113TH CONGRESS
2D SESSION

S. 3009

To improve end-of-life care.

IN THE SENATE OF THE UNITED STATES

DECEMBER 12, 2014

Mr. BLUMENTHAL (for himself and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To improve end-of-life care.

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 ''Advance Planning and Compassionate Care Act of 2014''.

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

SEC. 2. DEFINITIONS.

In this Act:

(1) ADVANCE CARE PLANNING.—The term ''advance care planning'' means the process of—

(A) determining an individual's priorities, values and goals for care in the future when the individual is no longer able to express his or her wishes;

(B) engaging family members, health care proxies, and health care providers in an ongoing dialogue about—

(i) the individual's wishes for care;

(ii) what the future may hold for people with serious illnesses or injuries;

(iii) how individuals, their health care proxies, and family members want their beliefs and preferences to guide care decisions; and

(iv) the steps that individuals and family members can take regarding, and the resources available to help with, finances, family matters, spiritual questions, and other issues that impact seriously ill or dying patients and their families; and

(C) executing and updating advance directives and appointing a health care proxy.

(2) ADVANCE DIRECTIVE.—The term ''advance directive'' means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.

(3) CHIP.—The term ''CHIP'' means the program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) END-OF-LIFE-CARE.—The term ''end-of-life care'' means all aspects of care of a patient with a potentially fatal condition, and includes care that is focused on specific preparations for an impending death.

(5) HEALTH CARE POWER OF ATTORNEY.—The term ''health care power of attorney'' means a legal document that identifies a health care proxy or decisionmaker for a patient who has the authority to act on the patient's behalf when the patient is unable to communicate his or her wishes for medical care on matters that the patient specifies when he or she is competent. Such term includes a durable power of attorney that relates to medical care.

(6) LIVING WILL.—The term ''living will'' means a legal document—

(A) used to specify the type of medical care (including any type of medical treatment, including life-sustaining procedures if that person becomes permanently unconscious or is otherwise dying) that an individual wants provided or withheld in the event the individual cannot

speak for himself or herself and cannot express his or her wishes; and

(B) that requires a physician to honor the provisions of upon receipt or to transfer the care of the individual covered by the document to another physician that will honor such provisions.

(7) MEDICAID.—The term ''Medicaid'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(8) MEDICARE.—The term ''Medicare'' means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(9) ORDERS FOR LIFE-SUSTAINING TREATMENT.—The term ''orders for life-sustaining treatment'' means a process for focusing a patients' values, goals, and preferences on current medical circumstances and to translate such into visible and portable medical orders applicable across care settings, including home, long-term care, emergency medical services, and hospitals.

(10) PALLIATIVE CARE.—The term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological,

social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

TITLE I—ADVANCE CARE PLANNING

Subtitle A—Consumer and Provider Education

PART I—CONSUMER EDUCATION

Subpart A—National Initiatives

SEC. 101. ADVANCE CARE PLANNING TELEPHONE HOTLINE.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and operate directly, or by grant, contract, or interagency agreement, a 24-hour toll-free telephone hotline to provide consumer information regarding advance care planning, including—

(1) an explanation of advanced care planning and its importance;

(2) issues to be considered when developing an individual's advance care plan;

(3) how to establish an advance directive;

(4) procedures to help ensure that an individual's directives for end-of-life care are followed;

(5) Federal and State-specific resources for assistance with advance care planning; and

(6) hospice and palliative care (including their respective purposes and services).

(b) ESTABLISHMENT.—In carrying out the requirements under subsection (a), the Director of the Centers for Disease Control and Prevention may designate an existing 24-hour toll-free telephone hotline or, if no such service is available or appropriate, establish a new 24-hour toll-free telephone hotline.

SEC. 102. ADVANCE CARE PLANNING INFORMATION CLEARINGHOUSES.

(a) EXPANSION OF NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) DEVELOPMENT.—Not later than January 1, 2015, the Secretary shall develop an online clearinghouse to provide comprehensive information regarding advance care planning.

(2) MAINTENANCE.—The advance care planning clearinghouse, which shall be clearly identifiable and available on the homepage of the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website, shall be

maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The advance care planning clearinghouse shall include—

(A) any relevant content contained in the national public education campaign required under section 104;

(B) content addressing—

(i) an explanation of advanced care planning and its importance;

(ii) issues to be considered when developing an individual's advance care plan;

(iii) how to establish an advance directive;

(iv) procedures to help ensure that an individual's directives for end-of-life care are followed; and

(v) hospice and palliative care (including their respective purposes and services);

(C) available Federal and State-specific resources for assistance with advance care planning, including—

(i) contact information for any State public health departments that are responsible for issues regarding end-of-life care;

(ii) contact information for relevant legal service organizations, including those funded under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(iii) advance directive forms for each State; and

(D) any additional information, as determined by the Secretary.

(b) ESTABLISHMENT OF PEDIATRIC ADVANCE CARE PLANNING CLEARINGHOUSE.—

(1) DEVELOPMENT.—Not later than January 1, 2016, the Secretary, in consultation with the Assistant Secretary for Children and Families of the Department of Health and Human Services, shall develop an online clearinghouse to provide comprehensive information regarding pediatric advance care planning.

(2) MAINTENANCE.—The pediatric advance care planning clearinghouse, which shall be clearly identifiable on the homepage of the Administration for Children and Families website, shall be maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The pediatric advance care planning clearinghouse shall provide advance care

planning information specific to children with life-threatening illnesses or injuries and their families.

SEC. 103. ADVANCE CARE PLANNING TOOLKIT.

(a) DEVELOPMENT.—Not later than July 1, 2015, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop an online advance care planning toolkit.

(b) MAINTENANCE.—The advance care planning toolkit, which shall be available in English, Spanish, and any other languages that the Secretary deems appropriate, shall be maintained and publicized by the Secretary on an ongoing basis and made available on the websites of the following agencies:

(1) The Centers for Disease Control and Prevention.

(2) The Department of Health and Human Service's National Clearinghouse for Long-Term Care Information.

(3) The Administration for Children and Families.

(c) CONTENT.—The advance care planning toolkit shall include content addressing—

(1) common issues and questions regarding advance care planning, including individuals and resources to contact for further inquiries;

(2) advance directives and their uses, including living wills and durable powers of attorney;

(3) the roles and responsibilities of a health care proxy;

(4) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(A) the advance care planning toll-free telephone hotline established under section 101;

(B) the advance care planning clearinghouses established under section 102;

(C) the advance care planning toolkit established under this section;

(D) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(E) website links or addresses for State-specific advance directive forms; and

(5) any additional information, as determined by the Secretary.

