

115TH CONGRESS
1ST SESSION

S. 1334

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 12, 2017

Mr. WARNER (for himself, Mr. ISAKSON, Ms. BALDWIN, Ms. COLLINS, Ms. KLOBUCHAR, and Mrs. CAPITO) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, 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 “Patient Choice and Quality Care Act of 2017”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. Advanced illness care and management model.

- Sec. 4. Quality measurement development and implementation.
- Sec. 5. Enhancing coverage of advance care planning services.
- Sec. 6. Advance care planning support tools.
- Sec. 7. Advance directives.
- Sec. 8. Additional requirements for facilities.
- Sec. 9. Grants for increasing public awareness and training.
- Sec. 10. Advance Care Planning Advisory Council.
- Sec. 11. Annual report on Medicare decedents.
- Sec. 12. Rule of construction.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) The population of the United States is esti-
 4 mated to age rapidly, with the number of people over
 5 the age of 65 set to double to more than 98 million,
 6 or 1 in 5 Americans, by 2040.

7 (2) As Americans live longer and healthier lives,
 8 they also face increased incidence of multiple serious
 9 or chronic progressive conditions and advanced ill-
 10 ness as they age.

11 (3) Americans with serious, chronic progressive,
 12 or advanced illness face a complicated and frag-
 13 mented system of care delivery that puts them at
 14 risk for repeat hospitalizations, adverse drug reac-
 15 tions, and conflicting medical advice that may be
 16 overwhelming to individuals and families.

17 (4) The progression of serious, chronic progres-
 18 sive, or advanced illness leads to the need for in-
 19 creasingly intensive decision support, health care
 20 services, and support from family caregivers.

1 (5) The complexity of care needed by individ-
2 uals with serious, chronic progressive, or advanced
3 illness may result in uncoordinated care, adverse
4 health outcomes, frustration, wasted time, and
5 undue emotional burdens on individuals and their
6 family caregivers.

7 (6) Numerous private sector leaders, including
8 hospitals, health systems, home health agencies, hos-
9 pice programs, long-term care providers, employers,
10 and other entities, have put in place innovative solu-
11 tions to provide more comprehensive and coordinated
12 care for Americans living with serious, chronic pro-
13 gressive, or advanced illness.

14 (7) Hospice and palliative care programs offer
15 patients and families appropriate and patient-cen-
16 tered care, delivered by an interdisciplinary care
17 team. These programs should serve as models for se-
18 rious, chronic progressive, or advanced illness care
19 delivery.

20 (8) Individuals have the well-established right
21 to accept or reject medical treatment that is offered
22 and all individuals should be afforded the oppor-
23 tunity to fully participate in decisions related to
24 their health care.

1 (9) Too often, individuals with serious, chronic
 2 progressive, or advanced illness do not understand
 3 the conditions they are facing or their treatment op-
 4 tions, and they do not receive the information or
 5 support they need to evaluate treatment options in
 6 light of their personal goals and values and to docu-
 7 ment treatment plans in a manner that allows pro-
 8 viders and facilities to follow their plans.

9 (10) Providing high-quality advanced care plan-
 10 ning services and supports to individuals with seri-
 11 ous, chronic progressive, or advanced illness will pro-
 12 tect and preserve their dignity and ensure care is
 13 aligned with an individual’s goals, values, and stated
 14 preferences.

15 **SEC. 3. ADVANCED ILLNESS CARE AND MANAGEMENT**
 16 **MODEL.**

17 Section 1115A of the Social Security Act (42 U.S.C.
 18 1315a) is amended—

19 (1) in subsection (b)(2)(A), by adding at the
 20 end the following new sentence: “The models se-
 21 lected under this subparagraph shall include the
 22 model described in subsection (h), which shall be im-
 23 plemented by not later than 1 year after the date of
 24 the enactment of the Patient Choice and Quality
 25 Care Act of 2017.”;

1 (2) by adding at the end the following new sub-
2 section:

3 “(h) ADVANCED ILLNESS CARE AND MANAGEMENT
4 MODEL.—

5 “(1) MODEL.—

6 “(A) IN GENERAL.—The model described
7 in this subparagraph is a model under which
8 payments are made under title XVIII to appli-
9 cable providers that furnish advanced illness
10 care and management services, including care
11 coordination and palliative care services, to eli-
12 gible individuals with serious, chronic progres-
13 sive, or advanced illness in order to test the use
14 of targeted advanced illness management and
15 early use of palliative care under the Medicare
16 program.

17 “(B) VOLUNTARY.—Participation under
18 the model shall be voluntary with respect to
19 both eligible individuals and applicable pro-
20 viders.

21 “(C) REQUIREMENTS.—

22 “(i) HOSPICE PROVIDER.—At least
23 one applicable provider selected for partici-
24 pation under the model shall be a hospice

1 program (as defined in section
2 1861(dd)(2)).

3 “(ii) COMPARISON.—The Secretary
4 shall establish the model in such a manner
5 as will permit the comparison of outcomes
6 for eligible individuals participating under
7 the model and eligible individuals who are
8 not so participating.

9 “(iii) INCORPORATION INTO EXISTING
10 MODELS.—In addition to operating the
11 model independently, the Secretary shall
12 incorporate the model into existing models
13 related to the Medicare program, such as
14 models involving accountable care organi-
15 zations, bundled payments, and value
16 based purchasing arrangements, and other
17 coordinated care models as the Secretary
18 determines to be appropriate.

