

118TH CONGRESS
2D SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Delivering Unified Access to Lifesaving Services Act of
6 2024” or the “DUALS Act of 2024”.

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

Sec. 1. Short title; table of contents.

2

TITLE I—STATE INTEGRATED CARE PROGRAMS FOR DUAL
ELIGIBLE INDIVIDUALS

Sec. 101. State implementation.

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

“Sec. 2201. Definitions.

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

“Sec. 2203. Enrollment in integrated care plans.

“Sec. 2204. Plan requirements and payments.

“Sec. 2205. Data collection and reporting.

“Sec. 2206. State ombudsman.

“Sec. 2207. Funding.

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

Sec. 102. Providing Federal Coordinated Health Care Office authority over dual snps.

Sec. 103. Additional conforming amendments.

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

Sec. 201. Identifying opportunities for State coordination with respect to eligibility determinations.

Sec. 202. Alignment of bidding, reporting, and other dates and deadlines for integrated care plans.

Sec. 203. Grants to State and local community organizations for outreach and enrollment.

Sec. 204. Application of model standards to information requirements for integrated care plans.

Sec. 205. Enrollment through independent brokers.

Sec. 206. Reducing threshold for look-alike D–SNP plans under Medicare Advantage.

Sec. 207. Requiring regular update of provider directories.

Sec. 208. Review of hospital quality star rating system.

Sec. 209. Requirement for FCHCO and State Medicaid agencies to develop maximum staffing ratios for care coordinators.

Sec. 210. CMMI testing of coverage of partial benefit dual eligible individuals through State Integrated Care Programs.

TITLE III—ADMINISTRATION

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

TITLE IV—PACE

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

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

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

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

Sec. 405. Ensuring Medicare-only PACE program enrollees have a choice of prescription drug plans under Medicare part D.

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

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

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

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

11 **“SEC. 2201. DEFINITIONS.**

12 “In this title:

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

17 “(2) DUAL ELIGIBLE INDIVIDUAL.—The term
 18 ‘dual eligible individual’ means an individual who is
 19 entitled to, or enrolled for, benefits under part A of
 20 title XVIII, or enrolled for benefits under part B of
 21 title XVIII, and is eligible for medical assistance for
 22 full benefits under title XIX under section
 23 1902(a)(10)(A) or 1902(a)(10)(C), by reason of sec-

1 tion 1902(f), or under any other category of eligi-
2 bility for medical assistance for full benefits under
3 such title, as determined by the Secretary.

4 “(3) INTEGRATED CARE PLAN.—The term ‘in-
5 tegrated care plan’ means an entity or organization
6 that is selected by a State under section 2202(a) to
7 provide fully integrated care for a dual eligible indi-
8 vidual in accordance with the requirements of this
9 title and related Federal and State regulations. Such
10 term shall not include a PACE program (as defined
11 in sections 1894(a)(2) and 1934(a)(2)).

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

14 “(a) STATE SELECTION OF PROGRAM MODELS.—
15 Not later than 1 year after the date on which the Director
16 first publishes the range of program models for providing
17 integrated care for dual eligible individuals required by
18 section 2208(b)(1), each State shall select from such pub-
19 lished models, and shall work with the Director to imple-
20 ment such models in the State in accordance with the re-
21 quirements of this title a program model to provide com-
22 prehensive, fully integrated care for dual eligible individ-
23 uals.

24 “(b) TIMING.—Each State shall work with the Direc-
25 tor to implement the models selected by the State under

1 subsection (a) so that, to the extent practicable, the State
2 may begin to enroll dual eligible individuals in the pro-
3 gram models selected during the 4th year that occurs after
4 the year in which the State makes such selection and, by
5 the end of such 4th year, the models are fully implemented
6 and operated in accordance with the requirements of this
7 title and related Federal and State regulations. Nothing
8 in this subsection shall prohibit a State from enrolling
9 dual eligible individuals in such program models earlier
10 than the end of such 4th year if the models are fully imple-
11 mented and operated in accordance with the requirements
12 of this title and related Federal and State regulations.

13 “(c) ADJUSTMENT AUTHORITY.—The Director may
14 modify the timing required by subsections (a) and (b) as
15 appropriate to account for the particular needs or cir-
16 cumstances of a State.

17 “(d) IMPLEMENTATION COUNCIL.—

18 “(1) IN GENERAL.—A State shall establish an
19 implementation council in accordance with such re-
20 quirements as the Secretary shall establish. The
21 members of the council shall include representatives
22 of a wide range of stakeholders relevant to the provi-
23 sion of integrated care for dual eligible individuals.

24 “(2) DUTIES.—The implementation council
25 shall provide advice and counsel to the State with re-

1 spect to the implementation of the models selected
2 by the State under subsection (a).

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

4 “(a) PASSIVE ENROLLMENT; OPT-OUT PER-
5 MITTED.—

6 “(1) PASSIVE ENROLLMENT AND NOTICE RE-
7 QUIREMENTS.—A State shall automatically enroll a
8 dual eligible individual with an integrated care plan
9 under a contract with the State provided that the
10 State notifies the individual that the individual will
11 be enrolled with such plan at least 60 days (90 days,
12 in the case of the first time the individual is pro-
13 vided such notice) prior to the effective date of such
14 enrollment. Notice provided to a dual eligible indi-
15 vidual under this paragraph shall include the fol-
16 lowing:

17 “(A) The name and contact information
18 for the integrated care plan.

19 “(B) The date on which the enrollment
20 takes effect and, if applicable, whether the
21 State has elected the option for a 12-month
22 continuous eligibility period under paragraph
23 (4).

24 “(C) A summary of the benefits to be pro-
25 vided by the plan.

1 “(D) Information regarding the provider
2 network of the plan.

3 “(E) Information regarding how the dual
4 eligible individual may elect to opt-out of enroll-
5 ment with the plan within 60 days (90 days, in
6 the case of the first time the individual is pro-
7 vided such notice).

8 “(2) ENROLLMENT IN PLAN WITH IN-NET-
9 WORK, PARTICIPATING PRIMARY CARE PROVIDER RE-
10 QUIRED.—A State shall not passively enroll a dual
11 eligible individual in an integrated care plan unless
12 the individual’s primary care physician is an in-net-
13 work, participating provider for the plan.

14 “(3) VOLUNTARY ENROLLMENT.—A State shall
15 offer a dual eligible individual the option to enroll in
16 an integrated care plan without regard to meeting
17 the requirement of paragraph (2).

18 “(4) STATE OPTION FOR CONTINUOUS ELIGI-
19 BILITY AND ENROLLMENT.—A State may elect for a
20 dual eligible individual who is determined to be eligi-
21 ble for medical assistance under the State plan
22 under title XIX or under a waiver of such plan and
23 who is enrolled with an integrated care plan under
24 a contract with the State to remain eligible for med-

1 ical assistance and enrolled with such plan until the
2 earlier of—

3 “(A) the end of the 12-month period begin-
4 ning on the date of such determination; or

5 “(B) the date that such individual ceases
6 to be a resident of such State.

