113TH CONGRESS
1ST SESSION

# S. 1439

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

AUGUST 1, 2013

Mr. WARNER (for himself and Mr. ISAKSON) 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.

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Care Planning Act of 2013''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) The population of the United States is estimated to age rapidly, with the number of people over the age of 65 set to double to more than 72,000,000, or 1 in 5 Americans, over the next two decades.

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

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

(4) The progression of advanced illness leads to the need for increasingly intensive decision support,

health care services, and support from family caregivers.

(5) The complexity of care needed by individuals with advanced illness may result in uncoordinated care, adverse health outcomes, frustration, wasted time, and undue emotional burdens on individuals and their family caregivers.

(6) Numerous private sector leaders, including hospitals, health systems, home health agencies, hospice programs, long-term care providers, employers, and other entities, have put in place innovative solutions to provide more comprehensive and coordinated care for Americans living with advanced illness.

(7) Hospice programs, as one of the longest standing Medicare care coordination benefits that offer a comprehensive set of services via an interdisciplinary team working to provide person- and family-centered care to the frailest and most vulnerable individuals in our communities, can serve as a model for advanced illness care delivery.

(8) Palliative care programs that serve patients beginning at diagnosis with advanced illness and provide care designed to reduce the symptom burden of illness can serve as a model for interdisciplinary

team care planning based on the individual's goals of care.

(9) The Government of the United States, as the Nation's largest purchaser of health care services, must learn from these innovators and encourage health care providers to furnish more supportive and comprehensive advanced illness care to improve the efficacy and quality of health care delivered for generations of Americans to come.

(10) Health care providers who serve individuals with advanced illness face complicated care systems and legal concerns that may result in over- or under-treatment of individuals with advanced illness.

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

(12) Too often, individuals with 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.

(13) Providing quality services and planning support to individuals with advanced illness will protect and preserve their dignity.

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

(a) MEDICARE COVERAGE OF PLANNING SERVICES.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by inserting ''and'' at the end; and

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

''(GG) planning services (as defined in subsection (iii));''.

(2) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Planning Services

''(iii)(1)(A) The term 'planning services' means a voluntary decisionmaking process that includes the elements described in paragraph (2) and is furnished to a planning services eligible individual by an applicable provider through an interdisciplinary team.

''(B) Planning services may only be furnished to a planning services eligible individual under this title once in each 12-month period.

''(2)(A) The elements described in this paragraph are the following:

''(i) One or more face-to-face encounters between one or more members of the interdisciplinary team and the individual and, at the individual's discretion, family caregivers, or, for an individual who lacks decisionmaking capacity under State law, the individual's legally authorized representative.

''(ii) The provision of information about the typical trajectory of illnesses or conditions that affect the individual, including foreseeable care decisions that may need to be made at a future time when the individual is likely to be unable to make decisions due to temporary or permanent cognitive incapacity.

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

''(iv) Providing the individual with (and discussing) information about the benefits and burdens of a relevant range of treatment options available to the individual, including disease modifying or potentially curative treatment, palliative care, which may be provided alone or in conjunction with disease modifying treatment, and, when the individual may be currently eligible or may become eligible for hospice care due to disease progression, hospice care. An applicable provider shall present and discuss relevant treatment options that may help the individual to achieve goals of care and may not exclude options based on an individual's age, disability status, or the presence of advanced illness unless, in the provider's clinical judgment, a treatment option will not achieve the outcome sought by the individual.

''(v) Assisting the individual in evaluating treatment options and approaches to care to identify those that most closely align with the individual's goals of care, values, and preferences.

''(vi) Preparing, and sharing with relevant providers, documentation—

''(I) that states the individual's goals of care, preferences, and values, preferred decisionmaking strategies, and a plan of care that is concrete, achievable, and actionable; and

''(II) that is in a paper or electronic format, on State or locally recognized forms that are used for the purpose of assuring that providers can follow the plan across care settings, such as advance directives or portable treatment orders.

''(vii) Referrals to providers, including medical and social service providers, who deliver care consistent with the plan.

''(viii) Providing culturally and educationally appropriate training for the individual and family caregivers to support their ability to carry out the plan.

