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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "_____ Act of _____".

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

TITLE I—STATE INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE INDIVIDUALS

SEC. 101. STATE IMPLEMENTATION.

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

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

"SEC. 2201. DEFINITIONS.

''In this title:

''(1) DIRECTOR.—The term 'Director' means the Director of the Federal Coordinated Health Care Office of the Centers for Medicare & Medicaid Services.

''(2) DUAL ELIGIBLE.—The term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under a State

plan under title XIX or under a waiver of such plan. Such term includes a full-benefit dual eligible individual and a Medicare Savings Program eligible individual.

''(3) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL.—The term 'full-benefit dual eligible individual' has the meaning given such term in section 1935(c)(6) but without the application of subparagraph (A)(i) of such section.

''(4) INTEGRATED CARE PLAN.—The term 'integrated care plan' means an entity or organization that provides fully integrated care, or partially integrated care for a dual eligible individual in accordance with the requirements of this title and related Federal and State regulations.

''(5) MEDICARE SAVINGS PROGRAM ELIGIBLE INDIVIDUAL.—The term 'Medicare Savings Program eligible individual' means an individual who is eligible for the low-income subsidy program under section 1860D–14, the Medicare Savings Program (as defined in section 1144(c)(7)), or both.

"SEC. 2202. STATE SELECTION OF PROGRAM MODELS, DEVELOPMENT, AND IMPLEMENTATION.

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

first publishes the range of program models for providing integrated care for dual eligible individuals required by section 2602(d)(9) of the Patient Protection and Affordable Care Act, each State shall select from such published models, and shall work with the Director to implement such models in the State in accordance with the requirements of this title—

''(1) a program model to provide comprehensive, fully integrated care for full-benefit dual eligible individuals; and

''(2) a program model to provide partially integrated care for Medicare Savings Program eligible individuals.

''(b) TIMING.—Each State shall work with the Director to implement the models selected by the State under subsection (a) so that, to the extent practicable, the State may begin to enroll dual eligible individuals in the program models selected during the 4th year that occurs after the year in which the State makes such selection and, by the end of such 4th year, the models are fully implemented and operated in accordance with the requirements of this title and related Federal and State regulations.

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

appropriate to account for the particular needs or circumstances of a State.

''(d) IMPLEMENTATION COUNCIL.—

''(1) IN GENERAL.—A State shall establish an implementation council in accordance with such requirements as the Secretary shall establish. The members of the council shall include representatives of a wide range of stakeholders relevant to the provision of integrated care for dual eligible individuals.

''(2) DUTIES.—The implementation counsel shall provide advice and counsel to the State with respect to the implementation of the models selected by the State under subsection (a).

"SEC. 2203. ENROLLMENT IN INTEGRATED CARE PLANS.

[''(a) PASSIVE ENROLLMENT; OPT-OUT PERMITTED.—**]**

[''(1) IN GENERAL.—Notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), but subject to the succeeding provisions of this section and title, a State shall require a dual eligible individual to enroll with an integrated care plan as a condition of receiving medical assistance under a State plan under title XIX or under a waiver of such plan (and, with respect to assistance furnished by or under arrangements with such integrated care plan,

to receive such assistance through the integrated care plan), so long as the integrated care plan and the contract with the State meet the applicable requirements of this title.]

[''(2) NOTICE REQUIREMENTS.—A State shall notify a dual eligible individual that the individual shall be enrolled with an integrated care plan under a contract with the State at least 60 days (90 days, in the case of the first time the individual is provided such notice) prior to the effective date of such enrollment. Notice provided to a dual eligible individual under this paragraph shall include the following:]

[''(A) The name and contact information for the integrated care plan and whether the plan provides fully or partially integrated care.]

[''(B) The date on which the enrollment takes effect and, if applicable, whether the State has elected the option for a 12-month.]

[''(C) A summary of the benefits to be provided by the plan.]

[''(D) Information regarding the provider network of the plan.]

[''(E) Information regarding how the dual eligible individual may elect to opt-out of enroll-

ment with the plan within 60 days (90 days, in the case of the first time the individual is provided such notice).]

[“(3) CHOICE OF COVERAGE REQUIRED.—A State shall not passively enroll a dual eligible individual in a fully integrated care plan or a partially integrated care plan (as applicable) unless—]

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

[“(B) the individual’s primary care physician is an in-network, participating provider for the plan.]

[“(4) VOLUNTARY ENROLLMENT PERMITTED.—A State may offer a dual eligible individual the option to enroll in a fully integrated care plan or a partially integrated care plan (as applicable) without regard to meeting the requirements of subparagraph (A) or (B) of paragraph (3).]

[“(5) STATE OPTION FOR CONTINUOUS ELIGIBILITY AND ENROLLMENT.—A State may elect for a dual eligible individual who is determined to be eligi-

ble for medical assistance under the State plan under title XIX or under a waiver of such plan and who is enrolled with an integrated care plan under a contract with the State to remain eligible for medical assistance and enrolled with such plan until the earlier of—]

[''(A) the end of the 12-month beginning on the date of such determination; or]

[''(B) the date that such individual ceases to be a resident of such State.]

