(a)(5)) are each amended by in-
23 serting “(or any age in the case of an individual who is
24 eligible for benefits under part A, or enrolled under part
25 B, of title XVIII)” after “is 55 years of age or older”．】

1 **[(b) EFFECTIVE DATE.—**The amendments made by
2 this section shall take effect on the date that is 180 days
3 after the date of enactment of this Act.]

4 **[SEC. 404. REMOVAL OF QUARTERLY RESTRICTIONS FOR**
5 **SUBMISSION OF A NEW PACE ORGANIZATION**
6 **APPLICATION, AND REMOVAL QUARTERLY**
7 **RESTRICTIONS FOR APPLICATIONS IN A NEW**
8 **SERVICE AREA.**

9 **[(a) IN GENERAL.—**Sections 1894(e) and 1934(e) of
10 the Social Security Act (42 U.S.C. 1395eee(e), 1396u–
11 4(e)) are each amended by adding at the end the following
12 new paragraph:]

13 **["(9) NO QUARTERLY OR GEOGRAPHIC LIMITA-**
14 **TIONS ON APPLICATIONS FOR PACE PROVIDER STA-**
15 **TUS.—**The Secretary shall not prohibit an entity
16 that meets the requirements for a PACE provider
17 under this section from—]

18 **["(A) submitting multiple applications in**
19 **the same quarter; or]**

20 **["(B) submitting multiple applications to**
21 **operate a PACE program in the same service**
22 **area.”.]**

23 **[(b) EFFECTIVE DATE.—**The amendments made by
24 this section shall take effect on the date that is 180 days
25 after the date of enactment of this Act.]

1 **[SEC. 405. COST OUTLIER PROTECTION FOR NEW PACE**
2 **PROVIDERS.**

3 **[***SLC: Based closely on rural PACE outlier program*
4 *established under sec. 5302(c) of the Deficit Reduction Act*
5 *of 2005.***]**

6 **[(a) DEFINITIONS.—In this section:]**

7 **[(1) ELIGIBLE OUTLIER PARTICIPANT.—**The
8 term “eligible outlier participant” means a PACE
9 program eligible individual (as defined in sections
10 1894(a)(5) and 1934(a)(5) of the Social Security
11 Act (42 U.S.C. 1395eee(a)(5), 1396u–4(a)(5))) with
12 respect to whom a new PACE provider incurs more
13 than \$50,000 in recognized costs in a 12-month pe-
14 riod.**]**

15 **[(2) PACE PROGRAM.—**The term “PACE pro-
16 gram” has the meaning given that term in sections
17 1894(a)(2) and 1934(a)(2) of the Social Security
18 Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).**]**

19 **[(3) PACE PROVIDER.—**The term “PACE pro-
20 vider” has the meaning given that term in section
21 1894(a)(3) or 1934(a)(3) of the Social Security Act
22 (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).**]**

23 **[(4) RECOGNIZED OUTLIER COSTS.—]**

24 **[(A) IN GENERAL.—**The term “recognized
25 outlier costs” means, with respect to services
26 furnished to an eligible outlier participant by a

1 new PACE provider, the least of the following
2 (as documented by the provider to the satisfac-
3 tion of the Secretary) for the provision of inpa-
4 tient and related physician and ancillary serv-
5 ices for the eligible outlier participant in a given
6 12-month period:】

7 【(i) If the services are provided under
8 a contract between the new PACE provider
9 and the service provider, the payment rate
10 specified under the contract.】

11 【(ii) The payment rate established
12 under the original Medicare fee-for-service
13 program for such service.】

14 【(iii) The amount actually paid for
15 the services by the new PACE provider.】

16 【(B) INCLUSION IN ONLY ONE PERIOD.—
17 Recognized outlier costs may not be included in
18 more than one 12-month period.】

19 【(5) SECRETARY.—The term “Secretary”
20 means the Secretary of Health and Human Serv-
21 ices.】

