

116TH CONGRESS
1ST SESSION

S. 829

To amend title XI of the Social Security Act to award cooperative agreements to improve care for individuals with advanced illnesses, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 14, 2019

Mr. WHITEHOUSE introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XI of the Social Security Act to award cooperative agreements to improve care for individuals with advanced illnesses, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Removing Barriers to
5 Person- and Family-Centered Care Act of 2019”.

6 **SEC. 2. COOPERATIVE AGREEMENTS TO IMPROVE CARE**
7 **FOR INDIVIDUALS WITH ADVANCED ILL-**
8 **NESSSES.**

9 (a) IN GENERAL.—Section 1115A of the Social Secu-
10 rity Act (42 U.S.C. 1315a) is amended—

1 (1) in the last sentence of subparagraph (A) of
 2 subsection (b)(2), by inserting “, and the model de-
 3 scribed in subsection (h)” before the period at the
 4 end; and

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

7 “(h) COOPERATIVE AGREEMENTS TO IMPROVE CARE
 8 FOR INDIVIDUALS WITH ADVANCED ILLNESSES.—

9 “(1) IN GENERAL.—The Secretary shall, acting
 10 through the Centers for Medicare & Medicaid Serv-
 11 ices, award up to 15 cooperative agreements to eligi-
 12 ble entities with the goals of—

13 “(A) addressing gaps in community capac-
 14 ity to provide high-quality, person- and family-
 15 centered care;

16 “(B) improving the integration and coordi-
 17 nation of clinical and nonclinical services;

18 “(C) expanding access to a comprehensive
 19 care planning process and services; and

20 “(D) developing and implementing alter-
 21 native payment models that provide account-
 22 ability for health care costs and quality out-
 23 comes.

24 “(2) ELIGIBLE ENTITY.—In this subsection, the
 25 term ‘eligible entity’ means the following:

1 “(A) A State Medicaid agency.

2 “(B) A State, local, or tribal health agen-
3 cy.

4 “(C) An accountable care organization
5 under section 1899 or an accountable care or-
6 ganization model tested under title XVIII or
7 with respect to such title under this section.

8 “(D) A Lead Organization (as defined in
9 paragraph (9)).

10 “(E) A quality improvement organization,
11 such as a Quality Innovation Network–Quality
12 Improvement Organization with a contract pur-
13 suant to part B of this title.

14 “(3) APPLICATION.—

15 “(A) IN GENERAL.—Eligible entities seek-
16 ing a cooperative agreement under this sub-
17 section shall submit to the Secretary an applica-
18 tion, at such time, and in such manner as the
19 Secretary may require. An application must in-
20 clude—

21 “(i) a list of participating practi-
22 tioners, providers of services, community-
23 based organizations, and other individuals
24 and entities;

1 “(ii) a description of the target popu-
2 lation or populations and geographic serv-
3 ice area;

4 “(iii) a description of the intended
5 uses of amounts awarded under paragraph
6 (4), and a plan for leveraging existing
7 funding sources to deliver services to the
8 target population or populations;

9 “(iv) a description of the intended
10 care delivery model and how the model
11 supports high-quality, person- and family-
12 centered care;

13 “(v) a plan for—

14 “(I) working with community-
15 based organizations, including faith-
16 based organizations and aging and
17 disability organizations;

18 “(II) improving community-based
19 supports for family caregivers; and

20 “(III) increasing the number of
21 individuals within the target popu-
22 lation or populations who—

23 “(aa) have communicated
24 their wishes regarding medical
25 treatment using State or locally

1 recognized forms, such as ad-
2 vance directives or portable med-
3 ical orders;

4 “(bb) have comprehensive
5 care plans that are concrete and
6 actionable; and

7 “(cc) have access to commu-
8 nity-based palliative care services;
9 and

10 “(vi) other information as determined
11 appropriate by the Secretary.

12 “(4) AWARD AMOUNTS.—

13 “(A) IN GENERAL.—The Secretary may
14 award up to \$5,000,000 under each cooperative
15 agreement under this subsection.

16 “(B) USE OF FUNDS.—Funds awarded
17 under a cooperative agreement may be used for
18 the following purposes:

19 “(i) To develop and implement a care
20 delivery model as described in paragraph
21 (5)(B)(i) and an alternative payment
22 model as described in paragraph (5)(B)(ii).

23 “(ii) To conduct education and train-
24 ing for health care professionals, bene-
25 ficiaries and family caregivers, or commu-

nity-based organizations in methods for documenting and sharing an individual's care goals, preferences, and values under such model.

“(iii) To hire staff to conduct care management and coordination activities as part of an interdisciplinary care team under such model.