''(b) CHANGE OF ENROLLMENT.—A State shall permit a dual eligible individual to change enrollment in an integrated care plan—

''(1) in the case of a full-benefit dual eligible individual, on a monthly basis if the individual is electing to enroll in another fully integrated care plan; and

''(2) in the case of any dual eligible individual—

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

"(B) during the 60-day period beginning on the date the individual receives notice from the State that the individual has been determined to no longer be eligible for treatment as a full-benefit dual eligible individual or as a Medicare Savings Program eligible individual (as applicable), if the individual is electing to change enrollment from a fully integrated care plan to a partially integrated care plan (if eligible) or is not eligible to enroll in any fully or partially integrated care plan.

"(c) CONTACT BY PLAN CARE COORDINATOR PERMITTED PRIOR TO EFFECTIVE DATE OF ENROLLMENT.—A care coordinator for an integrated care plan may contact a dual eligible individual who has been passively enrolled in the plan prior to the effective date of the enrollment.

"SEC. 2204. PLAN REQUIREMENTS AND PAYMENTS.

"(a) IN GENERAL.—A contract between a State and an offeror of an integrated care plan shall not be considered to meet the requirements of this title unless the plan and the contract provisions comply with the following requirements:

"(1) FULLY INTEGRATED CARE PLANS.—An offeror of an integrated care plan that provides com-

prehensive, fully integrated care for full-benefit dual eligible individuals shall—

"(A) offer a partially integrated care plan for Medicare Savings Program eligible individuals that includes the provider network for the fully integrated care plan; and

"(B) automatically transfer the enrollment of any individual who was a full-benefit dual eligible individual enrolled in the fully integrated care plan to such partially integrated care plan at the end of the 60-day period that begins on the date on which the plan receives notice from the State that the individual has been determined to no longer be eligible for treatment as a full-benefit dual eligible individual.

"(2) FULLY AND PARTIALLY INTEGRATED CARE PLANS.—An offeror of an integrated care plan shall—

"(A) permit a dual eligible individual who changes enrollment to another integrated care plan for which the individual's primary care provider is not a participating, in-network provider, or who disenrolls from an integrated care plan and does not enroll in another integrated care plan, a 30-day grace period during which

the individual may continue to be treated by their primary care provider and any such treatment shall be considered to be in-network treatment by the plan;

"(B) administer a health risk assessment to each dual eligible individual enrolled with the plan within 90 days of the effective date of the individual's enrollment and shall affirm no changes in the information provided at least every 12 months therefter, in accordance with the requirements of subsection (c);

"(C) provide benefits for a dual eligible individual under a comprehensive care plan in accordance with the requirements of subsections (d) and (f); and

"(D) assign a care coordinator to each dual eligible individual enrolled with the plan in accordance with the requirements of subsection (e).

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

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

''(c) HEALTH RISK ASSESSMENT.—An offeror of an integrated care plan shall administer a health risk assessment to each dual eligible individual enrolled with the plan using the standardized health risk assessment questionnaire developed by the Director under section 2602(d)(11) of the Patient Protection and Affordable Care Act and in accordance with such additional requirements as the State may establish. An integrated care plan may rely on the results of a previously administered health risk assessment of a dual eligible individual if such results are accessible to the plan and the dual eligible individual affirms no changes in the information previously provided.

''(d) BENEFITS.—

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

''(A) Clinical health services.

''(B) Behavioral health services.

''(C) Long-term services and supports.

''(2) CARVE-OUT EXCEPTIONS.—

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

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

"(i) the level of care provided for a dual eligible individual under the separate contract with respect to such services or supports is not less than the level of care that would be provided without the exception; and

"(ii) the dual eligible individual will not be subject to any unreasonable administrative requirements to access the services or supports.

"(B) PREFERRED CONTRACTORS.—A State shall give preference to entering into separate contracts for the provision of services or supports required under paragraph (1) with offers of fully integrated care plans under contract with the State.

"(3) SUPPLEMENTAL BENEFITS.—An integrated care plan may provide customized, supplemental benefits to a dual eligible individual enrolled with the plan, including supplemental health care benefits described in section 1852(a)(3), other primarily health-related benefits offered by Medicare

Advantage plans and benefits permitted by the Secretary to be offered as Special Supplemental Benefits for the Chronically Ill (SSBCI), without regard to whether the dual eligible individual has requisite condition or diagnosis, so long as the plan demonstrates to the Director and the State that the offering of such benefits has a positive impact on patient health.

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

''(1) serve as the single point of contact between the individual and the plan;

''(2) be responsible for helping the individual and their caregivers and family make benefit and service decisions;

''(3) design a beneficiary-focused comprehensive care plan for the individual that meets the requirements of subsection (f); and

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

"(f) COMPREHENSIVE CARE PLAN REQUIREMENTS.—The comprehensive care plan for a dual eligible individual shall be—

"(1) designed to address the totality of the individuals' medical, functional, behavioral, social, and caregiving needs and goals, and to the extent practicable, to apply to multiple years;

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

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

"(4) be approved by the individual (or by an authorized caregiver or guardian) prior to implementation; and

"(5) be reviewed at least annually and within 30 days of a major health event, such as hospitalization or an emergency room visit.

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

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

"SEC. 2205. DATA COLLECTION AND REPORTING.

