II

119TH CONGRESS
1ST SESSION

S. 1935

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

IN THE SENATE OF THE UNITED STATES

JUNE 3, 2025

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

---

A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Expanding Access to Palliative Care Act''.

SEC. 2. COMMUNITY-BASED PALLIATIVE CARE MODEL.

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

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

lected under this subparagraph shall include the testing of the model described in subsection (h).''; and

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

''(h) COMMUNITY-BASED PALLIATIVE CARE MODEL.—

''(1) IN GENERAL.—The CMI shall develop and implement a model to provide community-based palliative care and care coordination for high-risk beneficiaries, in co-management with other providers of services and suppliers, aimed at improving outcomes and experience of care and reducing unnecessary or unwanted emergency department visits and hospitalizations (in this subsection referred to as the 'model'), and that is intended to replace the Medicare Care Choices Model.

''(2) DURATION.—The model shall be implemented for a 5-year period, beginning not later than one year after the date of the enactment of this subsection.

''(3) TARGET POPULATION.—

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

''(i) entitled to, or enrolled for, benefits under part A of title XVIII; and

''(ii) with a diagnosis of a serious illness or injury, which may include a diagnosis of cancer, heart and vascular disease, pulmonary disease, human immunodeficiency virus/acquired immunodeficiency, Alzheimer's and dementia, stroke, serious injury requiring rehabilitation including burns, kidney disease, liver disease, Amyotrophic lateral sclerosis, any neuro degenerative disease, or any other serious illness or injury the Secretary determines appropriate.

''(B) NO EXCLUSION FOR PRIOR USE OF HOSPICE CARE BENEFITS.—An individual shall not be excluded from participation in the model based on prior use of hospice care benefits during any period prior to such participation, regardless of the source of coverage for such benefits.

''(4) PARTICIPATING PROVIDERS.—Providers eligible to participate under the model may include palliative care teams working as an independent practice or associated with a hospice program, home

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

''(5) TEAM-BASED APPROACH.—Under the model, at least one member of the multi-disciplinary palliative care team shall be certified in hospice and palliative care. This is a co-management model with palliative care aligning with primary and specialist care for a team-based approach. Care must be coordinated across providers and community services for inclusion of all pain, symptom management, disease-modifying and curative treatments, and other palliative care services.

''(6) LOCATION.—Care may be furnished under the model in any beneficiary 'home', including a caregiver's residence, an extended care facility, or a community setting as appropriate based on the individual's ability to access services. The model shall include access within an in-patient stay so long as the patient begins receiving palliative care services prior to admission. Services shall not be disrupted solely due to change in location from a residence to an in-patient setting, and shall be part of care coordination and care planning following hospital discharge.

''(7) SERVICES.—The model shall include items and services based on specific patient needs with respect to pain, symptom management, education, disease modifying treatments, advance care planning and shared decision making, goals clarification, mental health services, family and caregiver support services, spiritual support care, personal care assistance, and stress reduction therapies. This includes a comprehensive assessment of symptoms and stress factors that impact quality of life.

''(8) ACCESS.—Care shall be available under the model 24 hours a day, 7 days a week, and 365 days a year, including telehealth services. The CMI shall specifically consider the needs of rural and underserved areas and adjust accordingly to ensure equitable access to care. A broad range of providers must be included with no geographic limitations.

''(9) METRICS.—The CMI shall assess the model by comparing participants to other members of the target population who are receiving care outside of the model, including with respect to the following:

''(A) Demographics (including age, diagnosis, residence type, medical encounters in preceding 12 months leading to enrollment, geo-

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

"(B) Impact on utilization of items and services under title XVIII (such as emergency department services, hospital observation services, inpatient admissions, and intensive care unit (ICU) stays).

"(C) Election of hospice care.

"(D) Duration of hospice care.

"(E) Care Experience (beneficiary and caregiver).".

○