

117TH CONGRESS
1ST SESSION

H. R. 4942

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

IN THE HOUSE OF REPRESENTATIVES

AUGUST 6, 2021

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Bringing Enhanced
5 Treatments and Therapies to ESRD Recipients Kidney
6 Care Act” or the “BETTER Kidney Care Act”.

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1 (1) Although the relative rate of end-stage renal
2 disease (referred to in this section as “ESRD”)
3 among the Nation’s minority populations has de-
4 clined, significant disparities remain. Compared to
5 Whites, Black Americans are 2.6 times more likely
6 to have kidney failure, while Native Americans and
7 Alaska Natives are 1.2 times more likely. Hispanics
8 are 1.3 times more likely to have kidney failure com-
9 pared to non-Hispanics.

10 (2) Disparities also exist with respect to treat-
11 ment modalities. Specifically, although home dialysis
12 can offer advantages, Black, Hispanic, and Native
13 American and Alaska Native ESRD patients are less
14 likely to initiate home treatment than White ESRD
15 patients.

16 (3) Numerous studies show that individuals
17 with low incomes and in low-income communities are
18 at greater risk for ESRD.

19 (4) In addition to their kidney disease, ESRD
20 patients across all races and ethnicities often suffer
21 from one or more comorbidities. Eighty-eight per-
22 cent of ESRD patients have a history of hyper-
23 tension, 42 percent have diabetes, and nearly 30
24 percent have congestive heart failure.

1 (5) Each month, ESRD patients see multiple
2 providers and take several medications to manage
3 their kidney disease and comorbid conditions. Of all
4 patients, those with ESRD stand to benefit greatly
5 from better coordinated care.

6 (6) The Executive order on Advancing Amer-
7 ican Kidney Health recognizes the need to develop
8 and implement new ESRD care delivery models to
9 improve quality and value for ESRD patients and
10 the Medicare program.

11 (7) In alignment with that goal, it is imperative
12 that Medicare test new models that have at their
13 core an interdisciplinary care team, among other
14 structural requirements, to—

15 (A) help ESRD patients better navigate
16 the health care system;

17 (B) empower such patients to manage
18 their plan of care and medication regimen;

19 (C) support such patients in receiving the
20 treatment modality, including a kidney trans-
21 plant, as prescribed by their nephrologist;

22 (D) access services to meet the nonclinical
23 needs of such patients that can affect care out-
24 comes; and

1 (E) receive additional services, such as
2 transplant evaluation, palliative care, evaluation
3 for hospice eligibility, and vascular access care.

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

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

10 “DEMONSTRATION PROGRAM TO PROVIDE INTEGRATED
11 CARE FOR MEDICARE BENEFICIARIES WITH END-
12 STAGE RENAL DISEASE

13 “SEC. 1866G. (a) ESTABLISHMENT.—

14 “(1) IN GENERAL.—The Secretary shall con-
15 duct under this section the ESRD Fee-For-Service
16 Integrated Care Demonstration Program (in this
17 section referred to as the ‘Program’), which is vol-
18 untary for Program-eligible beneficiaries and eligible
19 participating providers, to assess the effects of alter-
20 native care delivery models and payment methodolo-
21 gies on patient care improvements under this title
22 for such beneficiaries. Under the Program—

23 “(A) Program-eligible beneficiaries shall be
24 considered original Medicare Fee-For-Service
25 beneficiaries (as defined in section 1899(h)(3))

1 for the duration of the participation of such
2 beneficiaries under the Program;

3 “(B) eligible participating providers may
4 form an ESRD Fee-For-Service Integrated
5 Care Organization (in this section referred to as
6 an ‘Organization’); and

7 “(C) an Organization shall integrate care
8 under the original Medicare Fee-For-Service
9 program under parts A and B for Program-eli-
10 gible beneficiaries.

11 “(2) DEFINITIONS.—In this section:

12 “(A) ELIGIBLE PARTICIPATING PRO-
13 VIDER.—The term ‘eligible participating pro-
14 vider’ means any of the following:

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

17 “(ii) An entity that owns one or more
18 of such facilities described in clause (i).

19 “(iii) A nephrologist (including a pedi-
20 atric nephrologist) or nephrology practice.

21 “(iv) Any other physician or physician
22 group practice.

23 “(v) A nurse practitioner, physician
24 assistant, or clinical nurse specialist (as
25 such terms are defined in section

1 1861(aa)(5)) or a clinical social worker (as
2 defined in section 1861(hh)(1)) working in
3 conjunction with such a nurse practitioner,
4 physician assistant, or clinical nurse spe-
5 cialist.

6 “(B) ELIGIBLE PARTICIPATING PART-
7 NER.—The term ‘eligible participating partner’
8 means, with respect to an Organization, any of
9 the following:

10 “(i) A Medicare Advantage plan de-
11 scribed in section 1851(a)(2) or a Medi-
12 care Advantage organization offering such
13 a plan.

14 “(ii) A Medicaid managed care orga-
15 nization (as defined in section 1903(m)).

16 “(iii) A hospital or an academic med-
17 ical center experienced in the care of pa-
18 tients receiving dialysis.

19 “(iv) Any other entity determined ap-
20 propriate by the Secretary.

21 “(C) PROGRAM-ELIGIBLE BENEFICIARY.—

22 “(i) IN GENERAL.—The term ‘Pro-
23 gram-eligible beneficiary’ means, with re-
24 spect to an Organization offering an
25 ESRD Fee-For-Service Integrated Care

1 Model, an individual entitled to benefits
2 under part A and enrolled under part B
3 (including such an individual entitled to
4 medical assistance under a State plan
5 under title XIX) who—

6 “(I) is identified by the Secretary
7 as having end-stage renal disease and
8 who is receiving renal dialysis services
9 under the original Medicare Fee-For-
10 Service program under parts A and B,
11 and is not enrolled in a Medicare Ad-
12 vantage plan under part C or group
13 health insurance coverage or indi-
14 vidual health insurance coverage (as
15 defined in section 2791(b) of the Pub-
16 lic Health Service Act (42 U.S.C.
17 300gg-91(b))) that is primary to cov-
18 erage under this title;

19 “(II) receives renal dialysis serv-
20 ices primarily from an eligible partici-
21 pating provider of such Organization,
22 including such renal dialysis services
23 received after being identified as a
24 suitable candidate for transplantation;
25 and

1 “(III) has attained the age of 18
2 years.

3 “(ii) AFFIRMATION OF PROGRAM ELI-
4 GIBILITY UPON HOSPICE ELECTION OR
5 KIDNEY TRANSPLANT.—A Program-eligible
6 beneficiary who was assigned to or elected
7 an ESRD Fee-For-Service Integrated Care
8 Model offered by an Organization and
9 who—

10 “(I) elects to receive hospice ben-
11 efits under section 1852(d)(1); or

12 “(II) receives a kidney transplant
13 as covered under this title and main-
14 tains entitlement to benefits under
15 part A and enrollment in part B on
16 the basis of end stage renal disease,
17 shall continue to meet the definition of
18 Program-eligible beneficiary established
19 under this subparagraph.