"(a) ANNUAL COLLECTION AND REPORTING BY STATES AND INTEGRATED CARE PLANS.—Each State and integrated care plans annually shall collect and report information and data to the Director in accordance with the requirements of this section and guidance and regulations issued under section 2602(d)(17) of the Patient Protection and Affordable Care Act that includes data collected by such plans with respect to a plan year regarding age, gender, disability (including specific disability statuses required to be reported by the Director), smoking status, mobility, employment status, education, race and ethnicity, and zip code, of dual eligible individuals enrolled in the plan.

"(b) COLLECTION AND REPORTING OF ADDITIONAL DATA AND INFORMATION PERMITTED.—A State may require an integrated care plan under contract with the State to collect and report to the State additional data and information.

["SEC. 2206. STATE OMBUDSMAN.

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

ferred to as the 'Office'). The Office may operate independent of, or in connection with, the State agency responsible for administering the Medicaid program under title XIX.]

[''(b) OMBUDSMAN.—The Office shall be headed by an individual, to be known as the State Integrated Care for Dual Eligible Individuals Ombudsman, who shall be selected from among individuals with expertise in and experience with integrated care models for dual eligible individuals, the Medicare program under title XVIII, and the Medicaid program under title XIX. The Ombudsman shall be responsible for the management, including the fiscal management, of the Office.]

[''(c) REQUIREMENTS.—]

[''(1) IN GENERAL.—The primary responsibility of the Office shall be to provide support and feedback for dual eligible individuals enrolled in integrated care plans under this title and caregivers or family members of such individuals who need assistance.]

[''(2) MINIMUM STAFFING RATIO.—The Office shall have a minimum staffing ratio of 1 employee for every 2,000 full-benefit dual eligible individuals in the State.]

[''(d) FUNDING.—]

[“(1) INITIAL FUNDING.—During the first 2 years of the Office’s operation, the Secretary shall pay the State [$_____] for each such year for expenditures necessary to establish and operate the Office from amounts appropriated under section 2207(b).]

[“(2) SUBSEQUENT FUNDING.—Beginning with the 3rd year of the Office’s operation, expenditures necessary to operate the Office shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan under title XIX and reimbursed in accordance with that section.]

“SEC. 2207. FUNDING.

“(a) PAYMENTS TO STATES.—From the sums appropriated under subsection (b), the Secretary shall pay to each State for each calendar year (beginning January 1 of the first full calendar year in which this title is implemented in the State), an amount equal to the sum of the following:

“(1) PAYMENTS TO INTEGRATED CARE PLANS UNDER CONTRACT WITH THE STATE.—An amount equal to [____] of the amount expended by the State for the quarter for making payments to inte-

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

''(2) SHARED SAVINGS COMPONENT.—The shared savings payment applicable to the State and the quarter, as determined in accordance with section 2602(d)(16) of the Patient Protection and Affordable Care Act.

''(3) GENERAL ADMINISTRATIVE EXPENSES.—An amount equal to [____] percent of the amount expended by State for the quarter for administrative expenses to carry out this title, other than data collection and reporting under section 2205, and subject to section 2207(d)(1).

''(4) DATA COLLECTION AND REPORTING.—An amount equal to [____] percent of the amount expended by State for the quarter for data collection and reporting expenses under section 2205.

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

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

title from the Federal Hospital Insurance Trust Fund (under section 1817) and from the Federal Supplementary Medical Insurance Trust Fund (under section 1841) (and from the Medicare Prescription Drug Account (under section 1860D–16) within such Trust Fund) such amounts as the Secretary determines appropriate, taking into account the reductions in payments from such Trust Funds and Account that are attributable to the enrollment of dual eligible individuals in integrated care plans under this title.

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

''SEC. 2208. FEDERAL ADMINISTRATION THROUGH THE FEDERAL COORDINATED HEALTH CARE OFFICE.

''(a) IN GENERAL.—The Director shall have primary authority for implementing and carrying out responsibilities of the Federal Government under this title.

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

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

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

SEC. 102. CONFORMING AMENDMENTS RELATING TO FEDERAL COORDINATED HEALTH CARE OFFICE RESPONSIBILITIES.

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

''(9) To develop and, not later than 180 days after the date of enactment of this paragraph, publish, a range of program models for providing integrated care for dual eligible individuals from which States shall select to develop and administer full and partial integrated care programs for dual eligible individuals, in accordance with title XXII of the Social Security Act. The program models developed and published under this paragraph shall include—

''(A) models for providing comprehensive, fully integrated care for dual eligible individuals

who are full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act but without the application of subparagraph (A)(i) of such section); and

"(B) models for providing partially integrated care for dual eligible individuals who are not full-benefit dual eligible individuals but who are eligible for the low-income subsidy program under section 1860D–14, the Medicare Savings Program (as defined in section 1144(c)(7)), or both, that includes supplemental benefits.".

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

"(10) To develop and, not later than 1 year after the date of enactment of this paragraph, publish a unified administrative appeals process for State integrated care programs for dual eligible individuals under title XXII of the Social Security Act to use in lieu of other administrative appeals processes involving Medicare and Medicaid.".

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

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

''(11) To develop a standardized health risk assessment questionnaire for dual eligible individuals that collects standard demographic data and information relating to food insecurity, access to transportation, internet access, utility difficulty, interpersonal safety, and housing instability.''.

