I

118TH CONGRESS
2D SESSION

H. R. 8503

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 HOUSE OF REPRESENTATIVES

MAY 22, 2024

Mr. KELLY of Pennsylvania (for himself and Mr. BERA) 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

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

TITLE I—STATE INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE INDIVIDUALS

Sec. 101. State implementation.

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

''Sec. 2201. Definitions.
''Sec. 2202. State selection of program models, development, and implementation.
''Sec. 2203. Enrollment in integrated care plans.
''Sec. 2204. Plan requirements and payments.
''Sec. 2205. Data collection and reporting.
''Sec. 2206. State ombudsman.
''Sec. 2207. Funding.
''Sec. 2208. Federal administration through the Federal Coordinated Health Care Office.
Sec. 102. 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 of 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.

TITLE I—STATE INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE INDIVIDUALS

SEC. 101. STATE IMPLEMENTATION.

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

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

"SEC. 2201. DEFINITIONS.

''In this title:

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

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

title XVIII, and is eligible for medical assistance for full benefits under title XIX under section 1902(a)(10)(A) or 1902(a)(10)(C), by reason of section 1902(f), or under any other category of eligibility for medical assistance for full benefits under such title, as determined by the Secretary.

''(3) INTEGRATED CARE PLAN.—The term 'integrated care plan' means an entity or organization that is selected by a State under section 2202(a) to provide fully integrated care for a dual eligible individual in accordance with the requirements of this title and related Federal and State regulations. Such term shall not include a PACE program (as defined in sections 1894(a)(2) and 1934(a)(2)).

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

''(a) STATE SELECTION OF PROGRAM MODELS.—Not later than 1 year after the date on which the Director first publishes the range of program models for providing integrated care for dual eligible individuals required by section 2208(b)(1), each State shall select from such published models, and shall work with the Director to implement such models in the State in accordance with the requirements of this title a program model to provide com-

prehensive, fully integrated care for dual eligible individuals.

''(b) TIMING.—Each State shall work with the Director to implement the models selected by the State under subsection (a) so that, to the extent practicable, the State may begin to enroll dual eligible individuals in the program models selected during the fourth year that occurs after the year in which the State makes such selection and, by the end of such fourth year, the models are fully implemented and operated in accordance with the requirements of this title and related Federal and State regulations. Nothing in this subsection shall prohibit a State from enrolling dual eligible individuals in such program models earlier than the end of such fourth year if the models are fully implemented and operated in accordance with the requirements of this title and related Federal and State regulations.

''(c) ADJUSTMENT AUTHORITY.—The Director may modify the timing required by subsections (a) and (b) as appropriate to account for the particular needs or circumstances of a State.

''(d) IMPLEMENTATION COUNCIL.—

''(1) IN GENERAL.—A State shall establish an implementation council in accordance with such requirements as the Secretary shall establish. The

members of the council shall include representatives of a wide range of stakeholders relevant to the provision of integrated care for dual eligible individuals.

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

"SEC. 2203. ENROLLMENT IN INTEGRATED CARE PLANS.

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

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

''(A) The name and contact information for the integrated care plan.

''(B) The date on which the enrollment takes effect and, if applicable, whether the

State has elected the option for a 12-month continuous eligibility period under paragraph (4).

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

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

''(E) Information regarding how the dual eligible individual may elect to opt-out of enrollment with the plan within 60 days (90 days, in the case of the first time the individual is provided such notice).

''(2) ENROLLMENT IN PLAN WITH IN-NETWORK, PARTICIPATING PRIMARY CARE PROVIDER REQUIRED.—A State shall not passively enroll a dual eligible individual in an integrated care plan unless the individual's primary care physician is an in-network, participating provider for the plan.

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

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

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

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

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

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

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

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

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

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

"SEC. 2204. PLAN REQUIREMENTS AND PAYMENTS.