20 “(b) ESRD FEE-FOR-SERVICE INTEGRATED CARE
21 ORGANIZATION ELIGIBILITY REQUIREMENTS.—

22 “(1) ORGANIZATIONS.—

23 “(A) IN GENERAL.—One or more eligible
24 participating providers may establish an Orga-
25 nization and may enter into, subject to sub-

1 paragraph (B), one or more partnership, owner-
2 ship, or co-ownership agreements with one or
3 more eligible participating partners to establish
4 an Organization or to offer one or more ESRD
5 Fee-For-Service Integrated Care Models in ac-
6 cordance with paragraph (2).

7 “(B) LIMITATION ON NUMBER OF AGREE-
8 MENTS.—The Secretary may specify a limita-
9 tion on the number of Organizations in which
10 an eligible participating partner may participate
11 for purposes of offering one or more ESRD
12 Fee-For-Service Integrated Care Models under
13 partnership, ownership, or co-ownership agree-
14 ments described in subparagraph (A).

15 “(C) MINIMUM PROGRAM ELIGIBLE BENE-
16 FICIARY PARTICIPATION REQUIREMENT.—

17 “(i) IN GENERAL.—Subject to clause
18 (ii), the Secretary may not enter into or
19 continue an agreement with an Organiza-
20 tion unless the Organization has at least
21 350 Program-eligible beneficiaries, or at
22 least 60 percent of Program-eligible bene-
23 ficiaries receiving care from the Organiza-
24 tion’s facilities, who are assigned to or
25 elect an ESRD Fee-For-Service Integrated

1 Model offered by the Organization and who
2 continue their assignment to or election of
3 the Organization.

4 “(ii) ALLOWING TRANSITION.—The
5 Secretary may waive the requirement
6 under clause (i) for an Organization dur-
7 ing the first agreement year with respect
8 to the Organization.

9 “(D) FISCAL SOUNDNESS REQUIRE-
10 MENTS.—

11 “(i) IN GENERAL.—The Secretary
12 shall enter into appropriate agreements
13 under this section only with Organizations
14 that demonstrate sufficient capital re-
15 serves, measured as a percentage of
16 monthly prospective payments described in
17 subsection (e) and consistent with capital
18 reserve requirements established by each
19 State in which the Organization operates,
20 subject to clause (ii).

21 “(ii) ALTERNATIVE MECHANISM TO
22 DEMONSTRATE RISK-BEARING CAPACITY.—
23 An Organization shall be considered to
24 meet the requirement in clause (i) if the
25 Organization includes at least one eligible

1 participating provider or eligible partici-
2 pating partner that—

3 “(I)(aa) is licensed under State
4 law as a risk-bearing entity eligible to
5 offer health insurance or health bene-
6 fits coverage in each State in which
7 the Organization participates in the
8 demonstration under this section; or

9 “(bb) is otherwise authorized by
10 each state in which the Organization
11 participates in the demonstration
12 under this section to bear risk for of-
13 fering health insurance or health ben-
14 efits;

15 “(II) agrees to bear risk under
16 the Organization; and

17 “(III) has the capacity to bear
18 risk commensurate with the Organiza-
19 tion’s expected expenditures under an
20 agreement under this section.

21 “(iii) DISCLOSURE.—Each Organiza-
22 tion with an agreement under this section
23 shall, in accordance with current regula-
24 tions of the Secretary that govern similar
25 disclosures, report to the Secretary finan-

1 cial information consistent with such infor-
2 mation required to be reported by a Medi-
3 care Advantage organization under part C
4 to demonstrate that the Organization has
5 a fiscally sound operation.

6 “(E) GOVERNANCE REQUIREMENTS.—

7 Each Organization with an agreement under
8 this section shall establish a governing body
9 with oversight responsibility for the Organiza-
10 tion’s compliance with Program requirements
11 that includes—

12 “(i) representation from each eligible
13 participating provider of such Organiza-
14 tion;

15 “(ii) at least two nephrologists, one of
16 which may be affiliated with an eligible
17 participating provider; and

18 “(iii) at least one beneficiary advo-
19 cate.

20 “(2) ESRD FEE-FOR-SERVICE INTEGRATED
21 CARE MODEL.—

22 “(A) BENEFIT REQUIREMENTS.—

23 “(i) IN GENERAL.—Subject to clause
24 (iii), an Organization shall offer an ESRD

1 Fee-For-Service Integrated Care Model
2 that shall—

3 “(I) cover all benefits under
4 parts A and B (subject to payment
5 rules regarding the treatment of and
6 payment for kidney organ acquisitions
7 and hospice described in subsections
8 (e)(3) and (4)); and

9 “(II) include services for transi-
10 tion (particularly including education)
11 into transplantation, palliative care,
12 and hospice.

13 “(ii) DETERMINATION AND TREAT-
14 MENT OF SAVINGS.—

15 “(I) IN GENERAL.—The Sec-
16 retary shall require any Organization
17 offering an ESRD Fee-For-Service
18 Integrated Care Model to provide for
19 the return under subclause (VI) to a
20 Program-eligible beneficiary assigned
21 to or who elects an Organization sav-
22 ings equal to the amount, if any, by
23 which the payment amount described
24 in subclause (V) with respect to the
25 Program-eligible beneficiary for a year

1 exceeds the average revenue amount
2 described in subclause (IV) with re-
3 spect to the Program-eligible bene-
4 ficiary for the year.

5 “(II) SAVINGS DETERMINATION
6 PROCESS.—The Secretary shall deter-
7 mine the savings described in sub-
8 clause (I) in the same manner as the
9 rebate calculation for individuals with
10 end-stage renal disease enrolled in
11 Medicare Advantage organizations
12 under section 1859(b)(6)(B)(iii).

13 “(III) APPLICATION OF MEDICAL
14 LOSS RATIO REQUIREMENTS.—Noth-
15 ing shall preclude the Secretary from
16 applying medical loss ratio require-
17 ments described in section 1857(e)(4)
18 under this section.

19 “(IV) AVERAGE REVENUE
20 AMOUNT DESCRIBED.—The revenue
21 amount described in this subclause,
22 with respect to an Organization offer-
23 ing an ESRD Fee-For-Service Inte-
24 grated Care Model and a Program-eli-
25 gible beneficiary assigned to or who

1 elects such Organization, is the Orga-
2 nization’s estimated average revenue
3 requirements, including administrative
4 costs and return on investment, for
5 the Organization to provide the bene-
6 fits described in clause (i) under the
7 Model for the Program-eligible bene-
8 ficiary for the year.

9 “(V) PAYMENT AMOUNT DE-
10 SCRIBED.—The payment amount de-
11 scribed in this subclause, with respect
12 to an Organization offering an ESRD
13 Fee-For-Service Integrated Care
14 Model and a Program-eligible bene-
15 ficiary assigned to or who elects such
16 Organization, is the payment amount
17 to the Organization under subsection
18 (e)(1) (adjusted pursuant to sub-
19 section (e)(2) and subject to the treat-
20 ment of payments for kidney acquisi-
21 tions and hospice care described in
22 paragraphs (3) and (4) of subsection
23 (e), respectively) made with respect to
24 the Program-eligible beneficiary for
25 the year.