(d) SUPPLEMENTAL BENEFITS STANDARDS AND REPORTING REQUIREMENTS.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)), as previously amended by this section, is further amended by adding at the end the following new paragraph:

''(12) To establish standards for reporting by States and integrated care plans under title XXII information relating to the offering and provision of supplemental benefits under section 2204(d)(3) of the Social Security Act, including data relating to enrollment, utilization, and outcomes, to annually publish a report regarding the offering and utilization of such benefits, and to study and report to the Secretary on whether to cap the actuarial dollar

value allowed for such benefits under titles XVIII, XIX, and XXII.''.

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

''(13) To establish a formula based on patient chronic conditions, activities of daily living standards, geographic, and such other factors as the Director determines are necessary for States and integrated care plans to use to determine the maximum staffing ratio for assigning care coordinators to dual eligible individuals enrolled with integrated care plans under title XXII.

''(14) To develop online training and professional development materials relating to the statutory and administrative requirements for providing integrated care for care coordinators for dual eligible individuals enrolled with integrated care plans under title XXI.''.

(f) ADMINISTRATION AND OVERSIGHT OF INTEGRATED CARE PLANS FOR DUAL ELIGIBLE INDIVIDUALS.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)), as previously

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

"(15) To develop and issue guidance and regulations related to the alignment of policy and operational process under the Medicare program under title XVIII and the Medicaid program under title XIX, necessary for implementation, administration, and oversight of integrated care plans for dual eligible individuals under title XXII.

"(16) To administer and provide oversight of integrated care plans for dual eligible individuals under title XXII, including with respect to the following:

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

"(B) Establishment and application of network adequacy standards for such plans that—

"(i) apply only with respect to such plans;

"(ii) allow the Director to waive compliance with such standards for integrated care plans that cannot meet the requirements in certain areas, but must operate

statewide to meet a States' selective contracting requirements; and

''(iii) allow the Director to consider flexibilities to support innovative models that do not rely on traditional time and distance standards, such as the use of telehealth.

[''(C) With respect to fully integrated care plans under title XXII, establishment and application of targeted, streamlined model-of-care requirements for such plans that include an integrated audit process, with shared responsibilities between the Director and States, and that requires the Director to share the results of such audits with State Medicaid programs. To the extent practicable, such requirements also shall be designed to be integrated with model of care requirements applicable to Medicaid managed care organizations.**]**

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

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

''(18) To develop and implement a shared savings payment for States to receive a share of savings to Federal spending in the Medicaid program established under title XIX as a result of the implementation and operation of integrated care plans for dual eligible individuals under title XXII.

[''(19) To develop a new star rating system for integrated care plans for dual eligible individuals under title XXII that rates the performance of each plan type separately, with State-specific measures and tied to single contracts, instead of the collective performance of all of the offeror's plans under contract with the State under that title, that include measures which directly reflect enrollee satisfaction, and that awards higher star ratings to plans based on their ability to retain enrollees.''.**]**

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

''(20) To establish data and information collection and reporting requirements for States and integrated care plans under section 2205, including re-

quired reporting of specific disability statuses and safeguards to protect patient privacy, and to annual publish not later than April of any year, the data and information collected and reported to the Director under such section for the preceding year.''.

[(h) QUALITY MEASURES.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)), as previously amended by this section, is further amended by adding at the end the following new paragraph:]

[''(21) To develop quality measures for the population of dual eligible individuals that are designed to be uniformly implemented across all platforms and health benefits plans that provide integrated care for such individuals under title XXII of the Social Security Act. Such measures shall include measures relating to patient satisfaction, quality of life, rates of emergency room use, institutionalization for long-term care, hospital admission and readmission rates, and medication errors. The Director shall regularly review and update such measures as necessary and may develop outcome-based quality measures for determining payments to health benefits plans that provide integrated care for dual eligi-

ble individuals under title XXII of the Social Security Act.''.]

(i) BEST PRACTICES.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)), as previously amended by this section, is further amended by adding at the end the following new paragraph:

''(22) To not less than annually publish best practices under title XXII for States and integrated care plans, including with respect to improving outreach to beneficiaries, improving comprehensive care plans and health risk assessments for dual eligible individuals, and developing a workforce that provides culturally intelligent and respectful care.''.

(j) TRAINING PROGRAMS.—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)), as previously amended by this section, is further amended by adding at the end the following new paragraph:

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

''(A) providers of care, services, and supports under such plans with respect to issues such as coordination of benefits, data sharing

barriers, quality ratings, and provider incentives;

''(B) State employees to increase Medicare expertise at State agencies responsible for administering Medicaid plans and waivers and contracting with integrated care plans under title XXII; and

''(C) insurance brokers and local counselors who help enroll individuals in Medicare, Medicaid, and integrated care plans under title XXII.''.

SEC. 103. ADDITIONAL CONFORMING AMENDMENTS.

(a) DEFINITION OF STATE.—Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended—

(1) by striking ''XIX, and XXI'' and inserting ''XIX, XXI, and XXII''; and

(2) by striking ''XIX and XXI'' and inserting ''XIX, XXI, and XXII''.

