

114TH CONGRESS  
1ST SESSION

# S. 1549

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

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## IN THE SENATE OF THE UNITED STATES

JUNE 10, 2015

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

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## 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 “Care Planning Act of 2015”.

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. Improvement of advanced illness planning and coordination.

- Sec. 4. Quality measurement development.
- Sec. 5. Inclusion of advance care planning materials in the Medicare & You handbook.
- Sec. 6. Improvement of policies related to the use and portability of advance directives.
- Sec. 7. Additional requirements for facilities.
- Sec. 8. Grants for increasing public awareness of advance care planning and advanced illness care.
- Sec. 9. 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  
6 72,000,000, or 1 in 5 Americans, over the next two  
7 decades.

8 (2) Americans today are living longer and  
9 healthier lives than ever before in the history of the  
10 United States yet are also facing increased incidence  
11 of multiple serious conditions as aging progresses.

12 (3) Americans with advanced illness face a com-  
13 plicated and fragmented system of care delivery that  
14 puts them at risk for repeat hospitalizations, adverse  
15 drug reactions, and conflicting medical advice that  
16 may be overwhelming to individuals and families.

17 (4) The progression of advanced illness leads to  
18 the need for increasingly intensive decision support,  
19 health care services, and support from family care-  
20 givers.

1           (5) The complexity of care needed by individ-  
2           uals with advanced illness may result in uncoordi-  
3           nated care, adverse health outcomes, frustration,  
4           wasted time, and undue emotional burdens on indi-  
5           viduals and their family caregivers.

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

12          (7) Hospice programs, as one of the longest  
13          standing Medicare care coordination benefits that  
14          offer a comprehensive set of services via an inter-  
15          disciplinary team working to provide person- and  
16          family-centered care to the frailest and most vulner-  
17          able individuals in our communities, can serve as a  
18          model for advanced illness care delivery.

19          (8) Palliative care programs that serve patients  
20          beginning at diagnosis with advanced illness and  
21          provide care designed to reduce the symptom burden  
22          of illness can serve as a model for interdisciplinary  
23          team care planning based on the individual's goals  
24          of care.

1           (9) The Government of the United States, as  
2           the Nation’s largest purchaser of health care serv-  
3           ices, must learn from these innovators and encour-  
4           age health care providers to furnish more supportive  
5           and comprehensive advanced illness care to improve  
6           the efficacy and quality of health care delivered for  
7           generations of Americans to come.

8           (10) Health care providers who serve individ-  
9           uals with advanced illness face complicated care sys-  
10          tems and legal concerns that may result in over- or  
11          under-treatment of individuals with advanced illness.

12          (11) Individuals have the well-established right  
13          to accept or reject medical treatment that is offered,  
14          as well as the well-established right to document  
15          their preferences for how treatment decisions should  
16          be made if, at some point in the future, they lose the  
17          ability to make health care decisions.

18          (12) Too often, individuals with advanced ill-  
19          ness do not understand the conditions they are fac-  
20          ing or their treatment options, and they do not re-  
21          ceive the information or support they need to evalu-  
22          ate treatment options in light of their personal goals  
23          and values and to document treatment plans in a  
24          manner that allows providers and facilities to follow  
25          their plans.

1           (13) Providing quality services and planning  
 2           support to individuals with advanced illness will pro-  
 3           tect and preserve their dignity.

4 **SEC. 3. IMPROVEMENT OF ADVANCED ILLNESS PLANNING**  
 5 **AND COORDINATION.**

6           (a) **MEDICARE COVERAGE OF PLANNING SERV-**  
 7 **ICES.—**

8           (1) **COVERAGE.**—Section 1861(s)(2) of the So-  
 9           cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-  
 10          ed—

11                   (A) in subparagraph (EE), by striking  
 12                   “and” at the end;

13                   (B) in subparagraph (FF), by inserting  
 14                   “and” at the end; and

15                   (C) by inserting after subparagraph (FF)  
 16                   the following new paragraph:

17                           “(GG) planning services (as defined in  
 18                           subsection (iii));”.