19 “(2) PAYMENTS.—Under the model, the Sec-
20 retary shall establish payment amounts for advanced
21 illness care and management services that is tar-
22 geted to eligible individuals with a serious, chronic
23 progressive, or advanced illness. The payments may
24 include payments under a fee schedule, capitated
25 payments, bundled payments, value-based pur-

1 chasing agreements, and other payment mechanisms
2 determined appropriate by the Secretary.

3 “(3) ADVANCED ILLNESS CARE AND MANAGE-
4 MENT SERVICES DEFINED.—In this subsection, the
5 term ‘advanced illness care and management serv-
6 ices’ means the following services, as appropriate for
7 the individual’s illness and stage of illness:

8 “(A) One or more face-to-face encounters
9 between one or more members of the inter-
10 disciplinary team and the individual and, at the
11 individual’s discretion, family caregivers, or, for
12 an individual who lacks decisionmaking capacity
13 under State law, the individual’s legally author-
14 ized representative.

15 “(B) The provision of information about
16 the typical trajectory of illnesses or conditions
17 that affect the individual, including foreseeable
18 care decisions that may need to be made at a
19 future time when the individual is likely to be
20 unable to make decisions due to temporary or
21 permanent cognitive or medical incapacity.

22 “(C) Assisting the individual in defining
23 and articulating goals of care, values, and pref-
24 erences.

“(D) Providing the individual with and discussing information about the benefits and burdens of relevant ranges of treatment options available to the individual, including disease modifying or potentially curative treatment, palliative care, which may be provided alone or in conjunction with disease modifying treatment, and, when the individual may be currently eligible or may become eligible for hospice care due to disease progression.

“(E) Assisting the individual in evaluating treatment options and approaches to care to identify those that most closely align with the individual’s goals of care, values, and preferences.

“(F) Preparing, and sharing with relevant providers, documentation—

“(i) that states the individual’s goals of care, preferences, and values, preferred decisionmaking strategies, and a plan of care that is concrete and actionable; and

“(ii) that is in State or locally recognized forms that are used for the purpose of assuring that providers can follow the

1 plan across care settings, such as advance
2 directives or portable treatment orders.

3 “(G) Referrals to providers, including med-
4 ical and social service providers, who deliver
5 care consistent with the plan.

6 “(H) Providing culturally and education-
7 ally appropriate training for the individual and
8 family caregivers to support their ability to
9 carry out the plan.

10 “(I) A multidimensional assessment of the
11 individual’s strengths and limitations.

12 “(J) An assessment of the individual’s paid
13 and unpaid supports, including family care-
14 givers.

15 “(K) Comprehensive medication review and
16 management (including, if appropriate, coun-
17 seling and self-management support).

18 “(L) Visits to the patient in all sites of
19 care (including the home, a hospital, and a
20 nursing home) as needed to respond appro-
21 priately to problems and concerns.

22 “(M) Additional services, consistent with
23 the care plan, that the interdisciplinary team
24 believes would assist the eligible individual and

1 family caregivers in more effectively managing
2 their health condition.

3 “(N) 24-Hour access to emergency support
4 in person or via telephone or telemedicine with
5 the individual’s medical record and care plan
6 available to the responder.

7 “(O) Care coordination and communication
8 across health care and social service settings
9 and providers, including involvement of the
10 interdisciplinary team to evaluate quality and
11 address concerns over time.

12 “(P) Such other palliative and other serv-
13 ices that the Secretary determines appropriate.

14 “(4) APPLICABLE PROVIDER DEFINED.—In this
15 subsection, the term ‘applicable provider’ means a
16 hospice program (as defined in section 1861(dd)(2))
17 or other provider of services (as defined in section
18 1861(u)) or supplier (as defined in section 1861(d))
19 that—

20 “(A) furnishes services through an inter-
21 disciplinary team; and

22 “(B) meets such other requirements the
23 Secretary may determine to be appropriate.

1 “(5) ELIGIBLE INDIVIDUAL DEFINED.—In this
2 subsection, the term ‘eligible individual’ means an
3 individual who—

4 “(A) is entitled to, or enrolled for, benefits
5 under part A of title XVIII and enrolled under
6 part B of such title, but not enrolled under part
7 C of such title;

8 “(B) resides at home or in an institutional
9 setting, whichever is consistent with their per-
10 sonal goals and preferences; and

11 “(C) meets at least one of the following:

12 “(i) The individual has the need for
13 assistance with two or more activities of
14 daily living (defined as bathing, dressing,
15 eating, getting out of bed or a chair, mobil-
16 ity, and toileting) that is caused by one or
17 more serious or life threatening conditions
18 or frailty and that is not associated with
19 an acute or post-operative condition.

20 “(ii) The individual is diagnosed with
21 a serious, chronic progressive or advanced
22 illness that—

23 “(I) has a strong negative impact
24 on the individual’s quality of life and

1 functioning in life roles, independent
 2 of its impact on mortality; or

3 “(II) is burdensome in symp-
 4 toms, treatments or caregiver stress.

5 “(iii) The individual is diagnosed
 6 with—

7 “(I) metastatic or locally ad-
 8 vanced cancer;

9 “(II) Alzheimer’s disease or an-
 10 other progressive dementia;

11 “(III) late-stage neuromuscular
 12 disease;

13 “(IV) late-stage diabetes;

14 “(V) late-stage kidney, liver,
 15 heart, gastrointestinal, cerebro-
 16 vascular, or lung disease; or

17 “(VI) age-related physical debil-
 18 ity.