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

10 “(1) on a monthly basis if the individual is
11 electing to enroll in another integrated care plan;

12 “(2) during the general enrollment period appli-
13 cable under section 1837, if the individual is electing
14 to disenroll from an integrated care plan and not en-
15 roll in another integrated care plan; and

16 “(3) during the 60-day period beginning on the
17 date the individual receives notice from the State
18 that the individual has been determined to no longer
19 be eligible for treatment as a dual eligible individual,
20 if the individual is no longer eligible to enroll in an
21 integrated care plan.

22 “(c) CONTACT BY PLAN CARE COORDINATOR PER-
23 MITTED PRIOR TO EFFECTIVE DATE OF ENROLLMENT.—
24 A care coordinator for an integrated care plan may contact

1 a dual eligible individual who has been passively enrolled
2 in the plan prior to the effective date of the enrollment.

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

4 “(a) IN GENERAL.—A contract between a State, an
5 offeror of an integrated care plan, and the Director shall
6 not be considered to meet the requirements of this title
7 unless—

8 “(1) in the case of a dual eligible individual en-
9 rolled with the plan who changes enrollment to an-
10 other integrated care plan for which the individual’s
11 primary care provider is not a participating, in-net-
12 work provider, or who disenrolls from the plan and
13 does not enroll in another integrated care plan, the
14 offeror of the plan will, during the 30-day period
15 that begins on the date on which the individual’s
16 disenrollment from the plan takes effect—

17 “(A) allow the individual to continue to be
18 treated by the individual’s primary care pro-
19 vider; and

20 “(B) cover any treatment provided to the
21 individual by such provider as if the individual
22 were still enrolled with the plan;

23 “(2) the offeror of the plan administers a
24 health risk assessment to each dual eligible indi-
25 vidual enrolled with the plan within 90 days of the

1 effective date of the individual’s enrollment in ac-
2 cordance with the requirements of subsection (c) and
3 shall affirm that there are no changes in the infor-
4 mation provided at least every 12 months thereafter;

5 “(3) the offeror of the plan provides benefits for
6 a dual eligible individual under a comprehensive care
7 plan in accordance with the requirements of sub-
8 sections (d) and (f);

9 “(4) the offeror of the plan assigns a care coor-
10 dinator to each dual eligible individual enrolled with
11 the plan in accordance with the requirements of sub-
12 section (e) and notifies such individual in a timely
13 and accessible manner when a new care coordinator
14 is assigned; and

15 “(5) the contract provides for payment to the
16 offeror for benefits provided to dual eligible individ-
17 uals enrolled with the plan using a financing struc-
18 ture that satisfies the requirements of section
19 2208(e).

20 “(b) DISREGARD OF CERTAIN DISENROLLMENT
21 DATA FOR RATINGS PURPOSES.—The disenrollment of a
22 dual eligible individual from an integrated care plan who
23 was passively enrolled in the plan under section 2203 shall
24 be disregarded for purposes of any data used for rating
25 of the plan for such plan year.

1 “(c) HEALTH RISK ASSESSMENT.—An offeror of an
2 integrated care plan shall administer a health risk assess-
3 ment to each dual eligible individual enrolled with the plan
4 using the standardized health risk assessment question-
5 naire developed by the Director under section 2208(b)(3)
6 and in accordance with such additional requirements as
7 the State may establish. An integrated care plan may rely
8 on the results of a previously administered health risk as-
9 sessment of a dual eligible individual if such results are
10 accessible to the plan and the dual eligible individual af-
11 firms that there are no changes in the information pre-
12 viously provided.

13 “(d) BENEFITS.—

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

18 “(A) Clinical health services.

19 “(B) Behavioral health services.

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

21 “(2) CARVE-OUT EXCEPTIONS.—The Director
22 may permit a State and integrated care plan to sep-
23 arately contract for the provision of services or sup-
24 ports required under paragraph (1) but only if the
25 State demonstrates to the Director that—

1 “(A) the level of care provided for a dual
2 eligible individual under the separate contract
3 with respect to such services or supports is not
4 less than the level of care that would be pro-
5 vided without the exception; and

6 “(B) the dual eligible individual will not be
7 subject to any unreasonable administrative re-
8 quirements to access the services or supports,
9 as determined by the Secretary.

10 “(3) SUPPLEMENTAL BENEFITS.—An inte-
11 grated care plan may provide customized, supple-
12 mental benefits to a dual eligible individual enrolled
13 with the plan, including supplemental health care
14 benefits described in section 1852(a)(3), other pri-
15 marily health-related benefits offered by Medicare
16 Advantage plans and benefits permitted by the Sec-
17 retary to be offered as Special Supplemental Bene-
18 fits for the Chronically Ill (SSBCI), without regard
19 to whether the dual eligible individual has a requisite
20 condition or diagnosis, so long as the plan dem-
21 onstrates to the Director and the State that the of-
22 fering of such benefits has a positive impact on pa-
23 tient health.

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

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

6 “(2) be responsible for helping the individual
7 and the individual’s caregivers and family make ben-
8 efit and service decisions;

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

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

16 “(f) COMPREHENSIVE CARE PLAN REQUIRE-
17 MENTS.—The comprehensive care plan for a dual eligible
18 individual enrolled in an integrated care plan shall be—

19 “(1) designed to address the totality of the indi-
20 vidual’s medical, functional, behavioral, social, and
21 caregiving needs and goals, and to the extent prac-
22 ticable, to apply to multiple years;

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

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

5 “(4) be approved by the individual (or by an
6 authorized caregiver or guardian) prior to implemen-
7 tation; and

8 “(5) be reviewed at least annually and within
9 30 days of a major health event, such as hospitaliza-
10 tion or an emergency room visit.

11 “(g) CONTINUITY OF CARE REQUIREMENT.—An in-
12 tegrated care plan shall provide a dual eligible individual
13 enrolled in the plan with a minimum 90-day transition pe-
14 riod for any active course of treatment when the individual
15 has enrolled in an integrated care plan after starting a
16 course of treatment, even if the service is furnished by
17 an out-of-network provider. This includes enrollees new to
18 a plan and enrollees new to Medicare. The integrated care
19 plan must not disrupt or require reauthorization for an
20 active course of treatment for new plan enrollees for a pe-
21 riod of at least 90 days. An integrated care plan may pro-
22 vide for a longer transition period than 90 days at the
23 option of the plan. For purposes of this subsection the
24 following definitions apply:

1 “(1) The term ‘course of treatment’ means as
2 a prescribed order or ordered course of treatment
3 for a specific individual with a specific condition is
4 outlined and decided upon ahead of time with the
5 patient and provider. A course of treatment may but
6 is not required to be part of a treatment plan.

7 “(2) The term ‘active course of treatment’
8 means a course of treatment in which a patient is
9 actively seeing the provider and following the course
10 of treatment.