19           (2) **SERVICES DESCRIBED.**—Section 1861 of  
 20           the Social Security Act (42 U.S.C. 1395x) is amend-  
 21           ed by adding at the end the following new sub-  
 22           section:

23                                   “Planning Services

24                   “(iii)(1)(A) The term ‘planning services’ means a vol-  
 25           untary decisionmaking process that includes the elements

1 described in paragraph (2) and is furnished to a planning  
2 services eligible individual by an applicable provider  
3 through an interdisciplinary team.

4 “(B)(i) Except as provided in clause (ii), planning  
5 services may only be furnished to a planning services eligi-  
6 ble individual under this title once in each 12-month pe-  
7 riod.

8 “(ii) The Secretary shall establish appropriate excep-  
9 tions to the frequency limitation under clause (i), such as  
10 when there is a change in the individual’s medical condi-  
11 tion.

12 “(2)(A) The elements described in this paragraph are  
13 the following:

14 “(i) One or more face-to-face encounters be-  
15 tween one or more members of the interdisciplinary  
16 team and the individual and, at the individual’s dis-  
17 cretion, family caregivers, or, for an individual who  
18 lacks decisionmaking capacity under State law, the  
19 individual’s legally authorized representative.

20 “(ii) The provision of information about the  
21 typical trajectory of illnesses or conditions that af-  
22 fect the individual, including foreseeable care deci-  
23 sions that may need to be made at a future time  
24 when the individual is likely to be unable to make

1 decisions due to temporary or permanent cognitive  
2 incapacity.

3 “(iii) Assisting the individual in defining and  
4 articulating goals of care, values, and preferences.

5 “(iv) Providing the individual with and dis-  
6 cussing information about the benefits and burdens  
7 of relevant ranges of treatment options available to  
8 the individual, including disease modifying or poten-  
9 tially curative treatment, palliative care, which may  
10 be provided alone or in conjunction with disease  
11 modifying treatment, and, when the individual may  
12 be currently eligible or may become eligible for hos-  
13 pice care due to disease progression.

14 “(v) Assisting the individual in evaluating treat-  
15 ment options and approaches to care to identify  
16 those that most closely align with the individual’s  
17 goals of care, values, and preferences.

18 “(vi) Preparing, and sharing with relevant pro-  
19 viders, documentation—

20 “(I) that states the individual’s goals of  
21 care, preferences, and values, preferred deci-  
22 sionmaking strategies, and a plan of care that  
23 is concrete and actionable; and

24 “(II) that is in State or locally recognized  
25 forms that are used for the purpose of assuring

1           that providers can follow the plan across care  
2           settings, such as advance directives or portable  
3           treatment orders.

4           “(vii) Referrals to providers, including medical  
5           and social service providers, who deliver care con-  
6           sistent with the plan.

7           “(viii) Providing culturally and educationally  
8           appropriate training for the individual and family  
9           caregivers to support their ability to carry out the  
10          plan.

11          “(B) Even when the individual’s decisional capacity  
12         is impaired and another person or entity, such as an ap-  
13         pointed agent, proxy, or surrogate, is exercising legal au-  
14         thority under State law governing decisionmaking on be-  
15         half of incapacitated individuals, the interdisciplinary  
16         team shall make a reasonable attempt to include the indi-  
17         vidual in the planning process.

18          “(3) For purposes of this subsection, the term ‘plan-  
19         ning services eligible individual’ means an individual that  
20         meets at least one of the following criteria:

21                 “(A) The individual is diagnosed with meta-  
22                 static or locally advanced cancer.

23                 “(B) The individual is diagnosed with Alz-  
24                 heimer’s disease or another progressive dementia.



1           “(C) The individual is diagnosed with late-stage  
2 neuromuscular disease.

3           “(D) The individual is diagnosed with late-stage  
4 diabetes.

5           “(E) The individual is diagnosed with late-stage  
6 kidney, liver, heart, gastrointestinal, cerebrovascular,  
7 or lung disease.

8           “(F) The individual needs assistance with two  
9 or more activities of daily living (defined as bathing,  
10 dressing, eating, getting out of bed or a chair, mobil-  
11 ity, and toileting) not associated with an acute or  
12 post-operative conditions that are caused by one or  
13 more serious or life threatening illnesses or frailty.

14           “(G) The individual meets other criteria deter-  
15 mined appropriate by the Secretary, including cri-  
16 teria that are designed to identify individuals with a  
17 need for planning services due to a serious or life  
18 threatening illness or risk of decline in cognitive  
19 function over time.

