I

118TH CONGRESS
1ST SESSION

H. R. 2853

To amend title XVIII of the Social Security Act to expand access to clinical care in the home, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 25, 2023

Mr. SMITH of Nebraska (for himself and Mrs. DINGELL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to expand access to clinical care in the home, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Expanding Care in the Home Act''.

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

SEC. 2. ENHANCING PRIMARY CARE IN THE HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (HHS Secretary) shall allow primary care providers (PCPs) enrolled in Medicare Part B to elect to receive a monthly capitated payment for Primary Care Qualified Evaluation and Management Services (PQEM) as an alternative to fee-for-service reimbursement. Providers shall be allowed to elect to receive a monthly capitated payment for a period of time ranging from one to five years.

(b) COVERED SERVICES.—The HHS Secretary shall annually identify PQEM services no later than October 1 each year. At a minimum, these services shall include the following services when billed by a primary care provider or a nonprimary care specialist (as outlined by the Secretary):

(1) Office or Other Outpatient Services (99201–99205, 99211–99215).

(2) Domiciliary, Rest Home or Custodial Care Services (99324–99328, 99334–99337).

(3) Domiciliary, Rest Home or Home Care Plan Oversight Services 99339–99340).

(4) Home Services (99341–99345, 99347–99350).

(5) Transitional Care Management Services (99495–99496).

(6) Care Coordination Management Services (99490).

(7) Wellness Visits (G0402, G0438, G0439).

(c) PAYMENT.—The capitated payment system designed by the HHS Secretary shall have the following:

(1) Base capitated payments should reflect the previous 3 years excluding the period during which there was an active public health emergency for COVID–19.

(2) There should be an increase in payments to reflect the need for PCPs to invest in changing their office practice workflow.

(3) Higher PCP payment could be possible through greater bonuses related to improving value through total cost of care and quality.

(4) PCPs electing capitated payments should be permitted to offer incentives to engage patients to be assigned to their patient care panels.

(d) ATTRIBUTION.—The HHS Secretary shall ensure that PCPs electing to receive a capitated payment have visibility and input into the attribution model used to at-

tribute patients to them. At a minimum, the attribution methodology should—

(1) patient attribution to panels should be prospective;

(2) panels should be updated monthly or quarterly; and

(3) PCPs should have a mechanism and incentives to enroll patients so they can influence who is attributed to their panel.

SEC. 3. IMPROVING COVERAGE FOR MEDICARE HOME INFUSION.

(a) IN GENERAL.—The HHS Secretary shall establish reimbursement for home infusion services and associated equipment and items under part B.

(b) COVERED SERVICES AND SUPPLIES.—Home Infusion Therapy (HIT) and associated equipment are defined to include—

(1) equipment (e.g., mechanical pumps) for drug administration of Eligible Infusion Drugs;

(2) items (other than drugs and equipment) used in connection with the delivery of Eligible Infusion Drugs such as disposable supplies for the drug administration (e.g., tubing, elastomeric pumps) and for the routine maintenance of the infusion access device;

(3) 24/7 availability of pharmacist professional services such as assessments, drug preparation and compounding, dispensing, clinical monitoring, administrative, and education; and

(4) 24/7 availability of nursing services (when not provided as part of a home health episode).

(c) QUALIFIED PROVIDERS.—Provided by a qualified home infusion therapy services supplier as defined in section 1861(iii)(3)(C) of this Act.

(d) ELIGIBLE INFUSION DRUGS.—Eligible part B and part D Infusion Drugs are defined as parenteral drugs or biologics administered through intravenous, intrathecal, intra-arterial, or subcutaneous access device, except—

(1) drugs and biologics on the self-administered drug list; and

(2) drugs and biologics covered under Part B Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

(e) CURRENT OR FUTURE INFUSION DRUGS.—Provided, nothing in this section shall be construed to change the coverage status of any current or future infusion drugs that meet the definition of a covered part D drug as defined at section 1860D–2(e) and which are paid under Medicare part D.

(f) REFERRING PROVIDERS.—Patients must be under the care of a physician, nurse practitioner, or physician assistant.