“(iv) To support the development of community-based palliative care teams and the delivery of related services.

“(v) To modify, upgrade, or purchase health information technology, including technologies that support data aggregation and analytics, electronic exchange of health information, accessibility of an individual's comprehensive care plan, or remote monitoring under such model.

“(vi) To conduct other activities determined appropriate by the Secretary.

“(5) IMPLEMENTATION.—

“(A) DURATION.—Each cooperative agreement under this subsection shall be awarded for a period of 7 years.

1 “(B) PRE-IMPLEMENTATION PERIOD.—

2 During the first 2 years of a cooperative agree-
 3 ment, an awardee shall work with the Secretary
 4 to—

5 “(i) develop a care delivery model
 6 using one or more of the waivers and ex-
 7 panded services described in paragraphs
 8 (7) and (8);

9 “(ii) develop an alternative payment
 10 model; and

11 “(iii) identify a set of quality meas-
 12 ures that will be reported on annually by
 13 participants in such model.

14 “(C) MODEL IMPLEMENTATION.—Begin-
 15 ning with the third year of a cooperative agree-
 16 ment, an awardee—

17 “(i) shall implement the care delivery
 18 model developed under subparagraph
 19 (B)(i) and the alternative payment model
 20 developed under subparagraph (B)(ii);

21 “(ii) shall annually report data on
 22 quality measures identified under subpara-
 23 graph (B)(iii) to the Secretary; and

24 “(iii) may, in accordance with para-
 25 graphs (7) and (8), receive waivers and

1 provide expanded services as described in
2 such paragraphs, respectively, as part of a
3 care delivery model that provides high-
4 quality, person- and family-centered care
5 to the target population or populations.

6 “(6) NOTIFICATION.—The Secretary shall pro-
7 vide guidance on notification and continuity-of-care
8 plan requirements in the event a participating pro-
9 vider leaves a model pursuant to a cooperative
10 agreement under this subsection.

11 “(7) WAIVER OF CERTAIN REQUIREMENTS.—In
12 addition to any waivers pursuant to subsection
13 (d)(1), the Secretary shall include the following
14 waivers of requirements and, where applicable, per-
15 mit Medicare Advantage organizations flexibility to
16 waive such requirements, with respect to coverage
17 of, and payment for, items and services furnished to
18 individuals pursuant to a cooperative agreement
19 under this subsection:

20 “(A) COVERAGE OF SERVICES RELATED TO
21 AN INDIVIDUAL’S TERMINAL ILLNESS.—A waiv-
22 er of the requirement described in section
23 1812(d)(2)(A) that an individual electing to re-
24 ceive hospice care shall be deemed to have
25 waived all rights to have payment made under

1 title XVIII with respect to services described in
 2 clause (ii)(I) of such section.

3 “(B) ALTERNATIVES IN FURNISHING OF
 4 HOME CARE.—With respect to home health
 5 services furnished to an individual by a home
 6 health agency, a waiver of the requirements de-
 7 scribed in sections 1814(a)(2) and
 8 1835(a)(2)(A), that—

9 “(i) a physician makes the certifi-
 10 cation (and recertification, where such
 11 services are provided over a period of time)
 12 as described in such sections;

13 “(ii) a plan for furnishing such serv-
 14 ices to such individual is established and
 15 periodically reviewed by a physician;

16 “(iii) such services are or were fur-
 17 nished while the individual was under the
 18 care of a physician; and

19 “(iv) the physician documents that the
 20 individual has had a face-to-face encounter
 21 as described in such sections,

22 provided that a nurse practitioner, clinical
 23 nurse specialist, or physician assistant (as those
 24 terms are defined in section 1861(aa)(5)), in
 25 accordance with State law, makes such certifi-

1 cation and recertification, establishes and peri-
2 odically reviews such plan, has the individual
3 under their care when such services are or were
4 furnished, and documents such face-to-face en-
5 counter.

6 “(C) ALTERNATIVE CERTIFICATION FOR
7 HOSPICE CARE.—A waiver of the requirements
8 described in subparagraphs (A) and (B) of sec-
9 tion 1814(a)(7) that an individual’s attending
10 physician and the medical director (or physician
11 member of the interdisciplinary group described
12 in section 1861(dd)(2)(B)) of the hospice pro-
13 gram providing (or arranging for) the individ-
14 ual’s hospice care certify that the individual is
15 terminally ill and periodically review the written
16 plan for hospice care, provided that such certifi-
17 cation and review is conducted by a nurse prac-
18 titioner, clinical nurse specialist, or physician
19 assistant (as those terms are defined in section
20 1861(aa)(5)) in accordance with State law.