20           “(4) For purposes of this subsection, the term ‘appli-  
21 cable provider’ means a hospice program (as defined in  
22 section 1861(dd)(2)) or other provider of services (as de-  
23 fined in section 1861(u)) or supplier (as defined in section  
24 1861(d)) that—

1           “(A) furnishes planning services through an  
2 interdisciplinary team; and

3           “(B) meets such other requirements the Sec-  
4 retary may determine to be appropriate.

5           “(5)(A) For purposes of this subsection, the term  
6 ‘interdisciplinary team’ means a group that—

7           “(i) includes the personnel described in sub-  
8 section (dd)(2)(B)(i);

9           “(ii) may include a chaplain, minister, or per-  
10 sonal religious or spiritual advisor;

11           “(iii) may include other direct care personnel;  
12 and

13           “(iv) meets requirements that may be estab-  
14 lished by the Secretary.

15           “(B) An applicable provider furnishing planning serv-  
16 ices to a planning services eligible individual shall offer  
17 to the individual (or the individual’s legally authorized rep-  
18 resentative when the individual has been found to lack  
19 decisional capacity) the opportunity to select either a  
20 chaplain affiliated with the provider, a minister, or per-  
21 sonal religious or spiritual advisor who can help to rep-  
22 resent the individual’s goals, values, and preferences to  
23 serve as a core team member at the individual’s (or legally  
24 authorized representative’s) request.

1       “(C) The requirements established by the Secretary  
2 under subparagraph (A)(ii) shall include a requirement  
3 that interdisciplinary team members (except for the cho-  
4 sen chaplain, minister, or personal religious or spiritual  
5 advisor) have training and experience in delivering person-  
6 directed planning services and in team-based delivery of  
7 services for individuals with dementing illness and individ-  
8 uals with a serious or life threatening illness.”.

9           (3) PAYMENT UNDER PHYSICIAN FEE SCHED-  
10 ULE.—Section 1848(j)(3) of the Social Security Act  
11 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting  
12 “(2)(GG),” after “(2)(FF) (including administration  
13 of the health risk assessment),”.

14           (4) FREQUENCY LIMITATION.—Section 1862(a)  
15 of the Social Security Act (42 U.S.C. 1395y(a)) is  
16 amended—

17           (A) in paragraph (1)—

18           (i) in subparagraph (O), by striking  
19 “and” at the end;

20           (ii) in subparagraph (P) by striking  
21 the semicolon at the end and inserting “,  
22 and”; and

23           (iii) by adding at the end the fol-  
24 lowing new subparagraph:

1           “(Q) in the case of planning services (as  
2           defined in section 1861(iii)(1)), which are fur-  
3           nished more frequently than is covered under  
4           subparagraph (B) of such section;” and

5           (B) in paragraph (7), by striking “or (P)”  
6           and inserting “(P), or (Q)”.

7           (5) EFFECTIVE DATE.—The amendments made  
8           by this subsection shall apply to services furnished  
9           on or after January 1, 2017.

10          (b) ADVANCED ILLNESS CARE COORDINATION SERV-  
11       ICES PROJECT.—Section 1115A(b)(2) of title XI of the  
12       Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

13           (1) in subparagraph (A), by adding at the end  
14           the following new sentence: “The models selected  
15           under this subparagraph shall include the model de-  
16           scribed in subparagraph (D) and such model shall be  
17           implemented by not later than December 31,  
18           2017.”; and

19           (2) by adding at the end the following new sub-  
20           paragraph:

21                   “(D) ADVANCED ILLNESS CARE COORDINA-  
22                   TION SERVICES MODEL.—

23                           “(i) MODEL.—

24                                   “(I) IN GENERAL.—The model  
25                                   described in this subparagraph is a

1 model under which payments are  
2 made to applicable providers that fur-  
3 nish advanced illness care coordina-  
4 tion services to eligible individuals.

5 “(II) REQUIREMENT.—At least  
6 one applicable provider selected for  
7 participation under the model shall be  
8 a hospice program (as defined in sec-  
9 tion 1861(dd)(2)).

10 “(ii) APPLICABLE PROVIDER.—In this  
11 subparagraph, the term ‘applicable pro-  
12 vider’ has the meaning given such term in  
13 section 1861(iii)(4).

