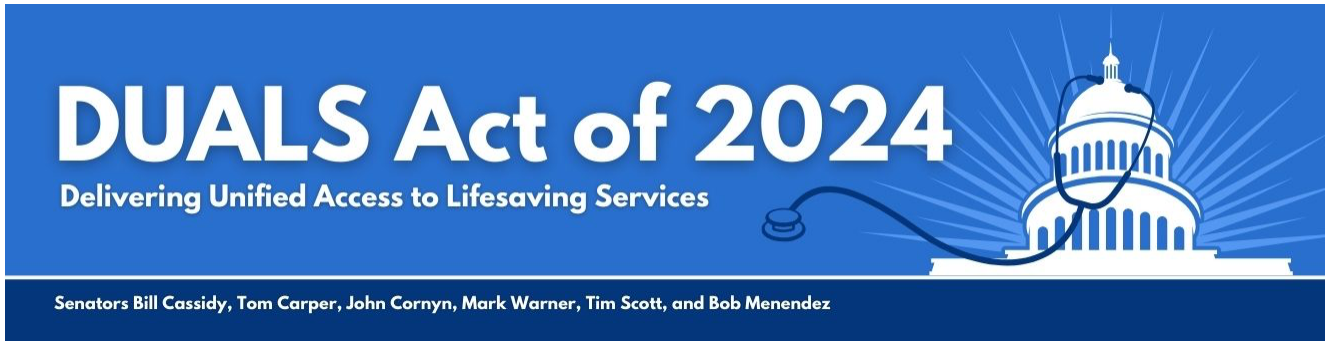

The Delivering Unified Access to Lifesaving Services Act of 2024

TITLE I

Sec. 101. State Implementation.

Sec. 2201. Definitions.
This section includes definitions.

Sec. 2202. State Selection of Program Models, Development, and Implementation.
This section outlines how states must select and develop their state integration option. Within one year of the publication of program models by MMCO, the state shall select their model and begin working with the Director of the MMCO to begin standing up their program. States must have a program ready to enroll beneficiaries within 5 years after passage of this legislation. States may stand up their program and begin enrolling beneficiaries before the 5 year deadline if they choose. The Director also has discretion to extend the timing to a later date if necessary. The section also details development of implementation councils.

Sec. 2203. Enrollment in Integrated Care.
This section allows states to passively enroll eligible individuals into the newly created integrated model. States must notify individuals at least 90 days before they are enrolled initially, and 60 prior for any additional time. An individual may not be passively enrolled unless their primary care physician is in-network. States have the option to continuously enroll individuals. Beneficiaries may enroll in an integrated plan on a monthly basis, but may not disenroll into a non-integrated plan outside of the normal enrollment window.

Sec. 2204. Plan Requirements and Payments.
This section outlines the requirements that states and plans must meet. It requires plans to give beneficiaries a 30 day period to continue coverage if they change plans, as well as a 90 day minimum for active treatments. It requires plans to assign a care coordinator and administer a health risk assessment, and establish supplementary benefits for the beneficiary. It outlines the specifics of the HRA as well as the supplementary benefits.

The section also requires plans to cover all services that a beneficiary may need, although states have flexibility in how those benefits are received. Finally, it details the requirements of the care coordinator.

Sec. 2205. Data Collection and Reporting.
This section requires annual collection of data on beneficiaries by plans and states. It also allows states to require plans to collect additional data.

Sec. 2206. State Ombudsman.
This section requires states to establish an ombudsman office to assist dual eligibles and their caregivers. It sets a minimum staffing level for the office, and provides funding from the federal government for the first two years, then moves to Medicaid matching for each subsequent year.

Sec. 2207. Funding.
This section provides the federal match funding for the integrated plan, as well as additional funding for general administrative expenses and data collection efforts. It also requires shared savings between states and the federal government.

Sec. 2208. Federal Administration Through the FCHCO.
This section establishes the FCHCO as the primary authority for implementing the integrated care model and outlines their responsibilities to implement sections of this legislation. It also gives them direct hire authority to ensure they have the staff they need to carry out their responsibilities.

Sec. 102. Providing Federal Coordinated Health Care Office Authority over Dual SNPs
This section provides authority to the FCHCO over Dual SNPs.