19 “(iv) The individual meets other cri-
 20 teria determined appropriate by the Sec-
 21 retary.

22 “(6) INTERDISCIPLINARY TEAM.—

23 “(A) IN GENERAL.—Subject to subpara-
 24 graph (B), in this subsection, the term ‘inter-
 25 disciplinary team’ means a group that—

1 “(i) includes at least—

2 “(I) one physician who is board
3 certified in geriatrics, internal medi-
4 cine, or family medicine;

5 “(II) one physician, advance
6 practice registered nurse, or physician
7 assistant, who is a palliative specialist
8 (defined as having a certification in
9 hospice and palliative care) or who
10 has at least one year’s experience pro-
11 viding hospice or palliative care;

12 “(III) one nurse; and

13 “(IV) one social worker;

14 “(ii) may include a chaplain, minister,
15 or pastoral counselor;

16 “(iii) may include other direct care
17 personnel (including pharmacists, dieti-
18 cians, physical therapists, occupational
19 therapists, and psychotherapists); and

20 “(iv) meets requirements that may be
21 established by the Secretary.

22 “(B) ADDITIONAL MEMBER AT THE RE-
23 QUEST OF THE ELIGIBLE INDIVIDUAL.—An ap-
24 plicable provider shall offer to the eligible indi-
25 vidual (or the individual’s legally authorized

representative when the individual has been found to lack decisional capacity) the opportunity to select either a chaplain affiliated with the applicable provider, a minister, or personal religious or spiritual advisor who can help to represent the individual's goals, values, and preferences to serve as a core interdisciplinary team member at the individual's (or legally authorized representative's) request."

SEC. 4. QUALITY MEASUREMENT DEVELOPMENT AND IMPLEMENTATION.

(a) FACILITATION OF INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY MEASURES REGARDING ADVANCED ILLNESS, PALLIATIVE, AND END-OF-LIFE CARE.—

(1) IN GENERAL.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph:

“(4) INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY MEASURES REGARDING ADVANCED ILLNESS, PALLIATIVE, AND END-OF-LIFE CARE.—

1 “(A) IN GENERAL.—The entity shall facili-
2 tate increased coordination and alignment be-
3 tween the public and private sector with respect
4 to quality measures regarding advanced illness,
5 palliative, and end-of-life care across the care
6 settings and programs described in this section
7 and across other services and care settings
8 under this title, as appropriate.

9 “(B) ENVIRONMENTAL SCAN.—The entity
10 shall conduct an environmental scan of meas-
11 ures, measure concepts, and preferred practices
12 for advanced illness, palliative, and end-of-life
13 care used in both the private and public sectors
14 and from multiple settings of care. Such scan
15 shall include a review of the following:

16 “(i) The process of eliciting and docu-
17 menting patient (and, where relevant and
18 appropriate, family caregiver or legally au-
19 thorized representative) goals, preferences,
20 and values regarding care and treatment,
21 including the articulation of goals for end-
22 of-life care that adequately reflect how the
23 patient wants to live.

24 “(ii) The effectiveness, patient-
25 centeredness (and, where relevant, family

caregiver-centeredness), and adequacy of care plans, including documentation of individual goals, preferences, and values.

“(iii) Agreement and consistency among—

“(I) the patient’s goals, preferences, and values;

“(II) any documented care plan; and

“(III) the care delivered.

“(iv) Timely and appropriate referral to hospice care.

“(C) IDENTIFICATION AND PRIORITIZATION OF MEASURES.—The entity shall, based on the scan conducted under subparagraph (B), identify and prioritize measures, measure concepts, and preferred practices, that are aligned across settings of care, condition, and patient population.

“(D) REPORT.—Not later than 18 months after the date of enactment of this paragraph, the entity shall submit to the Secretary a report containing the findings of the entity with respect to the environmental scan under subparagraph (B) and the identification and

1 prioritization of measures, measure concepts,
 2 and preferred practices under subparagraph
 3 (C).”.

4 (b) STUDY AND REPORT ON NIH DEVELOPMENT OF
 5 ADDITIONAL MEASURES RELATED TO CARE PLAN-
 6 NING.—Section 1890A of the Social Security Act (42
 7 U.S.C. 1395aaa–1) is amended by adding at the end the
 8 following new subsection:

9 “(g) STUDY AND REPORT ON NIH DEVELOPMENT
 10 OF ADDITIONAL MEASURES RELATED TO CARE PLAN-
 11 NING.—

12 “(1) STUDY.—The Secretary, in consultation
 13 with the Palliative Care Research Cooperative
 14 Group, the National Institute of Nursing Research,
 15 and the Office of End-of-Life and Palliative Care
 16 Research of the National Institutes of Health shall
 17 conduct a study regarding the development of meas-
 18 ures related to—

19 “(A) concordance of care between the
 20 wishes of an individual and the treatment re-
 21 ceived by the individual, including documenta-
 22 tion of such wishes in the medical record;

23 “(B) understanding the population with se-
 24 rious, chronic progressive, or advanced illness

1 that would benefit from palliative care and ad-
 2 vance care planning services; and

3 “(C) appropriate transitions to hospice
 4 care.

5 “(2) REPORT.—Not later than December 31,
 6 2019, the Secretary shall submit to Congress a re-
 7 port containing the results of the study conducted
 8 under paragraph (1).”.