11 “(h) **AUTHORITY TO APPLY FRAILTY ADJUSTMENT**
12 **FACTOR TO PLAN PAYMENTS.**—A contract between a
13 State, an integrated care plan, and the Director under this
14 title may apply a frailty adjustment factor with respect
15 to dual eligible individuals enrolled in the plan in the same
16 manner as is permitted under section 1853(a)(1)(B)(iv),
17 but without regard to requiring the plan to demonstrate
18 enrollment of a high concentration of frail individuals.

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

20 “(a) **ANNUAL COLLECTION AND REPORTING BY**
21 **STATES AND INTEGRATED CARE PLANS.**—Each State,
22 and each integrated care plan with a contract with a State
23 under this title, annually shall collect and report informa-
24 tion and data to the Director in accordance with the re-
25 quirements of this section and guidance and regulations

1 issued under section 2208(b)(7) that includes data col-
2 lected by such States and plans with respect to a plan
3 year regarding age, gender, disability (including specific
4 disability statuses required to be reported by the Direc-
5 tor), smoking status, mobility, employment status, edu-
6 cation, race and ethnicity, and zip code, of dual eligible
7 individuals enrolled in the plan.

8 “(b) COLLECTION AND REPORTING OF ADDITIONAL
9 DATA AND INFORMATION PERMITTED.—A State may re-
10 quire an integrated care plan with a contract with the
11 State under this title to collect and report to the State
12 additional data and information.

13 **“SEC. 2206. STATE OMBUDSMAN.**

14 “(a) IN GENERAL.—Each State shall establish and
15 operate an Office of the Ombudsman for Integrated Care
16 Plans for Dual Eligible Individuals (in this section re-
17 ferred to as the ‘Office’). The Office may operate inde-
18 pendently of, or in connection with, the State agency re-
19 sponsible for administering the Medicaid program under
20 title XIX.

21 “(b) OMBUDSMAN.—The Office shall be headed by an
22 individual, to be known as the State Integrated Care for
23 Dual Eligible Individuals Ombudsman, who shall be se-
24 lected from among individuals with expertise in and expe-
25 rience with integrated care models for dual eligible individ-

1 uals, the Medicare program under title XVIII, and the
2 Medicaid program under title XIX. The Ombudsman shall
3 be responsible for the management, including the fiscal
4 management, of the Office.

5 “(c) REQUIREMENTS.—

6 “(1) IN GENERAL.—The primary responsibility
7 of the Office shall be to provide support and feed-
8 back for dual eligible individuals enrolled in inte-
9 grated care plans under this title and caregivers or
10 family members of such individuals who need assist-
11 ance.

12 “(2) MINIMUM STAFFING RATIO.—The Office
13 shall have a minimum staffing ratio of 1 employee
14 for every 2,000 dual eligible individuals in the State.

15 “(d) FUNDING.—

16 “(1) INITIAL FUNDING.—During the first 2
17 years in which a State operates the Office, the Sec-
18 retary shall pay to the State for each such year for
19 expenditures necessary to establish and operate the
20 Office, from amounts appropriated under section
21 2207(c), an amount equal to \$50,000,000 multiplied
22 by the ratio of—

23 “(A) the number of dual eligible individ-
24 uals in the State; to

1 “(B) the number of dual eligible individ-
2 uals in all States.

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

10 **“SEC. 2207. FUNDING.**

11 “(a) TREATMENT OF STATE PAYMENTS TO INTE-
12 GRATED CARE PLANS AS MEDICAL ASSISTANCE.—
13 Amounts expended by a State for payments to an inte-
14 grated care plan for the Medicaid component of the capita-
15 tion payment described in section 2208(c) shall be treated
16 as medical assistance for which payment is made under
17 section 1903(a). Nothing in this title shall prevent a State
18 from providing medical assistance under title XIX to a
19 dual eligible individual for services for which coverage is
20 not provided under the integrated care plan with which
21 the individual is enrolled or from receiving payment under
22 section 1903(a) with respect to expenditures attributable
23 to providing such medical assistance.

24 “(b) PAYMENTS TO STATES.—From the sums appro-
25 priated under subsection (c), the Secretary shall pay to

1 each State for each calendar year (beginning January 1
2 of the first full calendar year in which this title is imple-
3 mented in the State), an amount equal to the sum of the
4 following:

5 “(1) SHARED SAVINGS COMPONENT.—The
6 shared savings payment applicable to the State and
7 the year, as determined in accordance with section
8 2208(b)(6)(D).

9 “(2) GENERAL ADMINISTRATIVE EXPENSES.—
10 For administrative expenses to carry out this title,
11 other than section 2205, an amount that bears the
12 same proportion to \$50,000,000 as the number of
13 dual eligible individuals in the State bears to the
14 number of dual eligible individuals in all States, as
15 determined by the Secretary.

16 “(3) DATA COLLECTION AND REPORTING.—For
17 data collection and reporting expenses under section
18 2205, an amount that bears the same proportion to
19 \$50,000,000 as the number of dual eligible individ-
20 uals in the State bears to the number of dual eligible
21 individuals in all States, as determined by the Sec-
22 retary.

23 “(c) APPROPRIATION.—There is appropriated, out of
24 any money in the Treasury not otherwise appropriated,
25 such amounts as may be required to provide payments to

1 States under this section, for each calendar year (begin-
2 ning January 1 of the first full calendar year in which
3 this title is implemented in any State), reduced by any
4 amounts made available from the Medicare trust funds
5 under subsection (d).

6 “(d) RELATION TO MEDICARE TRUST FUNDS.—
7 There shall be made available for carrying out this title,
8 and the Secretary shall provide for the transfer from the
9 Federal Hospital Insurance Trust Fund (under section
10 1817) and from the Federal Supplementary Medical In-
11 surance Trust Fund (under section 1841) (and from the
12 Medicare Prescription Drug Account (under section
13 1860D–16) within such Trust Fund) such amounts as the
14 Secretary determines appropriate, taking into account the
15 reductions in payments from such Trust Funds and Ac-
16 count that are attributable to the enrollment of dual eligi-
17 ble individuals in integrated care plans under this title,
18 for each calendar year (beginning January 1 of the first
19 full calendar year in which this title is implemented in any
20 State).

21 “(e) RELATION TO OTHER PAYMENTS.—Payments
22 provided under this section to a State are in addition to
23 payments provided under section 2208.

1 **“SEC. 2208. FEDERAL ADMINISTRATION THROUGH THE**
2 **FEDERAL COORDINATED HEALTH CARE OF-**
3 **FICE.**

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

7 “(b) RESPONSIBILITIES OF THE FCHCO.—In car-
8 rying out this title, the Director shall have the following
9 responsibilities:

10 “(1) DEVELOPMENT AND PUBLICATION OF IN-
11 TEGRATED CARE PROGRAM MODELS.—Subject to
12 subsection (c), to develop and, not later than 180
13 days after the date of enactment of this paragraph,
14 publish, a range of program models (including but
15 not limited to Medicare-Medicaid plans, accountable
16 care organizations, and dual eligible special needs
17 plans) for providing integrated care for dual eligible
18 individuals from which States shall select to develop
19 and administer integrated care programs for dual el-
20 ible individuals in accordance with this title.

