**COMPARISON: PROVISIONS OF PCQCA AND CARE PLANNING ACT**

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|  | **Patient Choice and Quality Care Act of 2017 (PCQCA)** **(H.R. 2797/S. 1334)** | **Care Planning Act of 2015** **(S. 1549)** |
| **Advanced Illness Planning and Coordination Services** | **Advanced Illness Care and Management Model. (Section 3)***Creates a new Medicare model for Advanced Illness Care and Management*: This section directs CMS to create and test a new model— offered both independently and in conjunction with other models—that would enable eligible individuals to voluntarily engage in a team-based planning process designed to align the care a patient receives with his or her goals of care, values, and preferences. Members of an interdisciplinary team would work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patient and caregivers by providing important information and services, including:* Assisting the patient in defining and articulating goals of care, values, and preferences;
* Providing information about disease trajectory;
* Discussing and evaluating how a range of treatment options align with patient goals;
* Preparing and sharing recognized documentation stating the patient’s goals of care, preferences, and values, preferred decision-making strategies, and plan of care;
* Referrals to medical or social service providers for care consistent with the plan;
* Providing training to the patient and caregivers to enable them to implement the plan;
* Providing site visits and additional services consistent with the care plan, to assist the patient and caregivers in

management of the condition; and* Facilitating care coordination and communication across health care and social service settings and providers, including 24-hour emergency support, while continuing to evaluate involvement of the team over time.

Services will be reimbursed according to a payment model established by the Secretary. | **Improvement of advanced illness planning and coordination. (Section 3)***Creates a Medicare benefit, Planning Services*: Eligible individuals with serious or life-threatening illness may elect to engage in a team-based planning process designed to align the care a patient receives with his or her goals of care, values, and preferences. Members of the interdisciplinary team would work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patient and caregivers by providing important information, including: * Assisting the patient in defining and articulating goals of care, values, and preferences;
* Providing information about disease trajectory;
* Discussing and evaluating how a range of treatment options align with patient goals;
* Preparing and sharing recognized documentation stating the patient’s goals of care, preferences, and values, preferred decision-making strategies, and plan of care;
* Referrals to medical or social service providers for care consistent with the plan; and
* Providing training to the patient and caregivers to enable them to implement the plan.