22 【(b) COST OUTLIER PROTECTION FOR NEW PACE
23 PROVIDERS.—】

24 【(1) ESTABLISHMENT OF FUND FOR REIM-
25 BURSEMENT OF OUTLIER COSTS FOR NEW PACE

1 PROVIDERS.—Notwithstanding any other provision
2 of law, the Secretary shall establish an outlier fund
3 to protect new PACE providers from exceptionally
4 high outlier costs.】

5 【(2) PAYMENT TO PACE PROVIDERS FOR REC-
6 OGNIZED OUTLIER COSTS.—Subject to paragraph
7 (3), if a PACE provider has recognized outlier costs
8 with respect to an eligible outlier participant the
9 Secretary shall pay such provider an amount equal
10 to 80 percent of such costs to the extent that they
11 exceed \$50,000.】

12 【(3) LIMITATIONS.—】

13 【(A) COSTS INCURRED PER ELIGIBLE
14 OUTLIER PARTICIPANT.—The total amount of
15 payments made to a PACE provider under this
16 subsection with respect to an eligible outlier
17 participant for any 12-month period shall not
18 exceed \$100,000 for the 12-month period used
19 to calculate the payment.】

20 【(B) COSTS INCURRED PER PROVIDER.—
21 No PACE provider may receive more than
22 \$500,000 in total payments under this sub-
23 section in a 12-month period.】

24 【(C) LIMITATION OF OUTLIER COST REIM-
25 BURSEMENT PERIOD.—A PACE provider shall

1 only receive payments under this subsection
2 with respect to costs incurred during the first
3 3 years of the provider's operation.】

4 **【(4) REQUIREMENT TO ACCESS RISK RESERVES**
5 **PRIOR TO PAYMENT.—**A PACE provider shall access
6 and exhaust any risk reserves held or arranged for
7 the provider (other than revenue or reserves main-
8 tained to satisfy the requirements of section
9 460.80(c) of title 42, Code of Federal Regulations)
10 prior to receiving any payment under this sub-
11 section.】

12 **【(5) APPLICATION.—**In order to receive a pay-
13 ment under this subsection with respect to an eligi-
14 ble outlier participant, a PACE provider shall sub-
15 mit an application containing—】

16 **【(A) documentation of the costs incurred**
17 with respect to the participant;】

18 **【(B) a certification that the provider has**
19 complied with the requirements of this sub-
20 section; and】

21 **【(C) such additional information as the**
22 Secretary may require.】

23 **【(c) APPROPRIATION.—***【SLC: Appropriate \$ for the*
24 *outlier fund? The rural outlier fund was funded at \$10M*
25 *for period of 2006-10.】】*

1 **[(d) ADJUSTMENT TO PACE COUNTY BENCH-**
2 **MARKS.—**In determining the capitation amounts under
3 section 1894(d)(2) of the Social Security Act (42 U.S.C.
4 1395eee(d)(2)) for any year beginning after the date of
5 enactment of this Act the Secretary shall—**]**

6 **[(1) estimate the amount of payments that the**
7 **Secretary expects to make under subsection (b) for**
8 **such year; and]**

9 **[(2) adjust such capitation amounts so that the**
10 **total amount of payments made to PACE providers**
11 **for the year (including payments under this sub-**
12 **section) shall not exceed the amount of payments**
13 **that would be made to PACE providers for the year**
14 **if this section had not been enacted.]**

15 **[SEC. 406. ENSURING MEDICARE-ONLY PACE PROGRAM EN-**
16 **ROLLEES HAVE A CHOICE OF PRESCRIPTION**
17 **DRUG PLANS UNDER MEDICARE PART D.**

18 Section 1860D–21(f) of the Social Security Act (42
19 U.S.C. 1395w–131(f)) is amended— **]**

20 **[(1) in paragraph (1), by striking “and (3)”**
21 **and inserting “(3), and (4)”;** and**]**