SEC. 104. NATIONAL PUBLIC EDUCATION CAMPAIGN.

(a) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, directly or through grants, contracts, or interagency agreements, develop and implement a national campaign to inform the public of the importance of advance care planning and of an individual's right to direct and participate in their health care decisions.

(2) CONTENT OF EDUCATIONAL CAMPAIGN.—The national public education campaign established under paragraph (1) shall—

(A) employ the use of various media, including regularly televised public service announcements;

(B) provide culturally and linguistically appropriate information;

(C) be conducted continuously over a period of not less than 5 years;

(D) identify and promote the advance care planning information available on the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website and Administration for Children and Families website, as well as any other relevant

Federal or State-specific advance care planning resources;

(E) raise public awareness of the consequences that may result if an individual is no longer able to express or communicate their health care decisions;

(F) address the importance of individuals speaking to family members, health care proxies, and health care providers as part of an ongoing dialogue regarding their health care choices;

(G) address the need for individuals to obtain readily available legal documents that express their health care decisions through advance directives (including living wills, comfort care orders, and durable powers of attorney for health care);

(H) raise public awareness regarding the availability of hospice and palliative care; and

(I) encourage individuals to speak with their physicians about their options and intentions for end-of-life care.

(3) EVALUATION.—

(A) IN GENERAL.—Not later than July 1, 2018, the Secretary, acting through the Direc-

tor of the Centers for Disease Control and Prevention, shall conduct a nationwide survey to evaluate whether the national campaign conducted under this subsection has achieved its goal of changing public awareness, attitudes, and behaviors regarding advance care planning.

(B) BASELINE SURVEY.—In order to evaluate the effectiveness of the national campaign, the Secretary shall conduct a baseline survey prior to implementation of the campaign.

(C) REPORTING REQUIREMENT.—Not later than December 31, 2018, the Secretary shall report the findings of such survey, as well as any recommendations that the Secretary determines appropriate regarding the need for continuation or legislative or administrative changes to facilitate changing public awareness, attitudes, and behaviors regarding advance care planning, to the appropriate committees of the Congress.

(b) REPEAL.—Section 4751(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note; Public Law 101–508) is repealed.

SEC. 105. UPDATE OF MEDICARE AND SOCIAL SECURITY HANDBOOKS.

(a) MEDICARE & YOU HANDBOOK.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall update the online version of the ''Plan Ahead for Long-Term Care'' section of the Medicare & You Handbook to include—

(A) an explanation of advance care planning and advance directives, including—

(i) living wills;

(ii) health care proxies; and

(iii) after-death directives;

(B) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(i) the advance care planning toll-free telephone hotline established under section 101;

(ii) the advance care planning clearinghouses established under section 102;

(iii) the advance care planning toolkit established under section 103;

(iv) available State legal service organizations to assist individuals with advance care planning, including those organiza-

tions that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(v) website links or addresses for State-specific advance directive forms; and

(C) any additional information, as determined by the Secretary.

(2) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in paragraph (1) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

(b) SOCIAL SECURITY HANDBOOK.—The Commissioner of Social Security shall—

(1) not later than 60 days after the date of enactment of this Act, update the online version of the Social Security Handbook for beneficiaries to include the information described in subsection (a)(1); and

(2) include such information in all paper and online versions of such handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

SEC. 106. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated for the period of fiscal years 2015 through 2019—

(1) $195,000,000 to the Secretary to carry out sections 101, 102, 103, 104 and 105(a); and

(2) $5,000,000 to the Commissioner of Social Security to carry out section 105(b).

Subpart B—State and Local Initiatives

SEC. 111. FINANCIAL ASSISTANCE FOR ADVANCE CARE PLANNING.

(a) LEGAL ASSISTANCE FOR ADVANCE CARE PLANNING.—

(1) DEFINITION OF RECIPIENT.—Section 1002(6) of the Legal Services Corporation Act (42 U.S.C. 2996a(6)) is amended by striking ''clause (A) of'' and inserting ''subparagraph (A) or (B) of''.

(2) ADVANCE CARE PLANNING.—Section 1006 of the Legal Services Corporation Act (42 U.S.C. 2996e) is amended—

(A) in subsection (a)(1)—

(i) by striking ''title, and (B) to make'' and inserting the following: ''title;

''(C) to make''; and

(ii) by inserting after subparagraph (A) the following:

''(B) to provide financial assistance, and make grants and contracts, as described in subparagraph (A), on a competitive basis for the purpose of providing legal assistance in the form of advance care planning (as defined in section 3 of the Advance Planning and Compassionate Care Act of 2014, and including providing information about State-specific advance directives, as defined in that section) for eligible clients under this title, including providing such planning to the family members of eligible clients and persons with power of attorney to make health care decisions for the clients; and''; and

(B) in subsection (b), by adding at the end the following:

''(2) Advance care planning provided in accordance with subsection (a)(1)(B) shall not be construed to violate the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).''.

(3) REPORTS.—Section 1008(a) of the Legal Services Corporation Act (42 U.S.C. 2996g(a)) is amended by adding at the end the following: ''The Corporation shall require such a report, on an annual basis, from each grantee, contractor, or other recipient of financial assistance under section 1006(a)(1)(B).''.

(4) AUTHORIZATION OF APPROPRIATIONS.—Section 1010 of the Legal Services Corporation Act (42 U.S.C. 2996i) is amended—

(A) in subsection (a)—

(i) by striking ''(a)'' and inserting ''(a)(1)'';

(ii) in the last sentence, by striking ''Appropriations for that purpose'' and inserting the following:

''(3) Appropriations for a purpose described in paragraph (1) or (2)''; and

(iii) by inserting before paragraph (3) (as designated by clause (ii)) the following:

''(2) There are authorized to be appropriated to carry out section 1006(a)(1)(B), $10,000,000 for each of fiscal years 2015, 2016, 2017, 2018, and 2019.''; and

(B) in subsection (d), by striking ''subsection (a)'' and inserting ''subsection (a)(1)''.

(5) EFFECTIVE DATE.—This subsection and the amendments made by this subsection take effect July 1, 2015.

(b) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to

award grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 to provide advance care planning services to Medicare beneficiaries, personal representatives of such beneficiaries, and the families of such beneficiaries. Such services shall include information regarding State-specific advance directives and ways to discuss individual care wishes with health care providers.

(2) REQUIREMENTS.—

(A) AWARD OF GRANTS.—In making grants under this subsection for a fiscal year, the Secretary shall satisfy the following requirements:

(i) Two-thirds of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted the Uniform Health-Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws and approved and recommended for enactment by all States

at the annual conference of such commissioners in 1993.