9 (c) MEDICARE PHYSICIAN FEE SCHEDULE.—Section
 10 1848(s)(1) of the Social Security Act (42 U.S.C. 1395w-
 11 4(s)(1)) is amended by adding at the end the following
 12 new subparagraph:

13 “(G) CLINICAL CARE MEASURES RELATING
 14 TO PALLIATIVE AND END-OF-LIFE CARE.—Be-
 15 ginning after the completion of the environ-
 16 mental scan under section 1890(b)(4)(B), with-
 17 in one or more appropriate quality domains, the
 18 Secretary shall, in consultation with the entity
 19 with a contract under section 1890(a), establish
 20 appropriate clinical care measures relating to
 21 palliative and end-of-life care, including at least
 22 one measure for each of the areas studied
 23 under subparagraphs (A), (B), and (C) of sec-
 24 tion 1890A(g)(1).”.

1 (d) POST-ACUTE CARE.—Section 1899B of the So-
 2 cial Security Act (42 U.S.C. 1395lll) is amended—

3 (1) in subsection (a)(2)(E)(i)—

4 (A) in subclause (IV), by striking “and” at
 5 the end;

6 (B) in subclause (V), by striking the period
 7 at the end and inserting “; and”; and

8 (C) by adding at the end the following new
 9 subclause:

10 “(VI) with respect to the domain
 11 described in subsection (c)(1)(F) (re-
 12 lating to end-of-life care)—

13 “(aa) for PAC providers de-
 14 scribed in clauses (ii), (iii), and
 15 (iv) of paragraph (2)(A), October
 16 1, 2020; and

17 “(bb) for PAC providers de-
 18 scribed in clauses (i) of such
 19 paragraph, January 1, 2021.”;
 20 and

21 (2) in subsection (c)(1), by adding at the end
 22 the following new subparagraph:

23 “(F) The effectiveness, patient-
 24 centeredness (and, where relevant, family care-
 25 giver-centeredness), and adequacy of care plans

and communications relating to such plans, including—

“(i) documentation of a patient’s goals, preferences, and values;

“(ii) agreement and consistency with respect to care among—

“(I) the patient’s goals, preferences, and values;

“(II) any documented care plan; and

“(III) the care delivered; and

“(iii) timely and appropriate referral to hospice care.”.

(e) MEDICARE ADVANTAGE.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following new subparagraph:

“(C) PALLIATIVE AND END-OF-LIFE CARE.—The Secretary, in consultation with the National Committee for Quality Assurance, shall prioritize the development of standards for palliative and end-of-life care, including transition to hospice care, with respect to Medicare Advantage organizations under this part for use under the quality improvement program under

1 paragraph (1) that are the equivalent of such
 2 standards in quality programs applicable to
 3 providers of services and suppliers under the
 4 original Medicare fee-for-service program under
 5 parts A and B.”.

6 (f) ALTERNATIVE PAYMENT MODELS.—Section
 7 1899(b)(3)(C) of the Social Security Act (42 U.S.C.
 8 1395jjj(b)(3)(C)) is amended—

9 (1) by striking “STANDARDS.—The Secretary”
 10 and inserting “STANDARDS.—

11 “(i) IN GENERAL.—The Secretary”;

12 and

13 (2) by adding at the end the following new
 14 clause:

15 “(ii) PALLIATIVE AND END-OF-LIFE
 16 CARE.—The Secretary, in consultation with
 17 the entity with a contract under section
 18 1890(a), shall ensure that quality perform-
 19 ance standards established under this sub-
 20 paragraph include measures that apply to
 21 palliative and end-of-life care, including
 22 transition to hospice care.”.

1 **SEC. 5. ENHANCING COVERAGE OF ADVANCE CARE PLAN-**
 2 **NING SERVICES.**

3 (a) DEFINITION.—Section 1861 of the Social Secu-
 4 rity Act (42 U.S.C. 1395x) is amended by adding at the
 5 end the following new subsection:

6 “Advance Care Planning Services

7 “(jjj)(1) The term ‘advance care planning services’
 8 means services identified as of the date of enactment of
 9 this subsection as Current Procedural Terminology (CPT)
 10 codes 99497 and 99498, and such codes as subsequently
 11 modified, that are furnished by a physician or other eligi-
 12 ble practitioner (as determined by the Secretary).

13 “(2) For purposes of paragraph (1), the term ‘eligible
 14 practitioner’ includes, in addition to a practitioner eligible
 15 to bill such CPT codes as of the date of enactment of this
 16 subsection, an individual who—

17 “(A) is a clinical social worker (as defined in
 18 subsection (hh)(1)); and

19 “(B) possesses—

20 “(i) a relevant care planning certification;

21 or

22 “(ii) experience providing care planning
 23 conversations or similar services, as defined by
 24 the Secretary, in the course of their work.”.

25 (b) NO APPLICATION OF COINSURANCE OR DEDUCT-
 26 IBLE.—

1 (1) AMOUNT.—Section 1833(a)(1) of the Social
 2 Security Act (42 U.S.C. 1395l(a)(1)) is amended—

3 (A) by striking “and (BB)” and inserting
 4 “(BB)”; and

5 (B) by inserting before the semicolon at
 6 the end the following: “, and (CC) with respect
 7 to advance care planning services (as defined in
 8 section 1861(jjj)(1)), the amounts paid shall be
 9 100 percent of the lesser of the actual charge
 10 for the services or the amount determined
 11 under the fee schedule established under section
 12 1848(b).”.