21 “(2) UNIFIED APPEALS PROCESS.—To develop
22 and, not later than 1 year after the date of enact-
23 ment of this paragraph, publish a unified adminis-
24 trative appeals process for State integrated care pro-
25 grams for dual eligible individuals under this title to

1 use in lieu of other administrative appeals processes
2 involving Medicare and Medicaid.

3 “(3) HEALTH RISK ASSESSMENT.—To develop
4 a standardized health risk assessment questionnaire
5 for dual eligible individuals that collects standard de-
6 mographic data and information relating to food in-
7 security, access to transportation, internet access,
8 utility difficulty, interpersonal safety, and housing
9 instability.

10 “(4) SUPPLEMENTAL BENEFITS STANDARDS
11 AND REPORTING REQUIREMENTS.—To establish
12 standards for reporting by States and integrated
13 care plans under title XXII information relating to
14 the offering and provision of supplemental benefits
15 under section 2204(d)(3), including data relating to
16 enrollment, utilization, and outcomes, to annually
17 publish a report regarding the offering and utiliza-
18 tion of such benefits, and to study and report to the
19 Secretary on whether to cap the actuarial dollar
20 value allowed for such benefits under titles XVIII,
21 XIX, and XXII.

22 “(5) CARE COORDINATOR REQUIREMENTS.—
23 To—

24 “(A) establish a formula based on patient
25 chronic conditions, activities of daily living

1 standards, geographic, and such other factors
2 as the Director determines are necessary for
3 States and integrated care plans to use to de-
4 termine the maximum staffing ratio for assign-
5 ing care coordinators to dual eligible individuals
6 enrolled with integrated care plans under this
7 title; and

8 “(B) develop online training and profes-
9 sional development materials relating to the
10 statutory and administrative requirements for
11 providing integrated care for care coordinators
12 for dual eligible individuals enrolled with inte-
13 grated care plans under this title.

14 “(6) ADMINISTRATION AND OVERSIGHT OF IN-
15 TEGRATED CARE PLANS FOR DUAL ELIGIBLE INDI-
16 VIDUALS.—To—

17 “(A) develop and issue guidance and regu-
18 lations related to the alignment of policy and
19 operational process under the Medicare pro-
20 gram under title XVIII and the Medicaid pro-
21 gram under title XIX, necessary for implemen-
22 tation, administration, and oversight of inte-
23 grated care plans for dual eligible individuals
24 under this title; and

1 “(B) administer and provide oversight of
2 integrated care plans for dual eligible individ-
3 uals under this title, including with respect to—

4 “(i) the development and application
5 of an integrated medical loss ratio for such
6 plans, in lieu of compliance with separate
7 medical loss ratio requirements under titles
8 XVIII and XIX;

9 “(ii) the establishment and application
10 of network adequacy standards for such
11 plans that—

12 “(I) apply only with respect to
13 such plans;

14 “(II) allow the Director to waive
15 compliance with such standards for
16 integrated care plans that cannot
17 meet the requirements in certain
18 areas, but must operate statewide to
19 meet a State’s selective contracting
20 requirements; and

21 “(III) allow the Director to con-
22 sider flexibilities to support innovative
23 models that do not rely on traditional
24 time and distance standards, such as
25 the use of telehealth; and

1 “(iii) the establishment and applica-
2 tion of targeted, streamlined model-of-care
3 requirements for such plans that include
4 an integrated audit process, with shared
5 responsibilities between the Director and
6 States, and that requires the Director to
7 share the results of such audits with State
8 Medicaid programs. To the extent prac-
9 ticable, such requirements also shall be de-
10 signed to be integrated with model of care
11 requirements applicable to Medicaid man-
12 aged care organizations;

13 “(C) develop contract management teams,
14 consisting of representatives from integrated
15 care plans with contracts with States under this
16 title, State agencies responsible for admin-
17 istering the State plan under title XIX or a
18 waiver of such plan, and the Federal Coordi-
19 nated Health Care Office, to oversee compliance
20 and performance of integrated care plans under
21 this title;

22 “(D) develop and implement a shared sav-
23 ings payment for States to receive a share of
24 savings to Federal spending in the Medicaid
25 program under title XIX as a result of the im-

1 plementation and operation of integrated care
2 plans for dual eligible individuals under this
3 title; and

4 “(E) develop a new star rating system for
5 integrated care plans for dual eligible individ-
6 uals under this title that rates the performance
7 of each plan type separately, with State-specific
8 measures and tied to single contracts, instead
9 of the collective performance of all of the
10 offeror’s plans under contract with the State
11 under that title, that include measures which
12 directly reflect enrollee satisfaction, and that
13 awards higher star ratings to plans based on
14 their ability to retain enrollees.

15 “(7) DATA COLLECTION AND REPORTING.—To
16 establish data and information collection and report-
17 ing requirements for States and integrated care
18 plans under section 2205, including required report-
19 ing of specific disability statuses and safeguards to
20 protect patient privacy, and to annually publish not
21 later than April 30 of any year, the data and infor-
22 mation collected and reported to the Director under
23 such section for the preceding year.

24 “(8) QUALITY MEASURES.—To develop quality
25 measures for the population of dual eligible individ-

1 uals that are designed to be uniformly implemented
2 across all platforms and health benefits plans that
3 provide integrated care for such individuals under
4 this title. Such measures shall include measures re-
5 lating to patient satisfaction, quality of life, rates of
6 emergency room use, institutionalization for long-
7 term care, hospital admission and readmission rates,
8 and medication errors. The Director shall regularly
9 review and update such measures as necessary and
10 may develop outcome-based quality measures for de-
11 termining payments to health benefits plans that
12 provide integrated care for dual eligible individuals
13 under this title.

14 “(9) BEST PRACTICES.—To not less than annu-
15 ally publish best practices under this title for States
16 and integrated care plans, including with respect to
17 improving outreach to beneficiaries, improving com-
18 prehensive care plans and health risk assessments
19 for dual eligible individuals, and developing a work-
20 force that provides culturally intelligent and respect-
21 ful care.

22 “(10) TRAINING PROGRAMS.—To develop train-
23 ing programs related to integrated care plans under
24 this title for—

1 “(A) providers of care, services, and sup-
2 ports under such plans with respect to issues
3 such as coordination of benefits, data sharing
4 barriers, quality ratings, and provider incen-
5 tives;

6 “(B) State employees to increase Medicare
7 expertise at State agencies responsible for ad-
8 ministering Medicaid plans and waivers and
9 contracting with integrated care plans under
10 this title; and

11 “(C) insurance brokers and local coun-
12 selors who help enroll individuals in Medicare,
13 Medicaid, and integrated care plans under this
14 title.

15 “(c) CAPITATED PAYMENT STRUCTURE FOR INTE-
16 GRATED CARE PROGRAM MODELS.—

17 “(1) IN GENERAL.—Each program model that
18 is designed by the Director under subsection (b)(1)
19 shall provide that payments shall be made to an in-
20 tegrated care plan for benefits provided under a con-
21 tract under this title using a capitated payment
22 structure under which, for each month that the inte-
23 grated care plan provides such benefits—

24 “(A) the State shall pay the integrated
25 care plan an amount equal to the Medicaid

1 component payment determined for the month;
2 and

3 “(B) the Secretary shall pay the integrated
4 care plan an amount equal to the Medicare
5 component payment determined for the month.