(ii) One-third of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted a uniform form for orders regarding life sustaining treatment as defined in section 1861(hhh)(5) of the Social Security Act (as amended by section 211 of this Act) or a comparable approach to advance care planning.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, a State shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the State is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No State shall be paid funds from a grant made under this subsection prior to July 1, 2015.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2015 through 2019 for purposes of awarding grants to States under paragraph (1).

(c) MEDICAID TRANSFORMATION GRANTS FOR ADVANCE CARE PLANNING.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title by making available to individuals enrolled in the State plan or under a waiver of such plan information regarding advance care planning (as defined in section 3 of the Advance Planning and Compassionate Care Act of 2014), including at time of enrollment or renewal of enrollment in the plan or waiver, through providers, and through such other in-

novative means as the State determines appropriate.'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(D) WORK PLAN REQUIRED FOR AWARD OF ADVANCE CARE PLANNING GRANTS.—Payment to a State under this subsection to adopt the innovative methods described in paragraph (2)(G) is conditioned on the State submitting to the Secretary an approved plan for expending the funds awarded to the State under this subsection.''; and

(3) in paragraph (4)—

(A) in subparagraph (A)—

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

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after clause (ii), the following new clause:

''(iii) $20,000,000 for each of fiscal years 2015 through 2019.''; and

(B) by striking subparagraph (B), and inserting the following:

"(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States awarded a grant for fiscal year 2015, 2016, 2017, 2018, or 2019. Such method shall provide that—

"(i) 100 percent of such funds for each of fiscal years 2015 through 2019 shall be awarded to States that design programs to adopt the innovative methods described in paragraph (2)(G); and

"(ii) in no event shall a payment to a State awarded a grant under this subsection for fiscal year 2015 be made prior to July 1, 2015.".

(d) ADVANCE CARE PLANNING COMMUNITY TRAINING GRANTS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)).

(2) REQUIREMENTS.—

(A) USE OF FUNDS.—Funds awarded to an area agency on aging under this subsection

shall be used to provide advance care planning education and training opportunities for local aging service providers and organizations.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, an area agency on aging shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the agency is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No area agency on aging shall be paid funds from a grant made under this subsection prior to July 1, 2015.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2015 through 2019 for purposes of awarding grants to area agencies on aging under paragraph (1).

(e) NONDUPLICATION OF ACTIVITIES.—The Secretary shall establish procedures to ensure that funds made available under grants awarded under this section or pursuant to amendments made by this section supplement, not supplant, existing Federal funding, and that such funds are not used to duplicate activities carried out under such grants or under other Federally funded programs.

SEC. 112. GRANTS FOR PROGRAMS FOR ORDERS REGARDING LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of—

(1) establishing new programs for orders regarding life sustaining treatment in States or localities;

(2) expanding or enhancing an existing program for orders regarding life sustaining treatment in States or localities; or

(3) providing a clearinghouse of information on programs for orders for life sustaining treatment and consultative services for the development or enhancement of such programs.

(b) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(1) developing such a program for the area that includes home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services within the area;

(2) securing consultative services and advice from institutions with experience in developing and managing such programs; and

(3) expanding an existing program for orders regarding life sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families or training of health care professionals.

(c) DISTRIBUTION OF FUNDS.—In funding grants under this section, the Secretary shall ensure that, of the funds appropriated to carry out this section for each fiscal year—

(1) at least two-thirds are used for establishing or developing new programs for orders regarding life sustaining treatment; and

(2) one-third is used for expanding or enhancing existing programs for orders regarding life sustaining treatment.

(d) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' includes—

(A) an academic medical center, a medical school, a State health department, a State medical association, a multi-State taskforce, a hospital, or a health system capable of administering a program for orders regarding life sustaining treatment for a State or locality; or

(B) any other health care agency or entity as the Secretary determines appropriate.

(2) The term ''order regarding life sustaining treatment'' has the meaning given such term in section 1861(hhh)(5) of the Social Security Act, as added by section 211.

(3) The term ''program for orders regarding life sustaining treatment'' means, with respect to an area, a program that supports the active use of orders regarding life sustaining treatment in the area.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2014 through 2019.

PART II—PROVIDER EDUCATION

SEC. 121. PUBLIC PROVIDER ADVANCE CARE PLANNING WEBSITE.

(a) DEVELOPMENT.—Not later than January 1, 2015, the Secretary, acting through the Administrator of

the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall establish a website for providers under Medicare, Medicaid, the Children's Health Insurance Program, the Indian Health Service (include contract providers) and other public health providers on each individual's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(b) MAINTENANCE.—The website, shall be maintained and publicized by the Secretary on an ongoing basis.

(c) CONTENT.—The website shall include content, tools, and resources necessary to do the following:

(1) Inform providers about the advance directive requirements under the health care programs described in subsection (a) and other State and Federal laws and regulations related to advance care planning.

(2) Educate providers about advance care planning quality improvement activities.

(3) Provide assistance to providers to—

(A) integrate advance directives into electronic health records, including oral directives; and

(B) develop and disseminate advance care planning informational materials for their patients.

(4) Inform providers about advance care planning continuing education requirements and opportunities.

(5) Encourage providers to discuss advance care planning with their patients of all ages.

(6) Assist providers' understanding of the continuum of end-of-life care services and supports available to patients, including palliative care and hospice.

(7) Inform providers of best practices for discussing end-of-life care with dying patients and their loved ones.

SEC. 122. CONTINUING EDUCATION FOR PHYSICIANS AND NURSES.

(a) IN GENERAL.—Not later than January 1, 2017, the Secretary, acting through the Director of Health Resources and Services Administration, shall develop, in consultation with health care providers and State boards of medicine and nursing, a curriculum for continuing education that States may adopt for physicians and nurses on advance care planning and end-of-life care.

(b) CONTENT.—

(1) IN GENERAL.—The continuing education curriculum developed under subsection (a) for physicians and nurses shall, at a minimum, include—

(A) a description of the meaning and importance of advance care planning;

(B) a description of advance directives, including living wills and durable powers of attorney, and the use of such directives;

(C) palliative care principles and approaches to care; and

(D) the continuum of end-of-life services and supports, including palliative care and hospice.

(2) ADDITIONAL CONTENT FOR PHYSICIANS.—The continuing education curriculum for physicians developed under subsection (a) shall include instruction on how to conduct advance care planning with patients and their loved ones.