13 (2) WAIVER OF APPLICATION OF DEDUCT-
 14 IBLE.—The first sentence of section 1833(b) of the
 15 Social Security Act (42 U.S.C. 1395l(b)) is amend-
 16 ed—

17 (A) by striking “and” before “(10)”; and

18 (B) by inserting before the period the fol-
 19 lowing: “, and (11) such deductible shall not
 20 apply with respect to advance care planning
 21 services (as defined in section 1861(jjj)(1))”.

22 (c) EFFECTIVE DATE.—The amendment made by
 23 this subsection shall apply to advance care planning serv-
 24 ices furnished on or after January 1, 2018.

1 **SEC. 6. ADVANCE CARE PLANNING SUPPORT TOOLS.**

2 (a) INCLUSION OF ADVANCE CARE PLANNING MATE-
3 RIALS IN THE MEDICARE & YOU HANDBOOK.—

4 (1) IN GENERAL.—Section 1804(a) of the So-
5 cial Security Act (42 U.S.C. 1395b–2(a)) is amend-
6 ed—

7 (A) in paragraph (2), by striking “and” at
8 the end;

9 (B) in paragraph (3), by striking the pe-
10 riod at the end and inserting a semicolon; and

11 (C) by inserting after paragraph (3) the
12 following new paragraphs:

13 “(4) information on—

14 “(A) care planning;

15 “(B) how individual goals, values, and
16 preferences should be considered in framing a
17 care plan; and

18 “(C) a range of approaches for treating se-
19 rious, chronic progressive, or advanced illness,
20 including disease modifying options, palliative
21 care that supports individuals from the onset of
22 serious, chronic progressive, or advanced illness
23 and can be provided at the same time as all
24 other care types, and hospice care; and

1 “(5) information on documentation options for
 2 care planning or advance care planning, including
 3 advance directives and portable treatment orders.”.

4 (2) EFFECTIVE DATE.—The amendments made
 5 by this section shall apply to notices distributed on
 6 or after January 1, 2018.

7 (b) ADVANCE CARE PLANNING STANDARDS FOR
 8 ELECTRONIC HEALTH RECORDS.—

9 (1) IN GENERAL.—Notwithstanding section
 10 3004(b)(3) of the Public Health Service Act (42
 11 U.S.C. 300jj–14(b)(3)), not later than 4 years after
 12 the date of the enactment of this Act, the Secretary
 13 of Health and Human Services shall adopt, by rule,
 14 standards for a qualified electronic health record (as
 15 defined in section 3000(13) of such Act (42 U.S.C.
 16 300jj(13)), with respect to organizing patient com-
 17 munications with health care providers about care
 18 goals and to provide one-click access to the fol-
 19 lowing:

20 (A) The patient’s current advance directive
 21 (as defined in section 1866(f)(3) of the Social
 22 Security Act (42 U.S.C. 1395cc(f)(3)), as appli-
 23 cable.

1 (B) The patient’s current order for life-
 2 sustaining treatment (described in section
 3 9(d)(3)(B)), as applicable.

4 (C) Documentation of advance care plan-
 5 ning discussion between the patient and the
 6 provider.

7 (2) TREATMENT OF STANDARDS.—A standard
 8 adopted under paragraph (1) shall be treated as a
 9 standard adopted under section 3004 of the Public
 10 Health Service Act (42 U.S.C. 300jj–14) for pur-
 11 poses of certifying qualified electronic health records
 12 pursuant to section 3001(c)(5) of such Act (42
 13 U.S.C. 300jj–11(c)(5)).

14 **SEC. 7. ADVANCE DIRECTIVES.**

15 (a) PORTABILITY.—Section 1866(f) of the Social Se-
 16 curity Act (42 U.S.C. 1395cc(f)) is amended by adding
 17 at the end the following new paragraph:

18 “(5)(A) An advance directive validly executed outside
 19 the State in which such directive is presented may be given
 20 effect by a provider of services or organization to the same
 21 extent as an advance directive validly executed under the
 22 law of the State in which it is presented.

23 “(B) In the absence of knowledge to the contrary,
 24 a physician or other health care provider or organization
 25 may presume that a written advance health care directive

1 or similar instrument, regardless of where executed, is
2 valid.

3 “(C) The provisions of this paragraph shall preempt
4 any State law on advance directive portability to the extent
5 such law is inconsistent with such provisions.

6 “(D) Nothing in the paragraph shall be construed
7 to—

8 “(i) authorize the administration of health care
9 treatment otherwise prohibited by the laws of the
10 State in which the directive is presented;

11 “(ii) require a provider of services or an organi-
12 zation to act in a manner contrary to its religious
13 or moral convictions;

14 “(iii) apply to a request or directive ordering a
15 sterilization or abortion or ordering withdrawal of
16 treatment from a pregnant woman if continued
17 treatment can reasonably be expected to bring her
18 child to live birth;

19 “(iv) prohibit the application of a State law
20 which allows for an objection on the basis of con-
21 science for any health care provider or any agent of
22 such provider which as a matter of conscience can-
23 not implement an advance directive or portable
24 treatment order; or

1 “(v) permit the Secretary to seek civil penalties,
 2 including exclusion from participation in the pro-
 3 gram under this title or the program under title
 4 XIX, against a provider or organization if the pro-
 5 vider or organization—

6 “(I) used reasonable efforts to deliver care
 7 that is consistent with an individual’s goals,
 8 preferences, and values when addressing deci-
 9 sionmaking for an individual who lacks
 10 decisional capacity; or

11 “(II) exercised its right of conscience in
 12 accordance with clause (ii) or (iv).”.

