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

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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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Removing Barriers to Person- and Family-Centered Care Act of 2019''.

SEC. 2. COOPERATIVE AGREEMENTS TO IMPROVE CARE FOR INDIVIDUALS WITH ADVANCED ILLNESSES.

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

(1) in the last sentence of subparagraph (A) of subsection (b)(2), by inserting ", and the model described in subsection (h)" before the period at the end; and

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

"(h) COOPERATIVE AGREEMENTS TO IMPROVE CARE FOR INDIVIDUALS WITH ADVANCED ILLNESSES.—

"(1) IN GENERAL.—The Secretary shall, acting through the Centers for Medicare & Medicaid Services, award up to 15 cooperative agreements to eligible entities with the goals of—

"(A) addressing gaps in community capacity to provide high-quality, person- and family-centered care;

"(B) improving the integration and coordination of clinical and nonclinical services;

"(C) expanding access to a comprehensive care planning process and services; and

"(D) developing and implementing alternative payment models that provide accountability for health care costs and quality outcomes.

"(2) ELIGIBLE ENTITY.—In this subsection, the term 'eligible entity' means the following:

''(A) A State Medicaid agency.

''(B) A State, local, or tribal health agency.

''(C) An accountable care organization under section 1899 or an accountable care organization model tested under title XVIII or with respect to such title under this section.

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

''(E) A quality improvement organization, such as a Quality Innovation Network–Quality Improvement Organization with a contract pursuant to part B of this title.

''(3) APPLICATION.—

''(A) IN GENERAL.—Eligible entities seeking a cooperative agreement under this subsection shall submit to the Secretary an application, at such time, and in such manner as the Secretary may require. An application must include—

''(i) a list of participating practitioners, providers of services, community-based organizations, and other individuals and entities;

"(ii) a description of the target population or populations and geographic service area;

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

"(iv) a description of the intended care delivery model and how the model supports high-quality, person- and family-centered care;

"(v) a plan for—

"(I) working with community-based organizations, including faith-based organizations and aging and disability organizations;

"(II) improving community-based supports for family caregivers; and

"(III) increasing the number of individuals within the target population or populations who—

"(aa) have communicated their wishes regarding medical treatment using State or locally

recognized forms, such as advance directives or portable medical orders;

''(bb) have comprehensive care plans that are concrete and actionable; and

''(cc) have access to community-based palliative care services; and

''(vi) other information as determined appropriate by the Secretary.

''(4) AWARD AMOUNTS.—

''(A) IN GENERAL.—The Secretary may award up to $5,000,000 under each cooperative agreement under this subsection.

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

''(i) To develop and implement a care delivery model as described in paragraph (5)(B)(i) and an alternative payment model as described in paragraph (5)(B)(ii).

''(ii) To conduct education and training for health care professionals, beneficiaries 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.

"(B) PRE-IMPLEMENTATION PERIOD.—During the first 2 years of a cooperative agreement, an awardee shall work with the Secretary to—

"(i) develop a care delivery model using one or more of the waivers and expanded services described in paragraphs (7) and (8);

"(ii) develop an alternative payment model; and

"(iii) identify a set of quality measures that will be reported on annually by participants in such model.

"(C) MODEL IMPLEMENTATION.—Beginning with the third year of a cooperative agreement, an awardee—

"(i) shall implement the care delivery model developed under subparagraph (B)(i) and the alternative payment model developed under subparagraph (B)(ii);

"(ii) shall annually report data on quality measures identified under subparagraph (B)(iii) to the Secretary; and

"(iii) may, in accordance with paragraphs (7) and (8), receive waivers and

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

''(6) NOTIFICATION.—The Secretary shall provide guidance on notification and continuity-of-care plan requirements in the event a participating provider leaves a model pursuant to a cooperative agreement under this subsection.

''(7) WAIVER OF CERTAIN REQUIREMENTS.—In addition to any waivers pursuant to subsection (d)(1), the Secretary shall include the following waivers of requirements and, where applicable, permit Medicare Advantage organizations flexibility to waive such requirements, with respect to coverage of, and payment for, items and services furnished to individuals pursuant to a cooperative agreement under this subsection:

''(A) COVERAGE OF SERVICES RELATED TO AN INDIVIDUAL'S TERMINAL ILLNESS.—A waiver of the requirement described in section 1812(d)(2)(A) that an individual electing to receive hospice care shall be deemed to have waived all rights to have payment made under

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

''(B) ALTERNATIVES IN FURNISHING OF HOME CARE.—With respect to home health services furnished to an individual by a home health agency, a waiver of the requirements described in sections 1814(a)(2) and 1835(a)(2)(A), that—

''(i) a physician makes the certification (and recertification, where such services are provided over a period of time) as described in such sections;

''(ii) a plan for furnishing such services to such individual is established and periodically reviewed by a physician;

''(iii) such services are or were furnished while the individual was under the care of a physician; and

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

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

cation and recertification, establishes and periodically reviews such plan, has the individual under their care when such services are or were furnished, and documents such face-to-face encounter.