14 “(iii) ADVANCED ILLNESS CARE CO-  
15 ORDINATION SERVICES.—In this subpara-  
16 graph, the term ‘advanced illness care co-  
17 ordination services’ means the following  
18 services:

19 “(I) Planning services (as defined  
20 in section 1861(iii)).

21 “(II) A multi-dimensional assess-  
22 ment of the individual’s strengths and  
23 limitations.

1           “(III) An assessment of the indi-  
2           vidual’s formal and informal supports,  
3           including family caregivers.

4           “(IV) Comprehensive medication  
5           review and management (including, if  
6           appropriate, counseling and self-man-  
7           agement support).

8           “(V) In-home supportive services  
9           for the eligible individual and family  
10          caregivers consistent with the care  
11          plan.

12          “(VI) 24-hour access to emer-  
13          gency support in person or via tele-  
14          phone or telemedicine with the indi-  
15          vidual’s medical record and care plan  
16          available to the responder.

17          “(VII) Coordination across  
18          health care and social service systems,  
19          including involvement of the inter-  
20          disciplinary team to evaluate quality  
21          and address concerns over time.

22          “(VIII) Such other services as  
23          specified by the Secretary.

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

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

9                   “(II) has the need for assistance  
10                  with two or more activities of daily  
11                  living (defined as bathing, dressing,  
12                  eating, getting out of bed or a chair,  
13                  mobility, and toileting) that is not as-  
14                  sociated with an acute or post-opera-  
15                  tive condition that is caused by one or  
16                  more serious or life threatening condi-  
17                  tions or frailty.”.

18 **SEC. 4. QUALITY MEASUREMENT DEVELOPMENT.**

19                  (a) IN GENERAL.—Section 931(c)(2) of the Public  
20                  Health Service Act (42 U.S.C. 299b–31(c)(2)) is amend-  
21                  ed—

22                         (1) by redesignating subparagraphs (I) and (J)  
23                         as subparagraphs (L) and (M), respectively; and

24                         (2) by inserting after subparagraph (H) the fol-  
25                         lowing new subparagraphs:

1           “(I) the process of eliciting and docu-  
2           menting patient (and, where relevant and ap-  
3           propriate, family caregiver) goals, preferences,  
4           and values from the patient or from a legally  
5           authorized representative, including the articu-  
6           lation of goals that accurately reflect how the  
7           patient wants to live;

8           “(J) the effectiveness, patient-centeredness  
9           (and, where relevant, family caregiver-  
10          centeredness), and accuracy of care plans, in-  
11          cluding documentation of individual goals, pref-  
12          erences, and values;

13          “(K) agreement and consistency among—

14                 “(i) the patient’s goals, values, and  
15                 preferences;

16                 “(ii) any documented care plan;

17                 “(iii) the treatment delivered; and

18                 “(iv) outcomes of treatment;”.

19          (b) AUTHORIZATION OF APPROPRIATIONS.—There  
20          are authorized to be appropriated to the Secretary of  
21          Health and Human Services to carry out the amendments  
22          made by this section, \$5,000,000 for fiscal year 2016.  
23          Amounts appropriated under the preceding sentence shall  
24          remain available until expended.



1 **SEC. 5. INCLUSION OF ADVANCE CARE PLANNING MATE-**  
2 **RIALS IN THE MEDICARE & YOU HANDBOOK.**

3 (a) IN GENERAL.—Section 1804(a) of the Social Se-  
4 curity Act (42 U.S.C. 1395b–2(a)) is amended—

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

7 (2) in paragraph (3), by striking the period at  
8 the end and inserting a semicolon; and

9 (3) by inserting after paragraph (3) the fol-  
10 lowing new paragraphs:

11 “(4) information on—

12 “(A) care planning;

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

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

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

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to notices distributed on or after  
3 January 1, 2017.