''(B) Even when the individual's decisional capacity is impaired and another person or entity, such as an appointed agent, proxy, or surrogate, is exercising legal authority under State law governing decisionmaking on behalf of incapacitated individuals, the interdisciplinary team shall make a reasonable attempt to include the individual in the planning process.

''(3) For purposes of this subsection, the term 'planning services eligible individual' means an individual that meets at least one of the following criteria:

''(A) The individual is diagnosed with metastatic or locally advanced cancer.

''(B) The individual is diagnosed with Alzheimer's disease or another progressive dementia.

''(C) The individual is diagnosed with late-stage neuromuscular disease.

''(D) The individual is diagnosed with late-stage diabetes.

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

''(F) The individual needs assistance with two or more activities of daily living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) that are caused by one or more progressive illnesses.

''(G) The individual meets other criteria determined appropriate by the Secretary, including criteria that are designed to identify individuals with a need for planning services due to advancing illness or risk of decline in cognitive function over time.

"(4) For purposes of this subsection, the term 'applicable provider' means a hospice program (as defined in section 1861(dd)(2)) or other provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)) that—

"(A) furnishes planning services through an interdisciplinary team; and

"(B) meets such other requirements the Secretary may determine to be appropriate.

"(5)(A) For purposes of this subsection, the term 'interdisciplinary team' means a group that—

"(i) includes—

"(I) a core team of a physician or an advance practice registered nurse, a social worker, a nurse; and, subject to subparagraph (B), a chaplain, a minister, or the individual's personal religious or spiritual advisor; and

"(II) when necessary to meet an individual's planning needs, other professionals, which may include a pharmacist, a licensed clinical social worker, and a psychologist, either as ongoing team members or who may be brought in as needed to address the individual's planning needs; and

''(ii) meets requirements that may be established by the Secretary.

''(B) An applicable provider furnishing planning services to a planning services eligible individual shall offer to the individual (or the individual's legally authorized representative when the individual has been found to lack decisional capacity) the opportunity to select either a chaplain affiliated with the provider, a minister, or personal religious or spiritual advisor who can help to represent the individual's goals, values, and preferences to serve as a core team member at the individual's (or legally authorized representative's) request.

''(C) The requirements established by the Secretary under subparagraph (A)(ii) shall include a requirement that interdisciplinary team members (except for the individuals's chosen minister or personal religious or spiritual advisor) have training and experience in delivering person-directed planning services and in team-based delivery of services for individuals with dementing illness and individuals with advanced illness.''.

(3) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(GG),'' after ''(2)(FF) (including administration of the health risk assessment),''.

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

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

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

''(Q) in the case of planning services (as defined in section 1861(iii)(1)), which are furnished more frequently than is covered under subparagraph (B) of such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2015.

(b) MEDICAID COVERAGE OF PLANNING SERVICES.—

(1) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(A) by redesignating paragraph (29) as paragraph (30);

(B) in paragraph (28), by striking at the end ''and''; and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) planning services (as defined in section 1861(iii)); and''.

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (28)'' and inserting '', (28), and (29)''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by paragraphs (1) and (2) take effect on January 1, 2015.

(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraphs (1) and (2), the State plan shall

not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

(c) ADVANCED ILLNESS CARE COORDINATION SERVICES PROJECT.—Section 1115A(b)(2) of title XI of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(1) in subparagraph (A), by adding at the end the following new sentence: ''The models selected under this subparagraph shall include the model described in subparagraph (D) and such model shall be implemented by not later than December 31, 2015.''; and

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

''(D) ADVANCED ILLNESS CARE COORDINATION SERVICES MODEL.—

''(i) MODEL.—

"(I) IN GENERAL.—The model described in this subparagraph is a model under which payments are made to applicable providers that furnish advanced illness care coordination services to eligible individuals.

"(II) REQUIREMENT.—At least one applicable provider selected for participation under the model shall be a hospice program (as defined in section 1861(dd)(2)).

"(ii) APPLICABLE PROVIDER.—In this subparagraph, the term 'applicable provider' means a hospice program (as defined in section 1861(dd)(2)) or other provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)) that—

"(I) furnishes advanced illness care coordination services through an interdisciplinary team (as defined in section 1861(iii)(5)); and

"(II) meets such other requirements the Secretary may determine to be appropriate.