6 “(2) DETERMINATION OF MEDICAID COMPO-
7 NENT PAYMENT.—For purposes of paragraph (1),
8 the Medicaid component payment payable to an inte-
9 grated care plan for a month shall be an amount
10 equal to the sum of the products of—

11 “(A) for each category of beneficiary, the
12 Medicaid capitation rate applicable to the cat-
13 egory of beneficiary (as determined by the Sec-
14 retary and specified in the contract between the
15 State, the Secretary, and the offeror of the
16 plan); and

17 “(B) the number of beneficiaries in such
18 category enrolled with the plan for the month.

19 “(3) DETERMINATION OF MEDICARE COMPO-
20 NENT PAYMENT.—For purposes of paragraph (1),
21 the Medicare component payment payable to an inte-
22 grated care plan for a month shall be an amount
23 equal to the sum of the products of—

24 “(A) for each category of beneficiary, the
25 Medicare capitation rate applicable to the cat-

1 egory of beneficiary (as determined by the Sec-
2 retary and specified in the contract between the
3 State, the Secretary, and the offeror of the
4 plan); and

5 “(B) the number of beneficiaries in such
6 category enrolled with the plan for the month.

7 “(4) APPLICATION OF RISK ADJUSTMENT
8 MODEL TO CAPITATION RATES.—The Medicaid and
9 Medicare capitation rates for each category of bene-
10 ficiary specified in a contract between a State, the
11 Secretary, and the offeror of an integrated care plan
12 shall be determined using the risk adjustment pay-
13 ment model developed under subsection (d).

14 “(d) RISK ADJUSTMENT PAYMENT MODEL FOR PRO-
15 VIDING HEALTH BENEFITS COVERAGE FOR DUAL ELIGI-
16 BLE INDIVIDUALS.—Not later than 1 year after the date
17 of enactment of this subsection, the Director shall enter
18 into a contract or other agreement with an independent
19 entity to develop a risk adjustment payment model for
20 dual eligible individuals that—

21 “(1) is designed to be uniformly implemented
22 across all platforms and health benefits plans that
23 provide integrated care for such individuals under
24 title XXII of the Social Security Act;

1 “(2) includes factors based on the health status
2 of such individuals; and

3 “(3) allows plan payments to be made and up-
4 dated on a monthly basis.

5 “(e) ADDITIONAL RESPONSIBILITIES WITH RESPECT
6 TO INTEGRATED CARE PLANS.—

7 “(1) OUTREACH TO MEDICAID PROVIDERS.—

8 Not later than 180 days after the date of enactment
9 of this subsection, the Director, in consultation with
10 State Medicaid programs, shall develop outreach
11 plans for such programs to use to contact providers
12 of health benefits, services, or supports for dual eli-
13 gible individuals and provide information and edu-
14 cation regarding the State Integrated Care Pro-
15 grams for Dual Eligible Individuals established
16 under this title, how such program will operate in
17 the State where such providers offer health benefits,
18 services or supports for such individuals, and the im-
19 pact of such program on such providers.

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

23 “(A) IN GENERAL.—Not later than 180
24 days after the date of enactment of this sub-
25 section, the Director, in consultation with the

1 Administrator of the Centers for Medicare &
2 Medicaid Services and State Medicaid pro-
3 grams, shall establish a plan for collecting data
4 on quality measures from health benefits plans
5 that provide integrated care for dual eligible in-
6 dividuals under Medicare or Medicaid. Such
7 data shall include, at a minimum, data relating
8 to provider network availability in both Medi-
9 care and Medicaid, providers in-network who
10 are accepting new Medicare and Medicaid pa-
11 tients, spending on supplemental benefits, and
12 claims denials.

13 “(B) AUTHORITY TO COLLECT ADDI-
14 TIONAL DATA AND INFORMATION; PUBLICA-
15 TION.—The Director may—

16 “(i) collect additional data and infor-
17 mation relating to the quality of care pro-
18 vided for dual eligible individuals by health
19 benefits plans that provide integrated care
20 for such individuals under Medicare or
21 Medicaid; and

22 “(ii) make the data and information
23 collected in accordance with this paragraph
24 publicly available.

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

12 “(4) ASSESSMENT OF NEED FOR CRITERIA TO
13 REGULATE AND EXPAND UTILIZATION OF INSTITU-
14 TIONAL SPECIAL NEEDS PLANS.—Not later than 180
15 days after the date of enactment of this subsection,
16 the Director, in consultation with the Administrator
17 of the Centers for Medicare & Medicaid Services,
18 shall assess the adequacy of regulations and over-
19 sight of Institutional Special Needs Plan to deter-
20 mine whether new, or additional requirements should
21 be established to improve the utilization, perform-
22 ance, and oversight of such plans and how such
23 plans may be offered under State Integrated Care
24 Programs for Dual Eligible Individuals established
25 under this title.

1 “(f) APPROPRIATIONS.—There are hereby appro-
2 priated, out of any funds in the Treasury not otherwise
3 appropriated, for the first fiscal year that begins after the
4 date of enactment of this title, and for each fiscal year
5 thereafter, such sums as are necessary to carry out this
6 title.

7 “(g) DIRECT-HIRE AUTHORITY.—In carrying out
8 this title, the Director shall have direct-hire authority to
9 the extent required to implement and administer this title
10 on a timely basis.”.

11 **SEC. 102. PROVIDING FEDERAL COORDINATED HEALTH**
12 **CARE OFFICE AUTHORITY OVER DUAL SNPS.**

13 (a) IN GENERAL.—Section 1859(f)(8) of the Social
14 Security Act (42 U.S.C. 1395w–28(f)(8)) is amended by
15 adding at the end the following new subparagraph:

16 “(F) AUTHORITY OF FEDERAL COORDI-
17 NATED HEALTH CARE OFFICE.—For plan years
18 beginning on or after January 1, 2025, the
19 Federal Coordinated Health Care Office estab-
20 lished under section 2602 of Public Law 111–
21 148 shall have primary authority for imple-
22 menting and carrying out responsibilities of the
23 Secretary with respect to the integration of spe-
24 cialized MA plans for special needs individuals

1 described in subsection (b)(6)(B)(ii) under this
2 subsection.”.

3 (b) CONFORMING AMENDMENT.—Section 2602(d)(6)
4 of the Patient Protection and Affordable Care Act (42
5 U.S.C. 1315b(d)(6)) is amended by inserting the following
6 before the period: “and, for plan years beginning on or
7 after January 1, 2025, to carry out subsection (f)(8)(F)
8 of such section”.

9 **SEC. 103. ADDITIONAL CONFORMING AMENDMENTS.**

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

13 (1) by striking “XIX, and XXI” and inserting
14 “XIX, XXI, and XXII”; and

15 (2) by striking “XIX and XXI” and inserting
16 “XIX, XXI, and XXII”.