4 **SEC. 6. IMPROVEMENT OF POLICIES RELATED TO THE USE**  
5 **AND PORTABILITY OF ADVANCE DIRECTIVES.**

6 (a) MEDICARE.—

7 (1) IN GENERAL.—Section 1866(f) of the Social  
8 Security Act (42 U.S.C. 1395cc(f)) is amended—

9 (A) in paragraph (1)—

10 (i) in subparagraph (A)(i)—

11 (I) by inserting “relevant” after  
12 “rights under”; and

13 (II) by striking “of the State”;

14 (ii) by striking subparagraph (B);

15 (iii) by redesignating subparagraphs  
16 (C), (D), and (E) as subparagraphs (G),  
17 (H), and (I), respectively;

18 (iv) by inserting after subparagraph  
19 (A) the following new subparagraphs:

20 “(B) to request and document in a prominent  
21 part of the individual’s current medical record the  
22 content of (or a copy of) an advance directive or  
23 portable treatment order;

1           “(C) to provide each individual with resources  
2           to assist them in understanding the information pro-  
3           vided to them pursuant to subparagraph (A);

4           “(D) in the case of an individual with decisional  
5           capacity under State law, to follow the individual’s  
6           current treatment instructions, as expressed in writ-  
7           ing or through verbal or non-verbal communications;

8           “(E) in the case of an individual who lacks  
9           decisional capacity—

10           “(i) to follow treatment decisions in ac-  
11           cordance with current advance directives and  
12           portable treatment orders that are valid under  
13           State law where the care is delivered and the  
14           instructions provided by legally authorized rep-  
15           resentatives in accordance with State law; and

16           “(ii) in the absence of a current advance  
17           directive or portable treatment order that is  
18           valid under State law where the care is deliv-  
19           ered or instructions provided by a legally au-  
20           thorized representative in accordance with State  
21           law, to deliver treatment based on credible evi-  
22           dence of the individual’s treatment preferences,  
23           goals, and values, which evidence may include a  
24           current advance directive or portable treatment  
25           order executed in another State;

1           “(F) that specify conditions or circumstances  
2           under which an advance directive, portable treat-  
3           ment order, or treatment directions from an indi-  
4           vidual or legally authorized representative would not  
5           be followed;”;

6                       (v) in subparagraph (H), as redesign-  
7                       nated by subparagraph (C), by striking  
8                       “State law” and all that follows through  
9                       “respecting” and inserting “this section  
10                      and relevant State and Federal law re-  
11                      specting”;

12                     (vi) in subparagraph (I), as redesign-  
13                     nated by subparagraph (C), by inserting  
14                     “and portable treatment orders” before the  
15                     period at the end;

16                     (vii) in the flush matter at the end, by  
17                     striking “(C)” and inserting “(G)”;

18                     (viii) by adding at the end the fol-  
19                     lowing new sentence: “Nothing in subpara-  
20                     graph (D) or (E) shall be construed to  
21                     apply to a request or directive ordering a  
22                     sterilization or abortion or ordering with-  
23                     drawal of treatment from a pregnant  
24                     woman if continued treatment can reason-

1 ably be expected to bring her child to live  
2 birth.”;

3 (B) by redesignating paragraphs (3) and  
4 (4) as paragraphs (4) and (5), respectively;

5 (C) by inserting after paragraph (2) the  
6 following new paragraph:

7 “(3) Nothing in this section shall be construed to pro-  
8 hibit the application of a State law which allows for an  
9 objection on the basis of conscience for any health care  
10 provider or any agent of such provider which as a matter  
11 of conscience cannot implement an advance directive or  
12 portable treatment order.”;

13 (D) in paragraph (4), as redesignated by  
14 paragraph (2)—

15 (i) by striking “a written” and insert-  
16 ing “an”;

17 (ii) by striking “State law” and in-  
18 serting “State or Federal law”; and

19 (iii) by striking “of the State”;

20 (E) by redesignating paragraph (5), as re-  
21 designated by paragraph (2), as paragraph (6);

22 (F) by inserting after paragraph (4) the  
23 following new paragraph:

24 “(5) In this subsection, the term ‘portable treatment  
25 order’ means a treatment order designed to document a

1 clinical process that includes shared, informed medical de-  
2 cisionmaking, that reflects the individual’s goals of care  
3 and values, and that is designed to apply across care set-  
4 tings, including the home.”; and

5 (G) by inserting after paragraph (6), as re-  
6 designated by paragraph (6), the following new  
7 paragraph:

8 “(7) Nothing in this subsection shall permit the Sec-  
9 retary to seek civil penalties, including exclusion from par-  
10 ticipation in the program under this title or the program  
11 under title XIX, against a provider or organization if the  
12 provider or organization—

13 “(A) used reasonable efforts to deliver care that  
14 is consistent with an individual’s goals, preferences,  
15 and values when addressing decisionmaking for an  
16 individual who lacks decisional capacity; or

17 “(B) exercised its right of conscience in accord-  
18 ance with paragraph (3).”.