13 (b) CLARIFICATION WITH RESPECT TO ADVANCE DI-
 14 RECTIVES.—Paragraph (2) of section 7 of the Assisted
 15 Suicide Funding Restriction Act of 1997 (42 U.S.C.
 16 14406) is amended to read as follows:

17 “(2) to require any provider or organization, or
 18 any employee of such a provider or organization, to
 19 follow or be bound by a request from an individual
 20 or legally authorized representative, an advance di-
 21 rective, or a portable treatment order that directs
 22 the purposeful causing of, or the purposeful assist-
 23 ing in causing, the death of any individuals, such as
 24 by assisted suicide, euthanasia, or mercy killing.”.

1 (c) GAO STUDY ON HEALTH CARE DECISIONMAKING
 2 LAWS AND BARRIERS TO THE USE OF ADVANCE DIREC-
 3 TIVES.—

4 (1) STUDY.—The Comptroller General of the
 5 United States shall conduct a study that examines
 6 the use, portability, and electronic storage of ad-
 7 vance directives and that identifies barriers towards
 8 adopting, using, and following advance directives in
 9 the clinical setting. Such examination shall include
 10 issues that remain unresolved after the Stage 3
 11 Meaningful Use final rule, including barriers and so-
 12 lutions to finding and accessing advance care plan-
 13 ning documents, best practices for alerting eligible
 14 providers to the presence of an advance care plan,
 15 and best practices for transmitting advance care
 16 plans across sites of care.

17 (2) REPORT.—Not later than 1 year after the
 18 date of the enactment of this Act, the Comptroller
 19 General shall submit to Congress a report on the
 20 study conducted under paragraph (1) and shall in-
 21 clude in the report such recommendations regarding
 22 improving advance health care planning as the
 23 Comptroller General deems appropriate.

24 **SEC. 8. ADDITIONAL REQUIREMENTS FOR FACILITIES.**

25 (a) REQUIREMENTS.—

1 (1) IN GENERAL.—Section 1866(a)(1) of the
 2 Social Security Act (42 U.S.C. 1395cc(a)(1)) is
 3 amended—

4 (A) in subparagraph (Y), by striking the
 5 period at the end and inserting “; and”; and

6 (B) by inserting after subparagraph (Y)
 7 the following new subparagraph:

8 “(Z) in the case of hospitals, skilled nursing fa-
 9 cilities, home health agencies, and hospice programs,
 10 to assure that documented care plans include any
 11 advance directives or portable treatment orders
 12 made while the individual received care by the pro-
 13 vider and that such plan is sent to the individual’s
 14 primary care provider upon discharge and any facil-
 15 ity to which the individual is transferred.”.

16 (2) EFFECTIVE DATE.—The amendments made
 17 by this subsection shall apply to agreements entered
 18 into or renewed on or after January 1, 2019.

19 (b) HHS STUDY AND REPORT.—

20 (1) STUDY.—The Secretary of Health and
 21 Human Services shall conduct a study on the extent
 22 to which hospitals, skilled nursing facilities, hospice
 23 programs, home health agencies, and providers of
 24 advance care planning services work with individuals
 25 to—

1 (A) engage in a care planning process;

2 (B) thoroughly and completely document
3 the care planning process in the medical record
4 and to update the care plan on a regular basis;

5 (C) complete documents necessary to sup-
6 port the treatment and care plan, such as port-
7 able treatment orders and advance directives;

8 (D) provide services and support that are
9 free from discrimination based on advanced
10 age, disability status, or diagnosis, including se-
11 rious, chronic progressive, or advanced illness;
12 and

13 (E) provide documentation necessary to
14 carry out the treatment plan to—

15 (i) subsequent providers or facilities;

16 and

17 (ii) the individual, their legally au-
18 thorized representatives, and, where appro-
19 priate and relevant, their family caregiver.

20 (2) REPORT.—Not later than January 1, 2021,
21 the Secretary of Health and Human Services shall
22 submit to Congress a report on the study conducted
23 under paragraph (1) together with recommendations
24 for such legislation and administrative action as the
25 Secretary determines to be appropriate.

1 **SEC. 9. GRANTS FOR INCREASING PUBLIC AWARENESS AND**
2 **TRAINING.**

3 (a) MATERIAL AND RESOURCES DEVELOPMENT.—

4 The Secretary of Health and Human Services (referred
5 to in this section as the “Secretary”), in consultation with
6 the Advance Care Planning Advisory Council (established
7 in section 10), may award grants to public or private enti-
8 ties (including, as appropriate, States, political subdivi-
9 sions of States, medical schools, nursing schools, health
10 care systems, faith-based organizations, and religious edu-
11 cational institutions), or a consortium of any such entities,
12 to develop online training modules, decision support tools,
13 and instructional materials for individuals, family care-
14 givers, and health care providers that include—

15 (1) with respect to healthy individuals, the im-
16 portance of—

17 (A) identifying an individual who will make
18 treatment decisions in the event of future cog-
19 nitive incapacity;