"(iii) ADVANCED ILLNESS CARE COORDINATION SERVICES.—In this subparagraph, the term 'advanced illness care coordination services' means the following services:

"(I) Planning services (as defined in section 1861(iii)).

"(II) A multi-dimensional assessment of the individual's strengths and limitations.

"(III) An assessment of the individual's formal and informal supports, including family caregivers.

"(IV) Comprehensive medication review and management (including, if appropriate, counseling and self-management support).

"(V) In-home supportive services for the eligible individual and family caregivers consistent with the care plan.

"(VI) 24-hour access to emergency support in person or via telephone or telemedicine with the indi-

vidual's medical record and care plan available to the responder.

''(VII) Coordination across health care and social service systems, including involvement of the interdisciplinary team to evaluate quality and address concerns.

''(VIII) Such other services as specified by the Secretary.

''(iv) ELIGIBLE INDIVIDUAL.—In this subparagraph, the term 'eligible individual' means an individual who—

''(I) is entitled to, or enrolled for, benefits under part A of title XVIII and enrolled under part B of such title, but not enrolled under part C of such title; and

''(II) has the need for assistance with two or more activities of daily living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) that are caused by one or more progressive conditions.''.

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

(a) IN GENERAL.—Section 931(c)(2) of the Public Health Service Act (42 U.S.C. 299b–31(c)(2)) is amended—

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

(2) by inserting after subparagraph (H) the following new subparagraphs:

"(I) the process of eliciting and documenting patient (and, where relevant and appropriate, family caregiver) goals, preferences, and values from the patient or from a legally authorized representative, including the articulation of goals that accurately reflect how the patient wants to live;

"(J) the effectiveness, patient-centeredness (and, where relevant, family caregiver-centeredness), and accuracy of care plans, including documentation of individual goals, preferences, and values;

"(K) agreement and consistency among—

"(i) the patient's goals, values, and preferences;

"(ii) any documented care plan;

"(iii) the treatment delivered; and

"(iv) outcomes of treatment;".

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out the amendments made by this section, $5,000,000 for fiscal year 2014. Amounts appropriated under the preceding sentence shall remain available until expended.

**SEC. 5. INCLUSION OF ADVANCE CARE PLANNING MATERIALS IN THE MEDICARE & YOU HANDBOOK.**

(a) IN GENERAL.—Section 1804(a) of the Social Security Act (42 U.S.C. 1395b–2(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

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

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

''(4) information on—

''(A) care planning;

''(B) how individual goals, values, and preferences should be considered in framing a care plan; and

''(C) a range of approaches for treating advanced illness, including disease modifying options, palliative care that supports individuals from the onset of advanced illness and can be

provided at the same time as all other care types, and hospice care; and

''(5) information on documentation options for care planning or advance care planning, including advance directives and portable treatment orders.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to notices distributed on or after January 1, 2015.

**SEC. 6. CARE PLANNING ADVISORY BOARD.**

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish the Care Planning Advisory Board (in this section referred to as the ''Advisory Board'').

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Advisory Board shall be composed of 15 members, to be appointed not later than 30 days after the date of the enactment of this Act, as follows:

(A) The President of the United States shall appoint 3 members.

(B) The majority leader of the Senate shall appoint 3 members.

(C) The minority leader of the Senate shall appoint 3 members.

(D) The Speaker of the House of Representatives shall appoint 3 members.

(E) The minority leader of the House of Representatives shall appoint 3 members.

(2) REPRESENTATION.—The membership of the Advisory Board shall include individuals who (with a preference for individuals who also are members of the group they are appointed to represent)—

(A) represent the interests of—

(i) patient advocacy groups;

(ii) older adults;

(iii) individuals with cognitive or functional limitations;

(iv) family caregivers for individuals described in clause (ii) or (iii);

(v) palliative care and hospice providers;

(vi) researchers;

(vii) ethicists;

(viii) faith communities;

(ix) health care providers; and

(x) health care facilities;

(B) have demonstrated experience in dealing with issues related to health care decision-making and health care policy; and

(C) represent the health care interests and needs of a variety of geographic areas and demographic groups.