19 (2) EFFECTIVE DATE.—The amendments made  
20 by paragraph (1) shall apply to provider agreements  
21 and contracts entered into, renewed, or extended  
22 under title XVIII of the Social Security Act on or  
23 after such date as the Secretary of Health and  
24 Human Services specifies, but in no case may such

1 date be later than 1 year after the date of the enact-  
2 ment of this Act.

3 (3) RULE OF CONSTRUCTION.—Nothing in the  
4 provisions of, or the amendments made by, this sub-  
5 section shall be construed to require a provider of  
6 services or an organization to act in a manner con-  
7 trary to its religious or moral convictions.

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

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

20 **SEC. 7. ADDITIONAL REQUIREMENTS FOR FACILITIES.**

21 (a) REQUIREMENTS.—

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

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

3 (B) in subparagraph (W), as added by sec-  
4 tion 3005(1)(C) of the Patient Protection and  
5 Affordable Care Act (Public Law 111–148), by  
6 redesignating such subparagraph as subpara-  
7 graph (X), moving such subparagraph to follow  
8 subparagraph (V), moving such subparagraph 2  
9 ems to the left, and striking the period at the  
10 end and inserting a comma;

11 (C) in subparagraph (W), as added by sec-  
12 tion 6406(b)(3) of the Patient Protection and  
13 Affordable Care Act (Public Law 111–148), by  
14 redesignating such subparagraph as subpara-  
15 graph (Y), moving such subparagraph to follow  
16 subparagraph (X), as added by subparagraph  
17 (B), moving such subparagraph 2 ems to the  
18 left, and striking the period at the end and in-  
19 serting “, and”; and

20 (D) by inserting after subparagraph (Y)  
21 the following new subparagraph:

22 “(Z) in the case of hospitals, skilled nursing fa-  
23 cilities, home health agencies, and hospice programs,  
24 to assure that documented care plans include any  
25 advance directives or portable treatment orders



1       made while the individual received care by the pro-  
2       vider and that such plan is sent to the individual’s  
3       primary care provider upon discharge and any facil-  
4       ity to which the individual is transferred.”.

5               (2) EFFECTIVE DATE.—The amendments made  
6       by this subsection shall apply to agreements entered  
7       into or renewed on or after January 1, 2017.

8       (b) HHS STUDY AND REPORT.—

9               (1) STUDY.—The Secretary of Health and  
10       Human Services shall conduct a study on the extent  
11       to which hospitals, skilled nursing facilities, hospice  
12       programs, home health agencies, and applicable pro-  
13       viders of planning services under section 1861(iii) of  
14       the Social Security Act, as added by section 3(a),  
15       work with individuals to—

16                       (A) engage in a care planning process;

17                       (B) thoroughly and completely document  
18       the care planning process in the medical record;

19                       (C) complete documents necessary to sup-  
20       port the treatment and care plan, such as port-  
21       able treatment orders and advance directives;

22                       (D) provide services and support that is  
23       free from discrimination based on advanced  
24       age, disability status, or advanced illness; and

1 (E) provide documentation necessary to  
2 carry out the treatment plan to—

3 (i) subsequent providers or facilities;

4 and

5 (ii) the individual, their legally au-  
6 thorized representatives, and, where appro-  
7 priate and relevant, their family caregiver.

8 (2) REPORT.—Not later than January 1, 2020,  
9 the Secretary of Health and Human Services shall  
10 submit to Congress a report on the study conducted  
11 under paragraph (1) together with recommendations  
12 for such legislation and administrative action as the  
13 Secretary determines to be appropriate.