(g) SAFETY AND QUALITY.—Consistent with standards of care found within commercial, Medicare Advantage, and State Medicaid programs with regard to sterile preparation of the drug to a final, useable form; timeliness of initiation of care; billing of drugs, items, and pharmacy services by a single entity; performing periodic assessments of patient satisfaction and collection and evaluation of quality outcome data; and maintaining a consolidated patient record of services provided in accordance with the plan of care.

(h)(1) REIMBURSEMENT.—A per infusion day payment is established and defined as ''a payment for the date on which a drug was administered to the individual at home (regardless of whether a skilled professional was physically present in the home of such individual on such date)''.

(2) MARKET RATES.—Such payment may be based on a market analysis of rates paid for home infusion supplies and services by the commercial sector and Medicare Advantage programs.

(3) PAYMENT ELIGIBILITY.—Nothing shall prevent a home infusion supplier from being paid a per infusion day

payment when a qualified home health agency provides the nursing services for the infusion therapy under the part A home health benefit.

SEC. 4. ESTABLISHING PAYMENT FOR STAFF-ASSISTED HOME DIALYSIS.

(a) IN GENERAL.—Section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) is amended by adding at the end the following new subparagraph:

"(J)(i) For services furnished on or after the date which is 1 year after the date of the enactment of this subparagraph which are staff-assisted home dialysis (as defined in clause (iv)(III)), the Secretary shall increase the single payment that would otherwise apply under this paragraph for renal dialysis services furnished to new and respite individuals in accordance with the payment system established under clause (iii) by qualified providers.

"(ii)(I) Subject to subclause (II), staff-assisted home dialysis may only be furnished during—

"(aa) with respect to an individual described in subclause (iv)(I)(aa), one 90-day period which may be renewed up to two 30-day periods; and

''(bb) with respect to an individual described in subclause (iv)(I)(bb) and notwithstanding whether such an individual receives any respite care under part A, any 30-day period.

''(II) Notwithstanding the limits described in subclause (I), staff-assisted home dialysis may be furnished for as long as the Secretary determines appropriate to an individual who—

''(aa) is blind;

''(bb) has a cognitive or neurological impairment (including a stroke, Alzheimer's, dementia amyotrophic lateral sclerosis, or any other impairment determined by the Secretary); or

''(cc) has any other illness or injury that reduces mobility (including cerebral palsy, spinal cord injuries, or any other illness or injury determined by the Secretary).

''(iii) The Secretary shall establish a prospective payment system through regulations to determine the amounts payable to qualified providers for staff-assisted home dialysis. In estab-

lishing such system, the Secretary may consider—

"(I) the costs of furnishing staff-assisted home dialysis;

"(II) consultations with dialysis providers, dialysis patients, private payers, and MA plans;

"(III) payment amounts for similar items and services under parts A and B; and

"(IV) payment amounts established by MA plans under part C, group health plans, and health insurance coverage offered by health insurance issuers.

"(iv) In this subparagraph:

"(I) The term 'new and respite individual' means an individual described in subsection (a) who is either—

"(aa) initiating either peritoneal or home hemodialysis; or

"(bb) receiving home dialysis and is unable to self-dialyze due to illness, injury, caregiver issues, or other temporary circumstances.

"(II) The term 'qualified provider' means a trained professional (as determined by the Secretary, including nurses and certified patient technicians) who furnishes renal dialysis services and—

"(aa) meets requirements (as determined by the Secretary) that ensures competency in patient care and modality usage; and

"(bb) provides in-person assistance to a patient for at least 75 percent of staff-assisted home dialysis sessions during a period described in clause (ii)(i).

"(III)(aa) The term 'staff-assisted home dialysis' means home dialysis using trained professionals to assist individuals who have been determined to have end stage renal disease, and the frequency of such home dialysis is determined by such professionals in coordination with the patient and his or her care partner, and outlined in a patient plan of care.

"(bb) In this subclause, the term 'care partner' means anyone who is designated

by the patient who assists the individual with the furnishing of home dialysis.

''(cc) In this subclause, the term 'patient plan of care' has the meaning given such term in section 494.90 of title 42, Code of Federal Regulations.''.