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

''(1) in the case of a dual eligible individual enrolled with the plan who changes enrollment to another integrated care plan for which the individual's primary care provider is not a participating, in-network provider, or who disenrolls from the plan and does not enroll in another integrated care plan, the offeror of the plan will, during the 30-day period that begins on the date on which the individual's disenrollment from the plan takes effect—

''(A) allow the individual to continue to be treated by the individual's primary care provider; and

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

''(2) the offeror of the plan administers a health risk assessment to each dual eligible individual enrolled with the plan within 90 days of the effective date of the individual's enrollment in accordance with the requirements of subsection (c) and shall affirm that there are no changes in the information provided at least every 12 months thereafter;

''(3) the offeror of the plan provides benefits for a dual eligible individual under a comprehensive care plan in accordance with the requirements of subsections (d) and (f);

''(4) the offeror of the plan assigns a care coordinator to each dual eligible individual enrolled with the plan in accordance with the requirements of subsection (e) and notifies such individual in a timely and accessible manner when a new care coordinator is assigned; and

''(5) the contract provides for payment to the offeror for benefits provided to dual eligible individuals enrolled with the plan using a financing structure that satisfies the requirements of section 2208(c).

''(b) DISREGARD OF CERTAIN DISENROLLMENT DATA FOR RATINGS PURPOSES.—The disenrollment of a dual eligible individual from an integrated care plan who

was passively enrolled in the plan under section 2203 shall be disregarded for purposes of any data used for rating of the plan for such plan year.

''(c) HEALTH RISK ASSESSMENT.—An offeror of an integrated care plan shall administer a health risk assessment to each dual eligible individual enrolled with the plan using the standardized health risk assessment questionnaire developed by the Director under section 2208(b)(3) and in accordance with such additional requirements as the State may establish. An integrated care plan may rely on the results of a previously administered health risk assessment of a dual eligible individual if such results are accessible to the plan and the dual eligible individual affirms that there are no changes in the information previously provided.

''(d) BENEFITS.—

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

''(A) Clinical health services.

''(B) Behavioral health services.

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

''(2) CARVE-OUT EXCEPTIONS.—The Director may permit a State and integrated care plan to sep-

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

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

"(B) the dual eligible individual will not be subject to any unreasonable administrative requirements to access the services or supports, as determined by the Secretary.

"(3) SUPPLEMENTAL BENEFITS.—An integrated care plan may provide customized, supplemental benefits to a dual eligible individual enrolled with the plan, including supplemental health care benefits described in section 1852(a)(3), other primarily health-related benefits offered by Medicare Advantage plans and benefits permitted by the Secretary to be offered as Special Supplemental Benefits for the Chronically Ill (SSBCI), without regard to whether the dual eligible individual has a requisite condition or diagnosis, so long as the plan demonstrates to the Director and the State that the of-

fering of such benefits has a positive impact on patient health.

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

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

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

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

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

''(f) COMPREHENSIVE CARE PLAN REQUIREMENTS.—The comprehensive care plan for a dual eligible individual enrolled in an integrated care plan shall be—

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

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

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

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

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

''(g) CONTINUITY OF CARE REQUIREMENT.—An integrated care plan shall provide a dual eligible individual enrolled in the plan with a minimum 90-day transition period for any active course of treatment when the individual has enrolled in an integrated care plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a plan and enrollees new to Medicare. The integrated care plan must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days. An integrated care plan may provide for a longer transition period than 90 days at the

option of the plan. For purposes of this subsection the following definitions apply:

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

''(2) The term 'active course of treatment' means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

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

"SEC. 2205. DATA COLLECTION AND REPORTING.

''(a) ANNUAL COLLECTION AND REPORTING BY STATES AND INTEGRATED CARE PLANS.—Each State, and each integrated care plan with a contract with a State under this title, annually shall collect and report informa-

tion and data to the Director in accordance with the requirements of this section and guidance and regulations issued under section 2208(b)(7) that includes data collected by such States and plans with respect to a plan year regarding age, gender, disability (including specific disability statuses required to be reported by the Director), smoking status, mobility, employment status, education, race and ethnicity, and zip code, of dual eligible individuals enrolled in the plan.

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

"SEC. 2206. STATE OMBUDSMAN.

''(a) IN GENERAL.—Each State shall establish and operate an Office of the Ombudsman for Integrated Care Plans for Dual Eligible Individuals (in this section referred to as the 'Office'). The Office may operate independently of, or in connection with, the State agency responsible for administering the Medicaid program under title XIX.