Planning services will be reimbursed by Medicare Part B under the physician fee schedule. Eligible individuals may receive the benefit no more than once a year, with exceptions to this frequency limitation established by the Secretary. *Requires CMMI to conduct an Advanced Illness Coordination Services (AICS) Project*: CMMI will conduct a five-year demonstration program offering AICS to individuals needing assistance in two or more progressive disease-related activities of daily living (ADLs). |
| **Quality Measurement Development/Implementation** | **Quality Measurement Development and Implementation (Section 4)***Facilitates increased coordination and alignment between the public and private sector quality measures:** Directs an environmental scan of existing quality measures, measure concepts, and preferred practices for advanced illness, palliative, and end-of-life care used in both private and public sectors and across multiple settings of care.
* Requires NIH to conduct a study regarding the development of measures related to key gaps, such as ensuring that care aligns with patient wishes, better understanding the population that would benefit from palliative care and advance care planning, and appropriate transitions to hospice.
* Directs the Secretary to develop and incorporate quality measures related to end-of-life care under the Medicare Access and CHIP Reauthorization Act (MACRA) and Improving Medicare Post-Acute Care Transformation Act (IMPACT) reforms, and into Medicare Advantage programs and Alternative Payment Models.
 | **Quality Measurement Development (Section 4)***Directs the Secretary to develop quality measures*: Appropriates $5 million for HHS to identify gaps and develop quality measures to evaluate the efficacy of Planning Services, focusing on evaluating quality by linking patient goals to the plan, treatment received, and treatment outcomes. |
| **Enhanced Advanced Care Planning Services** | **Enhancing coverage of advance care planning services. (Section 5)***Improves Medicare’s existing coverage for advance care planning services, by:*• Allowing appropriately trained or experienced clinical social workers to provide advance care planning services;• Ensuring that costs are not a barrier to patients using these services. |  |
| **Advance Care Planning Support Tools** | **Advance care planning support tools. (Section 6)***Will ensure that patients and providers have the support tools they need by:*• Directing the Secretary to include information in the Medicare & You Handbook about advance directives, planning services, planning tools, and portable treatment orders.• Requiring the Secretary to develop standards for including completed advance care planning documents within a patient’s electronic health record. | **Inclusion of Advanced Care Planning Materials in the Medicare & You Handbook (Section 5)***Directs the Secretary to include information in the Medicare & You Handbook about advance directives, planning services, planning tools, and portable treatment orders.* |
| **Improvement of Policies Related to the Use and Portability of Advance Directives and Portable Orders** | **Improvement of Policies Related to the Use and Portability of Advance Directives and Portable Orders (Section 7)***Requires Medicare providers of services and entities to follow individuals’ preferences:** Ensures that advance directives should follow the patient; regardless of the state or site of care
	+ Physicians and other health care providers and organizations must honor patient preferences in making treatment decisions.
* Directs the Comptroller General to study the use, portability, and electronic storage of advance directives.
 | **Improvement of Policies Related to the Use and Portability of Advance Directives and Portable Orders (Section 6)***Requires Medicare providers of services and entities to follow individuals’ preferences:* * Hospitals, home health agencies, hospices, and skilled nursing facilities must honor patient preferences in making treatment decisions. These facilities must have in place policies and procedures to:
	+ Provide individuals with information about their rights concerning medical decision-making;
	+ Include in the medical record the contents of, and whether individuals report having, an advance directive or portable treatment order;
	+ Offer individuals the opportunity to discuss advance directives with appropriately trained personnel;
	+ Provide care that is consistent with an individual’s preferences, or evidence of preferences; and
	+ Address circumstances under which providers would not comply with a documented preference
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| **Additional Requirements for Facilities** | **Additional Requirements for Facilities (Section 8)***Requires Medicare providers and entities to document plans made during the stay*:Healthcare facilities must assure that care plans made while an individual receives care are appropriately documented prior to discharge and sent to appropriate providers and facilities upon discharge. | **Additional Requirements for Facilities (Section 7)** *Requires Medicare providers and entities to document plans made during the stay*: Healthcare facilities must assure that care plans made while an individual receives care are appropriately documented prior to discharge and sent to appropriate providers and facilities upon discharge. |
| **Grants for Increasing Public Awareness of Advance Care Planning and Advanced Illness Care** | **Grants for Increasing Public Awareness of Advance Care Planning and Advanced Illness Care (Section 9)***Appropriates $50 million and authorizes the Secretary to award grants, to*:* Develop materials and resources addressing advance care planning for healthy individuals, the elements of care planning for individuals with advanced illness, the role and effective use of advance directives and portable treatment orders, the range of services designed for individuals facing advanced illness, and for training and professional development for clinicians who care for people with advanced serious illness;
* Establish and maintain web- and phone-based resources to disseminate resources and materials;
* Conduct a national public educational campaign;
* Establish, develop, and expand programs for life sustaining treatment (POLST) and similar programs, which help seriously ill patients identify their treatment preferences using a clear, standardized template.
 | **Grants for Increasing Public Awareness of Advance Care Planning and Advanced Illness Care (Section 8)** *Appropriates $15 million and authorizes the Secretary to award grants to public or private entities, to*: * Develop materials and resources addressing advance care planning for healthy individuals, the elements of care planning for individuals with advanced illness, the role and effective use of advance directives and portable treatment orders, or the range of services designed for individuals facing advanced illness;
* Establish and maintain web- and phone-based resources to disseminate resources and materials;
* Conduct a national public educational campaign
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| **Advance Care Planning Advisory Council** | **Advance Care Planning Advisory Council (Section 10)***Establishes an Advisory Council to advise the Secretary on issues of advanced and terminal illness.* |  |
| **Annual Report on Medicare Decedents** | **Annual report on Medicare decedents (Section 11)***Requires the Secretary to issue an annual report,* to:• Analyze the care or payer settings at the time of death;• Analyze the demographics and geographic information of Medicare decedents;• Evaluate Medicare claims data for services furnished in the last year of life. |  |
| **Rules of Construction** | **Rule of Construction (Section 12)***Establishes that this Act shall not be construed to limit restrictions of the Assisted Suicide Funding Restriction Act of 1997.* | **Rule of Construction (Section 9)***Establishes that this Act shall not be construed to limit restrictions of the Assisted Suicide Funding Restriction Act of 1997.* |