(b) PATIENT EDUCATION AND TRAINING RELATING TO STAFF-ASSISTED HOME DIALYSIS.—Section 1881(b)(5) of the Social Security Act (42 U.S.C. 1395rr(b)(5)) is amended—

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

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

(3) by adding at the end the following new subparagraphs:

''(D) educate patients of the opportunity to receive staff-assisted home dialysis (as defined in paragraph (14)(J)(iv)(III)) during the period beginning 30 days after the first day such facility furnishes renal dialysis services to an individual and ending 60 days after such day; and

''(E) provide for nurses, certified patient technicians, or other professionals to train patients and their care partners in skills and pro-

cedures needed to perform home dialysis (as defined in paragraph (14)(J)(iv)(III)) treatment—

"(i) regularly and independently;

"(ii) through telehealth services or through group training (as described in the interpretive guidance relating to tag number V590 of 'Advance Copy—End Stage Renal Disease (ESRD) Program Interpretive Guidance Version 1.1' (published on October 3, 2008)) in accordance with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

"(iii) in the home or resident of a patient, in a dialysis facility, or the place in which the patient intends to receive staff-assisted home dialysis.".

(c) OTHER PROVISIONS.—

(1) ANTI-KICKBACK STATUTE.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(B) in subparagraph (K), by striking the period at the end and inserting ''; and''; and

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

''(L) any remuneration relating to the furnishing of staff-assisted home dialysis (as defined in section 1881(b)(14)(J)(iv)(III)).''.

(2) CMI MODEL.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1320b–(b)(2)(B)) is amended by adding at the end the following new clause:

''(xxviii) Making payment to anyone who is designated by a patient who receives staff-assisted home dialysis (as defined in section 1881(b)(14)(J)(iv)(III)) and otherwise meets the requirements (as determined by the Secretary), notwithstanding whether an individual is a qualified provider (as defined in section 1881(b)(14)(J)(iv)(II)) or otherwise eligible for reimbursement under title XVIII.''.

(3) STUDY.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that examines racial disparities in the utilization of the home dialysis defined in section 1881(b)(14)(J)(iv)(III) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(J)(iv)(III)) and make recommendations on how to improve access to such dialysis for communities of color.

(4) PATIENT DECISION TOOL.—Not later than December 31, 2023, for the purpose of section 1881(b)(14)(J) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(J)), the Secretary of Health and Human Services shall convene a patient panel to create a patient-centered decision tool for dialysis patients to evaluate their lifestyle and goals and be assisted in choosing the dialysis modality that best suits them. This tool should include an acknowledgment that they are capable of home dialysis and want home dialysis, if that is the modality they choose.

(5) PATIENT QUALITY OF LIFE METRIC.—Section 1115A(b)(2)(B) of the Social Security Act (42

U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new subparagraph:

"(i) A patient quality of life metric for all patients utilizing dialysis regardless of modality with the intent of measuring and improving patient quality of life on dialysis.".

SEC. 5. ENSURING MEDICARE BENEFICIARIES HAVE ACCESS TO IN-HOME LABS.

(a) IN GENERAL.—The Secretary shall establish reimbursements for an add-on payment to cover travel costs and mailing costs associated with specimen collection of at-home clinical laboratory tests for eligible Medicare beneficiaries.

(b) COVERAGE.—The add-on payment shall apply to all at-home clinical laboratory tests currently reimbursed under Part B as ordered by an eligible Medicare provider.

(c) ELIGIBLE BENEFICIARIES.—The Secretary shall determine the screening tool or utilization management that would trigger beneficiary eligibility for at-home clinical laboratory tests. Eligibility shall be more comprehensive than the homebound status as defined in sections 1835(a) and 1814(a) of the Social Security Act. The screening tool shall consider other criteria such as chronic

conditions, social needs, barriers to accessing care, income level, or dual eligible status.

(d) ELIGIBLE SUPPLIERS.—The Secretary shall determine eligible suppliers for specimen collection of at-home clinical lab tests.

(e) PAYMENT FOR TRAVEL ALLOWANCE.—The Secretary shall establish payment methodology for the travel allowance reimbursement. The methodology shall account for geographic variation in costs of transportation.

(f) PAYMENT FOR MAILING COSTS.—The Secretary shall establish payment methodology for reimbursement of the cost for mailing completed at-home clinical lab tests. The reimbursement structure shall be tiered on shipping based upon the nature of the collection and processing needs, for example cold chain requirements, time sensitively, and other infectious disease protocols.

