

115TH CONGRESS
1ST SESSION

H. R. 2797

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 HOUSE OF REPRESENTATIVES

JUNE 7, 2017

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

A BILL

To 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
18 advanced illness care delivery.

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

24 (9) Too often, individuals with serious, chronic
25 progressive, or advanced illness do not understand

the conditions they are facing or their treatment options, and they do not receive the information or support they need to evaluate treatment options in light of their personal goals and values and to document treatment plans in a manner that allows providers and facilities to follow their plans.

(10) Providing high-quality advanced care planning services and supports to individuals with serious, chronic progressive, or advanced illness will protect and preserve their dignity and ensure care is aligned with an individual’s goals, values, and stated preferences.

SEC. 3. ADVANCED ILLNESS CARE AND MANAGEMENT MODEL.

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 model described in subsection (h), which shall be implemented by not later than 1 year after the date of the enactment of the Patient Choice and Quality Care Act of 2017.”; and

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

1 “(h) ADVANCED ILLNESS CARE AND MANAGEMENT
2 MODEL.—

3 “(1) MODEL.—

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

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

19 “(C) REQUIREMENTS.—

20 “(i) HOSPICE PROVIDER.—At least
21 one applicable provider selected for partici-
22 pation under the model shall be a hospice
23 program (as defined in section
24 1861(dd)(2)).

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

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

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

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

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

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

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

23 “(D) Providing the individual with and dis-
24 cussing information about the benefits and bur-
25 dens of relevant ranges of treatment options

1 available to the individual, including disease
2 modifying or potentially curative treatment, pal-
3 liative care, which may be provided alone or in
4 conjunction with disease modifying treatment,
5 and, when the individual may be currently eligi-
6 ble or may become eligible for hospice care due
7 to disease progression.

8 “(E) Assisting the individual in evaluating
9 treatment options and approaches to care to
10 identify those that most closely align with the
11 individual’s goals of care, values, and pref-
12 erences.

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

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

19 “(ii) that is in State or locally recog-
20 nized forms that are used for the purpose
21 of assuring that providers can follow the
22 plan across care settings, such as advance
23 directives or portable treatment orders.

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

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

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

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

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

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

20 “(M) Additional services, consistent with
21 the care plan, that the interdisciplinary team
22 believes would assist the eligible individual and
23 family caregivers in more effectively managing
24 their health condition.

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

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

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

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

18 “(A) furnishes services through an inter-
19 disciplinary team; and

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

22 “(5) ELIGIBLE INDIVIDUAL DEFINED.—In this
23 subsection, the term ‘eligible individual’ means an
24 individual who—

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

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

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

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

17 “(ii) The individual is diagnosed with
18 a serious, chronic progressive or advanced
19 illness that—

20 “(I) has a strong negative impact
21 on the individual’s quality of life and
22 functioning in life roles, independent
23 of its impact on mortality; or

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

1 “(iii) The individual is diagnosed
2 with—

3 “(I) metastatic or locally ad-
4 vanced cancer;

5 “(II) Alzheimer’s disease or an-
6 other progressive dementia;

7 “(III) late-stage neuromuscular
8 disease;

9 “(IV) late-stage diabetes;

10 “(V) late-stage kidney, liver,
11 heart, gastrointestinal, cerebro-
12 vascular, or lung disease; or

13 “(VI) age-related physical debil-
14 ity.

15 “(iv) The individual meets other cri-
16 teria determined appropriate by the Sec-
17 retary.

18 “(6) INTERDISCIPLINARY TEAM.—

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

22 “(i) includes at least—

23 “(I) one physician who is board
24 certified in geriatrics, internal medi-
25 cine, or family medicine;

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

8 “(III) one nurse; and

9 “(IV) one social worker;

10 “(ii) may include a chaplain, minister,
11 or pastoral counselor;

12 “(iii) may include other direct care
13 personnel (including pharmacists, dieti-
14 cians, physical therapists, occupational
15 therapists, and psychotherapists); and

16 “(iv) meets requirements that may be
17 established by the Secretary.

18 “(B) ADDITIONAL MEMBER AT THE RE-
19 QUEST OF THE ELIGIBLE INDIVIDUAL.—An ap-
20 plicable provider shall offer to the eligible indi-
21 vidual (or the individual’s legally authorized
22 representative when the individual has been
23 found to lack decisional capacity) the oppor-
24 tunity to select either a chaplain affiliated with
25 the applicable provider, a minister, or personal

1 religious or spiritual advisor who can help to
 2 represent the individual's goals, values, and
 3 preferences to serve as a core interdisciplinary
 4 team member at the individual's (or legally au-
 5 thorized representative's) request.”.