Sec. 103. Additional Conforming Amendments.
This section modifies current Medicare and Medicaid statute regarding enrollment and payments.

TITLE II

Sec. 201. Identifying Opportunities for State Coordination with Respect to Eligibility Determinations.
This section requires the Secretary, in consultation with states, to determine if there are opportunities to align eligibility for state and federal health programs with respect to dual eligibles.

Sec. 202. Alignment of Bidding, Reporting, and Other Dates and Deadlines for Integrated Care Plans.
This section requires the Director, within 180 days, to review bidding, reporting, and other dates and deadlines within the Medicare, Medicaid, and integrated programs, and gives them the authority to align those dates and deadlines.

Sec. 203. Grants to States and Local Community Organizations for Outreach and Enrollment.
This section appropriates an unspecified amount of money for the Secretary to award grants to state and local community organizations to conduct outreach and enroll beneficiaries in the integrated care models. It also requires the Secretary to create model standards for the outreach, such as easy to read materials and materials available online and easy to access for people with disabilities.

Sec. 204. Application of Model Standards to Information Requirements for Integrated Care Plans.

This section requires the Director and CMS Administrator to issue regulations on how information is distributed to beneficiaries.

Sec. 205. Enrollment Through Independent Brokers.

This section requires the Director and CMS Administrator to issue guidance that only independent brokers may enroll beneficiaries into integrated care plans, that the broker will only receive a commission on the initial enrollment each year, and that if a broker disenrolls a beneficiary from an integrated care plan to a non-integrate plan, they must inform the beneficiary of the health benefits they are being disenrolled from, and that the individual is being enrolled in a plan that may provide partial or no integrated care.

Sec. 206. Reducing Threshold for Look-Alike D-SNP Plans Under Medicare Advantage.

This section requires the Secretary to implement regulations reducing the number of duals allowed in a non-integrated plan to 50 percent. It only counts full-benefit dual eligibles in that number.

Sec. 207. Requiring Regular Update of Provider Directories.

This section requires the Director to issue regulations requiring integrated care plans to regularly update their provider directories, and include this as a measure in the star rating system.

Sec. 208. Review of Hospital Quality Star Rating System.

This section requires the Administrator to review the hospital quality star rating system and identify any administrative or legislative fixes to ensure adequate information is collected.

Sec. 209. Requirement for FCHCO and State Medicaid Agencies to Develop Maximum Staffing Ratios for Care Coordinators.

This section requires the Director, in consultation with State Medicaid agencies, to develop model legislation that sets staffing ratios for care coordinators. They must submit this legislation to Congress within 180 days of enactment.

Sec. 210. CMMI Testing of Coverage of Partial Benefit Dual Eligible Individuals Through State Integrated Care Program.

This section requires CMMI to develop a demonstration program allowing states to cover partial-benefit duals under the integrated care plans developed by states.

TITLE III

Sec. 301. Alignment of Billing Codes Under Titles XVIII, XIX, and XXII.

This section requires the Director to review billing codes under Medicare, Medicaid, and the newly integrated model program, and make adjustments so that codes are uniform in each program, where possible.

TITLE IV

Sec. 401. Requiring States to Offer PACE Program Services to Eligible Individuals.

This section establishes, within 180 days of enactment, PACE providers may operate in any state.

Sec. 402. Enrollment of PACE Beneficiaries at any Time.

This section allows PACE to enroll beneficiaries at any time during the month, instead of on the first of the month.

Sec. 403. Extending Eligibility for PACE to Medicare-Eligible Individuals Under the Age of 55.

This section allows PACE to enroll beneficiaries under the age of 55 if they are Medicare eligible.

Sec. 404. Removal of Quarterly Restrictions for Submission of a New PACE Organization Applications, and Removal Quarterly Restrictions for Applications in New Service Areas.

This section allows PACE organizations to submit multiple applications within the same quarter and in the same service area.

Sec. 405. Ensuring Medicare-Only PACE Program Enrollees Have a Choice of Prescription Drug Plans Under Medicare Part D.

This section allows Medicare-only PACE beneficiaries to purchase prescription drug plans through a separate Part D plan as opposed to a PACE formulary.