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

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

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

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

(1) by striking ''or'' at the end of paragraph (26);

(2) by striking the period at the end of paragraph (27) and inserting ''; or'';

(3) by inserting after paragraph (27) the following new paragraph:

''(28) with respect to any amount expended for medical assistance for a dual eligible individual (as defined in section 2201) enrolled in a integrated care plan under title XXII, except specifically permitted under such title.''; and

(4) in the third sentence, by striking '', and (18)'' and inserting '', (18), and (28)''.

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

[SEC. 201. DEVELOPMENT OF NEW RISK ADJUSTMENT PAYMENT MODEL.

Section 2602 of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b) is amended by adding at the end the following:**]**

["(g) RISK ADJUSTMENT PAYMENT MODEL FOR PROVIDING HEALTH BENEFITS COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS.—Not later than 1 year after the date of enactment of this subsection, the Director shall enter into a contract or other agreement with an independent entity to develop a risk adjustment payment model for dual eligible individuals that—**]**

["(1) is designed to be uniformly implemented across all platforms and health benefits plans that provide integrated care for such individuals under title XXII of the Social Security Act;**]**

["(2) includes factors based on the health status of such individuals; and**]**

["(3) allows plan payments to be made and updated on a monthly basis.".**]**

SEC. 202. IDENTIFYING OPPORTUNITIES FOR STATE COORDINATION WITH RESPECT TO ELIGIBILITY DETERMINATIONS.

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

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

(2) issue guidance for States that identifies opportunities for better coordination of such processes among States.

SEC. 203. ALIGNMENT OF BIDDING, REPORTING, AND OTHER DATES AND DEADLINES FOR INTEGRATED CARE PLANS.

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

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

(1) review bidding, reporting, and other significant dates and deadlines applicable to integrated care plans under the Medicare program, the Medicaid program, and State Integrated Care Programs for Dual Eligible Individuals under XXII of the Social Security Act; and

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

SEC. 204. GRANTS TO STATE AND LOCAL COMMUNITY ORGANIZATIONS FOR OUTREACH AND ENROLLMENT.

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

grated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act.

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

(1) Information and education support is available for individuals in a range of languages, and online, over the phone, and in person.

(2) Materials presented are easy to read, written in as low a reading comprehension level as possible, and are in the proper language for the individual involved.

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

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

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

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

SEC. 205. APPLICATION OF MODEL STANDARDS TO INFORMATION REQUIREMENTS FOR INTEGRATED CARE PLANS.

Not later than 1 year after the date of enactment of this Act, the Director of the Federal Coordinated Health Care Office of the Centers for Medicare & Medicaid Services and the Administrator of the Centers for Medicare & Medicaid Services jointly shall issue guidance or regulations requiring that any notice or informational materials provided to a dual eligible individual (as defined in section 2201 of the Social Security Act) by such Director, Administrator, States, or health benefits plans that provide integrated care for such individuals under the Medicare program, the Medicaid program, or under State Integrated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act complies with the model standards issued under section 204(b).

SEC. 206. ENROLLMENT THROUGH INDEPENDENT BROKERS.

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

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

(1) a dual eligible individual (as defined in section 2201 of the Social Security Act) may not be enrolled in a health benefits plan that provides integrated care for such individual under XXII of the Social Security Act through a broker unless the broker is an independent broker (as defined under such guidance or regulations);

(2) the commission an independent broker may receive with respect to the enrollment of a dual eligible individual in any such health benefits plan is limited to the initial enrollment of the individual in any such plan by such broker; and

(3) if a broker disenrolls a dual eligible individual from any such health benefits plan that provides fully integrated care to a plan that provides partial or no integrated care, the broker, in accordance with the model standards issued under section 204(b), shall inform the individual—

(A) of the health benefits plan the individual is being disenrolled from; and

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

no integrated care and the potential implications of such disenrollment and enrollment on the individual's care; and

SEC. 207. REDUCING THRESHOLD FOR LOOK-ALIKE D–SNP PLANS UNDER MEDICARE ADVANTAGE.

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

(1) shall implement section 422.514(d)(1)(ii) of title 42, Code of Federal Regulations (or any successor regulations) by substituting ''50 percent'' for ''80 percent''; and

(2) shall only count full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))) for purposes of applying the threshold under such section.

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

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

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

SEC. 209. REQUIRING REGULATE UPDATE OF PROVIDER DIRECTORIES.

Not later than 1 year after the date of enactment of this Act, the Director of the Federal Coordinated Health Care Office of the Centers for Medicare & Medicaid Services and the Administrator of the Centers for Medicare & Medicaid Services shall promulgate regulations that—

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

(2) include a measure relating to provider director currency rating on star rating systems for Medicare Advantage plans under section 1853(o) of the Social Security Act (42 U.S.C. 1395w–23(o)) and integrated care plans under title XXII of such Act.

SEC. 210. ADDITIONAL RESPONSIBILITIES FOR THE FEDERAL COORDINATED HEALTH CARE OFFICE WITH RESPECT TO INTEGRATED CARE PLANS UNDER MEDICAID AND MEDICARE.