Subtitle B—Portability of Advance Directives; Health Information Technology

SEC. 131. 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 (B), by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

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

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.''; and

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

''(5)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider of services, a Medicare Advantage organization, or a prepaid or eligible organization shall be given the same effect by that provider or organization as an advance directive validly executed under

the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advanced directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(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 (B)—

(i) by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''; and

(ii) by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

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

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.''; and

(2) by adding at the end the following paragraph:

''(6)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider or organization shall

be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advance directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (G) through (O) as subparagraphs (H) through (P), respectively; and

(2) by inserting after subparagraph (F) the following:

"(G) Section 1902(w) (relating to advance directives).".

(d) STUDY AND REPORT REGARDING IMPLEMENTATION.—

(1) STUDY.—The Secretary shall conduct a study regarding the implementation of the amendments made by subsections (a) and (b).

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsections (a), (b), and (c) 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.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), on or after such date as the Secretary specifies, but in no case may such date be later than 1 year after the date of 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 or a State child health plan under title XXI of such Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsections (b) and (c), 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 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. 132. STATE ADVANCE DIRECTIVE REGISTRIES; DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g) is amended by inserting after section 399S the following new sections:

"SEC. 399S–1. STATE ADVANCE DIRECTIVE REGISTRIES.

''(a) STATE ADVANCE DIRECTIVE REGISTRY.—In this section, the term 'State advance directive registry' means a secure, electronic database that—

''(1) is available free of charge to residents of a State; and

''(2) stores advance directive documents and makes such documents accessible to medical service providers in accordance with Federal and State privacy laws.

''(b) GRANT PROGRAM.—Beginning on July 1, 2015, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to eligible entities to establish and operate, directly or indirectly (by competitive grant or competitive contract), State advance directive registries.

''(c) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall—

''(A) be a State department of health; and

''(B) submit to the Director an application at such time, in such manner, and containing—

''(i) a plan for the establishment and operation of a State advance directive registry; and

''(ii) such other information as the Director may require.

''(2) NO REQUIREMENT OF NOTATION MECHANISM.—The Secretary shall not require that an entity establish and operate a driver's license advance directive notation mechanism for State residents under section 399V to be eligible to receive a grant under this section.

''(d) ANNUAL REPORT.—For each year for which an entity receives an award under this section, such entity shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the registry.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2015 and each fiscal year thereafter.

''SEC. 399S–2. DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

''(a) IN GENERAL.—Beginning July 1, 2015, the Secretary, acting through the Director of the Centers for Dis-

ease Control and Prevention, shall award grants on a competitive basis to States to establish and operate a mechanism for a State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

''(1) establish and operate a State advance directive registry under section 399S–1; and

''(2) submit to the Director an application at such time, in such manner, and containing—

''(A) a plan that includes a description of how the State will—

''(i) disseminate information about advance directives at the time of driver's license application or renewal;

''(ii) enable each State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license in a manner consistent with the notice on such a license indicating a driver's intent to be an organ donor; and

''(iii) coordinate with the State department of health to ensure that, if a

State resident has an advance directive notice on his or her driver's license, the existence of such advance directive is included in the State registry established under section 399S–1; and

''(B) any other information as the Director may require.

''(c) ANNUAL REPORT.—For each year for which a State receives an award under this section, such State shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the mechanism.

''(d) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2015 and each fiscal year thereafter.''.

SEC. 133. GAO STUDY AND REPORT ON ESTABLISHMENT OF NATIONAL ADVANCE DIRECTIVE REGISTRY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the feasibility of a national registry for advance directives, 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 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Comptroller General of the United States determines to be appropriate.

Subtitle C—National Uniform Policy on Advance Care Planning

SEC. 141. STUDY AND REPORT BY THE SECRETARY REGARDING THE ESTABLISHMENT AND IMPLEMENTATION OF A NATIONAL UNIFORM POLICY ON ADVANCE DIRECTIVES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary, acting through the Office of the Assistant Secretary for Planning and Evaluation, shall conduct a thorough study of all matters relating to the establishment and implementation of a national uniform policy on advance directives for individuals receiving items and services under titles XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq., or 1397aa et seq.).

(2) MATTERS STUDIED.—The matters studied by the Secretary under paragraph (1) shall include issues concerning—

(A) family satisfaction that a patient's wishes, as stated in the patient's advance directive, were carried out;

(B) the portability of advance directives, including cases involving the transfer of an individual from 1 health care setting to another;

(C) immunity from civil liability and criminal responsibility for health care providers that follow the instructions in an individual's advance directive that was validly executed in, and consistent with the laws of, the State in which it was executed;

(D) conditions under which an advance directive is operative;

(E) revocation of an advance directive by an individual;

(F) the criteria used by States for determining that an individual has a terminal condition;

(G) surrogate decisionmaking regarding end-of-life care;

(H) the provision of adequate palliative care (as defined in paragraph (3)), including pain management;

(I) adequate and timely referrals to hospice care programs; and

(J) the end-of-life care needs of children and their families.

(3) PALLIATIVE CARE.—For purposes of paragraph (2)(H), the term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) CONSULTATION.—In conducting the study and developing the report under this section, the Secretary shall consult with the Uniform Law Commissioners, and other interested parties.

TITLE II—COMPASSIONATE CARE

Subtitle A—Workforce Development

PART I—EDUCATION AND TRAINING

SEC. 201. NATIONAL GERIATRIC AND PALLIATIVE CARE SERVICES CORPS.

Section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended—

(1) by redesignating subsection (j) as subsection (k); and

(2) by inserting after subsection (i), the following:

''(j) NATIONAL GERIATRIC AND PALLIATIVE CARE SERVICES CORPS.—

''(1) ESTABLISHMENT.—Not later than January 1, 2017, the Secretary shall establish within the National Health Service Corps a National Geriatric and Palliative Care Services Corps (referred to in this subsection as the 'Corps') which shall consist of—

''(A) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate;

''(B) such civilian employees of the United States as the Secretary may appoint; and

''(C) such other individuals who are not employees of the United States.

''(2) DUTIES.—The Corps shall be utilized by the Secretary to provide geriatric and palliative care services within health professional shortage areas.

''(3) APPLICATION OF PROVISIONS.—The loan-forgiveness, scholarship, and direct financial incentives programs provided for under this section shall apply to physicians, nurses, and other health professionals (as identified by the Secretary) with respect to the training necessary to enable such individuals to become geriatric or palliative care specialists and provide geriatric and palliative care services in health professional shortage areas.

''(4) REPORT.—Not later than 6 months prior to the date on which the Secretary establishes the Corps under paragraph (1), the Secretary shall submit to Congress a report concerning the organization of the Corps, the application process for membership in the Corps, and the funding necessary for the Corps (targeted by profession and by specialization).''.