1 “(VI) RETURNING SAVINGS TO
2 PROGRAM-ELIGIBLE BENE-
3 FICIARIES.—An Organization shall, in
4 a manner specified by the Secretary
5 and consistent with returning Medi-
6 care Advantage rebates to individuals
7 under part C, return the amount
8 under subclause (I) to a Program-eli-
9 gible beneficiary through offering ben-
10 efits not covered under the original
11 Medicare Fee-For-Service program
12 consistent with the types of benefits,
13 including non-health related benefits,
14 that Medicare Advantage organiza-
15 tions may offer.

16 “(iii) BENEFIT REQUIREMENTS FOR
17 DUAL ELIGIBLES.—In the case of a Pro-
18 gram-eligible beneficiary who is entitled to
19 medical assistance under a State plan
20 under title XIX, an Organization, in ac-
21 cordance with a mutual agreement entered
22 into between the State and Organization
23 under subsection (e)(7)—

24 “(I) shall provide, or arrange for
25 the provision of, all benefits (other

1 than long-term services and supports)
2 for which the Program-eligible bene-
3 ficiary is entitled to under a State
4 plan under title XIX; and

5 “(II) may elect to provide, or ar-
6 range for the provision of, long-term
7 services and supports for which the
8 Program-eligible beneficiary is entitled
9 under a State plan under title XIX,
10 including services related to the tran-
11 sition into palliative care or hospice.

12 “(iv) APPLICATION OF MEDICARE FFS
13 PROVIDER CHOICE AND COST-SHARING RE-
14 QUIREMENTS.—Under an ESRD Fee-For-
15 Service Integrated Care Model offered by
16 an Organization, the Organization shall—

17 “(I) allow Program-eligible bene-
18 ficiaries to receive benefits as de-
19 scribed in subsection (b)(2)(A)(i)(I)
20 from any provider of services or sup-
21 plier enrolled under this title and who
22 otherwise meets all applicable require-
23 ments under this title;

24 “(II) not apply any cost-sharing
25 requirements for benefits described in

1 subsection (b)(2)(A)(i)(I) in addition
2 to premium and cost-sharing require-
3 ments, respectively, that would be ap-
4 plicable under part A or part B for
5 such benefits.

6 “(v) PROMOTING ACCESS TO HIGH-
7 QUALITY PROVIDERS.—An Organization
8 offering an ESRD Fee-For-Service Inte-
9 grated Care Model shall develop and imple-
10 ment performance-based incentives, includ-
11 ing financial incentives funded through
12 payments made to an Organization under
13 subsection (e), for providers of services and
14 suppliers to promote delivery of high qual-
15 ity and efficient care. Such incentives shall
16 comply with section 1852(j)(4) and section
17 422.208 of title 42, Code of Federal regu-
18 lations (as in effect on the date of enact-
19 ment of this section) and be based on clin-
20 ical measures or non-clinical measures,
21 such as with respect to notification of pa-
22 tient discharge from a hospital, patient
23 education (such as with respect to treat-
24 ment options, including disease mainte-
25 nance, and nutrition), rates of completion

1 of patient education categorized by race,
2 rates of completion of transplant evalua-
3 tion for patients who are clinically eligible
4 for transplant, rates of completion of
5 transplant evaluation categorized by race,
6 and the interoperability of electronic health
7 records developed by an Organization ac-
8 cording to requirements and standards
9 specified by the Secretary pursuant to sub-
10 paragraph (B).

11 “(B) QUALITY AND REPORTING REQUIRE-
12 MENTS.—

13 “(i) CLINICAL MEASURES.—Under the
14 Program, the Secretary shall—

15 “(I) require each participating
16 Organization to submit to the Sec-
17 retary data on clinical measures devel-
18 oped using, as a reference, measures
19 submitted by organizations partici-
20 pating in the Comprehensive ESRD
21 Care Initiative operated by the Center
22 for Medicare and Medicaid Innovation
23 to assess the quality of care provided;

24 “(II) establish requirements for
25 participating Organizations to submit

1 to the Secretary, in a form and man-
2 ner specified by the Secretary, infor-
3 mation on such measures; and

4 “(III) establish standards for
5 making information on quality under
6 the Program established under this
7 section as assessed using clinical
8 measures described in subclause (I)
9 available to the public.

10 As part of the standards described in sub-
11 clause (III) the Secretary shall, in con-
12 sultation with relevant stakeholders, de-
13 velop standards that would establish a
14 minimum threshold for the volume of indi-
15 vidual patients to be listed for transplant
16 in an Organ Procurement and Transplant
17 Network under contract with the Secretary
18 and that would measure the number of in-
19 dividuals that an Organization moved on
20 to, kept on, or removed from the trans-
21 plant list and the number of individuals
22 that receive a transplant after partici-
23 pating in the Organization. The number of
24 Program-eligible beneficiaries assigned to
25 an Organization on the transplant list that

1 have not opted out at the time of the
2 agreement between the Secretary and an
3 Organization shall be noted as part of such
4 agreement. Organizations shall submit
5 such measures as a condition of payment
6 and Program-eligible beneficiary assign-
7 ment under this subsection.

8 “(ii) REQUIREMENT FOR STAKE-
9 HOLDER INPUT.—In developing measures
10 and requirements under subclauses (I) and
11 (II) of clause (i), the Secretary shall re-
12 quest and consider input from a stake-
13 holder board that includes at least one
14 nephrologist, a pediatric nephrologist,
15 other suppliers and providers of services as
16 determined appropriate by the Secretary,
17 renal dialysis facilities, beneficiary advo-
18 cates, a health equity expert, a mental
19 health provider, a transplant surgeon, and
20 Medicare-approved transplant programs.
21 Section 14 of the Federal Advisory Com-
22 mittee Act shall not apply to the stake-
23 holder board.

24 “(iii) ADDITIONAL ASSESSMENTS AND
25 REPORTING REQUIREMENTS.—The Sec-

1 retary shall assess the extent to which an
2 Organization offers integrated and patient-
3 centered care through analysis of informa-
4 tion obtained from Program-eligible bene-
5 ficiaries assigned to or who elect the Orga-
6 nization through surveys, such as the In-
7 Center Hemodialysis Consumer Assess-
8 ment of Healthcare Providers and Sys-
9 tems.

10 “(iv) NO EFFECT ON OTHER RENAL
11 DIALYSIS FACILITY QUALITY REQUIRE-
12 MENTS.—Nothing in this section shall be
13 construed as affecting the requirements es-
14 tablished under section 1881(h).

15 “(v) PRIORITIZATION OF QUALITY
16 MEASURE REPORTING.—The Secretary
17 shall give priority to the development and
18 reporting of quality measures that allow
19 the assessment of health outcomes of pa-
20 tients, care coordination, patient experi-
21 ence and satisfaction, medication reconcili-
22 ation, patient safety, and other evidence-
23 based quality measures determined appro-
24 priate by the Secretary.