21 “(D) COVERAGE OF SKILLED NURSING
22 SERVICES WITHOUT INPATIENT STAY.—With
23 respect to extended care services furnished to
24 an individual by a skilled nursing facility, a
25 waiver of the requirement described in section

1861(i) that an individual must have been an inpatient in a hospital for not less than 3 consecutive days before his discharge and transfer to the skilled nursing facility before such extended care services may be deemed post-hospital extended care services.

“(E) COVERAGE OF HOME HEALTH CARE WITHOUT HOMEBOUND STATUS REQUIREMENT.—With respect to home health services furnished to an individual by a home health agency (as defined in section 1861(o)), a waiver of the requirements described in sections 1814(a)(2)(C) and 1835(a)(2)(A) that the individual is or was confined to his or her home.

“(8) AVAILABILITY OF EXPANDED SERVICES.—A hospice program that participates in an alternative payment model pursuant to a cooperative agreement under this subsection may receive an add-on payment, as determined by the Secretary, for furnishing the following services to the target population or populations under such model:

“(A) INPATIENT ALTERNATIVE TO ROUTINE HOSPICE CARE.—

“(i) IN GENERAL.—Notwithstanding regulations in effect prior to the enactment

1 of this subsection, if an assessment meet-
2 ing such requirements as the Secretary de-
3 termines appropriate has been made that
4 the home of an individual who is certified
5 for hospice care and has elected to receive
6 hospice care is unsafe or unsuitable for the
7 provision of such care, such individual may
8 receive such care in an inpatient setting,
9 including a hospice program that meets the
10 conditions of participation specified in sec-
11 tion 418.110 of title 42, Code of Federal
12 Regulations (as in effect on the date of en-
13 actment of this subparagraph), or a skilled
14 nursing facility that meets the standards
15 specified in subsections (b) and (e) of such
16 section, for the duration an individual has
17 elected to receive hospice care. The assess-
18 ment described in the preceding sentence
19 may be conducted by the individual's at-
20 tending physician, a nurse practitioner,
21 clinical nurse specialist, or physician as-
22 sistant (as those terms are defined in sec-
23 tion 1861(aa)(5)), or the medical director
24 (or physician member of the interdiscipli-
25 nary group described in section

1861(dd)(2)(B)) of the hospice program providing (or arranging for) the individual's hospice care.

“(ii) APPLICATION OF LIMITATION ON INPATIENT CARE DAYS.—For purposes of any limitation on the number of total inpatient care days for which a hospice may receive payment, hospice care that is provided in an inpatient setting under this subparagraph (but would otherwise be provided in an outpatient setting) shall not count towards such limitation.

“(B) HOME-BASED ALTERNATIVE TO INPATIENT RESPITE CARE.—

“(i) IN GENERAL.—Notwithstanding section 1861(dd)(1)(G), an individual who is certified for hospice care and has elected to receive hospice care may receive short-term, home-based respite care as an alternative to inpatient respite care.

“(ii) LIMITATIONS.—The home-based respite care described in clause (i) is subject to the same limitations that apply to inpatient respite care under section 1861(dd)(1)(G), including the limitation

1 that respite care may be provided only on
2 an intermittent, non-routine, and occa-
3 sional basis and may not be provided con-
4 secutively over longer than 5 days.

5 “(9) DEFINITIONS.—In this subsection:

6 “(A) LEAD ORGANIZATION.—The term
7 ‘Lead Organization’ means a covered entity for
8 purposes of compliance with the regulations
9 promulgated under section 264(c) of the Health
10 Insurance Portability and Accountability Act of
11 1996 (42 U.S.C. 1320d–2 note) that will con-
12 vene community partners to coordinate, man-
13 age, and expand services for the target popu-
14 lation or populations and be accountable for
15 costs and quality outcomes under the coopera-
16 tive agreement.

17 “(B) COOPERATIVE AGREEMENT.—The
18 term ‘cooperative agreement’ means an agree-
19 ment between the Secretary and an eligible en-
20 tity under this subsection.

21 “(C) PHYSICIAN.—The term ‘physician’
22 has the meaning given such term in section
23 1861(r)(1).

1 “(D) PRACTITIONER.—The term ‘practi-
 2 tioner’ has the meaning given such term in sec-
 3 tion 1842(b)(18)(C).

4 “(E) PROVIDER OF SERVICES.—The term
 5 ‘provider of services’ has the meaning given
 6 such term in section 1861(u).