22 **[(2) by adding at the end the following new**
23 **paragraph:]**

24 **[“(4) ENSURING CHOICE OF PRESCRIPTION**
25 **DRUG PLANS.—]**

1 **【“(A) IN GENERAL.—**For plan years be-
2 ginning on or after January 1, 2024, subject to
3 the succeeding provisions of this paragraph, an
4 applicable PACE program enrollee may elect to
5 enroll in a qualified standalone prescription
6 drug plan, in accordance with rules established
7 by the Secretary pursuant to this paragraph,
8 while enrolled under a PACE program.**】**

9 **【“(B) DEFINITION OF APPLICABLE PACE**
10 PROGRAM ENROLLEE; QUALIFIED STANDALONE
11 PRESCRIPTION DRUG PLAN.—In this para-
12 graph:**】**

13 **【“(i) APPLICABLE PACE PROGRAM**
14 ENROLLEE.—The term ‘applicable PACE
15 program enrollee’ means a part D eligible
16 individual who—**】**

17 **【“(I) is not entitled to medical**
18 assistance under title XIX; and**】**

19 **【“(II) is enrolled under a PACE**
20 program offered by a PACE pro-
21 vider.**】**

22 **【“(ii) QUALIFIED STANDALONE PRE-**
23 SCRIPTION DRUG PLAN.—The term ‘quali-
24 fied standalone prescription drug plan’
25 means, with respect to an applicable PACE

1 program enrollee, a prescription drug
2 plan—】

3 【“(I) that is not an MA-PD
4 plan;】

5 【“(II) that is not operated by the
6 PACE program under which the indi-
7 vidual is enrolled; and】

8 【“(III) for which the Secretary
9 determines, with respect to the appli-
10 cable PACE program enrollees en-
11 rolled in a PACE program offered by
12 such PACE provider, that—】

13 【“(aa) the estimated bene-
14 ficiary out-of-pocket costs (as de-
15 fined in clause (iii)) for the plan
16 year for qualified prescription
17 drug coverage under the plan is
18 equal to or less than the esti-
19 mated out-of-pocket costs for
20 such coverage under the prescrip-
21 tion drug plan offered by the
22 PACE program in which the ap-
23 plicable PACE program enrollee
24 is enrolled; and】

1 【“(bb) the estimated total
2 amount of Federal subsidies for
3 the plan year for qualified pre-
4 scription drug coverage under the
5 plan (which may be estimated
6 using data from the previous
7 plan year) is equal to or less than
8 the estimated subsidy amount for
9 such coverage under the prescrip-
10 tion drug plan offered by the
11 PACE program in which the ap-
12 plicable PACE program enrollee
13 is enrolled.】

14 【“(iii) OUT-OF-POCKET COSTS DE-
15 FINED.—In this paragraph, the term ‘out-
16 of-pocket costs’ includes premiums imposed
17 under a prescription drug plan and, in the
18 case of coverage under a qualified stand-
19 alone prescription drug plan, deductibles,
20 copayments, coinsurance, and other cost-
21 sharing.】

22 【“(C) OUT-OF-POCKET COSTS.—In the
23 case where an applicable PACE program en-
24 rollee elects to enroll in a qualified standalone
25 prescription drug plan pursuant to this para-

1 graph, the individual shall be responsible for
2 any out-of-pocket costs imposed under the plan
3 (including costs for nonformulary drugs) after
4 the application of any subsidies under section
5 1860D–14 for an applicable PACE program en-
6 rollee who is a subsidy eligible individual (as de-
7 fined in section 1860D–14(a)(3)).】

8 【“(D) REQUIREMENTS FOR PACE PRO-
9 GRAMS.—】

10 【“(i) EDUCATING AND HELPING EN-
11 ROLL BENEFICIARIES INTO A PART D PLAN
12 OPTION.—A PACE program shall be re-
13 quired to provide—】