''(b) OMBUDSMAN.—The Office shall be headed by an individual, to be known as the State Integrated Care for Dual Eligible Individuals Ombudsman, who shall be se-

lected from among individuals with expertise in and experience with integrated care models for dual eligible individuals, the Medicare program under title XVIII, and the Medicaid program under title XIX. The Ombudsman shall be responsible for the management, including the fiscal management, of the Office.

''(c) REQUIREMENTS.—

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

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

''(d) FUNDING.—

''(1) INITIAL FUNDING.—During the first 2 years in which a State operates the Office, the Secretary shall pay to the State for each such year for expenditures necessary to establish and operate the Office, from amounts appropriated under section 2207(c), an amount equal to $50,000,000 multiplied by the ratio of—

''(A) the number of dual eligible individuals in the State; to

''(B) the number of dual eligible individuals in all States.

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

''SEC. 2207. FUNDING.

''(a) TREATMENT OF STATE PAYMENTS TO INTEGRATED CARE PLANS AS MEDICAL ASSISTANCE.—Amounts expended by a State for payments to an integrated care plan for the Medicaid component of the capitation payment described in section 2208(c) shall be treated as medical assistance for which payment is made under section 1903(a). Nothing in this title shall prevent a State from providing medical assistance under title XIX to a dual eligible individual for services for which coverage is not provided under the integrated care plan with which the individual is enrolled or from receiving payment under section 1903(a) with respect to expenditures attributable to providing such medical assistance.

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

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

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

''(3) DATA COLLECTION AND REPORTING.—For data collection and reporting expenses under section 2205, an amount that bears the same proportion to $50,000,000 as the number of dual eligible individuals in the State bears to the number of dual eligible individuals in all States, as determined by the Secretary.

''(c) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, such amounts as may be required to provide payments to States under this section, for each calendar year (beginning January 1 of the first full calendar year in which this title is implemented in any State), reduced by any amounts made available from the Medicare trust funds under subsection (d).

''(d) RELATION TO MEDICARE TRUST FUNDS.—There shall be made available for carrying out this title, and the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund (under section 1817) and from the Federal Supplementary Medical Insurance Trust Fund (under section 1841) (and from the Medicare Prescription Drug Account (under section 1860D–16) within such Trust Fund) such amounts as the Secretary determines appropriate, taking into account the reductions in payments from such Trust Funds and Account that are attributable to the enrollment of dual eligible individuals in integrated care plans under this title, for each calendar year (beginning January 1 of the first full calendar year in which this title is implemented in any State).

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

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

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

''(b) RESPONSIBILITIES OF THE FCHCO.—In carrying out this title, the Director shall have the following responsibilities:

''(1) DEVELOPMENT AND PUBLICATION OF INTEGRATED CARE PROGRAM MODELS.—Subject to subsection (c), to develop and, not later than 180 days after the date of enactment of this paragraph, publish, a range of program models (including but not limited to Medicare-Medicaid plans, accountable care organizations, and dual eligible special needs plans) for providing integrated care for dual eligible individuals from which States shall select to develop and administer integrated care programs for dual eligible individuals in accordance with this title.

''(2) UNIFIED APPEALS PROCESS.—To develop and, not later than 1 year after the date of enact-

ment of this paragraph, publish a unified administrative appeals process for State integrated care programs for dual eligible individuals under this title to use in lieu of other administrative appeals processes involving Medicare and Medicaid.

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

''(4) SUPPLEMENTAL BENEFITS STANDARDS AND REPORTING REQUIREMENTS.—To establish standards for reporting by States and integrated care plans under title XXII information relating to the offering and provision of supplemental benefits under section 2204(d)(3), including data relating to enrollment, utilization, and outcomes, to annually publish a report regarding the offering and utilization of such benefits, and to study and report to the Secretary on whether to cap the actuarial dollar value allowed for such benefits under titles XVIII, XIX, and XXII.