(c) DUTIES.—The Advisory Board shall advise the Secretary on issues related to care planning, advanced illness coordination services, advance care planning, and documentation options, including how to—

(1) assure that individuals with advanced illness receive person- and family-centered care;

(2) assist individuals with advanced illness to develop a treatment plan that is formed around their goals, values, and preferences, that is informed by research on disease trajectory, and that includes a documented plan that is realistic, actionable, and concrete, and that may include the use of advance directives, portable treatment orders (where appropriate), or other forms used in the State or locality;

(3) develop and monitor a demonstration program that includes an optimal service array to support individuals with advanced illness with services designed to manage symptoms as illness progresses;

(4) provide health care that is consistent with individuals' current treatment preferences or, for those whose capacity to make decisions is impaired, with the individuals' values and goals, and specific

directions documented in advance directives and portable treatment orders;

(5) encourage provider participation in educational and training activities addressing care planning, advanced illness care, and advance care planning;

(6) develop quality measures, including process, outcome, and experience measures, that applicable providers should report for planning services (as defined in section 1861(iii) of the Social Security Act, as added by section 3);

(7) determine the appropriate role for discharge planners in educating individuals and their families about care planning services, advance care planning, palliative care, hospice, advance directives, portable treatment orders, and other relevant services, supports, planning tools, and documentation options;

(8) develop and promote best practices in communications about advanced illness between providers, individuals, and family caregivers in different settings, including acute care hospitals;

(9) evaluate the feasibility of replacing life expectancy in months with clinical criteria to determine eligibility for hospice care; and

(10) promote effective advance care planning and effective and appropriate use of portable treatment orders.

(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Advisory Board.

(e) PAY AND REIMBURSEMENT.—

(1) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in paragraph (2), a member of the Advisory Board may not receive pay, allowances, or benefits by reason of their service on the Board.

(2) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(f) REPORT.—Not later than 3 years after the establishment of the Advisory Board, the Advisory Board shall submit to Congress a final report containing the findings and conclusions of the Advisory Board, together with recommendations for such legislation and administrative actions as the Advisory Board considers appropriate.

(g) TERMINATION.—The Advisory Board shall terminate 30 days after submitting the report under subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

**SEC. 7. IMPROVEMENT OF POLICIES RELATED TO THE USE AND PORTABILITY OF ADVANCE DIRECTIVES.**

(a) MEDICARE.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)(i), by striking ''State law'' and all that follows through ''medical care'' and inserting ''relevant State and Federal law (whether statutory or as recognized by the courts) to make decisions concerning medical care'';

(B) by striking subparagraph (B);

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

(D) by inserting after subparagraph (A) the following new subparagraphs:

''(B) to document in a prominent part of the individual's current medical record whether or not the individual has an advance directive or portable treatment order, to request a copy of the advance directive or portable treatment order, as applicable,

and if received, to include the copy (or the content of the document or documents) in a prominent part of such record;

''(C) to provide each individual with the opportunity to discuss the information provided pursuant to subparagraph (A) with an appropriately trained employee or volunteer of the provider or organization;

''(D) for an individual with decisional capacity under State law, to follow the individual's current treatment instructions, as expressed in writing or through verbal or nonverbal communications;

''(E) for an individual who lacks decisional capacity—

''(i) to ensure that treatment decisions are made in accordance with current preferences, values, and goals of the individual, when possible to ascertain and follow, and in accordance with current advance directives and portable treatment orders that are valid under State law where the care is delivered, and instructions provided by legally authorized representatives in accordance with State and Federal law;

''(ii) in the absence of a current advance directive or portable treatment order that is

valid under State law where the care is delivered, to deliver treatment based on credible evidence of the individual's treatment preferences, goals, and values, such as a current advance directive or portable treatment order executed in another State or past statements about treatment preferences; and

''(iii) to reconcile actual or suspected discrepancies among advance directives, portable treatment orders, and other evidence in accordance with State law, and, where State law is silent, to reconcile discrepancies in the manner most likely to deliver treatment that is consistent with the individual's treatment preferences, goals, and values;