SEC. 202. EXEMPTION OF PALLIATIVE MEDICINE FELLOWSHIP TRAINING FROM MEDICARE GRADUATE MEDICAL EDUCATION CAPS.

(a) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)) is amended—

(1) in clause (i), by inserting ''clause (iii) and'' after ''subject to''; and

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

''(iii) INCREASE ALLOWED FOR PALLIATIVE MEDICINE FELLOWSHIP TRAINING.—For cost reporting periods beginning on or after January 1, 2016, in applying clause (i), there shall not be taken into account full-time equivalent residents in the field of allopathic or osteopathic medicine who are in palliative medicine fellowship training that is approved by the Accreditation Council for Graduate Medical Education.''.

(b) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by redesignating the second clause (x), as added by section 5505(b) of the Patient Protection

and Affordable Care Act (Public Law 111–148), as clause (xi) and moving such clause 4 ems to the left, and realigning the left margins of subclauses (II) and (III) of such clause and items (aa), (bb), (cc), and (dd) of subclause (II) of such clause appropriately; and

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

''(xii) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

SEC. 203. MEDICAL SCHOOL CURRICULA.

(a) IN GENERAL.—The Secretary, in consultation with the Association of American Medical Colleges, shall establish guidelines for the imposition by medical schools of a minimum amount of end-of-life training as a requirement for obtaining a Doctor of Medicine degree in the field of allopathic or osteopathic medicine.

(b) TRAINING.—Under the guidelines established under subsection (a), minimum training shall include—

(1) training in how to discuss and help patients and their loved ones with advance care planning;

(2) with respect to students and trainees who will work with children, specialized pediatric training;

(3) training in the continuum of end-of-life services and supports, including palliative care and hospice;

(4) training in how to discuss end-of-life care with dying patients and their loved ones; and

(5) medical and legal issues training.

(c) DISTRIBUTION.—Not later than January 1, 2016, the Secretary shall disseminate the guidelines established under subsection (a) to medical schools.

(d) COMPLIANCE.—Effective beginning not later than July 1, 2017, a medical school that is receiving Federal assistance shall be required to implement the guidelines established under subsection (a). A medical school that the Secretary determines is not implementing such guidelines shall not be eligible for Federal assistance.

Subtitle B—Coverage Under Medicare, Medicaid, and CHIP

PART I—COVERAGE OF ADVANCE CARE PLANNING

SEC. 211. MEDICARE, MEDICAID, AND CHIP COVERAGE.

(a) MEDICARE.—

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

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (EE);

(ii) by adding ''and'' at the end of subparagraph (FF); and

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

''(GG) advance care planning consultation (as defined in subsection (iii)(1));''; and

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

''Advance Care Planning Consultation

''(iii)(1) Subject to paragraphs (3) and (4), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to subparagraphs (A) and (B) of paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3)(A) An initial preventive physical examination under subsection (ww), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

''(B) An advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

''(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's au-

thority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

''(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

''(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

''(iv) is portable across care settings; and

''(v) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

''(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

''(i) the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems;

''(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

''(iii) the use of antibiotics; and

''(iv) the use of artificially administered nutrition and hydration.''.

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

(3) 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 advance care planning consultations (as defined in section 1861(iii)(1)), which are performed more frequently than is covered under such section;''; and

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

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2016.

(b) MEDICAID.—

(1) MANDATORY BENEFIT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended in the matter preceding clause (i) by striking ''and (28)'' and inserting ''(28), and (29)''.

(2) MEDICAL ASSISTANCE.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in subsection (a)—

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

(ii) by redesignating paragraph (29) as paragraph (30); and

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

''(29) advance care planning consultations (as defined in subsection (ee));''; and

(B) by adding at the end the following:

''(ee)(1) For purposes of subsection (a)(29), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal

service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders for life sustaining treatments or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including re-

quirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3) An advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5) For purposes of this subsection, the term 'orders regarding life sustaining treatment' has the meaning given that term in section 1861(iii)(5).''.

(c) CHIP.—

(1) CHILD HEALTH ASSISTANCE.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj) is amended—

(A) by redesignating paragraph (28) as paragraph (29); and

(B) by inserting after paragraph (27), the following:

''(28) Advance care planning consultations (as defined in section 1905(ee)).''.

(2) MANDATORY COVERAGE.—

(A) IN GENERAL.—Section 2103 of such Act (42 U.S.C. 1397cc), is amended—

(i) in subsection (a), in the matter preceding paragraph (1), by striking ''and (7)'' and inserting ''(7), and (9)''; and

(ii) in subsection (c), by adding at the end the following:

''(9) END-OF-LIFE CARE.—The child health assistance provided to a targeted low-income child shall include coverage of advance care planning consultations (as defined in section 1905(ee) and at the same payment rate as the rate that would apply to such a consultation under the State plan under title XIX).''.

(B) CONFORMING AMENDMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(a)(7)(B)) is amended by striking ''section 2103(c)(5)'' and inserting ''paragraphs (5) and (9) of section 2103(c)''.

(d) DEFINITION OF ADVANCE DIRECTIVE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) MEDICARE.—Section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care

directive and a health care directive recognized under State law.''.

(2) MEDICAID AND CHIP.—Section 1902(w)(4) of such Act (42 U.S.C. 1396a(w)(4)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(e) EFFECTIVE DATE.—The amendments made by this section take effect January 1, 2015.

PART II—HOSPICE

SEC. 221. ADOPTION OF MEDPAC HOSPICE PAYMENT METHODOLOGY RECOMMENDATIONS.

Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(8)(A) The Secretary shall conduct an evaluation of the recommendations of the Medicare Payment Commission for reforming the hospice care

benefit under this title that are contained in chapter 6 of the Commission's report entitled 'Report to Congress: Medicare Payment Policy (March 2009)', including the impact that such recommendations if implemented would have on access to care and the quality of care. In conducting such evaluation, the Secretary shall take into account data collected in accordance with section 263(b) of the Advance Planning and Compassionate Care Act of 2014.

''(B) Based on the results of the examination conducted under subparagraph (A), the Secretary shall make appropriate refinements to the recommendations described in subparagraph (A). Such refinements shall take into account—

''(i) the impact on patient populations with longer that average lengths of stay;

''(ii) the impact on populations with shorter that average lengths of stay; and

''(iii) the utilization patterns of hospice providers in underserved areas, including rural hospices.