Section 2602 of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b), as amended by section 201, is further amended by adding at the end the following:

''(h) ADDITIONAL RESPONSIBILITIES WITH RESPECT TO INTEGRATED CARE PLANS UNDER MEDICAID AND MEDICARE.—

''(1) OUTREACH TO MEDICAID PROVIDERS.—Not later than 180 days after the date of enactment of this subsection, the Director, in consultation with State Medicaid programs, shall develop outreach plans for such programs to use to contact providers of health benefits, services, or supports for dual eligible individuals and provide information and education regarding the State Integrated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act, how such program will operate in the State where such providers offer health benefits, services or supports for such individuals, and the impact of such program on such providers.

"(2) COLLECTION OF DATA ON QUALITY MEASURES FROM INTEGRATED CARE PLANS UNDER MEDICAID AND MEDICARE.—

"(A) IN GENERAL.—Not later than 180 days after the date of enactment of this subsection, the Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services and State Medicaid programs, shall establish a plan for collecting data on quality measures from health benefits plans that provide integrated care for dual eligible individuals under Medicare or Medicaid. Such data shall include, at a minimum, data relating to provider network availability in both Medicare and Medicaid, providers in-network who are accepting new Medicare and Medicaid patients, spending on supplemental benefits, and claims denials.

"(B) AUTHORITY TO COLLECT ADDITIONAL DATA AND INFORMATION; PUBLICATION.—The Director may—

"(i) collect additional data and information relating to the quality of care provided for dual eligible individuals by health benefits plans that provide integrated care

for such individuals under Medicare or Medicaid; and

''(ii) make the data and information collected in accordance with this paragraph publicly available.

''(3) DEVELOPMENT OF AN ALIGNED PROGRAM FOR INSTITUTIONAL SPECIAL NEEDS PLANS UNDER MEDICAID.—Not later than 180 days after the date of enactment of this subsection, the Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services and State Medicaid programs, shall developed an aligned program for offering Institutional Special Needs Plans under Medicaid that has 1 entity financially responsible for providing health benefits, services, and supports for dual eligible individuals.

''(4) ASSESSMENT OF NEED FOR CRITERIA TO REGULATE AND EXPAND UTILIZATION OF INSTITUTIONAL SPECIAL NEEDS PLANS.—Not later than 180 days after the date of enactment of this subsection, the Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall assess the adequacy of regulations and oversight of Institutional Special Needs Plan to determine whether new, or additional requirements should

be established to improve the utilization, performance, and oversight of such plans and how such plans may be offered under State Integrated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act.''.

SEC. 211. REVIEW OF HOSPITAL QUALITY STAR RATING SYSTEM.

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

(1) review the hospital quality star rating system under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(2) identify such administrative and legislative changes as are needed to ensure that sufficient information is collected under such system regarding hospitals to effectively measure hospital quality.

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

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

care coordinator-to-patient ratio. Such process shall take into account the varying needs required by different categories of patients.

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

(1) the Secretary of Health and Human Services;

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

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

TITLE III—ADMINISTRATION

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

Not later than 180 days after the date of enactment of this Act, the Director of the Federal Coordinated Health Care Office of the Centers for Medicare & Medicaid Services and the Administrator of the Centers for Medicare & Medicaid Services shall—

(1) review billing codes under the Medicare program, the Medicaid program, and State Integrated

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

(2) identify such administrative and legislative changes as are need to ensure that all such billing codes are aligned and consistent under all such programs.

SEC. 302. REQUIRING ACCOUNTABLE CARE ORGANIZATIONS TO HAVE A STATE MEDICAID AGENCY CONTRACT.

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

"(J) The ACO shall have a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which a Medicare fee-for-service beneficiary assigned to the ACO is entitled to receive as medical assistance under title XIX.".

[TITLE IV—PACE]

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

[(a) IN GENERAL.—Section 1934 of the Social Security Act (42 U.S.C. 1396u–4) is amended—]

[(1) in subsection (a)(1)—]

[(A) by striking ''A State may elect to provide'' and inserting ''A State shall provide''; and]

[(B) by striking ''A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.'';]

[(2) in subsection (e)—]

[(A) in paragraph (1)—]

[(i) by striking ''(A) IN GENERAL.—The Secretary'' and inserting ''The Secretary''; and]

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

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

[(3) in subsection (h)(2)—]

[(A) by striking ''(A) IN GENERAL.—Except as provided under subparagraph (B), and'' and inserting ''Except as provided under''; and]

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

[(b) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—]

[(1) in paragraph (86), by striking ''; and'' and inserting a semicolon;]

[(2) in paragraph (87)(D), by striking the period at the end and inserting ''; and''; and]

[(3) by inserting after paragraph (87) the following new paragraph;]

[''(88) provide, in accordance with section 1934, that the State shall provide medical assistance with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement.''.]

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

[SEC. 402. ENROLLMENT OF PACE BENEFICIARIES AT ANY TIME.

[(a) IN GENERAL.—Sections 1894(d)(5)(A) and 1934(d)(5)(A) (42 U.S.C. 1395eee(d)(5)(A), 1396u–4(d)(5)(A)) are each amended—]

[(1) in the subparagraph header, by inserting ''ENROLLMENT OR'';]

[(2) by inserting ''PACE program eligible individuals to enroll in a PACE program at any time and'' after ''shall permit''; and]

[(3) by adding at the end the following sentence: ''The amount of any capitated payment made to a PACE provider under subsection (d)(1) may be adjusted to account for any PACE program eligible individuals who enroll after the first day of a month (with the amount of such payment adjustment being proportional to the portion of such month for which the individual is enrolled)''.]