''(5) CARE COORDINATOR REQUIREMENTS.—To—

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

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

''(6) ADMINISTRATION AND OVERSIGHT OF INTEGRATED CARE PLANS FOR DUAL ELIGIBLE INDIVIDUALS.—To—

''(A) develop and issue guidance and regulations related to the alignment of policy and operational process under the Medicare program under title XVIII and the Medicaid program under title XIX, necessary for implemen-

tation, administration, and oversight of integrated care plans for dual eligible individuals under this title; and

''(B) administer and provide oversight of integrated care plans for dual eligible individuals under this title, including with respect to—

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

''(ii) the establishment and application of network adequacy standards for such plans that—

''(I) apply only with respect to such plans;

''(II) allow the Director to waive compliance with such standards for integrated care plans that cannot meet the requirements in certain areas, but must operate statewide to meet a State's selective contracting requirements; and

''(III) allow the Director to consider flexibilities to support innovative

models that do not rely on traditional time and distance standards, such as the use of telehealth; and

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

''(C) develop contract management teams, consisting of representatives from integrated care plans with contracts with States under this title, State agencies responsible for administering the State plan under title XIX or a waiver of such plan, and the Federal Coordinated Health Care Office, to oversee compliance and performance of integrated care plans under this title;

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

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

''(7) DATA COLLECTION AND REPORTING.—To establish data and information collection and reporting requirements for States and integrated care plans under section 2205, including required reporting of specific disability statuses and safeguards to protect patient privacy, and to annually publish not later than April 30 of any year, the data and infor-

mation collected and reported to the Director under such section for the preceding year.

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

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

''(10) TRAINING PROGRAMS.—To develop training programs related to integrated care plans under this title for—

''(A) providers of care, services, and supports under such plans with respect to issues such as coordination of benefits, data sharing barriers, quality ratings, and provider incentives;

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

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

''(c) CAPITATED PAYMENT STRUCTURE FOR INTEGRATED CARE PROGRAM MODELS.—

''(1) IN GENERAL.—Each program model that is designed by the Director under subsection (b)(1) shall provide that payments shall be made to an integrated care plan for benefits provided under a contract under this title using a capitated payment

structure under which, for each month that the integrated care plan provides such benefits—

"(A) the State shall pay the integrated care plan an amount equal to the Medicaid component payment determined for the month; and

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

"(2) DETERMINATION OF MEDICAID COMPONENT PAYMENT.—For purposes of paragraph (1), the Medicaid component payment payable to an integrated care plan for a month shall be an amount equal to the sum of the products of—

"(A) for each category of beneficiary, the Medicaid capitation rate applicable to the category of beneficiary (as determined by the Secretary and specified in the contract between the State, the Secretary, and the offeror of the plan); and

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

"(3) DETERMINATION OF MEDICARE COMPONENT PAYMENT.—For purposes of paragraph (1), the Medicare component payment payable to an inte-

grated care plan for a month shall be an amount equal to the sum of the products of—

"(A) for each category of beneficiary, the Medicare capitation rate applicable to the category of beneficiary (as determined by the Secretary and specified in the contract between the State, the Secretary, and the offeror of the plan); and

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

"(4) APPLICATION OF RISK ADJUSTMENT MODEL TO CAPITATION RATES.—The Medicaid and Medicare capitation rates for each category of beneficiary specified in a contract between a State, the Secretary, and the offeror of an integrated care plan shall be determined using the risk adjustment payment model developed under subsection (d).

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

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

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

''(3) allows plan payments to be made and updated on a monthly basis.

''(e) ADDITIONAL RESPONSIBILITIES WITH RESPECT TO INTEGRATED CARE PLANS.—

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

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

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

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

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

for such individuals under Medicare or Medicaid; and

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

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

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

be established to improve the utilization, performance, and oversight of such plans and how such plans may be offered under State Integrated Care Programs for Dual Eligible Individuals established under this title.

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

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

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

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

''(F) AUTHORITY OF FEDERAL COORDINATED HEALTH CARE OFFICE.—For plan years beginning on or after January 1, 2025, the Federal Coordinated Health Care Office established under section 2602 of Public Law 111–

148 shall have primary authority for implementing and carrying out responsibilities of the Secretary with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this subsection.''.

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

SEC. 103. ADDITIONAL CONFORMING AMENDMENTS.