''(F) that specify narrow, but potentially recurring, conditions or circumstances under which an advance directive, portable treatment order, or treatment directions from an individual or legally authorized representative would not be followed, such as—

''(i) where the validity or authenticity of a document is in question;

''(ii) where there is evidence that an individual's preferences changed after the individual

documented preferences in an advance directive or portable treatment order;

''(iii) where the treatment sought by the individual is not medically indicated; and

''(iv) because of conscience objections in accordance with paragraph (3);'';

(E) in subparagraph (H), as redesignated by subparagraph (C), by striking ''State law'' and all that follows through ''respecting'' and inserting ''this section and relevant State and Federal law (whether statutory or as recognized by the courts) respecting'';

(F) in subparagraph (I), as redesignated by subparagraph (C), by inserting ''and portable treatment orders'' before the period at the end;

(G) in the flush matter at the end, by striking ''(C)'' and inserting ''(G)''; and

(H) by adding at the end the following new sentence: ''Nothing in subparagraph (D) or (E) shall be construed to apply to sterilization or abortion.'';

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

(3) by inserting after paragraph (2) the following new paragraph:

''(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.'';

(4) in paragraph (4), as redesignated by paragraph (2)—

(A) by striking ''written'';

(B) by striking ''State law'' and inserting ''State or Federal law''; and

(C) by striking ''of the State'';

(5) by redesignating paragraph (5), as redesignated by paragraph (2), as paragraph (6);

(6) by inserting after paragraph (4) the following new paragraph:

''(5) In this subsection, the term 'portable treatment order' means a treatment order designed to document a clinical process that includes shared, informed medical decisionmaking, that reflects the individual's goals of care and values, and that is designed to apply across care settings, including the home.''; and

(7) by inserting after paragraph (6), as redesignated by paragraph (6), the following new paragraph:

''(7) Nothing in this subsection shall permit the Secretary to seek civil penalties, including exclusion from participation in the program under this title or the program under title XIX, against an individual or entity if the individual or entity—

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

''(B) declined to furnish care in accordance with paragraph (3).''.

(b) MEDICAID.—Section 1902(w) of the Social Security Act (42 U.S.C. 1396a(w)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)(i), by striking ''State law'' and all that follows through ''medical care'' and inserting ''relevant State and Federal law (whether statutory or as recognized by the courts) to make decisions concerning medical care'';

(B) by striking subparagraph (B);

(C) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (F), (G), and (H), respectively;

(D) by inserting after subparagraph (A) the following new subparagraphs:

''(B) to document in a prominent part of the individual's current medical record whether or not the individual has an advance directive or portable treatment order, to request a copy of the advance directive and or portable treatment order, and if received, to include the copy (or the content of the document or documents) in a prominent part of such record;

''(C) to provide each individual with the opportunity to discuss the information provided pursuant to subparagraph (A) with an appropriately trained personnel of the provider or organization;

''(D) for an individual with decisional capacity under State law, to follow the individual's current treatment instructions, as expressed in writing or through verbal or non-verbal communications;

''(E) for an individual who lacks decisional capacity—

''(i) to ensure that treatment decisions are made in accordance with State law addressing

legally authorized representatives and advance directives;

''(ii) in the absence of a current advance directive or portable treatment order, to deliver treatment based on credible evidence of the individual's treatment preferences, goals, and values, such as an advance directive or portable treatment order executed in another State or past statements about treatment preferences; and

''(iii) to reconcile actual or suspected discrepancies among advance directives, portable treatment orders, and other evidence in accordance with State law, and, where State law is silent, to reconcile discrepancies in the manner most likely to deliver treatment that is consistent with the individual's treatment preferences, goals, and values;

''(F) that specify narrow, but potentially recurring, conditions or circumstances under which an advance directive, portable treatment order, or treatment directions from an individual or legally authorized representative would not be followed, such as—

''(i) where the validity or authenticity of a document is in question;

''(ii) where there is evidence that an individual's preferences changed after the individual documented preferences in an advance directive or portable treatment order;

''(iii) where the treatment sought by the individual is not medically indicated; and

''(iv) because of conscience objections in accordance with paragraph (3);'';