6 **SEC. 4. QUALITY MEASUREMENT DEVELOPMENT AND IM-**
 7 **PLEMENTATION.**

8 (a) FACILITATION OF INCREASED COORDINATION
 9 AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE
 10 SECTOR WITH RESPECT TO QUALITY MEASURES RE-
 11 GARDING ADVANCED ILLNESS, PALLIATIVE, AND END-OF-
 12 LIFE CARE.—

13 (1) IN GENERAL.—Section 1890(b) of the So-
 14 cial Security Act (42 U.S.C. 1395aaa(b)) is amend-
 15 ed by inserting after paragraph (3) the following
 16 new paragraph:

17 “(4) INCREASED COORDINATION AND ALIGN-
 18 MENT BETWEEN THE PUBLIC AND PRIVATE SECTOR
 19 WITH RESPECT TO QUALITY MEASURES REGARDING
 20 ADVANCED ILLNESS, PALLIATIVE, AND END-OF-LIFE
 21 CARE.—

22 “(A) IN GENERAL.—The entity shall facili-
 23 tate increased coordination and alignment be-
 24 tween the public and private sector with respect
 25 to quality measures regarding advanced illness,

1 palliative, and end-of-life care across the care
2 settings and programs described in this section
3 and across other services and care settings
4 under this title, as appropriate.

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

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

20 “(ii) The effectiveness, patient-
21 centeredness (and, where relevant, family
22 caregiver-centeredness), and adequacy of
23 care plans, including documentation of in-
24 dividual goals, preferences, and values.

1 “(iii) Agreement and consistency
2 among—

3 “(I) the patient’s goals, pref-
4 erences, and values;

5 “(II) any documented care plan;
6 and

7 “(III) the care delivered.

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

10 “(C) IDENTIFICATION AND
11 PRIORITIZATION OF MEASURES.—The entity
12 shall, based on the scan conducted under sub-
13 paragraph (B), identify and prioritize measures,
14 measure concepts, and preferred practices, that
15 are aligned across settings of care, condition,
16 and patient population.

17 “(D) REPORT.—Not later than 18 months
18 after the date of enactment of this paragraph,
19 the entity shall submit to the Secretary a report
20 containing the findings of the entity with re-
21 spect to the environmental scan under subpara-
22 graph (B) and the identification and
23 prioritization of measures, measure concepts,
24 and preferred practices under subparagraph
25 (C).”.

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

6 “(g) STUDY AND REPORT ON NIH DEVELOPMENT
7 OF ADDITIONAL MEASURES RELATED TO CARE PLAN-
8 NING.—

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

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

20 “(B) understanding the population with se-
21 rious, chronic progressive, or advanced illness
22 that would benefit from palliative care and ad-
23 vance care planning services; and

24 “(C) appropriate transitions to hospice
25 care.

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

5 (c) MEDICARE PHYSICIAN FEE SCHEDULE.—Section
 6 1848(s)(1) of the Social Security Act (42 U.S.C. 1395w-
 7 4(s)(1)) is amended by adding at the end the following
 8 new subparagraph:

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

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

23 (1) in subsection (a)(2)(E)(i)—

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

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

3 (C) by adding at the end the following new
4 subclause:

5 “(VI) with respect to the domain
6 described in subsection (c)(1)(F) (re-
7 lating to end-of-life care)—

8 “(aa) for PAC providers de-
9 scribed in clauses (ii), (iii), and
10 (iv) of paragraph (2)(A), October
11 1, 2020; and

12 “(bb) for PAC providers de-
13 scribed in clauses (i) of such
14 paragraph, January 1, 2021.”;
15 and

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

18 “(F) The effectiveness, patient-
19 centeredness (and, where relevant, family care-
20 giver-centeredness), and adequacy of care plans
21 and communications relating to such plans, in-
22 cluding—

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

1 “(ii) agreement and consistency with
2 respect to care among—
3 “(I) the patient’s goals, pref-
4 erences, and values;
5 “(II) any documented care plan;
6 and
7 “(III) the care delivered; and
8 “(iii) timely and appropriate referral
9 to hospice care.”.

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

14 “(C) PALLIATIVE AND END-OF-LIFE
15 CARE.—The Secretary, in consultation with the
16 National Committee for Quality Assurance,
17 shall prioritize the development of standards for
18 palliative and end-of-life care, including transi-
19 tion to hospice care, with respect to Medicare
20 Advantage organizations under this part for use
21 under the quality improvement program under
22 paragraph (1) that are the equivalent of such
23 standards in quality programs applicable to
24 providers of services and suppliers under the

1 original Medicare fee-for-service program under
 2 parts A and B.”.