14 【“(I) information to all applica-
15 ble PACE program enrollees who are
16 enrolled under the PACE program re-
17 garding the option to enroll in a quali-
18 fied standalone prescription drug plan
19 under this paragraph; and】

20 【“(II) upon request of an appli-
21 cable PACE program enrollee, coun-
22 seling and coordination to assist appli-
23 cable PACE program enrollees in
24 making decisions regarding the selec-

1 tion of qualified standalone prescrip-
2 tion drug plans available to them.】

3 【“(ii) MONITORING DRUG UTILIZA-
4 TION, ADHERENCE, AND SPEND.—A PACE
5 program shall be required to monitor drug
6 utilization, medication adherence, and drug
7 spending (through claims data shared pur-
8 suant to subparagraph (F) and otherwise)
9 throughout the year with respect to any
10 applicable PACE program enrollee who
11 elects to enroll in a qualified standalone
12 prescription drug plan under this para-
13 graph in order to coordinate with the PDP
14 sponsor of such plan regarding the drug
15 benefits offered by the plan, including
16 upon request of an applicable PACE pro-
17 gram enrollee the filing of any grievances
18 or appeals with the plan on behalf of the
19 applicable PACE program enrollee.】

20 【“(E) DISENROLLMENT.—An applicable
21 PACE program enrollee may disenroll from the
22 qualified standalone prescription drug plan
23 elected by such applicable PACE program en-
24 rollee under subparagraph (A) if the enrollee
25 changes medication during the plan year or can

1 demonstrate an unexpected increase in out-of-
2 pocket costs post enrollment.】

3 【“(F) CLAIMS SHARING.—In the case
4 where an applicable PACE program enrollee en-
5 rolls in a qualified standalone prescription drug
6 plan, the PACE program in which the indi-
7 vidual is enrolled and the PDP sponsor of the
8 qualified standalone prescription drug plan shall
9 share claims data with each other with respect
10 to the applicable PACE program enrollee as
11 needed to support care management for the ap-
12 plicable PACE program enrollee (including for
13 purposes of monitoring and coordination re-
14 quired under subparagraph (D)(ii)) and for
15 purposes of comprehensive risk adjustment
16 under section 1894(d). Such data shall be
17 shared without the need for any formal or in-
18 formal request of the PACE program in which
19 the individual is enrolled or the PDP sponsor of
20 the qualified standalone prescription drug plan
21 in which the applicable PACE program enrollee
22 is enrolled.】

23 【“(G) RULE OF CONSTRUCTION.—The au-
24 thority established under this paragraph for an
25 applicable PACE program enrollee to elect to

1 enroll in a qualified standalone prescription
2 drug plan shall not be construed as permitting
3 an applicable PACE program enrollee to enroll
4 in a prescription drug plan that is not a quali-
5 fied standalone prescription drug plan.】

6 【“(H) RELATION TO PACE STATUTES.—】

7 【“(i) IN GENERAL.—The authority
8 provided under this paragraph for an ap-
9 plicable PACE program enrollee to elect to
10 enroll in a qualified standalone prescription
11 drug plan shall apply notwithstanding sub-
12 section (a)(1)(B)(1) of section 1894 and
13 such other provisions of sections 1894 and
14 1934 as the Secretary determines may con-
15 flict with the authority provided for under
16 this paragraph, including subsections
17 (a)(2)(B), (b)(1)(A)(i), (b)(1)(C),
18 (f)(2)(B)(ii), and (f)(2)(B)(v) of such sec-
19 tions.】

20 【“(ii) CLARIFICATION ON PAYMENT
21 FOR PART D DRUG COVERAGE.—Insofar as
22 an applicable PACE program enrollee is
23 enrolled in a qualified standalone prescrip-
24 tion drug plan under this paragraph, the
25 PACE program shall not be entitled to

1 payment under section 1894(d) for the
2 provision of qualified prescription drug
3 coverage under such standalone prescrip-
4 tion drug plan with respect to such appli-
5 cable PACE program enrollee.”.]