1 “(C) REQUIREMENTS FOR ESRD FEE-FOR-
2 SERVICE INTEGRATED CARE STRATEGY.—

3 “(i) IN GENERAL.—An Organization
4 seeking a contract under this section to
5 offer one or more ESRD Fee-For-Service
6 Integrated Care Models shall develop and
7 submit for the Secretary’s approval as part
8 of the application of the Organization to
9 participate in the Program under this sec-
10 tion, subject to clauses (ii) and (iii), an
11 ESRD Fee-For-Service Integrated Care
12 Strategy.

13 “(ii) ESRD FEE-FOR-SERVICE INTE-
14 GRATED CARE STRATEGY.—In assessing an
15 ESRD Fee-For-Service Integrated Care
16 Strategy under clause (i), the Secretary
17 shall consider the extent to which the
18 Strategy includes elements such as the fol-
19 lowing:

20 “(I) Use of interdisciplinary care
21 teams led by at least one nephrologist,
22 and comprised of registered nurses,
23 social workers, renal dialysis facility
24 managers, and as appropriate other

1 representatives from alternative set-
2 tings described in subclause (VIII).

3 “(II) Use of a decision process
4 for care plans and care management
5 that includes the nephrologist, a mem-
6 ber of the transplant evaluation team,
7 and other practitioners responsible for
8 direct delivery of care to Program-eli-
9 gible beneficiaries assigned to or who
10 elect the Organization involved.

11 “(III) Use of health risk and
12 other assessments to determine the
13 physical, psychosocial, nutrition, lan-
14 guage, cultural, and other needs of
15 Program-eligible beneficiaries assigned
16 to or who elect the Organization in-
17 volved.

18 “(IV) Development and at least
19 annual updating of individualized care
20 plans that incorporate at least the
21 medical, social, and functional needs,
22 preferences, and care goals of Pro-
23 gram-eligible beneficiaries assigned to
24 or who elect the Organization, includ-

1 ing a discussion on reconsideration of
2 the method and location of dialysis.

3 “(V) Coordination and furnishing
4 of non-clinical coordination benefits,
5 such as transportation, aimed at im-
6 proving the adherence of Program-eli-
7 gible beneficiaries assigned to or who
8 elect the Organization with care rec-
9 ommendations.

10 “(VI) As appropriate, coordina-
11 tion services, such as transplant eval-
12 uation, palliative care, evaluation for
13 hospice eligibility, and vascular access
14 care.

15 “(VII) In the case of an indi-
16 vidual who, during an assignment to,
17 or an election of an ESRD Fee-For-
18 Service Integrated Care model offered
19 by an Organization, receives confirma-
20 tion that a kidney transplant is immi-
21 nent, the provision of counseling serv-
22 ices by an interdisciplinary care team
23 described in subclause (I) to such in-
24 dividual on preparation for and poten-

1 tial benefits and risks associated with
2 such transplant.

3 “(VIII) Delivery of benefits and
4 services in settings alternative to tra-
5 ditional clinical settings, such as the
6 home of the Program-eligible bene-
7 ficiary.

8 “(IX) Use of patient reminder
9 systems.

10 “(X) Education programs for pa-
11 tients, families, and caregivers.

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

14 “(XII) Use of team-based health
15 care delivery models that provide com-
16 prehensive and continuous medical
17 care, such as medical homes.

18 “(XIII) Co-location of providers
19 and services.

20 “(XIV) Use of a demonstrated
21 capacity to share electronic health
22 record information across sites of
23 care.

24 “(XV) Use of programs to pro-
25 mote better adherence to rec-

1 ommended treatment regimens, in-
2 cluding prescription drug, by individ-
3 uals, including by addressing barriers
4 to access to care by such individuals,
5 including strategies to coordinate any
6 prescription drug benefits under any
7 prescription drug plan under part D
8 in which a Program-eligible bene-
9 ficiary is enrolled.

10 “(XVI) Use of defined protocols,
11 developed in conjunction with the pe-
12 diatric nephrology community, to fa-
13 cilitate the transition of pediatric indi-
14 viduals into adult end-stage renal dis-
15 ease care.

16 “(XVII) Use of health equity ex-
17 perts to implement programs and pro-
18 tocols which seek to decrease gender,
19 racial, ethnic, and language inequities.

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

24 “(3) BENEFICIARY PROTECTIONS.—

1 “(A) SEAMLESS ACCESS TO CARE.—The
2 Secretary shall ensure that the Organization es-
3 tablishes processes and takes steps necessary,
4 including educating relevant providers of serv-
5 ices and suppliers about the Program, to ensure
6 that Program-eligible beneficiaries assigned to
7 or who elected an ESRD Fee-For-Service Inte-
8 grated Care Model offered by an Organization
9 do not experience any disruption in access to
10 providers of services and suppliers furnishing
11 benefits under this title due to such assignment
12 or election. Assignment to or an election of an
13 ESRD Fee-For-Service Integrated Care Model
14 offered by an Organization shall not be con-
15 strued as affecting a Program-eligible bene-
16 ficiary’s ability to receive benefits described in
17 subsection (b)(2)(A)(i)(I) from any provider of
18 services or suppliers enrolled and who otherwise
19 meets requirements under this title, as de-
20 scribed in subsection (b)(2)(A)(iv).

21 “(B) ANTI-DISCRIMINATION.—Each agree-
22 ment between the Secretary and an Organiza-
23 tion under this section shall—

24 “(i) provide that each eligible partici-
25 pating provider of such Organization may

1 not deny, limit, or condition the furnishing
2 of services, or affect the quality of services
3 furnished, under this title to Program-eli-
4 gible beneficiaries on whether or not such
5 a beneficiary is assigned to or elects the
6 Organization; and

7 “(ii) prohibit the Organization from
8 engaging in any activity that could reason-
9 ably be expected to have the effect of deny-
10 ing or discouraging assignment to or an
11 election of an ESRD Fee-For-Service Inte-
12 grated Care Model offered by an Organiza-
13 tion by a Program-eligible beneficiary
14 whose medical condition or history indi-
15 cates a need for substantial future medical
16 services.

17 “(C) QUALITY ASSURANCE; PATIENT SAFE-
18 GUARDS.—Each agreement between the Sec-
19 retary and an Organization under this section
20 shall require that such Organization have in ef-
21 fect at a minimum—

22 “(i) a written plan of quality assur-
23 ance and improvement, and procedures im-
24 plementing such plan, in accordance with
25 regulations; and

1 “(ii) written safeguards of the rights
2 of Program-eligible beneficiaries assigned
3 to or who elect the Organization (including
4 a patient bill of rights and procedures for
5 grievances and appeals) in accordance with
6 regulations and with other requirements of
7 this title and applicable Federal and State
8 laws designed to protect Program-eligible
9 beneficiaries (including those who are enti-
10 tled to medical assistance under a State
11 plan under title XIX).