20 (B) discussing values and goals relevant to
21 serious injury or illness; and

22 (C) completing an advance directive that—

23 (i) appoints a surrogate; and

24 (ii) documents goals and values and
25 other information that should be consid-
26 ered in making treatment decisions;

1 (2) with respect to individuals with serious,
 2 chronic progressive, or advanced illness, the impor-
 3 tance of—

4 (A) articulating goals of care;

5 (B) understanding prognosis and typical
 6 disease trajectory;

7 (C) evaluating treatment options in light of
 8 goals of care;

9 (D) developing a treatment plan; and

10 (E) documenting the treatment plan on ad-
 11 vance directives, portable treatment orders, and
 12 other documentation forms used in the locality
 13 where the plan is to be executed;

14 (3) the role and effective use of State and other
 15 advance directive forms and portable treatment or-
 16 ders;

17 (4) the range of services for individuals facing
 18 serious, chronic progressive, or advanced illness, in-
 19 cluding advance care planning services, palliative
 20 care, and hospice care; and

21 (5) with respect to providers of advance care
 22 planning, advance illness care, hospice care, and pal-
 23 liative care in hospital, hospice, home, community,
 24 and long-term care settings, material to assist in—

1 (A) developing and implementing programs
 2 and initiatives to train and educate individuals;

3 (B) providing training and continuing edu-
 4 cation to individuals who will provide advance
 5 care planning services or palliative care in the
 6 hospital, hospice, home, community, and long-
 7 term care settings; and

8 (C) developing curricula or teaching mate-
 9 rials related to advance care planning or pallia-
 10 tive care in such settings.

11 (b) ESTABLISHMENT AND MAINTENANCE OF WEB-
 12 AND TELEPHONE-BASED RESOURCES.—

13 (1) IN GENERAL.—The Secretary may award
 14 grants to public or private entities (including States,
 15 political subdivisions of States, faith-based organiza-
 16 tions, and religious educational institutions), or a
 17 consortium of any such entities, to establish and
 18 maintain an Internet website and telephone hotline
 19 to disseminate resources developed under subsection
 20 (a) and materials for faith communities designed by
 21 the Department of Health and Human Services Cen-
 22 ter for Faith-Based and Neighborhood Partnerships.

23 (2) ABILITY TO SUSTAIN ACTIVITIES.—In deter-
 24 mining whether to award a grant under paragraph
 25 (1), the Secretary shall take into account the ability

1 of an entity to sustain the activities described in
 2 paragraph (1) beyond the initial grant period.

3 (c) NATIONAL PUBLIC EDUCATION CAMPAIGN.—The
 4 Secretary may award grants to public or private entities
 5 (including States, political subdivisions of States, faith-
 6 based organizations, and religious educational institu-
 7 tions) to conduct a national public education campaign to
 8 raise public awareness of advance care planning and seri-
 9 ous, chronic progressive, or advanced illness care, includ-
 10 ing the availability of the resources created under this sec-
 11 tion.

12 (d) ORDERS FOR LIFE-SUSTAINING TREATMENT.—

13 (1) IN GENERAL.—The Secretary may award
 14 grants to eligible entities for the purposes of car-
 15 rying out the activities under paragraph (2).

16 (2) AUTHORIZED ACTIVITIES.—Activities fund-
 17 ed through a grant under this section for an area
 18 may include—

19 (A) establishing and operating a National
 20 Resource Center on POLST Programs to pro-
 21 vide—

22 (i) technical assistance and profes-
 23 sional training to programs for orders for
 24 life-sustaining treatment;

1 (ii) analysis and dissemination of best
 2 practices in implementing program for or-
 3 ders for life-sustaining treatment;

4 (iii) voluntary standards for the estab-
 5 lishment and operation of program for or-
 6 ders for life-sustaining treatment; and

7 (iv) compilations and summaries of
 8 recently conducted research and other re-
 9 sources relevant to program for orders for
 10 life-sustaining treatment;

11 (B) developing such a program for the
 12 area that includes hospitals, home care, hospice,
 13 long-term care, community and assisted living
 14 residences, skilled nursing facilities, and emer-
 15 gency medical services within a State; and

16 (C) expanding an existing program for or-
 17 ders regarding life-sustaining treatment to serve
 18 more patients or enhance the quality of serv-
 19 ices, including educational services for patients
 20 and patients' families, training of health care
 21 professionals, or establishing an orders for life-
 22 sustaining treatment registry.

23 (3) DEFINITIONS.—In this subsection—

24 (A) the term “eligible entity” means—

1 (i) an academic medical center, a
 2 medical school, a State health department,
 3 a State medical association, a multistate
 4 task force, a hospital, or a health system
 5 capable of administering a program for
 6 physician orders regarding life-sustaining
 7 treatment for a State; or

8 (ii) any other health care agency or
 9 entity as the Secretary determines appro-
 10 priate; and

11 (B) the term “program for orders for life-
 12 sustaining treatment” means a program that,
 13 regardless of its name—

14 (i) implements a clinical process de-
 15 signed to facilitate shared, informed med-
 16 ical decisionmaking and communication be-
 17 tween health care professionals and pa-
 18 tients with serious, progressive illness or
 19 frailty and results in a set of medical or-
 20 ders that—

21 (I) are consistent with the na-
 22 tional standard as reflected by the
 23 National POLST Paradigm, rep-
 24 resenting health care providers, orga-
 25 nizations, and stakeholders;

1 (II) are portable and honored
2 across care settings; and

3 (III) address key medical deci-
4 sions consistent with the patient's
5 goals of care; and

6 (ii) is guided by a coalition of stake-
7 holders, such as patient advocacy groups
8 and representatives from across the con-
9 tinuum of health care services, disability
10 rights advocates, senior advocates, emer-
11 gency medical services, long-term care,
12 medical associations, hospitals, home
13 health, hospice, palliative care, nursing as-
14 sociations, the State agency responsible for
15 senior and disability services, faith-based
16 groups, and the State department of
17 health.