''(C) Not later than January 1, 2018, the Secretary shall submit to Congress a report that contains a detailed description of—

"(i) the refinements determined appropriate by the Secretary under subparagraph (B);

"(ii) the revisions that the Secretary will implement through regulation under this title pursuant to subparagraph (D); and

"(iii) the revisions that the Secretary determines require additional legislative action by Congress.

"(D)(i) The Secretary shall implement the recommendations described in subparagraph (A), as refined under subparagraph (B).

"(ii) Subject to clause (iii), the implementation of such recommendations shall apply to hospice care furnished on or after January 1, 2019.

"(iii) The Secretary shall establish an appropriate transition to the implementation of such recommendations.

"(E) For purposes of carrying out the provisions of this paragraph, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817, of such sums as may be necessary to the Centers for Medicare & Medicaid Services Program Management Account.".

SEC. 222. REMOVING HOSPICE INPATIENT DAYS IN SETTING PER DIEM RATES FOR CRITICAL ACCESS HOSPITALS.

Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)), as amended by section 4102(b)(2) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new paragraph:

''(6) For cost reporting periods beginning on or after January 1, 2016, the Secretary shall remove Medicare-certified hospice inpatient days from the calculation of per diem rates for inpatient critical access hospital services.''.

SEC. 223. HOSPICE PAYMENTS FOR DUAL ELIGIBLE INDIVIDUALS RESIDING IN LONG-TERM CARE FACILITIES.

(a) IN GENERAL.—Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(i) PAYMENTS FOR DUAL ELIGIBLE INDIVIDUALS RESIDING IN LONG-TERM CARE FACILITIES.—For cost reporting periods beginning on or after January 1, 2016, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish procedures under which payments for room and board under the State Medicaid plan with respect to an applicable individual are made directly to the long-term care facil-

ity (as defined by the Secretary for purposes of title XIX) the individual is a resident of. For purposes of the preceding sentence, the term 'applicable individual' means an individual who is entitled to or enrolled for benefits under part A or enrolled for benefits under part B and is eligible for medical assistance for hospice care under a State plan under title XIX.''.

(b) STATE PLAN REQUIREMENT.—

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (74), by striking ''and'' at the end;

(B) in paragraph (80), by striking ''and'' at the end;

(C) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(D) by inserting after paragraph (81) the following new paragraph:

''(82) provide that the State will make payments for room and board with respect to applicable individuals in accordance with section 1888(i).''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by paragraph (1) take effect on January 1, 2016.

(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 paragraph (1), 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 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. 224. DELINEATION OF RESPECTIVE CARE RESPONSIBILITIES OF HOSPICE PROGRAMS AND LONG-TERM CARE FACILITIES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy), as amended by section 223(a), is amended by adding at the end the following new subsection:

''(j) DELINEATION OF RESPECTIVE CARE RESPONSIBILITIES OF HOSPICE PROGRAMS AND LONG-TERM CARE FACILITIES.—Not later than July 1, 2016, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall delineate and enforce the respective care responsibilities of hospice programs and long-term care facilities (as defined by the Secretary for purposes of title XIX) with respect to individuals residing in such facilities who are furnished hospice care.''.

SEC. 225. ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY CERTIFICATION AND RECERTIFICATION RECOMMENDATIONS.

In accordance with the recommendations of the Medicare Payment Advisory Commission contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy'', section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end; and

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

''(E) on or after January 1, 2016—

''(i) a hospice physician or advance practice nurse visits the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services); and

''(ii) any certification or recertification under subparagraph (A) includes a brief narrative describing the clinical basis for the individual's prognosis (in accordance with procedures established by the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services); and''.

SEC. 226. CONCURRENT CARE FOR CHILDREN.

(a) PERMITTING MEDICARE HOSPICE BENEFICIARIES 18 YEARS OF AGE OR YOUNGER TO RECEIVE CURATIVE CARE.—

(1) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended—

(A) in subsection (a)(4), by inserting ''(subject to the second sentence of subsection (d)(2)(A))'' after ''in lieu of certain other benefits''; and

(B) in subsection (d)—

(i) in paragraph (1), by inserting '' , subject to the second sentence of paragraph (2)(A),'' after ''instead''; and

(ii) in paragraph (2)(A), by adding at the end the following new sentence: ''Clause (ii)(I) shall not apply to an individual who is 18 years of age or younger.''

(2) CONFORMING AMENDMENT.—Section 1862(a)(1)(C) of the Social Security Act (42 U.S.C. 1395y(a)(1)(C)) is amended inserting ''subject to the second sentence of section 1812(d)(2)(A),'' after ''hospice care,''.

(b) APPLICATION TO MEDICAID AND CHIP.—

(1) MEDICAID.—Section 1905(o)(1)(A) of the Social Security Act (42 U.S.C. 1395d(o)(1)(A)) is

amended by inserting ''(subject, in the case of an individual who is a child, to the second sentence of such section)'' after ''section 1812(d)(2)(A)''.

(2) CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by striking ''(concurrent'' and all that follows through the period and inserting ''(concurrent, in the case of an individual who is a child, with care related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2016.

SEC. 227. MAKING HOSPICE A REQUIRED BENEFIT UNDER MEDICAID AND CHIP.

(a) MANDATORY BENEFIT.—

(1) MEDICAID.—

(A) IN GENERAL.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 211(b)(1), is amended in the matter preceding clause (i) by inserting ''(18),'' after ''(17),''.

(B) CONFORMING AMENDMENT.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) is amended—

(i) in clause (iii)—

(I) in subclause (I), by inserting ''and hospice care'' after ''ambulatory services''; and

(II) in subclause (II), by inserting ''and hospice care'' after ''delivery services''; and

(ii) in clause (iv), by inserting ''and (18)'' after ''(17)''.

(2) CHIP.—Section 2103(c)(9) of such Act (42 U.S.C. 1397cc(c)(9)), as added by section 211(c)(2)(A), is amended by inserting ''and hospice care'' before the period.

(b) EFFECTIVE DATE.—The amendments made subsection (a) take effect on January 1, 2016.

SEC. 228. MEDICARE HOSPICE PAYMENT MODEL DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—Not later than July 1, 2017, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall conduct demonstration projects to examine ways to

improve how the Medicare hospice care benefit predicts disease trajectory. Projects shall include the following models:

(1) Models that better and more appropriately care for, and transition as needed, patients in their last years of life who need palliative care, but do not qualify for hospice care under the Medicare hospice eligibility criteria.

(2) Models that better and more appropriately care for long-term patients who are not recertified in hospice but still need palliative care.

(3) Any other models determined appropriate by the Secretary.