12 “(D) OVERSIGHT.—The Secretary shall
13 develop and implement an oversight program to
14 monitor an Organization’s compliance with Pro-
15 gram requirements under an agreement under
16 this section.

17 “(4) TREATMENT AS ALTERNATIVE PAYMENT
18 MODEL AND ELIGIBLE ALTERNATIVE PAYMENT EN-
19 TITY.—

20 “(A) TREATMENT OF PROGRAM.—The
21 ESRD Fee-For-Service Integrated Care Dem-
22 onstration Program established under this sec-
23 tion shall meet the definition of an alternative
24 payment model described in section
25 1833(z)(3)(C)(iv).

1 “(B) TREATMENT OF ORGANIZATION.—An
2 Organization offering one or more ESRD Fee-
3 For-Service Integrated Care Models shall be
4 treated under this section as an eligible alter-
5 native payment entity as described in clauses (i)
6 and (ii)(I) of section 1833(z)(3)(D).

7 “(c) PROGRAM OPERATION AND SCOPE.—

8 “(1) IN GENERAL.—The Secretary shall develop
9 a process such that an Organization can apply to
10 offer one or more ESRD Fee-For-Service Integrated
11 Care Models. Such application shall include informa-
12 tion on at least the following:

13 “(A) The estimated average revenue
14 amount described in subsection (b)(2)(A)(ii)(II)
15 for the Organization to cover benefits described
16 in subsection (b)(2)(A)(i)(I).

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

19 “(C) A description of the Organization’s
20 ESRD Fee-For-Service Integrated Care strat-
21 egy specified in subsection (b)(2)(D), including
22 a detailed explanation of the Organization’s ap-
23 proach to fulfill the requirement to coordinate
24 the delivery of multidisciplinary health and so-
25 cial services that, pursuant to a mutual agree-

1 ment between a State and Organization, inte-
2 grates acute and long-term care services and
3 supports.

4 “(2) PROGRAM INITIATION.—The Secretary
5 shall initiate the Program such that Organizations
6 begin serving Program-eligible beneficiaries not later
7 than January 1, 2024.

8 “(3) INITIAL AGREEMENT PERIOD.—The Sec-
9 retary shall enter into agreements for an initial pe-
10 riod of not less than 5 years with all Organizations
11 that meet all Program requirements established
12 under this section, as determined by the Secretary
13 through the application process described in para-
14 graph (1).

15 “(4) ALLOWANCE FOR SERVICE AREA EXPAN-
16 SIONS.—During each year of the Program’s oper-
17 ation, the Secretary shall allow an Organization with
18 an agreement under this section to expand its serv-
19 ice area during the initial agreement period upon the
20 Secretary’s determination, through the application
21 process described in paragraph (1), that the Organi-
22 zation meets all Program requirements established
23 under this section.

24 “(5) CONTRACT SUSPENSION AND TERMI-
25 NATION PROCESS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B)(ii), the Secretary may suspend as-
3 signment to or an election of an ESRD Fee-
4 For-Service Integrated Care Model offered by
5 an Organization if the Organization fails to
6 comply with any Program requirements speci-
7 fied in an agreement under this section. An Or-
8 ganization also shall be considered not in com-
9 pliance if, for any calendar month during an
10 agreement year, more than 50 percent of the
11 total number of Program-eligible beneficiaries
12 assigned to or who elect an ESRD Fee-For-
13 Service Integrated Care Model offered by the
14 Organization opt out of the Program.

15 “(B) OPPORTUNITY FOR CORRECTIVE AC-
16 TION PLAN AND APPEAL.—

17 “(i) IN GENERAL.—Prior to sus-
18 pending assignment to or an election of an
19 ESRD Fee-For-Service Integrated Care
20 Model offered by an Organization or termi-
21 nating an agreement under this section,
22 the Secretary shall afford an Organization
23 sufficient opportunity to remedy any defi-
24 ciencies in complying with any Program re-
25 quirements under this section by imple-

1 menting a corrective action plan. Any cor-
2 rective action plan implemented under this
3 subparagraph shall specify a date by which
4 the Organization shall resolve such defi-
5 ciencies and shall remain in effect until
6 such time that the Secretary confirms that
7 the Organization has achieved compliance.

8 “(ii) IMPOSITION OF AGREEMENT SUS-
9 PENSION OR TERMINATION.—In the case
10 of an Organization that fails to achieve
11 compliance by the date specified in correc-
12 tive action plan, subject to clause (iii) and
13 depending on the severity of a compliance
14 deficiency, the Secretary in a manner con-
15 sistent with processes established under
16 part C of this title may—

17 “(I) suspend Program-eligible
18 beneficiaries’ assignments to or an
19 election of an ESRD Fee-For-Service
20 Integrated Care Model offered by an
21 Organization; or

22 “(II) terminate an agreement
23 with an Organization under this sec-
24 tion.

1 “(iii) IMMEDIATE AGREEMENT TERMI-
2 NATION FOR VIOLATING THE PROHIBITION
3 ON DISCRIMINATION.—Notwithstanding
4 the corrective action plan process estab-
5 lished under clause (i), the Secretary may,
6 in addition to the circumstances under
7 which a contract under part C may be im-
8 mediately terminated, immediately termi-
9 nate an agreement under this section with
10 an Organization if the Secretary—

11 “(I) notifies the Organization of
12 the intent to investigate allegations of
13 systematic activities with the intent of
14 violating the prohibition on discrimi-
15 nation established under subsection
16 (b)(3)(B)(ii);

17 “(II) determines, after con-
18 ducting a rigorous analysis of all
19 available data based on a sufficient
20 sample size, that the Organization en-
21 gaged in systematic activities with the
22 intent of violating the prohibition on
23 discrimination established in sub-
24 section (b)(3)(B)(ii); and

1 “(III) discloses credible evidence
2 to the Organization regarding a deter-
3 mination made under subclause (II).

4 “(iv) RECOVERY OF MONTHLY PRO-
5 SPECTIVE PAYMENTS.—The Secretary may
6 recover the prorated share of any monthly
7 prospective payments described in sub-
8 section (e) covering the period of the
9 month following an agreement termination
10 if such agreement termination is effective
11 in the middle of a calendar month.

12 “(v) NOTIFICATION OF PROGRAM-ELI-
13 GIBLE BENEFICIARY UPON AGREEMENT
14 TERMINATION.—Each agreement under
15 this section between the Secretary and an
16 Organization shall require the Organiza-
17 tion to provide and pay for written notice
18 in advance of an agreement’s termination,
19 as well as a description of alternatives for
20 obtaining benefits under this title, in a
21 manner consistent with beneficiary notifi-
22 cation requirements in the event of a con-
23 tract termination under part C.

24 “(6) PROGRAM EVALUATION.—The Secretary
25 shall conduct an evaluation of the Program under

1 this section to inform a determination regarding a
2 Program expansion under paragraph (7). Such eval-
3 uation shall include an analysis of—

4 “(A) the quality of care furnished under
5 the Program, including the measurement of pa-
6 tient-level outcomes and patient experience and
7 patient-reported outcome measures determined
8 appropriate by the Secretary; and

9 “(B) the changes in spending under parts
10 A and B by reason of the Program.