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

21 “(4) ADDITIONAL ENROLLMENT OPTION FOR
22 DUAL ELIGIBLE INDIVIDUALS.—Dual eligible individ-
23 uals (as defined in section 2201) may also be eligible
24 to enroll in an integrated care plan under title
25 XXII.”.

1 (c) PREVENTING DUPLICATE PAYMENTS UNDER
2 MEDICAID.—Section 1903(i) of the Social Security Act
3 (42 U.S.C. 1396b(i)) is amended—

4 (1) by striking “or” at the end of paragraph
5 (26);

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

8 (3) by inserting after paragraph (27) the fol-
9 lowing new paragraph:

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

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

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

6 **SEC. 201. IDENTIFYING OPPORTUNITIES FOR STATE CO-**
7 **ORDINATION WITH RESPECT TO ELIGIBILITY**
8 **DETERMINATIONS.**

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

12 (1) review State processes for determining
13 whether an individual is a full-benefit dual individual
14 (as defined in section 1935(c)(6) of the Social Secu-
15 rity Act (42 U.S.C. 1396u–5(c)(6)) but without the
16 application of subparagraph (A)(i) of such section)
17 and whether an individual is eligible for the low-in-
18 come subsidy program under section 1860D–14 of
19 the Social Security Act (42 U.S.C. 1395w–114) and
20 the Medicare Savings Program (as defined in section
21 1144(c)(7) of such Act (42 U.S.C. 1320b–
22 14(c)(7))); and

23 (2) issue guidance for States that identifies op-
24 portunities for better coordination of such processes
25 between the States and the Federal government.

1 **SEC. 202. ALIGNMENT OF BIDDING, REPORTING, AND**
2 **OTHER DATES AND DEADLINES FOR INTE-**
3 **GRATED CARE PLANS.**

4 Not later than 180 days after the date of enactment
5 of this Act, the Director of the Federal Coordinated
6 Health Care Office of the Centers for Medicare & Med-
7 icaid Services and the Administrator of the Centers for
8 Medicare & Medicaid Services shall—

9 (1) review bidding, reporting, and other signifi-
10 cant dates and deadlines applicable to integrated
11 care plans under the Medicare program, the Med-
12 icaid program, and State Integrated Care Programs
13 for Dual Eligible Individuals under title XXII of the
14 Social Security Act; and

15 (2) identify such administrative and legislative
16 changes as are needed to ensure that all such dates
17 and deadlines are aligned and consistent under all
18 such programs.

19 **SEC. 203. GRANTS TO STATE AND LOCAL COMMUNITY OR-**
20 **GANIZATIONS FOR OUTREACH AND ENROLL-**
21 **MENT.**

22 (a) IN GENERAL.—From the amounts appropriated
23 under subsection (c) for a fiscal year, the Secretary of
24 Health and Human Services (in this section referred to
25 as the “Secretary”) shall award grants to State and local
26 community organizations to conduct outreach and enroll-

1 ment efforts that are designed to increase the enrollment
2 of dual eligible individuals (as defined in section 2201 of
3 the Social Security Act) in health benefits plans that pro-
4 vide integrated care for such individuals under State Inte-
5 grated Care Programs for Dual Eligible Individuals estab-
6 lished under XXII of the Social Security Act.

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

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

16 (2) Materials presented are easy to read, writ-
17 ten in as low a reading comprehension level as pos-
18 sible, and are in the proper language for the indi-
19 vidual involved.

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

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

1 (c) APPROPRIATION.—There is appropriated, out of
2 any money in the Treasury not otherwise appropriated,
3 for the first fiscal year that begins after the date of enact-
4 ment of this Act, and for each fiscal year thereafter,
5 \$50,000,000 to carry out this section.

6 **SEC. 204. APPLICATION OF MODEL STANDARDS TO INFOR-**
7 **MATION REQUIREMENTS FOR INTEGRATED**
8 **CARE PLANS.**

9 Not later than 1 year after the date of enactment
10 of this Act, the Director of the Federal Coordinated
11 Health Care Office of the Centers for Medicare & Med-
12 icaid Services and the Administrator of the Centers for
13 Medicare & Medicaid Services jointly shall issue guidance
14 or regulations requiring that any notice or informational
15 materials provided to a dual eligible individual (as defined
16 in section 2201 of the Social Security Act) by such Direc-
17 tor, Administrator, States, or health benefits plans that
18 provide integrated care for such individuals under the
19 Medicare program, the Medicaid program, or under State
20 Integrated Care Programs for Dual Eligible Individuals
21 established under XXII of the Social Security Act com-
22 plies with the model standards issued under section
23 203(b).

1 **SEC. 205. ENROLLMENT THROUGH INDEPENDENT BRO-**
2 **KERS.**

3 Not later than 1 year after the date of enactment
4 of this Act, the Director of the Federal Coordinated
5 Health Care Office of the Centers for Medicare & Med-
6 icaid Services and the Administrator of the Centers for
7 Medicare & Medicaid Services jointly shall issue guidance
8 or regulations providing that—

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

16 (2) an independent broker may receive a com-
17 mission for the initial enrollment of a dual eligible
18 individual in such a plan, but no commission shall
19 be available to any broker for any subsequent enroll-
20 ment of such individual in any such plan;

21 (3) if a broker disenrolls a dual eligible indi-
22 vidual from any such health benefits plan to a plan
23 that provides partial or no integrated care, the
24 broker, in accordance with the model standards
25 issued under section 204(b), shall inform the indi-
26 vidual—

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

3 (B) that the individual is being enrolled in
4 a health benefits plan that provides partial or
5 no integrated care and the potential implica-
6 tions of such disenrollment and enrollment on
7 the individual's care.

8 **SEC. 206. REDUCING THRESHOLD FOR LOOK-ALIKE D-SNP**
9 **PLANS UNDER MEDICARE ADVANTAGE.**

10 For the first full plan year that begins on or after
11 the date that is 1 year after the date of enactment of this
12 Act, and each subsequent plan year, the Secretary of
13 Health and Human Services—

14 (1) shall implement section 422.514(d)(1)(ii) of
15 title 42, Code of Federal Regulations (or any suc-
16 cessor regulations) by substituting “50 percent” for
17 “80 percent”; and

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

1 **SEC. 207. REQUIRING REGULAR UPDATE OF PROVIDER DI-**
2 **RECTORIES.**

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

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

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

19 **SEC. 208. REVIEW OF HOSPITAL QUALITY STAR RATING**
20 **SYSTEM.**

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

24 (1) review the hospital quality star rating sys-
25 tem under the Medicare program under title XVIII

1 of the Social Security Act (42 U.S.C. 1395 et seq.);
2 and

3 (2) identify such administrative and legislative
4 changes as are needed to ensure that sufficient in-
5 formation is collected under such system regarding
6 hospitals to effectively measure hospital quality.