18 (e) AUTHORIZATION OF APPROPRIATIONS.—

19 (1) IN GENERAL.—There are authorized to be
20 appropriated to the Secretary, for purposes of
21 awarding grants under this section, \$50,000,000 for
22 the period of fiscal years 2018 through 2022.

23 (2) LIMITATION.—None of the funds appro-
24 priated under paragraph (1) shall be used to—

25 (A) develop a model advance directive;

1 (B) develop or employ a dollars-per-quality
 2 adjusted life year (or similar measure that dis-
 3 counts the value of a life because of an individ-
 4 ual's disability); or

5 (C) make a grant to a private entity that
 6 advocates, promotes, or facilitates any item or
 7 procedure for which funding is unavailable
 8 under the Assisted Suicide Funding Restriction
 9 Act of 1997 (Public Law 105–12).

10 **SEC. 10. ADVANCE CARE PLANNING ADVISORY COUNCIL.**

11 (a) ESTABLISHMENT.—Not later than 180 days after
 12 the date of the enactment of this Act, the Secretary of
 13 Health and Human Services (in this section referred to
 14 as the “Secretary”) shall establish within the Office of the
 15 Secretary an advisory committee to be known as the Ad-
 16 vance Care Planning Advisory Council (in this section re-
 17 ferred to as the “Council”).

18 (b) DUTIES.—

19 (1) MISSION.—The Council shall advise the
 20 Secretary regarding the compilation, development,
 21 and dissemination of resources for developed with
 22 grants awarded under section 9.

23 (2) RESPONSIBILITIES.—Responsibilities of the
 24 council include the following:

1 (A) Ensuring that resources provided con-
2 tain unbiased information about the range of
3 options available to individuals with serious,
4 chronic progressive, advanced, or terminal ill-
5 ness, including information about conventional,
6 curative treatments, palliative care, and hospice
7 care.

8 (B) Developing strategies for increasing
9 public understanding about serious, chronic
10 progressive, or advanced illness and the impor-
11 tant role advance care planning can play in doc-
12 umenting an individual's wishes for medical
13 care for loved ones in the event that the indi-
14 vidual cannot communicate such wishes.

15 (C) Compiling information for dissemina-
16 tion regarding existing advance care planning
17 models including POLST, advance directives,
18 and healthcare proxies.

19 (D) Promoting interagency coordination
20 and minimizing overlap regarding advance care
21 planning, including opportunities to coordinate
22 efforts between the Federal agencies and exter-
23 nal stakeholders.

1 (E) Identifying and evaluating cross-cut-
2 ting issues such as pediatric end-of-life care and
3 advance care planning access issues.

4 (c) MEMBERSHIP.—

5 (1) IN GENERAL.—The Council shall be com-
6 posed of up to 15 members appointed by the Sec-
7 retary from among qualified individuals who are not
8 officers or employees of the Federal Government.

9 (2) GROUPS.—The members of the Council
10 shall include the following:

11 (A) At least 3 members with clinical train-
12 ing and an expertise in palliative care, advanced
13 illness, or end-of-life care.

14 (B) At least 3 members from patient and
15 family advocacy groups.

16 (C) At least 3 members from religious or
17 spiritual organizations.

18 (D) Other members from interested stake-
19 holder groups with a proven expertise in pallia-
20 tive, chronic, advanced, or end-of-life care.

21 (d) APPLICABILITY OF FACA.—The Council shall be
22 treated as an advisory committee subject to the Federal
23 Advisory Committee Act (5 U.S.C. App.).

1 **SEC. 11. ANNUAL REPORT ON MEDICARE DECEDENTS.**

2 The Secretary of Health and Human Services shall
3 issue for each fiscal year (beginning no later than fiscal
4 year 2018) an annual report that analyzes the cir-
5 cumstances of Medicare beneficiaries who died during the
6 fiscal year covered by such report. Such analysis shall in-
7 clude at least the following with respect to such decedents:

8 (1) Information on the care or payor settings
9 (such as under part A or part C of Medicare) at the
10 time of death.

11 (2) Information on the demographic character-
12 istics of such decedents.

13 (3) Information on the geographic distribution
14 of such decedents.

15 (4) An evaluation of the Medicare claims data
16 for such decedents for services furnished in the last
17 year of life, including an analysis of the setting of
18 care for decedents who had more than one chronic
19 illness at the time of death.

20 (5) Such other information as the Secretary
21 deems appropriate.

22 **SEC. 12. RULE OF CONSTRUCTION.**

23 Nothing in the provisions of, or the amendments
24 made by, this Act shall be construed to limit the restric-
25 tions of, or to authorize the use of Federal funds for any
26 service, material, or activity pertaining to an item or serv-

1 ice or procedure for which funds are unavailable under,
2 the Assisted Suicide Funding Restriction Act of 1997
3 (Public Law 105–12).

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