11 “(7) PROGRAM EXPANSION.—

12 “(A) IN GENERAL.—The Secretary may,
13 through rulemaking, expand the duration and
14 scope of the Program under this section, to the
15 extent determined appropriate by the Secretary,
16 if—

17 “(i) the Secretary determines that
18 such expansion is expected to—

19 “(I) reduce spending under this
20 title without reducing the quality of
21 patient care; or

22 “(II) improve the quality of pa-
23 tient care without increasing spending
24 under this title;

1 “(ii) the Chief Actuary of the Centers
2 for Medicare & Medicaid Services certifies
3 that such expansion would reduce (or
4 would not result in any increase in) net
5 program spending under this title; and

6 “(iii) the Secretary determines that
7 such expansion would not deny or limit the
8 coverage or provision of benefits under this
9 title for applicable individuals.

10 “(B) ENSURING PROGRAM CONTINUITY.—

11 The Secretary shall implement any Program ex-
12 pansion made in accordance with this para-
13 graph in a manner that ensures that Program-
14 eligible beneficiaries and Organizations with an
15 agreement under this section do not experience
16 any disruptions in the Program.

17 “(8) PART D DATA SHARING ARRANGEMENT.—

18 The Secretary on a monthly basis shall, in accord-
19 ance with the regulations promulgated under section
20 264(c) of the Health Insurance Portability and Ac-
21 countability Act of 1996, provide access to Organiza-
22 tions to part D data claims that include part D data
23 on Program-eligible beneficiaries assigned to or an
24 election of an ESRD Fee-For-Service Integrated
25 Care Model offered by an Organization unless a Pro-

1 gram-eligible beneficiary opts out of such data shar-
2 ing.

3 “(9) FUNDING.—The Secretary shall allocate
4 funds made available under section 1115A(f)(1) to
5 implement and evaluate the demonstration program
6 established under this section.

7 “(d) IDENTIFICATION AND ASSIGNMENT OF PRO-
8 GRAM-ELIGIBLE BENEFICIARIES.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish a process for the initial and ongoing identifica-
11 tion of Program-eligible beneficiaries.

12 “(2) ASSIGNMENT OF PROGRAM-ELIGIBLE
13 BENEFICIARIES TO AN ORGANIZATION’S ESRD FEE-
14 FOR-SERVICE INTEGRATED CARE MODEL.—

15 “(A) IN GENERAL.—Under the Program,
16 the Secretary shall assign all Program-eligible
17 beneficiaries to an ESRD Fee-For-Service Inte-
18 grated Care Model offered by an Organization
19 that includes the dialysis facility at which the
20 Program-eligible beneficiary primarily receives
21 renal dialysis services.

22 “(B) OPT-OUT PERIOD AND CHANGES
23 UPON INITIAL ASSIGNMENT OR ELECTION.—
24 The Secretary shall provide for a 90-day period
25 beginning on the date on which the assignment

1 of or election made by a Program-eligible bene-
2 ficiary into an ESRD Fee-For-Service Inte-
3 grated Care Model offered by an Organization
4 becomes effective during which a Program-eli-
5 ble beneficiary may—

6 “(i) opt out of the Program; or

7 “(ii) make a one-time change of as-
8 signment or election into an ESRD Fee-
9 For-Service Integrated Care Model offered
10 by a different Organization.

11 “(C) DEEMED RE-ASSIGNMENT AND RE-
12 ELECTION.—The Secretary shall establish a
13 process through which a Program-eligible bene-
14 ficiary assigned to or who elects an ESRD Fee-
15 For-Service Integrated Care Model offered by
16 an Organization with respect to a year is
17 deemed, unless the Program-eligible beneficiary
18 otherwise changes such assignment or election
19 under this paragraph, to have elected to con-
20 tinue such assignment or election with respect
21 to the subsequent year.

22 “(D) ANNUAL OPPORTUNITY TO OPT OUT
23 OR ELECT AN ESRD FEE-FOR-SERVICE INTE-
24 GRATED CARE MODEL OFFERED BY A DIF-
25 FERENT ORGANIZATION.—

1 “(i) IN GENERAL.—Annually, a Pro-
2 gram-eligible beneficiary shall be given a
3 90-day period to—

4 “(I) opt out of the Program; or

5 “(II) make a one-time change of
6 assignment or election into an ESRD
7 Fee-For-Service Integrated Care
8 Model offered by a different Organiza-
9 tion.

10 “(ii) ALIGNMENT WITH MEDICARE AD-
11 VANTAGE OPEN ENROLLMENT PERIOD.—
12 To the extent practicable, the Secretary
13 shall align the annual 90-day period de-
14 scribed in clause (i) with the Medicare Ad-
15 vantage open enrollment period.

16 “(E) OPT OUT FOR CHANGE IN PRINCIPAL
17 DIAGNOSIS OR ENTERING HOME DIALYSIS
18 TREATMENT.—In addition to any other period
19 during which a Program-eligible beneficiary
20 may, pursuant to this paragraph, opt out of the
21 Program, in the case of a Program-eligible ben-
22 eficiary who, after assignment under this para-
23 graph, is diagnosed with a principal diagnosis
24 (as defined by the Secretary) other than end-
25 stage renal disease or enters into home dialysis

1 treatment, such individual shall be given the op-
2 portunity to opt out of the Program during
3 such period as specified by the Secretary.

4 “(3) PROGRAM-ELIGIBLE BENEFICIARY NOTIFI-
5 CATION.—

6 “(A) IN GENERAL.—The Secretary shall
7 ensure that an Organization notifies Program-
8 eligible beneficiaries about the Program under
9 this section and provides them with materials
10 explaining the Program, including—

11 “(i) information about receiving bene-
12 fits under this title through such Organiza-
13 tion; and

14 “(ii) an explanation that they retain
15 the right to receive care from any Medicare
16 provider.

17 “(B) TIMING OF NOTIFICATION.—Upon as-
18 signment to or election of an ESRD Fee-For-
19 Service Integrated Care Model offered by an
20 Organization, the Secretary shall provide the
21 Organization written notification confirming the
22 beneficiary’s assignment or election and not
23 later than 15 business days after the date of re-
24 ceipt of such notification, the Organization shall

1 provide written notice to the Program-eligible
2 beneficiary of such assignment or election.

3 “(C) CONTENT OF WRITTEN NOTICE.—
4 Subject to subparagraph (D), such notification
5 shall—

6 “(i) inform Program-eligible bene-
7 ficiaries about the Program using an infor-
8 mation guide developed by the Organiza-
9 tion and approved by the Secretary;

10 “(ii) include the distribution of other
11 Program materials developed by the Orga-
12 nization and approved by the Secretary;

13 “(iii) inform Program-eligible bene-
14 ficiaries about the importance of transplan-
15 tation as the best outcome, as well as min-
16 imum requirements for transplant eligi-
17 bility before and during dialysis treatment;
18 and

19 “(iv) provide contact information for
20 representatives of the Organization to re-
21 spond to Program-eligible beneficiaries’
22 questions.