(g) BENEFICIARY COSTS.—No provision in this section shall impact the coinsurance applied to beneficiaries as currently reimbursed for clinical laboratory tests.

SEC. 6. EXPANDING ADVANCED DIAGNOSTIC IMAGING IN THE HOME.

(a) GENERAL.—The Secretary shall conduct an evaluation of Medicare reimbursable advanced diagnostic imaging as defined in subsection (e)(1)(B) of section 1834 of the Social Security Act. The purpose of the evaluation

shall be to consider expansions to reimbursable at-home advanced diagnostic imaging services, including costs of transportation.

(b) MINIMUM ACTION.—At a minimum, the Secretary shall permit the delivery and reimbursement of ultrasound imaging in the home, including the cost of transportation.

(c) ELIGIBILITY.—The Secretary shall determine the screening tool or utilization management that would trigger beneficiary eligibility for at-home advanced diagnostic services. Eligibility shall be more comprehensive than the homebound status as defined in sections 1835(a) and 1814(a) of the Social Security Act. The screening tool shall consider other criteria such as chronic conditions, social needs, barriers to accessing care, income level, or dual eligible status.

(d) AUTHORITY.—The Secretary shall have the authority to expand the types of at-home advanced diagnostic imaging services reimbursable under Medicare, if medically appropriate and safe.

(e) PAYMENT.—No provision in this section shall impact the payment rates set annually through the physician fee schedule.

(f) REPORT TO CONGRESS.—The Secretary shall submit the findings from the evaluation in section (a) in a

report to Congress not later than 90 days after enacted. The report should provide justification for the Secretary's decision not to expand particular diagnostic services in the home and recommendations to further expand advanced diagnostic imaging in the home.

SEC. 7. DELIVERING PERSONAL CARE SERVICES TO MEDICARE BENEFICIARIES.

(a) GENERAL.—The Social Security Act is amended to establish coverage for personal care assistance services as defined in subsection (k) to eligible Medicare beneficiaries (''Benefit'' hereafter).

(b) SERVICES.—Up to 12 hours per week of personal care assistance services in increments of no less than four hours.

(c) TIME LIMITED BENEFIT.—If prescribed by a qualified Medicare provider, the eligible beneficiary is entitled to 30 days of personal care services and eligible for two additional 30-day periods if the provider deems it is appropriate. The Benefit shall be capped at 90 days per calendar year.

(d) ELIGIBILITY.—To be considered eligible for the Benefit, the beneficiary—

(1) must be Medicare eligible;

(2) must not be Medicaid-eligible;

(3) must have an income at or below 400 percent of the Federal Poverty Level (FPL);

(4) must be functionally disabled as defined in subsection (l); and

(5) must have four or more chronic conditions as defined by the Secretary or had a qualified hospitalization stay, as defined by the Secretary, in the last 30 days.

(e) OTHER ELIGIBILITY REQUIREMENTS.—The Secretary may consider other eligibility requirements that are known to, based on evaluation and research, improve value of care and coordination of care. For example, the beneficiary could be required to attend an annual wellness visit or be aligned with a primary care provider or specialist who functions as a primary care provider.

(f) BENEFIT DETERMINATION PROCESS.—The Secretary shall establish a process to validate beneficiary eligibility for the Benefit through a determination process. Additionally, the Secretary shall put in place an appeals process to review possible wrongful determinations.

(g) COINSURANCE.—After 30 days of personal care services, a 20 percent coinsurance shall apply for the remaining Benefit period.

(h) REIMBURSEMENT.—The Secretary will establish an hourly rate for personal care services through the an-

nual physician fee schedule. The hourly rate should be based on a blend of the Department of Veterans Affairs fee schedule for the homemaker/home health aide service (G0156) and averages for private sector home care.

(i) VALUE-BASED CARE REIMBURSEMENT.—The Secretary should establish a value-based component to the reimbursement of the Benefit that focuses on reducing medical needs. For example, a portion of the fee-for-service reimbursement could be withheld and if certain quality measures (e.g., avoiding unnecessary hospitalizations) are achieved, the remaining portion of the reimbursement would be paid.

(j) OVERSIGHT.—The Secretary shall establish a process to certify personal care agencies, for example requirements for Federal background checks, and other appropriate oversight. Personal care aides shall be employed by an agency. To ensure sufficient number of providers, Agencies providing solely personal care services as defined in this section shall not be required to comply with Conditions of Participation (CoPs).