7 **SEC. 209. REQUIREMENT FOR FCHCO AND STATE MEDICAID**
8 **AGENCIES TO DEVELOP MAXIMUM STAFFING**
9 **RATIOS FOR CARE COORDINATORS.**

10 (a) IN GENERAL.—The Director of the Federal Co-
11 ordinated Health Care Office, in consultation with State
12 Medicaid agencies, shall develop model Federal legislation
13 that would establish a process for determining a maximum
14 care coordinator-to-patient ratio for integrated care plans
15 providing care to dual eligible individuals under an inte-
16 grated care model under title XXII of the Social Security
17 Act. Such process shall take into account the varying
18 needs required by different categories of patients.

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

24 (1) the Secretary of Health and Human Serv-
25 ices;

- 1 (2) the Committee on Finance of the Senate;
- 2 (3) the Committee on Energy and Commerce of
- 3 the House of Representatives; and
- 4 (4) the Committee on Ways and Means of the
- 5 House of Representatives.

6 **SEC. 210. CMMI TESTING OF COVERAGE OF PARTIAL BEN-**

7 **EFIT DUAL ELIGIBLE INDIVIDUALS THROUGH**

8 **STATE INTEGRATED CARE PROGRAMS.**

9 Section 1115A of the Social Security Act (42 U.S.C.

10 1315a) is amended—

11 (1) in subsection (b)(2)(A), by adding at the

12 end the following new sentence: “The models se-

13 lected under this subparagraph shall include the

14 testing of the model described in subsection (h)(1).”;

15 and

16 (2) by adding at the end the following new sub-

17 section:

18 “(h) TESTING OF MODEL FOR PROVIDING COVERAGE

19 OF PARTIAL BENEFIT DUAL ELIGIBLE INDIVIDUALS

20 THROUGH PARTIALLY INTEGRATED CARE PLANS UNDER

21 STATE INTEGRATED CARE PROGRAMS.—

22 “(1) IN GENERAL.—The model described in this

23 paragraph is a model under which States may offer

24 coverage to partial benefit dual eligible individuals

25 through partially integrated care plans under State

1 Integrated Care Programs established under title
2 XXII.

3 “(2) PARTIAL BENEFIT DUAL ELIGIBLE INDI-
4 VIDUAL.—For purposes of this subsection, the term
5 ‘partial benefit dual eligible individual’ means an in-
6 dividual who—

7 “(A) is eligible for the low-income subsidy
8 program under section 1860D–14, the Medicare
9 Savings Program (as defined in section
10 1144(c)(7)), or both; and

11 “(B) is not a full-benefit dual eligible indi-
12 vidual (as such term is defined in section
13 1935(c)(6), but without the application of sub-
14 paragraph (A)(i) of such section).”.

15 **TITLE III—ADMINISTRATION**

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

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

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

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

3 (2) conduct at least 1 listening session open to
4 the public on the alignment of billing under the pro-
5 grams identified in paragraph (1); and

6 (3) identify such administrative and legislative
7 changes as are needed to ensure that all such billing
8 codes are aligned and consistent under all such pro-
9 grams.

10 **TITLE IV—PACE**

11 **SEC. 401. REQUIRING STATES TO OFFER PACE PROGRAM**

12 **SERVICES TO ELIGIBLE INDIVIDUALS.**

13 (a) IN GENERAL.—Section 1934 of the Social Secu-
14 rity Act (42 U.S.C. 1396u–4) is amended—

15 (1) in subsection (a)(1)—

16 (A) by striking “A State may elect to pro-
17 vide” and inserting “A State shall provide”;
18 and

19 (B) by striking “A State may establish a
20 numerical limit on the number of individuals
21 who may be enrolled in a PACE program under
22 a PACE program agreement.”;

23 (2) in subsection (e)—

24 (A) in paragraph (1)—

1 (i) by striking “(A) IN GENERAL.—
2 The Secretary” and inserting “The Sec-
3 retary”; and

4 (ii) by striking subparagraph (B);
5 (B) in paragraph (2)(A)(ii); and
6 (3) in subsection (h)(2)—

7 (A) by striking “(A) IN GENERAL.—Except
8 as provided under subparagraph (B), and” and
9 inserting “Except as provided under”; and

10 (B) by striking subparagraph (B).

11 (b) STATE PLAN REQUIREMENT.—Section 1902(a)
12 of the Social Security Act (42 U.S.C. 1396a(a)) is amend-
13 ed—

14 (1) in paragraph (86), by striking “; and” and
15 inserting a semicolon;

16 (2) in paragraph (87)(D), by striking the period
17 at the end and inserting “; and”; and

18 (3) by inserting after paragraph (87) the fol-
19 lowing new paragraph;

20 “(88) provide, in accordance with section 1934,
21 that the State shall provide medical assistance with
22 respect to PACE program services to PACE pro-
23 gram eligible individuals who are eligible for medical
24 assistance under the State plan and who are enrolled

1 in a PACE program under a PACE program agree-
2 ment.”.

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

6 **SEC. 402. ENROLLMENT OF PACE BENEFICIARIES AT ANY**
7 **TIME.**

8 (a) IN GENERAL.—Sections 1894(d)(5)(A) and
9 1934(d)(5)(A) (42 U.S.C. 1395eee(d)(5)(A), 1396u-
10 4(d)(5)(A)) are each amended—

11 (1) in the subparagraph header, by inserting
12 “ENROLLMENT OR”;

13 (2) by inserting “PACE program eligible indi-
14 viduals to enroll in a PACE program at any time
15 and” after “shall permit”; and

16 (3) by adding at the end the following sentence:
17 “The amount of any capitated payment made to a
18 PACE provider under subsection (d)(1) may be ad-
19 justed to account for any PACE program eligible in-
20 dividuals who enroll after the first day of a month
21 (with the amount of such payment adjustment being
22 proportional to the portion of such month for which
23 the individual is enrolled)”.

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

4 **SEC. 403. EXTENDING ELIGIBILITY FOR PACE TO MEDI-**
5 **CARE-ELIGIBLE INDIVIDUALS UNDER THE**
6 **AGE OF 55.**

7 (a) IN GENERAL.—Sections 1894(a)(5)(A) and
8 1934(a)(5)(A) of the Social Security Act (42 U.S.C.
9 1395eee(a)(5), 1396u–4(a)(5)) are each amended by in-
10 serting “(or any age in the case of an individual who is
11 eligible for benefits under part A, or enrolled under part
12 B, of title XVIII)” after “is 55 years of age or older”.

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

16 **SEC. 404. REMOVAL OF QUARTERLY RESTRICTIONS FOR**
17 **SUBMISSION OF A NEW PACE ORGANIZATION**
18 **APPLICATION, AND REMOVAL QUARTERLY**
19 **RESTRICTIONS FOR APPLICATIONS IN A NEW**
20 **SERVICE AREA.**

21 (a) IN GENERAL.—Sections 1894(e) and 1934(e) of
22 the Social Security Act (42 U.S.C. 1395eee(e), 1396u–
23 4(e)) are each amended by adding at the end the following
24 new paragraph:

1 “(9) NO QUARTERLY OR GEOGRAPHIC LIMITA-
2 TIONS ON APPLICATIONS FOR PACE PROVIDER STA-
3 TUS.—The Secretary shall not prohibit an entity
4 that meets the requirements for a PACE provider
5 under this section from—

6 “(A) submitting multiple applications in
7 the same quarter; or

8 “(B) submitting multiple applications to
9 operate a PACE program in the same service
10 area.”.

