

118TH CONGRESS
1ST SESSION

S. 1845

To amend title XI of the Social Security Act to provide for the testing
of a community-based palliative care model.

IN THE SENATE OF THE UNITED STATES

JUNE 7, 2023

Ms. ROSEN (for herself, Mr. BARRASSO, Ms. BALDWIN, and Mrs. FISCHER)
introduced the following bill; which was read twice and referred to the
Committee on Finance

A BILL

To amend title XI of the Social Security Act to provide
for the testing of a community-based palliative care model.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Expanding Access to
5 Palliative Care Act”.

6 **SEC. 2. COMMUNITY-BASED PALLIATIVE CARE MODEL.**

7 Section 1115A of the Social Security Act (42 U.S.C.
8 1315a) is amended—

9 (1) in subsection (b)(2)(A), by adding at the
10 end the following new sentence: “The models se-

1 lected under this subparagraph shall include the
 2 testing of the model described in subsection (h).”;
 3 and

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

6 “(h) COMMUNITY-BASED PALLIATIVE CARE
 7 MODEL.—

8 “(1) IN GENERAL.—The CMI shall develop and
 9 implement a model to provide community-based pal-
 10 liative care and care coordination for high-risk bene-
 11 ficiaries, in co-management with other providers of
 12 services and suppliers, aimed at improving outcomes
 13 and experience of care and reducing unnecessary or
 14 unwanted emergency department visits and hos-
 15 pitalizations (in this subsection referred to as the
 16 ‘model’), and that is intended to replace the Medi-
 17 care Care Choices Model.

18 “(2) DURATION.—The model shall be imple-
 19 mented for a 5-year period, beginning not later than
 20 one year after the date of the enactment of this sub-
 21 section.

22 “(3) TARGET POPULATION.—

23 “(A) IN GENERAL.—The target population
 24 for the model is an individual—

1 “(i) entitled to, or enrolled for, bene-
2 fits under part A of title XVIII; and

3 “(ii) with a diagnosis of a serious ill-
4 ness or injury, which may include a diag-
5 nosis of cancer, heart and vascular disease,
6 pulmonary disease, human immuno-
7 deficiency virus/acquired immunodeficiency,
8 Alzheimer’s and dementia, stroke, serious
9 injury requiring rehabilitation including
10 burns, kidney disease, liver disease,
11 Amyotrophic lateral sclerosis, any neuro
12 degenerative disease, or any other serious
13 illness or injury the Secretary determines
14 appropriate.

15 “(B) NO EXCLUSION FOR PRIOR USE OF
16 HOSPICE CARE BENEFITS.—An individual shall
17 not be excluded from participation in the model
18 based on prior use of hospice care benefits dur-
19 ing any period prior to such participation, re-
20 gardless of the source of coverage for such ben-
21 efits.

22 “(4) PARTICIPATING PROVIDERS.—Providers el-
23 igible to participate under the model may include
24 palliative care teams working as an independent
25 practice or associated with a hospice program, home

1 health agencies, hospitals, integrated health systems,
2 and other facilities determined appropriate by the
3 Secretary.

4 “(5) TEAM-BASED APPROACH.—Under the
5 model, at least one member of the multi-disciplinary
6 palliative care team shall be certified in hospice and
7 palliative care. This is a co-management model with
8 palliative care aligning with primary and specialist
9 care for a team-based approach. Care must be co-
10 ordinated across providers and community services
11 for inclusion of all pain, symptom management, dis-
12 ease-modifying and curative treatments, and other
13 palliative care services.

14 “(6) LOCATION.—Care may be furnished under
15 the model in any beneficiary ‘home’, including a
16 caregiver’s residence, an extended care facility, or a
17 community setting as appropriate based on the indi-
18 vidual’s ability to access services. The model shall
19 include access within an in-patient stay so long as
20 the patient begins receiving palliative care services
21 prior to admission. Services shall not be disrupted
22 solely due to change in location from a residence to
23 an in-patient setting, and shall be part of care co-
24 ordination and care planning following hospital dis-
25 charge.

1 “(7) SERVICES.—The model shall include items
2 and services based on specific patient needs with re-
3 spect to pain, symptom management, education, dis-
4 ease modifying treatments, advance care planning
5 and shared decision making, goals clarification, men-
6 tal health services, family and caregiver support
7 services, spiritual support care, personal care assist-
8 ance, and stress reduction therapies. This includes a
9 comprehensive assessment of symptoms and stress
10 factors that impact quality of life.

11 “(8) ACCESS.—Care shall be available under
12 the model 24 hours a day, 7 days a week, and 365
13 days a year, including telehealth services. The CMI
14 shall specifically consider the needs of rural and un-
15 derserved areas and adjust accordingly to ensure eq-
16 uitable access to care. A broad range of providers
17 must be included with no geographic limitations.

18 “(9) METRICS.—The CMI shall assess the
19 model by comparing participants to other members
20 of the target population who are receiving care out-
21 side of the model, including with respect to the fol-
22 lowing:

23 “(A) Demographics (including age, diag-
24 nosis, residence type, medical encounters in pre-
25 ceding 12 months leading to enrollment, geo-

1 graphic location (such as urban or rural) and
2 others as determined by the CMI).

3 “(B) Impact on utilization of items and
4 services under title XVIII (such as emergency
5 department services, hospital observation serv-
6 ices, inpatient admissions, and intensive care
7 unit (ICU) stays).

8 “(C) Election of hospice care.

9 “(D) Duration of hospice care.

10 “(E) Care Experience (beneficiary and
11 caregiver).”.

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