23 “(D) LIMITATION ON UNSOLICITED NOTI-
24 FICATION.—

1 “(i) IN GENERAL.—Under the Pro-
2 gram, no person or entity (other than the
3 Secretary, an employee of the Secretary, or
4 an employee or volunteer of a federally au-
5 thorized State Health Insurance Assistance
6 Program (SHIP)), subject to clause (ii),
7 may provide any information about the
8 Program, including information, materials,
9 and assistance described in subparagraph
10 (B), to a Program-eligible beneficiary un-
11 less such Program-eligible beneficiary re-
12 quests such information, materials, or as-
13 sistance.

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

24 “(iii) PARITY IN NOTIFICATION.—In
25 the case that an eligible participating pro-

1 vider that is part of an Organization par-
2 ticipates in notifying Program-eligible
3 beneficiaries about the Program under this
4 subparagraph, such notification shall be
5 provided in the same manner to all Pro-
6 gram-eligible beneficiaries to which, pursu-
7 ant to clause (ii), such eligible partici-
8 pating provider may provide information,
9 materials, and assistance described in such
10 clause.

11 “(E) PROGRAM-ELIGIBLE BENEFICIARY
12 GRIEVANCE AND APPEAL RIGHTS.—Program-el-
13 igible beneficiaries participating in the Program
14 under this section shall have grievance and ap-
15 peal rights and procedures consistent with those
16 rights and procedures established under sub-
17 sections (f) and (g) of section 1852.

18 “(e) ESRD FEE-FOR-SERVICE INTEGRATED CARE
19 PROGRAM MONTHLY PAYMENT AND CLAIMS PROCESSING
20 MECHANISM.—

21 “(1) IN GENERAL.—For each Program-eligible
22 beneficiary receiving care through an Organization,
23 the Secretary shall make a monthly prospective pay-
24 ment in accordance with payment rates that would
25 be determined under section 1853(a)(1)(H).

1 “(2) APPLICATION OF HEALTH STATUS RISK
2 ADJUSTMENT METHODOLOGY.—The Secretary shall
3 adjust the monthly prospective payment to an Orga-
4 nization under this subsection in the same manner
5 in which the payment amount to a Medicare Advan-
6 tage plan is adjusted under section 1853(a)(1)(C).

7 “(3) TREATMENT OF AND PAYMENT FOR KID-
8 NEY ACQUISITION COSTS.—

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

17 “(B) FFS TREATMENT OF AND PAYMENT
18 FOR KIDNEY ACQUISITIONS.—An Organization
19 shall provide all benefits described in subsection
20 (b)(2)(A)(i), except for kidney acquisition costs.
21 Payment for kidney acquisition costs covered
22 under this title furnished to a Program-eligible
23 beneficiary shall be made in accordance with
24 this title and in such amounts as would other-
25 wise be made and determined for such items

1 and services provided to such a beneficiary not
2 participating in the Program under this section.

3 “(4) TREATMENT OF AND PAYMENT FOR HOS-
4 PICE CARE.—

5 “(A) IN GENERAL.—An agreement under
6 this section shall require an Organization to in-
7 form each Program-eligible beneficiary who is
8 assigned to or elects an ESRD Fee-For-Service
9 Integrated Care Model offered by the Organiza-
10 tion about the availability of hospice care if—

11 “(i) a hospice program participating
12 under this title is located within the Orga-
13 nization’s service area; or

14 “(ii) it is common practice to refer pa-
15 tients to hospice programs outside such
16 service area.

17 “(B) PAYMENT.—If a Program-eligible
18 beneficiary who is assigned to or elects an
19 ESRD Fee-For-Service Integrated Care Model
20 offered by an Organization with an agreement
21 under this section makes an election under sec-
22 tion 1812(d)(1) to receive hospice care from a
23 particular hospice program—

24 “(i) payment for the care furnished to
25 the Program-eligible beneficiary shall be

1 made by the Secretary to the hospice pro-
2 gram elected by the Program-eligible bene-
3 ficiary;

4 “(ii) payment for other services for
5 which the Program-eligible beneficiary in-
6 dividual is eligible notwithstanding the
7 Program-eligible beneficiary’s election of
8 hospice care under section 1812(d)(1), in-
9 cluding services not related to the Pro-
10 gram-eligible beneficiary’s terminal illness,
11 shall be made by the Secretary to the Or-
12 ganization or the provider or supplier of
13 the service instead of the monthly prospec-
14 tive payment determined under subsection
15 (f); and

16 “(iii) the Secretary shall continue to
17 make monthly payments to the Organiza-
18 tion in an amount equal to the value of
19 benefits and services determined under
20 subsection (b)(2)(A)(ii)(IV).

21 “(5) APPLICATION OF CMI CLAIMS PROCESSING
22 FRAMEWORK.—

23 “(A) IN GENERAL.—Under the Program,
24 the Secretary shall apply a claims processing
25 framework based on those that the Center for

1 Medicare and Medicaid Innovation applies
2 under various direct contracting models under
3 section 1115A such that—

4 “(i) providers of services and suppliers
5 serving Program-eligible beneficiaries con-
6 tinue to submit claims to a medicare ad-
7 ministrative contractor;

8 “(ii) the Secretary forwards claims to
9 the Organization for payment; and

10 “(iii) the Organization pays providers
11 of services and suppliers an amount equal
12 to the amount that they would otherwise
13 receive under the original Medicare Fee-
14 For-Service program plus any additional
15 amount to which the provider may be eligi-
16 ble under subsection (b)(2)(A)(v) of this
17 section.

18 “(B) APPLICATION OF BALANCE BILLING
19 LIMITATIONS.—Section 1852(a)(2)(A) (relating
20 to payments made by an MA organization to a
21 non-contract provider of services), section
22 1852(k)(1) (relating to limitations on balance
23 billing), and section 1866(a)(1)(o) (relating to
24 payments made by an MA organization to a

1 non-contract supplier) shall apply to the Pro-
2 gram.

3 “(C) PAYMENTS FOR GRADUATE MEDICAL
4 EDUCATION.—Section 1886(d)(11) and section
5 1886(h)(3)(D) (relating to payments for grad-
6 uate medical education) shall apply to Organi-
7 zations and providers of services under the Pro-
8 gram.

9 “(6) NO EFFECT ON MA ESRD RATE SETTING
10 OR RISK ADJUSTMENT MODEL.—To ensure the in-
11 tegrity of the Medicare Advantage end stage renal
12 disease rate setting process and risk adjustment fac-
13 tors applied to Medicare Advantage end stage renal
14 disease rates, claims paid on behalf of Program-eli-
15 gible beneficiaries shall not be included in neither the
16 determination of such rates nor the development of
17 such risk adjustment factors.