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

14 **SEC. 405. ENSURING MEDICARE-ONLY PACE PROGRAM EN-**
15 **ROLLEES HAVE A CHOICE OF PRESCRIPTION**
16 **DRUG PLANS UNDER MEDICARE PART D.**

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

19 (1) in paragraph (1), by striking “and (3)” and
20 inserting “(3), and (4)”; and

21 (2) by adding at the end the following new
22 paragraph:

23 “(4) ENSURING CHOICE OF PRESCRIPTION
24 DRUG PLANS.—

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

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

12 “(i) APPLICABLE PACE PROGRAM EN-
13 ROLLEE.—The term ‘applicable PACE pro-
14 gram enrollee’ means a part D eligible in-
15 dividual who—

16 “(I) is not entitled to medical as-
17 sistance under title XIX; and

18 “(II) is enrolled under a PACE
19 program offered by a PACE provider.

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

1 “(I) that is not an MA–PD plan;

2 “(II) that is not operated by the

3 PACE program under which the indi-

4 vidual is enrolled; and

5 “(III) for which the Secretary de-

6 termines, with respect to the applica-

7 ble PACE program enrollees enrolled

8 in a PACE program offered by such

9 PACE provider, that—

10 “(aa) the estimated bene-

11 ficiary out-of-pocket costs (as de-

12 fined in clause (iii)) for the plan

13 year for qualified prescription

14 drug coverage under the plan is

15 equal to or less than the esti-

16 mated out-of-pocket costs for

17 such coverage under the prescrip-

18 tion drug plan offered by the

19 PACE program in which the ap-

20 plicable PACE program enrollee

21 is enrolled; and

22 “(bb) the estimated total

23 amount of Federal subsidies for

24 the plan year for qualified pre-

25 scription drug coverage under the

1 plan (which may be estimated
2 using data from the previous
3 plan year) is equal to or less than
4 the estimated subsidy amount for
5 such coverage under the prescrip-
6 tion drug plan offered by the
7 PACE program in which the ap-
8 plicable PACE program enrollee
9 is enrolled.

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

18 “(C) OUT-OF-POCKET COSTS.—In the case
19 where an applicable PACE program enrollee
20 elects to enroll in a qualified standalone pre-
21 scription drug plan pursuant to this paragraph,
22 the individual shall be responsible for any out-
23 of-pocket costs imposed under the plan (includ-
24 ing costs for nonformulary drugs) after the ap-
25 plication of any subsidies under section 1860D–

1 14 for an applicable PACE program enrollee
2 who is a subsidy eligible individual (as defined
3 in section 1860D–14(a)(3)).

4 “(D) REQUIREMENTS FOR PACE PRO-
5 GRAMS.—

6 “(i) EDUCATING AND HELPING EN-
7 ROLL BENEFICIARIES INTO A PART D PLAN
8 OPTION.—A PACE program shall be re-
9 quired to provide—

10 “(I) information to all applicable
11 PACE program enrollees who are en-
12 rolled under the PACE program re-
13 garding the option to enroll in a quali-
14 fied standalone prescription drug plan
15 under this paragraph; and

16 “(II) upon request of an applica-
17 ble PACE program enrollee, coun-
18 seling and coordination to assist appli-
19 cable PACE program enrollees in
20 making decisions regarding the selec-
21 tion of qualified standalone prescrip-
22 tion drug plans available to them.

23 “(ii) MONITORING DRUG UTILIZATION,
24 ADHERENCE, AND SPEND.—A PACE pro-
25 gram shall be required to monitor drug

1 utilization, medication adherence, and drug
2 spending (through claims data shared pur-
3 suant to subparagraph (F) and otherwise)
4 throughout the year with respect to any
5 applicable PACE program enrollee who
6 elects to enroll in a qualified standalone
7 prescription drug plan under this para-
8 graph in order to coordinate with the PDP
9 sponsor of such plan regarding the drug
10 benefits offered by the plan, including
11 upon request of an applicable PACE pro-
12 gram enrollee the filing of any grievances
13 or appeals with the plan on behalf of the
14 applicable PACE program enrollee.

15 “(E) DISENROLLMENT.—An applicable
16 PACE program enrollee may disenroll from the
17 qualified standalone prescription drug plan
18 elected by such applicable PACE program en-
19 rollee under subparagraph (A) if the enrollee
20 changes medication during the plan year or can
21 demonstrate an unexpected increase in out-of-
22 pocket costs post enrollment.

23 “(F) CLAIMS SHARING.—In the case where
24 an applicable PACE program enrollee enrolls in
25 a qualified standalone prescription drug plan,

1 the PACE program in which the individual is
2 enrolled and the PDP sponsor of the qualified
3 standalone prescription drug plan shall share
4 claims data with each other with respect to the
5 applicable PACE program enrollee as needed to
6 support care management for the applicable
7 PACE program enrollee (including for purposes
8 of monitoring and coordination required under
9 subparagraph (D)(ii)) and for purposes of com-
10 prehensive risk adjustment under section
11 1894(d). Such data shall be shared without the
12 need for any formal or informal request of the
13 PACE program in which the individual is en-
14 rolled or the PDP sponsor of the qualified
15 standalone prescription drug plan in which the
16 applicable PACE program enrollee is enrolled.

17 “(G) RULE OF CONSTRUCTION.—The au-
18 thority established under this paragraph for an
19 applicable PACE program enrollee to elect to
20 enroll in a qualified standalone prescription
21 drug plan shall not be construed as permitting
22 an applicable PACE program enrollee to enroll
23 in a prescription drug plan that is not a quali-
24 fied standalone prescription drug plan.

25 “(H) RELATION TO PACE STATUTES.—

1 “(i) IN GENERAL.—The authority pro-
2 vided under this paragraph for an applica-
3 ble PACE program enrollee to elect to en-
4 roll in a qualified standalone prescription
5 drug plan shall apply notwithstanding sub-
6 section (a)(1)(B)(1) of section 1894 and
7 such other provisions of sections 1894 and
8 1934 as the Secretary determines may con-
9 flict with the authority provided for under
10 this paragraph, including subsections
11 (a)(2)(B), (b)(1)(A)(i), (b)(1)(C),
12 (f)(2)(B)(ii), and (f)(2)(B)(v) of such sec-
13 tions.

14 “(ii) CLARIFICATION ON PAYMENT
15 FOR PART D DRUG COVERAGE.—Insofar as
16 an applicable PACE program enrollee is
17 enrolled in a qualified standalone prescrip-
18 tion drug plan under this paragraph, the
19 PACE program shall not be entitled to
20 payment under section 1894(d) for the
21 provision of qualified prescription drug
22 coverage under such standalone prescrip-
23 tion drug plan with respect to such appli-
24 cable PACE program enrollee.”.