3 (f) ALTERNATIVE PAYMENT MODELS.—Section
 4 1899(b)(3)(C) of the Social Security Act (42 U.S.C.
 5 1395jjj(b)(3)(C)) is amended—

6 (1) by striking “STANDARDS.—The Secretary”
 7 and inserting “STANDARDS.—

8 “(i) IN GENERAL.—The Secretary”;
 9 and

10 (2) by adding at the end the following new
 11 clause:

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

20 **SEC. 5. ENHANCING COVERAGE OF ADVANCE CARE PLAN-**
 21 **NING SERVICES.**

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

1 “Advance Care Planning Services

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

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

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

14 “(B) possesses—

15 “(i) a relevant care planning certification;

16 or

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

20 (b) NO APPLICATION OF COINSURANCE OR DEDUCT-
 21 IBLE.—

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

24 (A) by striking “and (BB)” and inserting

25 “(BB)”; and

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

9 (2) WAIVER OF APPLICATION OF DEDUCT-
 10 IBLE.—The first sentence of section 1833(b) of the
 11 Social Security Act (42 U.S.C. 1395l(b)) is amend-
 12 ed—

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

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

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

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

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

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

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

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

8 (C) by inserting after paragraph (3) the
9 following new paragraphs:

10 “(4) information on—

11 “(A) care planning;

12 “(B) how individual goals, values, and
13 preferences should be considered in framing a
14 care plan; and

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

21 “(5) information on documentation options for
22 care planning or advance care planning, including
23 advance directives and portable treatment orders.”.

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

4 (b) ADVANCE CARE PLANNING STANDARDS FOR
5 ELECTRONIC HEALTH RECORDS.—

6 (1) IN GENERAL.—Notwithstanding section
7 3004(b)(3) of the Public Health Service Act (42
8 U.S.C. 300jj–14(b)(3)), not later than 4 years after
9 the date of the enactment of this Act, the Secretary
10 of Health and Human Services shall adopt, by rule,
11 standards for a qualified electronic health record (as
12 defined in section 3000(13) of such Act (42 U.S.C.
13 300jj(13))), with respect to organizing patient com-
14 munications with health care providers about care
15 goals and to provide one-click access to the fol-
16 lowing:

17 (A) The patient’s current advance directive
18 (as defined in section 1866(f)(3) of the Social
19 Security Act (42 U.S.C. 1395cc(f)(3))), as ap-
20 plicable.

21 (B) The patient’s current order for life-
22 sustaining treatment (described in section
23 9(d)(3)(B)), as applicable.

1 (C) Documentation of advance care plan-
 2 ning discussion between the patient and the
 3 provider.

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

11 **SEC. 7. ADVANCE DIRECTIVES.**

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

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

20 “(B) In the absence of knowledge to the contrary,
 21 a physician or other health care provider or organization
 22 may presume that a written advance health care directive
 23 or similar instrument, regardless of where executed, is
 24 valid.

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

4 “(D) Nothing in the paragraph shall be construed
5 to—

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

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

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

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

23 “(v) permit the Secretary to seek civil penalties,
24 including exclusion from participation in the pro-
25 gram under this title or the program under title

1 XIX, against a provider or organization if the pro-
2 vider or organization—

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

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

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

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

22 (c) GAO STUDY ON HEALTH CARE DECISIONMAKING
23 LAWS AND BARRIERS TO THE USE OF ADVANCE DIREC-
24 TIVES.—

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

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

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

22 (a) REQUIREMENTS.—

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

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

3 (B) by inserting after subparagraph (Y)
 4 the following new subparagraph:

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

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

16 (b) HHS STUDY AND REPORT.—

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

23 (A) engage in a care planning process;

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

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

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

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

14 (i) subsequent providers or facilities;

15 and

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

19 (2) REPORT.—Not later than January 1, 2021,
20 the Secretary of Health and Human Services shall
21 submit to Congress a report on the study conducted
22 under paragraph (1) together with recommendations
23 for such legislation and administrative action as the
24 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 ad-
9 vanced illness care, including the availability of the re-
10 sources created under this section.

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

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

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

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

21 (i) technical assistance and profes-
22 sional training to programs for orders for
23 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, and advanced illness and the im-
11 portant role advance care planning can play in
12 documenting 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).

○