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

[SEC. 403. EXTENDING ELIGIBILITY FOR PACE TO MEDICARE-ELIGIBLE INDIVIDUALS UNDER THE AGE OF 55.

[(a) IN GENERAL.—Sections 1894(a)(5)(A) and 1934(a)(5)(A) of the Social Security Act (42 U.S.C. 1395eee(a)(5), 1396u–4(a)(5)) are each amended by inserting ''(or any age in the case of an individual who is eligible for benefits under part A, or enrolled under part B, of title XVIII)'' after ''is 55 years of age or older''.]

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

[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.

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

[''(9) NO QUARTERLY OR GEOGRAPHIC LIMITATIONS ON APPLICATIONS FOR PACE PROVIDER STATUS.—The Secretary shall not prohibit an entity that meets the requirements for a PACE provider under this section from—]

[''(A) submitting multiple applications in the same quarter; or]

[''(B) submitting multiple applications to operate a PACE program in the same service area.''.]

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

[SEC. 405. COST OUTLIER PROTECTION FOR NEW PACE PROVIDERS.

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

[(a) DEFINITIONS.—In this section:]

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

[(2) PACE PROGRAM.—The term ''PACE program'' has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).]

[(3) PACE PROVIDER.—The term ''PACE provider'' has the meaning given that term in section 1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).]

[(4) RECOGNIZED OUTLIER COSTS.—]

[(A) IN GENERAL.—The term ''recognized outlier costs'' means, with respect to services furnished to an eligible outlier participant by a

new PACE provider, the least of the following (as documented by the provider to the satisfaction of the Secretary) for the provision of inpatient and related physician and ancillary services for the eligible outlier participant in a given 12-month period:]

[(i) If the services are provided under a contract between the new PACE provider and the service provider, the payment rate specified under the contract.]

[(ii) The payment rate established under the original Medicare fee-for-service program for such service.]

[(iii) The amount actually paid for the services by the new PACE provider.]

[(B) INCLUSION IN ONLY ONE PERIOD.—Recognized outlier costs may not be included in more than one 12-month period.]

[(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.]

[(b) COST OUTLIER PROTECTION FOR NEW PACE PROVIDERS.—]

[(1) ESTABLISHMENT OF FUND FOR REIMBURSEMENT OF OUTLIER COSTS FOR NEW PACE

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

[(2) PAYMENT TO PACE PROVIDERS FOR RECOGNIZED OUTLIER COSTS.—Subject to paragraph (3), if a PACE provider has recognized outlier costs with respect to an eligible outlier participant the Secretary shall pay such provider an amount equal to 80 percent of such costs to the extent that they exceed $50,000.]

[(3) LIMITATIONS.—]

[(A) COSTS INCURRED PER ELIGIBLE OUTLIER PARTICIPANT.—The total amount of payments made to a PACE provider under this subsection with respect to an eligible outlier participant for any 12-month period shall not exceed $100,000 for the 12-month period used to calculate the payment.]

[(B) COSTS INCURRED PER PROVIDER.—No PACE provider may receive more than $500,000 in total payments under this subsection in a 12-month period.]

[(C) LIMITATION OF OUTLIER COST REIMBURSEMENT PERIOD.—A PACE provider shall

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

[(4) REQUIREMENT TO ACCESS RISK RESERVES PRIOR TO PAYMENT.—A PACE provider shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) prior to receiving any payment under this subsection.]

[(5) APPLICATION.—In order to receive a payment under this subsection with respect to an eligible outlier participant, a PACE provider shall submit an application containing—]

[(A) documentation of the costs incurred with respect to the participant;]

[(B) a certification that the provider has complied with the requirements of this subsection; and]

[(C) such additional information as the Secretary may require.]

[(c) APPROPRIATION.—[*SLC: Appropriate $ for the outlier fund? The rural outlier fund was funded at $10M for period of 2006-10.*]]

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

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

[(2) adjust such capitation amounts so that the total amount of payments made to PACE providers for the year (including payments under this subsection) shall not exceed the amount of payments that would be made to PACE providers for the year if this section had not been enacted.]

[SEC. 406. ENSURING MEDICARE-ONLY PACE PROGRAM ENROLLEES HAVE A CHOICE OF PRESCRIPTION DRUG PLANS UNDER MEDICARE PART D.

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

[(1) in paragraph (1), by striking ''and (3)'' and inserting ''(3), and (4)''; and]

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

[''(4) ENSURING CHOICE OF PRESCRIPTION DRUG PLANS.—]

[“(A) IN GENERAL.—For plan years beginning on or after January 1, 2024, subject to the succeeding provisions of this paragraph, an applicable PACE program enrollee may elect to enroll in a qualified standalone prescription drug plan, in accordance with rules established by the Secretary pursuant to this paragraph, while enrolled under a PACE program.]

[“(B) DEFINITION OF APPLICABLE PACE PROGRAM ENROLLEE; QUALIFIED STANDALONE PRESCRIPTION DRUG PLAN.—In this paragraph:]

[“(i) APPLICABLE PACE PROGRAM ENROLLEE.—The term ‘applicable PACE program enrollee’ means a part D eligible individual who—]

[“(I) is not entitled to medical assistance under title XIX; and]

[“(II) is enrolled under a PACE program offered by a PACE provider.]