(b) WAIVER AUTHORITY.—The Secretary may waive compliance of such requirements of titles XI and XVIII of the Social Security Act as the Secretary determines necessary to conduct the demonstration projects under this section.

(c) REPORTS.—The Secretary shall submit to Congress periodic reports on the demonstration projects conducted under this section.

SEC. 229. MEDPAC STUDIES AND REPORTS.

(a) STUDY AND REPORT REGARDING AN ALTERNATIVE PAYMENT METHODOLOGY FOR HOSPICE CARE UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the establishment of a reimbursement system for hospice care furnished under the Medicare program that is based on diagnoses. In conducting such study, the Commission shall use data collected under new provider data requirements. Such study shall include an analysis of the following:

(A) Whether such a reimbursement system better meets patient needs and better corresponds with provider resource expenditures than the current system.

(B) Whether such a reimbursement system improves quality, including facilitating standardization of care toward best practices and diagnoses-specific clinical pathways in hospice.

(C) Whether such a reimbursement system could address concerns about the blanket 6-month terminal prognosis requirement in hospice.

(D) Whether such a reimbursement system is more cost effective than the current system.

(E) Any other areas determined appropriate by the Commission.

(2) REPORT.—Not later than June 15, 2018, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) STUDY AND REPORT REGARDING RURAL HOSPICE TRANSPORTATION COSTS UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Commission shall conduct a study on rural Medicare hospice transportation mileage to determine potential Medicare reimbursement changes to account for potential higher costs.

(2) REPORT.—Not later than June 15, 2018, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(c) EVALUATION OF REIMBURSEMENT DISINCENTIVES TO ELECT MEDICARE HOSPICE WITHIN THE MEDICARE SKILLED NURSING FACILITY BENEFIT.—

(1) STUDY.—The Commission shall conduct a study to determine potential Medicare reimbursement changes to remove Medicare reimbursement

disincentives for patients in a skilled nursing facility who want to elect hospice.

(2) REPORT.—Not later than June 15, 2018, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

SEC. 230. HHS EVALUATIONS.

(a) EVALUATION OF ACCESS TO HOSPICE AND HOSPITAL-BASED PALLIATIVE CARE.—

(1) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct an evaluation of geographic areas and populations underserved by hospice and hospital-based palliative care to identify potential barriers to access.

(2) REPORT.—Not later than December 31, 2017, the Secretary shall report to Congress, on the evaluation conducted under subsection (a) together with recommendations for such legislation and administrative action as the Secretary determines appropriate to address barriers to access to hospice and hospital-based palliative care.

(b) EVALUATION OF AWARENESS AND USE OF HOSPICE RESPITE CARE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) EVALUATION.—The Secretary, acting through the Director of the Centers for Medicare and Medicaid Services, shall evaluate the awareness and use of hospice respite care by informal caregivers of beneficiaries under Medicare, Medicaid, and CHIP.

(2) REPORT.—Not later than December 31, 2015, the Secretary shall report to Congress, on the evaluation conducted under subsection (a) together with recommendations for such legislation and administrative action as the Secretary determines appropriate to increase awareness or use of hospice respite care under Medicare, Medicaid, and CHIP.

Subtitle C—Quality Improvement

SEC. 241. PATIENT SATISFACTION SURVEYS.

Not later than January 1, 2017, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish a mechanism for—

(1) collecting information from patients (or their health care proxies or families members in the event patients are unable to speak for themselves) in

relevant provider settings regarding their care at the end of life; and

(2) incorporating such information in a timely manner into mechanisms used by the Administrator to provide quality of care information to consumers, including the Hospital Compare and Nursing Home Compare websites maintained by the Administrator.

SEC. 242. DEVELOPMENT OF CORE END-OF-LIFE CARE QUALITY MEASURES ACROSS EACH RELEVANT PROVIDER SETTING.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Agency for Healthcare Research and Quality (in this section referred to as the ''Administrator'') and in consultation with the Director of the National Institutes of Health, shall require specific end-of-life quality measures for each relevant provider setting, as identified by the Administrator, in accordance with the requirements of subsection (b).

(b) REQUIREMENTS.—For purposes of subsection (a), the requirements specified in this subsection are the following:

(1) Selection of the specific measure or measures for an identified provider setting shall be—

(A) based on an assessment of what is likely to have the greatest positive impact on quality of end-of-life care in that setting; and

(B) made in consultation with affected providers and public and private organizations, that have developed such measures.

(2) The measures may be structure-oriented, process-oriented, or outcome-oriented, as determined appropriate by the Administrator.

(3) The Administrator shall ensure that reporting requirements related to such measures are imposed consistent with other applicable laws and regulations, and in a manner that takes into account existing measures, the needs of patient populations, and the specific services provided.

(4) Not later than—

(A) April 1, 2016, the Secretary shall disseminate the reporting requirements to all affected providers; and

(B) April 1, 2017, initial reporting relating to the measures shall begin.

SEC. 243. ACCREDITATION OF HOSPITAL-BASED PALLIATIVE CARE PROGRAMS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Qual-

ity, shall designate a public or private agency, entity, or organization to develop requirements, standards, and procedures for accreditation of hospital-based palliative care programs.

(b) REPORTING.—Not later than January 1, 2017, the Secretary shall prepare and submit a report to Congress on the proposed accreditation process for hospital-based palliative care programs.

(c) ACCREDITATION.—Not later than July 1, 2017, the Secretary shall—

(1) establish and promulgate standards and procedures for accreditation of hospital-based palliative care programs; and

(2) designate an agency, entity, or organization that shall be responsible for certifying such programs in accordance with the standards established under paragraph (1).

(d) DEFINITIONS.—For the purposes of this section:

(1) The term ''hospital-based palliative care program'' means a hospital-based program that is comprised of an interdisciplinary team that specializes in providing palliative care services and consultations in a variety of health care settings, including hospitals, nursing homes, and home and community-based services.

(2) The term ''interdisciplinary team'' means a group of health care professionals (consisting of, at a minimum, a doctor, a nurse, and a social worker) that have received specialized training in palliative care.

SEC. 244. SURVEY AND DATA REQUIREMENTS FOR ALL MEDICARE PARTICIPATING HOSPICE PROGRAMS.

(a) HOSPICE SURVEYS.—Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)) is amended by adding at the end the following new paragraph:

''(6) In accordance with the recommendations of the Medicare Payment Advisory Commission contained in the March 2009 report entitled 'Report to Congress: Medicare Payment Policy', the Secretary shall establish, effective July 1, 2015, the following survey requirements for hospice programs:

''(A) Any hospice program seeking initial certification under this title on or after that date shall be subject to an initial survey by an appropriate State or local agency, or an approved accreditation agency, not later than 6 months after the program first seeks such certification.