(E) in subparagraph (H), as redesignated by subparagraph (C), by striking ''State law'' and all that follows through ''respecting'' and inserting ''this section and relevant State and Federal law (whether statutory or as recognized by the courts) respecting'';

(F) in subparagraph (I), as redesignated by subparagraph (C), by inserting ''and portable treatment orders'' before the period at the end;

(G) in the flush matter at the end, by striking ''(C)'' and inserting ''(G)''; and

(H) by adding at the end the following new sentence: ''Nothing in subparagraph (D) or (E) shall be construed to apply to sterilization or abortion.''; and

(2) in paragraph (4)—

(A) by striking ''written'';

(B) by striking ''State law'' and inserting ''State or Federal law''; and

(C) by striking ''of the State'';

(3) by redesignating paragraph (5) as paragraph (6);

(4) by inserting after paragraph (4) the following new paragraph:

''(5) In this subsection, the term 'portable treatment order' means a treatment order designed to document a clinical process that includes shared, informed medical decisionmaking, that reflects the individual's goals of care and values, and that is designed to apply across care settings, including the home.''; and

(5) by inserting after paragraph (6), as redesignated by paragraph (3), the following new paragraph:

''(7) Nothing in this subsection shall permit the Secretary to seek civil penalties, including exclusion from participation in the program under this title or the program under title XVIII, against an individual or entity if the individual or entity—

''(A) used reasonable efforts to deliver care that is consistent with an individual's goals, preferences,

and values when addressing decisionmaking for an individual who lacks decisional capacity; or

''(B) declined to furnish care in accordance with paragraph (3).''.

(c) CLARIFICATION WITH RESPECT TO ADVANCE DIRECTIVES.—Section 7 of the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14406) is amended—

(1) in paragraph (1), by striking ''or'' at the end; and

(2) by striking paragraph (2) and inserting the following:

''(2) to require any provider or organization, or any employee of such a provider or organization, to follow or be bound by a request from an individual or legally authorized representative, an advance directive, or a portable treatment order that directs the purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing; or

''(3) to allow discrimination against or imposition of penalties on any provider or organization, or any employee of such a provider or organization, that refuses, for any reason, including an objection based on a religious, conscience, or moral objection, to inform, counsel, or in any way participate in the

purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsections (a) and (b) shall apply to provider agreements and contracts entered into, renewed, or extended under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and to State plans under title XIX of such Act (42 U.S.C. 1396 et seq.), on or after such date as the Secretary of Health and Human Services specifies, but in no case may such date be later than 1 year after the date of the enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the

first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

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

(a) REQUIREMENTS.—

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

(A) in subparagraph (V), by striking ''and'' at the end;

(B) in subparagraph (W), as added by section 3005(1)(C) of the Patient Protection and Affordable Care Act (Public Law 111–148), by redesignating such subparagraph as subparagraph (X), moving such subparagraph to follow subparagraph (V), moving such subparagraph 2 ems to the left, and striking the period at the end and inserting a comma;

(C) in subparagraph (W), as added by section 6406(b)(3) of the Patient Protection and Affordable Care Act (Public Law 111–148), by

redesignating such subparagraph as subparagraph (Y), moving such subparagraph to follow subparagraph (X), as added by subparagraph (B), moving such subparagraph 2 ems to the left, and striking the period at the end and inserting ", and"; and

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

"(Z) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to assure that appropriate documentation of care plans made while the individual received care by or through the provider (which may include advance directives, portable orders, or other locally appropriate documents) be completed prior to discharge to allow the plan to be carried out after discharge.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to agreements entered into or renewed on or after January 1, 2015.

(b) HHS STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the extent to which hospitals, skilled nursing facilities, hospice programs, home health agencies, and applicable providers of planning services under section 1861(iii) of

the Social Security Act, as added by section 3(a), work with individuals to—

(A) engage in a care planning process;

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

(C) complete documents necessary to support the treatment and care plan, such as portable treatment orders and advance directives;

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

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

(i) subsequent providers or facilities; and

(ii) the individual, their legally authorized representatives, and, where appropriate and relevant, their family caregiver.