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

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

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

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

''(4) ADDITIONAL ENROLLMENT OPTION FOR DUAL ELIGIBLE INDIVIDUALS.—Dual eligible individuals (as defined in section 2201) may also be eligible to enroll in an integrated care plan under title XXII.''.

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

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

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

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

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

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

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

SEC. 201. IDENTIFYING OPPORTUNITIES FOR STATE COORDINATION WITH RESPECT TO ELIGIBILITY DETERMINATIONS.

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

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

(2) issue guidance for States that identifies opportunities for better coordination of such processes between the States and the Federal government.

SEC. 202. ALIGNMENT OF BIDDING, REPORTING, AND OTHER DATES AND DEADLINES FOR INTEGRATED CARE PLANS.

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

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

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

SEC. 203. GRANTS TO STATE AND LOCAL COMMUNITY ORGANIZATIONS FOR OUTREACH AND ENROLLMENT.

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

ment efforts that are designed to increase the enrollment of dual eligible individuals (as defined in section 2201 of the Social Security Act) in health benefits plans that provide integrated care for such individuals under State Integrated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act.

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

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

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

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

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

(c) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the first fiscal year that begins after the date of enactment of this Act, and for each fiscal year thereafter, $50,000,000 to carry out this section.

SEC. 204. APPLICATION OF MODEL STANDARDS TO INFORMATION REQUIREMENTS FOR INTEGRATED CARE PLANS.

Not later than 1 year after the date of enactment of this Act, the Director of the Federal Coordinated Health Care Office of the Centers for Medicare & Medicaid Services and the Administrator of the Centers for Medicare & Medicaid Services jointly shall issue guidance or regulations requiring that any notice or informational materials provided to a dual eligible individual (as defined in section 2201 of the Social Security Act) by such Director, Administrator, States, or health benefits plans that provide integrated care for such individuals under the Medicare program, the Medicaid program, or under State Integrated Care Programs for Dual Eligible Individuals established under XXII of the Social Security Act complies with the model standards issued under section 203(b).

SEC. 205. ENROLLMENT THROUGH INDEPENDENT BROKERS.

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

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

(2) an independent broker may receive a commission for the initial enrollment of a dual eligible individual in such a plan, but no commission shall be available to any broker for any subsequent enrollment of such individual in any such plan;

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

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

(B) that the individual is being enrolled in a health benefits plan that provides partial or no integrated care and the potential implications of such disenrollment and enrollment on the individual's care.

SEC. 206. REDUCING THRESHOLD FOR LOOK-ALIKE D–SNP PLANS UNDER MEDICARE ADVANTAGE.

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

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

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

SEC. 207. REQUIRING REGULAR UPDATE OF PROVIDER DIRECTORIES.

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

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

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

SEC. 208. REVIEW OF HOSPITAL QUALITY STAR RATING SYSTEM.

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

(1) review the hospital quality star rating system under the Medicare program under title XVIII

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

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

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

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

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

(1) the Secretary of Health and Human Services;

(2) the Committee on Finance of the Senate;

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

(4) the Committee on Ways and Means of the House of Representatives.

SEC. 210. CMMI TESTING OF COVERAGE OF PARTIAL BENEFIT DUAL ELIGIBLE INDIVIDUALS THROUGH STATE INTEGRATED CARE PROGRAMS.

Section 1115A of the Social Security Act (42 U.S.C. 1315a) is amended—

(1) in subsection (b)(2)(A), by adding at the end the following new sentence: ''The models selected under this subparagraph shall include the testing of the model described in subsection (h)(1).''; and

(2) by adding at the end the following new subsection:

''(h) TESTING OF MODEL FOR PROVIDING COVERAGE OF PARTIAL BENEFIT DUAL ELIGIBLE INDIVIDUALS THROUGH PARTIALLY INTEGRATED CARE PLANS UNDER STATE INTEGRATED CARE PROGRAMS.—

''(1) IN GENERAL.—The model described in this paragraph is a model under which States may offer coverage to partial benefit dual eligible individuals through partially integrated care plans under State

Integrated Care Programs established under title XXII.

''(2) PARTIAL BENEFIT DUAL ELIGIBLE INDIVIDUAL.—For purposes of this subsection, the term 'partial benefit dual eligible individual' means an individual who—

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

''(B) is not a full-benefit dual eligible individual (as such term is defined in section 1935(c)(6), but without the application of subparagraph (A)(i) of such section).''.