7 “(F) TARGET POPULATION.—The term
 8 ‘target population’ means individuals who—

9 “(i) are enrolled for benefits under
 10 parts A and B of title XVIII, enrolled in
 11 a Medicare Advantage plan under part C
 12 of such title, enrolled under a State Med-
 13 icaid plan, or dually eligible for benefits
 14 under titles XVIII and XIX;

15 “(ii) have one or more advanced
 16 chronic conditions, as determined by the
 17 Secretary, such as late-stage cancer, con-
 18 gestive heart failure, chronic kidney dis-
 19 ease, chronic obstructive pulmonary dis-
 20 ease, geriatric frailty, Alzheimer’s disease,
 21 or other forms of progressive dementia;
 22 and

23 “(iii) have demonstrated—

24 “(I) evidence of recent and pro-
 25 gressive cognitive impairment; or

1 “(II) a functional limitation re-
 2 quiring the assistance of another per-
 3 son (such as an inability to perform
 4 two or more activities of daily liv-
 5 ing).”.

6 (b) AVAILABILITY OF FUNDING.—Section
 7 1115A(f)(2) of the Social Security Act (42 U.S.C.
 8 1315a(f)(2)) is amended—

9 (1) by striking “Out of amounts appropriated”
 10 and inserting “(A) Out of amounts appropriated”;
 11 and

12 (2) by adding at the end the following new sub-
 13 paragraph:

14 “(B) Out of the amount appropriated
 15 under subparagraph (C) of paragraph (1),
 16 \$75,000,000 shall be made available for the
 17 purpose of awarding funds under subsection
 18 (h)(4), which shall remain available for such
 19 purpose until expended.”.

20 **SEC. 3. IDENTIFICATION AND DEVELOPMENT OF QUALITY**
 21 **MEASURES RELATING TO ADVANCED ILL-**
 22 **NESS CARE.**

23 Section 1890A of the Social Security Act (42 U.S.C.
 24 1395aaa–1) is amended by adding at the end the following
 25 new subsection:

1 “(h) ADVANCED ILLNESS CARE QUALITY MEAS-
2 URES.—

3 “(1) IN GENERAL.—The Secretary, in consulta-
4 tion with the Administrator of the Centers for Medi-
5 care & Medicaid Services, the Director of the Agency
6 for Healthcare Research and Quality, the Adminis-
7 trator of the Administration for Community Living,
8 and the entity with a contract under section
9 1890(a), shall establish a core set of evidence-based
10 quality measures relating to advanced illness care.
11 Such quality measures may include outcome, struc-
12 tural, and process measures in the following do-
13 mains:

14 “(A) Person and family experience of care.

15 “(B) Access to needed services (medical
16 and supportive), such as home care, palliative
17 care, and timely referral to hospice.

18 “(C) Alignment of care with an individ-
19 ual’s preferences, goals, and values.

20 “(D) Screening and treatment for physical
21 symptoms, such as dyspnea, nausea, and con-
22 stipation.

23 “(E) Utilization of health care and support
24 services.

1 “(F) Shared decision making and informed
2 consent.

3 “(2) PROCESS FOR IDENTIFYING AND DEVEL-
4 OPING QUALITY MEASURES.—In identifying and de-
5 veloping the quality measures for the core set de-
6 scribed in paragraph (1), the Secretary shall take
7 the following actions:

8 “(A) IDENTIFY EXISTING MEASURES.—
9 Identify existing quality measures relating to
10 advanced illness care that are in use under pub-
11 lic and privately sponsored health care arrange-
12 ments.

13 “(B) DEVELOPMENT OF MEASURES.—
14 Enter into grants, contracts, or intergovern-
15 mental agreements with eligible entities for the
16 purposes of developing quality measures (which
17 may include improving existing quality meas-
18 ures) relating to advanced illness care that, to
19 the extent practicable, allow for the use of
20 health information technologies in collecting
21 data relating to such quality measures.

22 “(C) STAKEHOLDER FEEDBACK.—Solicit
23 feedback from a wide array of stakeholders on
24 quality measures to include in the core set.

25 “(3) PUBLICATION AND UPDATES.—

1 “(A) PUBLICATION.—Not later than Janu-
2 ary 1, 2022, the Secretary shall publish a core
3 set of quality measures for advanced illness
4 care.

5 “(B) UPDATES.—Beginning January 1,
6 2024 (and every 2 years thereafter), the Sec-
7 retary, in coordination with the entity with a
8 contract under section 1890(a), shall solicit
9 stakeholder feedback and publish an updated
10 set of quality measures, prioritizing measures
11 that address gap areas related to advanced ill-
12 ness care.

13 “(4) FUNDING.—There are authorized to be ap-
14 propriated such sums as may be necessary to carry
15 out this subsection.”.

○