(2) REPORT.—Not later than January 1, 2018, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

**SEC. 9. GRANTS FOR INCREASING PUBLIC AWARENESS OF ADVANCE CARE PLANNING AND ADVANCED ILLNESS CARE.**

(a) MATERIAL AND RESOURCES DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') is authorized to award grants to entities described in subsection (d) to develop online training modules, decision support tools, and instructional materials for individuals, family caregivers, and health care providers that include—

(A) for healthy individuals, the importance of—

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

(ii) discussing values and goals relevant to catastrophic injury or illness; and

(iii) completing an advance directive that—

(I) appoints a surrogate; and

(II) documents goals and values and other information that should be considered in making treatment decisions;

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

(i) articulating goals of care;

(ii) understanding prognosis and typical disease trajectory;

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

(iv) developing a treatment plan; and

(v) documenting the treatment plan on advance directives, portable treatment orders, and other documentation forms used in the locality where the plan is to be executed;

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

(D) the range of services for individuals facing advanced illness, including planning services, palliative care, and hospice care.

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 3 years.

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

(1) IN GENERAL.—The Secretary is authorized to award grants to entities described in subsection

(d) to establish and maintain a website and telephone hotline to disseminate resources developed under subsection (a) and materials designed by the Department of Health and Human Services Center for Faith-Based and Neighborhood Partnerships for faith communities.

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 5 years.

(3) ABILITY TO SUSTAIN ACTIVITIES.—The Secretary shall take into account the ability of an entity to sustain the activities described in paragraph (1) beyond the 5-year grant period in determining whether to award a grant under paragraph (1) to the entity.

(c) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

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

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 5 years.

(d) ELIGIBLE ENTITIES.—Entities described in this subsection are public or private entities (including States or political subdivisions of a State, faith-based organizations, and religious educational institutions), or a consortium of any such entities.

(e) AUTHORIZATION OF APPROPRIATIONS.—

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

(A) for purposes of making grants under subsection (a), $5,000,000 for fiscal year 2015, to remain available until expended;

(B) for purposes of making grants under subsection (b), $5,000,000 for fiscal year 2015, to remain available until expended; and

(C) for purposes of making grants under subsection (c), $5,000,000 for fiscal year 2015 to remain available until expended.

(2) LIMITATION.—None of the funds appropriated under paragraph (1) shall be used to—

(A) develop a model advance directive;

(B) develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability); or

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

**SEC. 10. HHS STUDY AND REPORT ON THE STORAGE OF ADVANCE DIRECTIVES.**

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on State and regional activities with respect to storing completed advance directives and portable treatment orders. Such study shall include an analysis of the practicality and feasibility of establishing a national registry for completed advance directives and portable treatment orders, taking into consideration the constraints created by the privacy provisions enacted as a result of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) REPORT.—Not later than January 1, 2017, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

**SEC. 11. GAO STUDY AND REPORT ON THE PROVISIONS OF, AND AMENDMENTS MADE BY, THIS ACT.**

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the provisions of, and amendments made by, this Act, including the quality (such as individual and family experience, individual understanding of treatment choices, and alignment among individual goals, values, and preferences, the documented care plan, treatment delivered, and treatment outcomes) associated with such provisions and such amendments.

(b) REPORT.—Not later than January 1, 2018, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

**SEC. 12. CONSULTATION WITH THE CARE PLANNING ADVISORY BOARD.**

The Secretary of Health and Human Services shall consult with the Care Planning Advisory Board established under section 6 in order to ensure that every activity carried out under the provisions of, and amendments made by, this Act will help individuals to—

(1) receive education and care that is free from discrimination based on advanced age, disability status, or presence of advanced illness;

(2) develop plans and receive care that is consistent with each individual's goals, values and preferences; and

(3) receive an explanation of a range of perspectives on approaches for treating advanced illness, including disease modifying options, palliative care that supports individuals from the onset of advanced illness and can be provided at the same time as all other care types, and hospice care.

**SEC. 13. RULE OF CONSTRUCTION.**

Nothing in the provisions of, or the amendments made by, this Act shall be construed to limit the restrictions of, or to authorize the use of Federal funds for any service, material, or activity pertaining to an item or service or procedure for which funds are unavailable under, the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12).

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