18 “(7) AGREEMENT BETWEEN A STATE AND OR-
19 GANIZATION FOR MEDICAID BENEFITS.—In the case
20 that a State and Organization enter into a mutual
21 agreement under which the Organization coordinates
22 benefits under title XIX for Program-eligible bene-
23 ficiaries eligible for benefits under this title and title
24 XIX such mutual agreement shall specify the pay-

1 ment from the State for providing or arranging for
2 the provision of such benefits.

3 “(8) AFFIRMATION OF STATE OBLIGATIONS TO
4 PAY PREMIUM AND COST-SHARING AMOUNTS.—A
5 State shall continue to make medical assistance
6 under the State plan under title XIX available for
7 the duration of the Program for Medicare cost-shar-
8 ing (as defined in section 1905(p)(3)) under this
9 title for qualified Medicare beneficiaries described in
10 section 1905(p)(1) and other individuals who are
11 Program-eligible beneficiaries assigned to or who
12 elect an Organization and entitled to medical assist-
13 ance for premiums and such cost-sharing under the
14 State plan under title XIX in an amount equal to
15 the amount of medical assistance that would be
16 made available by such State if such Program-eli-
17 gible beneficiaries were not participating in the Pro-
18 gram under this section.

19 “(f) WAIVER AUTHORITY.—

20 “(1) IN GENERAL.—The Secretary shall waive
21 those requirements waived under section 1899 deter-
22 mined by the Secretary to be relevant and necessary
23 for the operation of the Program under this section
24 and may waive, as necessary, such additional re-
25 quirements that have been or may be waived based

1 on authority established under section 1115A for
2 purposes of models tested by the Centers for Medi-
3 care and Medicaid Innovation in order to carry out
4 the Program under this section.

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

12 “(g) REPORT.—Not later than December 31, 2025,
13 the Medicare Payment Advisory Commission shall submit
14 to Congress an interim report on the Program.”.

15 (b) RULES OF CONSTRUCTION.—

16 (1) USE OF MEDICARE SUPPLEMENTAL POLICY
17 UNDER AN ESRD FEE-FOR-SERVICE INTEGRATED
18 CARE MODEL.—Nothing in the provisions of, or
19 amendments made by, this Act shall be construed to
20 prevent a Program-eligible beneficiary assigned to,
21 or who elects, an ESRD Fee-For-Service Integrated
22 Care Model offered by an Organization with an
23 agreement under this section from enrolling in or
24 continuing enrollment in a medicare supplemental
25 policy available to such Program-eligible beneficiary

1 or receiving benefits under such medicare supple-
2 mental policy throughout the duration of the Pro-
3 gram-eligible beneficiary's participation in an ESRD
4 Fee-For-Service Integrated Care model offered by an
5 Organizations with an agreement under this section.

6 (2) APPLICATION OF STATE RULES REGARDING
7 ISSUANCE OF MEDICARE SUPPLEMENTAL POLICIES
8 TO INDIVIDUAL UNDER AGE 65.—Nothing in the pro-
9 visions of, or amendments made by, this Act shall be
10 construed to establish a Federal requirement on an
11 issuer of a medicare supplemental policy to offer
12 such medicare supplemental policy to individuals
13 under age 65.

14 (3) CONTINUED AVAILABILITY OF MEDICARE
15 SUPPLEMENTAL POLICIES TO INDIVIDUALS UNDER
16 AGE 65.—Nothing in the provisions of, or amend-
17 ments made by, this Act shall be construed to affect
18 a State's authority to require an issuer of a medi-
19 care supplemental policy to offer such medicare sup-
20 plemental policy to individual.

21 (4) CONTINUED APPLICATION OF EDUCATION
22 REQUIREMENT.—Nothing in the provisions of, or the
23 amendments made by, this Act shall be construed to
24 exempt dialysis facilities participating in an Organi-
25 zation from complying with Medicare rules that re-

1 quire such Organizations to educate their patients
2 about all treatment modalities, including home dialy-
3 sis and transplantation.

4 (5) PARTICIPATION IN ESRD TREATMENT
5 CHOICES DEMONSTRATION.—Nothing in the provi-
6 sions of, or the amendments made by, this Act shall
7 be construed to exempt an Organization under the
8 ESRD FFS Integrated Care demonstration from
9 participating in the Centers for Medicare & Medicaid
10 Innovation’s mandatory ESRD Treatment Choices
11 demonstration.

12 (c) GAO STUDY AND REPORT ON PAYMENT ADE-
13 QUACY FOR PEDIATRIC ESRD SERVICES.—

14 (1) STUDY ON PAYMENT FOR PEDIATRIC ESRD
15 SERVICES.—The Comptroller General of the United
16 States shall conduct a study to examine the accuracy
17 of pediatric data reported to the Centers for Medi-
18 care & Medicaid Services as part of the ESRD pro-
19 spective payment system. The study shall evaluate
20 whether the organizations described in section
21 1866G of the Social Security Act, as added by sub-
22 section (a), and the existing prospective payment
23 system accurately capture and reimburse costs of pe-
24 diatric dialysis care and include an analysis of the
25 following factors that influence such costs:

1 (A) Increased acuity of nursing care com-
2 pared to adult dialysis patients, especially for
3 smaller and younger pediatric hemodialysis pa-
4 tients.

5 (B) Need for developmental and behavioral
6 specialists, including child life specialists.

7 (C) Need for more frequent assessment by
8 pediatric dieticians to adjust formulas and diet
9 for the specialized growth and nutrition require-
10 ments of children treated with dialysis.

11 (D) Need for social workers, school liai-
12 sons, and other trained individuals designated
13 to help families navigate challenging psycho-
14 social situations and to coordinate with schools
15 to ensure school attendance and optimize school
16 performance among pediatric dialysis patients.

17 (E) Need for a broader array of dialysis
18 supplies, including different-sized dialyzers, tub-
19 ing, and peritoneal fluid bags to accommodate
20 care provided infants through young adults.

21 (2) REPORT.—Not later than 18 months after
22 the date of the enactment of this Act, the Comp-
23 troller General shall submit to Congress a report
24 containing the results of the study conducted under
25 paragraph (1), together with recommendations for

1 such legislation and administrative action as the
2 Comptroller General determines appropriate.

3 (d) GAO STUDY AND REPORT ON THE IMPACT OF
4 RACE-BASED CORRECTION OF eGFR ON REFERRAL OF
5 ESRD PATIENTS FOR TRANSPLANT EVALUATION.—

6 (1) STUDY ON IMPACT OF RACE-BASED COR-
7 RECTION OF EGFR ON REFERRAL OF ESRD PA-
8 TIENTS FOR TRANSPLANT EVALUATION.—The
9 Comptroller General of the United States shall con-
10 duct a study to examine the impact of race-based
11 correction of the estimated glomerular filtration rate
12 (referred to in this subsection as “eGFR”) on the
13 referral of ESRD patients for transplant evaluation.

14 (2) REPORT.—Not later than 18 months after
15 the date of enactment of this Act, the Comptroller
16 General shall submit to Congress a report containing
17 the results of the study conducted under paragraph
18 (1), together with recommendations for such legisla-
19 tion and administrative action as the Comptroller
20 General determines appropriate.

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