TITLE III—ADMINISTRATION

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

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

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

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

(2) conduct at least one listening session open to the public on the alignment of billing under the programs identified in paragraph (1); and

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

TITLE IV—PACE

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

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

(1) in subsection (a)(1)—

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

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

(2) in subsection (e)—

(A) in paragraph (1)—

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

(ii) by striking subparagraph (B);

(B) in paragraph (2)(A)(ii); and

(3) in subsection (h)(2)—

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

(B) by striking subparagraph (B).

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

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

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

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

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

in a PACE program under a PACE program agreement.''.

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

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

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

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

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

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

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

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

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

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

SEC. 404. REMOVAL OF QUARTERLY RESTRICTIONS FOR SUBMISSION OF A NEW PACE ORGANIZATION APPLICATION, AND REMOVAL OF QUARTERLY RESTRICTIONS FOR APPLICATIONS IN A NEW SERVICE AREA.

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

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

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

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

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

SEC. 405. ENSURING MEDICARE-ONLY PACE PROGRAM ENROLLEES HAVE A CHOICE OF PRESCRIPTION DRUG PLANS UNDER MEDICARE PART D.

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

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

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

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

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

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

''(i) APPLICABLE PACE PROGRAM ENROLLEE.—The term 'applicable PACE program enrollee' means a part D eligible individual who—

''(I) is not entitled to medical assistance under title XIX; and

''(II) is enrolled under a PACE program offered by a PACE provider.

''(ii) QUALIFIED STANDALONE PRESCRIPTION DRUG PLAN.—The term 'qualified standalone prescription drug plan' means, with respect to an applicable PACE program enrollee, a prescription drug plan—

"(I) that is not an MA–PD plan;

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

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

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

"(bb) the estimated total amount of Federal subsidies for the plan year for qualified prescription drug coverage under the

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

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

''(C) OUT-OF-POCKET COSTS.—In the case where an applicable PACE program enrollee elects to enroll in a qualified standalone prescription drug plan pursuant to this paragraph, the individual shall be responsible for any out-of-pocket costs imposed under the plan (including costs for nonformulary drugs) after the application of any subsidies under section 1860D–

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

''(D) REQUIREMENTS FOR PACE PROGRAMS.—

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

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

''(II) upon request of an applicable PACE program enrollee, counseling and coordination to assist applicable PACE program enrollees in making decisions regarding the selection of qualified standalone prescription drug plans available to them.

''(ii) MONITORING DRUG UTILIZATION, ADHERENCE, AND SPEND.—A PACE program shall be required to monitor drug

utilization, medication adherence, and drug spending (through claims data shared pursuant to subparagraph (F) and otherwise) throughout the year with respect to any applicable PACE program enrollee who elects to enroll in a qualified standalone prescription drug plan under this paragraph in order to coordinate with the PDP sponsor of such plan regarding the drug benefits offered by the plan, including upon request of an applicable PACE program enrollee the filing of any grievances or appeals with the plan on behalf of the applicable PACE program enrollee.

''(E) DISENROLLMENT.—An applicable PACE program enrollee may disenroll from the qualified standalone prescription drug plan elected by such applicable PACE program enrollee under subparagraph (A) if the enrollee changes medication during the plan year or can demonstrate an unexpected increase in out-of-pocket costs post enrollment.

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

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

''(G) RULE OF CONSTRUCTION.—The authority established under this paragraph for an applicable PACE program enrollee to elect to enroll in a qualified standalone prescription drug plan shall not be construed as permitting an applicable PACE program enrollee to enroll in a prescription drug plan that is not a qualified standalone prescription drug plan.

''(H) RELATION TO PACE STATUTES.—

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

"(ii) CLARIFICATION ON PAYMENT FOR PART D DRUG COVERAGE.—Insofar as an applicable PACE program enrollee is enrolled in a qualified standalone prescription drug plan under this paragraph, the PACE program shall not be entitled to payment under section 1894(d) for the provision of qualified prescription drug coverage under such standalone prescription drug plan with respect to such applicable PACE program enrollee.".

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