[“(ii) QUALIFIED STANDALONE PRESCRIPTION DRUG PLAN.—The term ‘qualified standalone prescription drug plan’ means, with respect to an applicable PACE

program enrollee, a prescription drug plan—]

[“(I) that is not an MA–PD plan;]

[“(II) that is not operated by the PACE program under which the individual is enrolled; and]

[“(III) for which the Secretary determines, with respect to the applicable PACE program enrollees enrolled in a PACE program offered by such PACE provider, that—]

[“(aa) the estimated beneficiary out-of-pocket costs (as defined in clause (iii)) for the plan year for qualified prescription drug coverage under the plan is equal to or less than the estimated out-of-pocket costs for such coverage under the prescription drug plan offered by the PACE program in which the applicable PACE program enrollee is enrolled; and]

[“(bb) the estimated total amount of Federal subsidies for the plan year for qualified prescription drug coverage under the plan (which may be estimated using data from the previous plan year) is equal to or less than the estimated subsidy amount for such coverage under the prescription drug plan offered by the PACE program in which the applicable PACE program enrollee is enrolled.]

[“(iii) OUT-OF-POCKET COSTS DEFINED.—In this paragraph, the term ‘out-of-pocket costs’ includes premiums imposed under a prescription drug plan and, in the case of coverage under a qualified standalone prescription drug plan, deductibles, copayments, coinsurance, and other cost-sharing.]

[“(C) OUT-OF-POCKET COSTS.—In the case where an applicable PACE program enrollee elects to enroll in a qualified standalone prescription drug plan pursuant to this para-

graph, the individual shall be responsible for any out-of-pocket costs imposed under the plan (including costs for nonformulary drugs) after the application of any subsidies under section 1860D–14 for an applicable PACE program enrollee who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)).]

[''(D) REQUIREMENTS FOR PACE PROGRAMS.—]

[''(i) EDUCATING AND HELPING ENROLL BENEFICIARIES INTO A PART D PLAN OPTION.—A PACE program shall be required to provide—]

[''(I) information to all applicable PACE program enrollees who are enrolled under the PACE program regarding the option to enroll in a qualified standalone prescription drug plan under this paragraph; and]

[''(II) upon request of an applicable PACE program enrollee, counseling and coordination to assist applicable PACE program enrollees in making decisions regarding the selec-

tion of qualified standalone prescription drug plans available to them.]

[“(ii) MONITORING DRUG UTILIZATION, ADHERENCE, AND SPEND.—A PACE program shall be required to monitor drug utilization, medication adherence, and drug spending (through claims data shared pursuant to subparagraph (F) and otherwise) throughout the year with respect to any applicable PACE program enrollee who elects to enroll in a qualified standalone prescription drug plan under this paragraph in order to coordinate with the PDP sponsor of such plan regarding the drug benefits offered by the plan, including upon request of an applicable PACE program enrollee the filing of any grievances or appeals with the plan on behalf of the applicable PACE program enrollee.]

[“(E) DISENROLLMENT.—An applicable PACE program enrollee may disenroll from the qualified standalone prescription drug plan elected by such applicable PACE program enrollee under subparagraph (A) if the enrollee changes medication during the plan year or can

demonstrate an unexpected increase in out-of-pocket costs post enrollment.]

[“(F) CLAIMS SHARING.—In the case where an applicable PACE program enrollee enrolls in a qualified standalone prescription drug plan, the PACE program in which the individual is enrolled and the PDP sponsor of the qualified standalone prescription drug plan shall share claims data with each other with respect to the applicable PACE program enrollee as needed to support care management for the applicable PACE program enrollee (including for purposes of monitoring and coordination required under subparagraph (D)(ii)) and for purposes of comprehensive risk adjustment under section 1894(d). Such data shall be shared without the need for any formal or informal request of the PACE program in which the individual is enrolled or the PDP sponsor of the qualified standalone prescription drug plan in which the applicable PACE program enrollee is enrolled.]

[“(G) RULE OF CONSTRUCTION.—The authority established under this paragraph for an applicable PACE program enrollee to elect to

enroll in a qualified standalone prescription drug plan shall not be construed as permitting an applicable PACE program enrollee to enroll in a prescription drug plan that is not a qualified standalone prescription drug plan.]

[''(H) RELATION TO PACE STATUTES.—]

[''(i) IN GENERAL.—The authority provided under this paragraph for an applicable PACE program enrollee to elect to enroll in a qualified standalone prescription drug plan shall apply notwithstanding subsection (a)(1)(B)(1) of section 1894 and such other provisions of sections 1894 and 1934 as the Secretary determines may conflict with the authority provided for under this paragraph, including subsections (a)(2)(B), (b)(1)(A)(i), (b)(1)(C), (f)(2)(B)(ii), and (f)(2)(B)(v) of such sections.]

[''(ii) CLARIFICATION ON PAYMENT FOR PART D DRUG COVERAGE.—Insofar as an applicable PACE program enrollee is enrolled in a qualified standalone prescription drug plan under this paragraph, the PACE program shall not be entitled to

payment under section 1894(d) for the provision of qualified prescription drug coverage under such standalone prescription drug plan with respect to such applicable PACE program enrollee.''.]