14 **SEC. 8. GRANTS FOR INCREASING PUBLIC AWARENESS OF**  
15 **ADVANCE CARE PLANNING AND ADVANCED**  
16 **ILLNESS CARE.**

17 (a) MATERIAL AND RESOURCES DEVELOPMENT.—

18 (1) IN GENERAL.—The Secretary of Health and  
19 Human Services (in this section referred to as the  
20 “Secretary”) is authorized to award grants to enti-  
21 ties described in subsection (d) to develop online  
22 training modules, decision support tools, and in-  
23 structional materials for individuals, family care-  
24 givers, and health care providers that include—

1 (A) for healthy individuals, the importance  
2 of—

3 (i) identifying an individual who will  
4 make treatment decisions in the event of  
5 future cognitive incapacity;

6 (ii) discussing values and goals rel-  
7 evant to catastrophic injury or illness; and

8 (iii) completing an advance directive  
9 that—

10 (I) appoints a surrogate; and

11 (II) documents goals and values  
12 and other information that should be  
13 considered in making treatment deci-  
14 sions;

15 (B) for individuals with advanced illness,  
16 the importance of—

17 (i) articulating goals of care;

18 (ii) understanding prognosis and typ-  
19 ical disease trajectory;

20 (iii) evaluating treatment options in  
21 light of goals of care;

22 (iv) developing a treatment plan; and

23 (v) documenting the treatment plan  
24 on advance directives, portable treatment  
25 orders, and other documentation forms

1           used in the locality where the plan is to be  
2           executed;

3           (C) the role and effective use of State and  
4           other advance directive forms and portable  
5           treatment orders; and

6           (D) the range of services for individuals  
7           facing advanced illness, including planning serv-  
8           ices, palliative care, and hospice care.

9           (2) PERIOD.—Any grant awarded under para-  
10          graph (1) shall be for a period of 3 years.

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

13           (1) IN GENERAL.—The Secretary is authorized  
14          to award grants to entities described in subsection  
15          (d) to establish and maintain a website and tele-  
16          phone hotline to disseminate resources developed  
17          under subsection (a) and materials designed by the  
18          Department of Health and Human Services Center  
19          for Faith-Based and Neighborhood Partnerships for  
20          faith communities.

21           (2) PERIOD.—Any grant awarded under para-  
22          graph (1) shall be for a period of 5 years.

23           (3) ABILITY TO SUSTAIN ACTIVITIES.—The  
24          Secretary shall take into account the ability of an  
25          entity to sustain the activities described in para-

1 graph (1) beyond the 5-year grant period in deter-  
2 mining whether to award a grant under paragraph  
3 (1) to the entity.

4 (c) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

5 (1) IN GENERAL.—The Secretary is authorized  
6 to award grants to entities described in subsection  
7 (d) to conduct a national public education campaign  
8 to raise public awareness of advance care planning  
9 and advanced illness care, including the availability  
10 of the resources created under subsections (a) and  
11 (b).

12 (2) PERIOD.—Any grant awarded under para-  
13 graph (1) shall be for a period of 5 years.

14 (d) ELIGIBLE ENTITIES.—Entities described in this  
15 subsection are public or private entities (including States  
16 or political subdivisions of a State, faith-based organiza-  
17 tions, and religious educational institutions), or a consor-  
18 tium of any such entities.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—

20 (1) IN GENERAL.—There are authorized to be  
21 appropriated to the Secretary—

22 (A) for purposes of making grants under  
23 subsection (a), \$5,000,000 for fiscal year 2017,  
24 to remain available until expended;

1 (B) for purposes of making grants under  
2 subsection (b), \$5,000,000 for fiscal year 2017,  
3 to remain available until expended; and

4 (C) for purposes of making grants under  
5 subsection (c), \$5,000,000 for fiscal year 2017  
6 to remain available until expended.

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

9 (A) develop a model advance directive;

10 (B) develop or employ a dollars-per-quality  
11 adjusted life year (or similar measure that dis-  
12 counts the value of a life because of an individ-  
13 ual's disability); or

14 (C) make a grant to a private entity that  
15 advocates, promotes, or facilitates any item or  
16 procedure for which funding is unavailable  
17 under the Assisted Suicide Funding Restriction  
18 Act of 1997 (Public Law 105–12).

19 **SEC. 9. RULE OF CONSTRUCTION.**

20 Nothing in the provisions of, or the amendments  
21 made by, this Act shall be construed to limit the restric-  
22 tions of, or to authorize the use of Federal funds for any  
23 service, material, or activity pertaining to an item or serv-  
24 ice or procedure for which funds are unavailable under,

- 1 the Assisted Suicide Funding Restriction Act of 1997
- 2 (Public Law 105–12).

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