''(C) ALTERNATIVE CERTIFICATION FOR HOSPICE CARE.—A waiver of the requirements described in subparagraphs (A) and (B) of section 1814(a)(7) that an individual's attending physician and the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the individual's hospice care certify that the individual is terminally ill and periodically review the written plan for hospice care, provided that such certification and review is conducted by a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)) in accordance with State law.

''(D) COVERAGE OF SKILLED NURSING SERVICES WITHOUT INPATIENT STAY.—With respect to extended care services furnished to an individual by a skilled nursing facility, a 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

of this subsection, if an assessment meeting such requirements as the Secretary determines appropriate has been made that the home of an individual who is certified for hospice care and has elected to receive hospice care is unsafe or unsuitable for the provision of such care, such individual may receive such care in an inpatient setting, including a hospice program that meets the conditions of participation specified in section 418.110 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this subparagraph), or a skilled nursing facility that meets the standards specified in subsections (b) and (e) of such section, for the duration an individual has elected to receive hospice care. The assessment described in the preceding sentence may be conducted by the individual's attending physician, a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)), or the medical director (or physician member of the interdisciplinary 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

that respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be provided consecutively over longer than 5 days.

''(9) DEFINITIONS.—In this subsection:

''(A) LEAD ORGANIZATION.—The term 'Lead Organization' means a covered entity for purposes of compliance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) that will convene community partners to coordinate, manage, and expand services for the target population or populations and be accountable for costs and quality outcomes under the cooperative agreement.

''(B) COOPERATIVE AGREEMENT.—The term 'cooperative agreement' means an agreement between the Secretary and an eligible entity under this subsection.

''(C) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

"(D) PRACTITIONER.—The term 'practitioner' has the meaning given such term in section 1842(b)(18)(C).

"(E) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

"(F) TARGET POPULATION.—The term 'target population' means individuals who—

"(i) are enrolled for benefits under parts A and B of title XVIII, enrolled in a Medicare Advantage plan under part C of such title, enrolled under a State Medicaid plan, or dually eligible for benefits under titles XVIII and XIX;

"(ii) have one or more advanced chronic conditions, as determined by the Secretary, such as late-stage cancer, congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease, geriatric frailty, Alzheimer's disease, or other forms of progressive dementia; and

"(iii) have demonstrated—

"(I) evidence of recent and progressive cognitive impairment; or

''(II) a functional limitation requiring the assistance of another person (such as an inability to perform two or more activities of daily living).''.

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

(1) by striking ''Out of amounts appropriated'' and inserting ''(A) Out of amounts appropriated''; and

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

''(B) Out of the amount appropriated under subparagraph (C) of paragraph (1), $75,000,000 shall be made available for the purpose of awarding funds under subsection (h)(4), which shall remain available for such purpose until expended.''.

SEC. 3. IDENTIFICATION AND DEVELOPMENT OF QUALITY MEASURES RELATING TO ADVANCED ILLNESS CARE.

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

''(h) ADVANCED ILLNESS CARE QUALITY MEASURES.—

''(1) IN GENERAL.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Agency for Healthcare Research and Quality, the Administrator of the Administration for Community Living, and the entity with a contract under section 1890(a), shall establish a core set of evidence-based quality measures relating to advanced illness care. Such quality measures may include outcome, structural, and process measures in the following domains:

''(A) Person and family experience of care.

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

''(C) Alignment of care with an individual's preferences, goals, and values.

''(D) Screening and treatment for physical symptoms, such as dyspnea, nausea, and constipation.

''(E) Utilization of health care and support services.

''(F) Shared decision making and informed consent.

''(2) PROCESS FOR IDENTIFYING AND DEVELOPING QUALITY MEASURES.—In identifying and developing the quality measures for the core set described in paragraph (1), the Secretary shall take the following actions:

''(A) IDENTIFY EXISTING MEASURES.—Identify existing quality measures relating to advanced illness care that are in use under public and privately sponsored health care arrangements.

''(B) DEVELOPMENT OF MEASURES.—Enter into grants, contracts, or intergovernmental agreements with eligible entities for the purposes of developing quality measures (which may include improving existing quality measures) relating to advanced illness care that, to the extent practicable, allow for the use of health information technologies in collecting data relating to such quality measures.

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

''(3) PUBLICATION AND UPDATES.—

"(A) PUBLICATION.—Not later than January 1, 2022, the Secretary shall publish a core set of quality measures for advanced illness care.

"(B) UPDATES.—Beginning January 1, 2024 (and every 2 years thereafter), the Secretary, in coordination with the entity with a contract under section 1890(a), shall solicit stakeholder feedback and publish an updated set of quality measures, prioritizing measures that address gap areas related to advanced illness care.

"(4) FUNDING.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection.".

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