''(B) All hospice programs certified for participation under this title shall be subject to a standard

survey by an appropriate State or local agency, or an approved accreditation agency, at least every 3 years after initially being so certified.''.

(b) REQUIRED HOSPICE RESOURCE INPUTS DATA.—Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)), as amended by subsection (a), is amended—

(1) in paragraph (2)—

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

(B) by redesignating subparagraph (G) as subparagraph (H); and

(C) by inserting after subparagraph (F) the following new subparagraph:

''(G) complies with the reporting requirements under paragraph (7); and''; and

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

''(7)(A) In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as contained in the March 2009 report entitled 'Report to Congress: Medicare Payment Policy'), beginning January 1, 2016, a hospice program shall report to the Secretary, in such form and manner, and at such intervals, as the Secretary

shall require, the following data with respect to each patient visit:

''(i) Visit type (such as admission, routine, emergency, education for family, other).

''(ii) Visit length.

''(iii) Professional or paraprofessional disciplines involved in the visit, including nurse, social worker, home health aide, physician, nurse practitioner, chaplain or spiritual counselor, counselor, dietician, physical therapist, occupational therapist, speech language pathologist, music or art therapist, and including bereavement and support services provided to a family after a patient's death.

''(iv) Drugs and other therapeutic interventions provided.

''(v) Home medical equipment and other medical supplies provided.

''(B) In collecting the data required under subparagraph (A), the Secretary shall ensure that the data are reported in a manner that allows for summarized cross-tabulations of the data by patients' terminal diagnoses, lengths of stay, age, sex, and race.''.

Subtitle D—Additional Reports, Research, and Evaluations

SEC. 251. NATIONAL CENTER ON PALLIATIVE AND END-OF-LIFE CARE.

Part E of title IV of the Public Health Service Act (42 U.S.C. 287 et seq.) is amended by adding at the end the following:

"Subpart 7—National Center on Palliative and End-of-Life Care

"SEC. 485J. NATIONAL CENTER ON PALLIATIVE AND END-OF-LIFE CARE.

''(a) ESTABLISHMENT.—Not later than July 1, 2016, there shall be established within the National Institutes of Health, a National Center on Palliative and End-of-Life Care (referred to in this section as the 'Center').

''(b) PURPOSE.—The general purpose of the Center is to conduct and support research relating to palliative and end-of-life care interventions and approaches.

''(c) ACTIVITIES.—The Center shall—

''(1) develop and continuously update a research agenda with the goal of—

''(A) providing a better biomedical understanding of the end of life; and

''(B) improving the quality of care and life at the end of life; and

''(2) provide funding for peer-review-selected extra- and intra-mural research that includes the evaluation of existing, and the development of new, palliative and end-of-life care interventions and approaches.''.

SEC. 252. NATIONAL MORTALITY FOLLOWBACK SURVEY.

(a) IN GENERAL.—Not later than December 31, 2015, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall renew and conduct the National Mortality Followback Survey (referred to in this section as the ''Survey'') to collect data on end-of-life care.

(b) PURPOSE.—The purpose of the Survey shall be to gain a better understanding of current end-of-life care in the United States.

(c) QUESTIONS.—

(1) IN GENERAL.—In conducting the Survey, the Director of the Centers for Disease Control and Prevention shall, at a minimum, include the following questions with respect to the loved one of a respondent:

(A) Did he or she have an advance directive, and if so, when it was completed.

(B) Did he or she have an order for life-sustaining treatment, and if so, when was it completed.

(C) Did he or she have a durable power of attorney, and if so, when it was completed.

(D) Had he or she discussed his or her wishes with loved ones, and if so, when.

(E) Had he or she discussed his or her wishes with his or her physician, and if so, when.

(F) In the opinion of the respondent, was he or she satisfied with the care he or she received in the last year of life and in the last week of life.

(G) Was he or she cared for by hospice, and if so, when.

(H) Was he or she cared for by palliative care specialists, and if so, when.

(I) Did he or she receive effective pain management (if needed).

(J) What was the experience of the main caregiver (including if such caregiver was the respondent), and whether he or she received sufficient support in this role.

(2) ADDITIONAL QUESTIONS.—Additional questions to be asked during the Survey shall be determined by the Director of the Centers for Disease Control and Prevention on an ongoing basis with input from relevant research entities.

SEC. 253. DEMONSTRATION PROJECTS FOR USE OF TELEMEDICINE SERVICES IN ADVANCE CARE PLANNING.

(a) IN GENERAL.—Not later than July 1, 2018, the Secretary shall establish a demonstration program to reimburse eligible entities for costs associated with the use of telemedicine services (including equipment and connection costs) to provide advance care planning consultations with geographically distant physicians and their patients.

(b) DURATION.—The demonstration project under this section shall be conducted for at least a 3-year period.

(c) DEFINITIONS.—For purposes of this section:

(1) The term ''eligible entity'' means a physician or an advance practice nurse who provides services pursuant to a hospital-based palliative care program (as defined in section 262(d)(1)).

(2) The term ''geographically distant'' has the meaning given that term by the Secretary for purposes of conducting the demonstration program established under this section.

(3) The term ''telemedicine services'' means a service or consultation provided via telecommunication equipment that allows an eligible entity to exchange or discuss medical information with a patient or a health care professional at a separate location through real-time videoconferencing, or a similar format, for the purpose of providing health care diagnosis and treatment.

(d) FUNDING.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out this section.

SEC. 254. INSPECTOR GENERAL INVESTIGATION OF FRAUD AND ABUSE.

In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy''), the Secretary shall direct the Office of the Inspector General of the Department of Health and Human Services to investigate, not later than January 1, 2017, the following with respect to hospice benefit under Medicare, Medicaid, and CHIP:

(1) The prevalence of financial relationships between hospices and long-term care facilities, such as nursing facilities and assisted living facilities, that

may represent a conflict of interest and influence admissions to hospice.

(2) Differences in patterns of nursing home referrals to hospice.

(3) The appropriateness of enrollment practices for hospices with unusual utilization patterns (such as high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices).

(4) The appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

SEC. 255. GAO STUDY AND REPORT ON PROVIDER ADHERENCE TO ADVANCE DIRECTIVES.

Not later than January 1, 2017, the Comptroller General of the United States shall conduct a study of the extent to which providers comply with advance directives under the Medicare and Medicaid programs and shall submit a report to Congress on the results of such study, together with such recommendations for administrative or legislative changes as the Comptroller General determines appropriate.

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