(k) OVERLAP.—The Secretary shall develop criteria describing how model overlap will be addressed when patients are eligible for the Benefit and are otherwise participating in a payment and delivery reform model under section 1899 or through the Center for Medicare and Med-

icaid Innovation. The Secretary shall exclude costs of the Benefit from reconciliation in these payment and delivery reform models as appropriate to limit unintended consequences.

(l) DEFINITIONS.—

(1) FUNCTIONALLY DISABLED.—An individual is ''functionally disabled'' if the individual—

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is—

(i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or

(ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) PERSONAL CARE ASSISTANCE SERVICES.—Assistance with activities of daily living, as defined at subsection III of this section, which do not require the skills of qualified technical or professional personnel.

(3) ACTIVITIES OF DAILY LIVING.—As defined in 42 CFR § 441.505, activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

SEC. 8. BUILDING THE FUTURE OF THE HOME-BASED CARE WORKFORCE.

(a) CREATION OF GRANTS TO COMMUNITIES TO FOSTER HOME-BASED CARE PROFESSIONALS.—

(1) GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may award grants to entities to invest in developing the home-based care workforce.

(2) ELIGIBLE GRANTEES.—The Secretary may award grants to nonprofit hospital or health systems, community-based organizations, non-profit home health agencies or personal care organizations, State and local health agencies, and other entities identified by the Secretary.

(3) USE OF FUNDS.—The grantee may use funds for the following:

(A) Invest in transitioning facility-based medical personnel to care models that are focused on delivering care in the home.

(B) Establish career advancement training to improve the unique needs of medical personnel entering the home, for example training for cultural sensitivity, use of digital technologies, and best practices.

(C) Recruit new medical personnel that will be responsible for delivering care or support services for care models in the home.

(4) APPLICATION.—To be eligible to receive a grant, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) PRIORITY.—In selecting grant recipients, the Secretary shall prioritize entities that are able to provide evidence that they primarily serve minority populations, operate in a medically underserved community or a health professional shortage area, or are heavily community-focused.

(6) GRANTEE REPORTING REQUIREMENTS.—Each entity awarded a grant shall submit an annual report to the Secretary on the activities conducted under such grant, and other information as the Secretary may require.

(7) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this section and every 5 years thereafter, the Secretary shall submit a report to Congress that provides a summary of the activities and outcomes associated with grants made under this section.

(8) APPROPRIATION.—To carry out this section, there is authorized to be appropriated $50,000,000 to remain available until expended.

(b) ESTABLISHMENT OF HOME-BASED NURSING TASK FORCE.—

(1) GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a task force on developing standards for a home-based nursing board certification (in this section referred to as the ''Task Force'').

(2) DUTIES.—Not later than 12 months after the establishment of the Task Force, the Task Force shall develop and submit to the Secretary rec-

ommendations and strategies for the Department of Health and Human Services for the following:

(A) Identify key considerations and opportunities for a potential registered nurse board certification in home-based care.

(B) Develop the specifications and eligibility requirements that would need to be met for a nursing board certification in home-based care.

(C) Outline the benefits and potential issues that would be associated with establishing a nursing board certification in home-based care.

(3) CONSIDERATIONS.—In developing recommendations and strategies, the Task Force shall consider the following:

(A) Current and future state of the in-home registered nursing workforce, including projected job needs.

(B) Factors influencing individuals to pursue careers in home-based care nursing.

(C) Access and barriers to in-home nursing career opportunities for vulnerable or underrepresented populations into nursing.

(D) Unique role the in-home registered nursing workforce plays in engaging with caregivers.

(E) Differences in facility-based care verses home-based care from the perspective of the nurse, such as clinical competency, burnout, level of experience required, cultural sensitivities required, stressors, and more.

(4) PUBLIC REPORT.—Not later than 60 days after the submission of the recommendations and strategies, the Secretary shall submit to the Congress a report containing such recommendations and strategies.

(5) PERIOD OF APPOINTMENT.—Members shall be appointed to the Task Force the duration of the existence of the Task Force.

(6) COMPENSATION.—Task Force members shall serve without compensation.

(7) SUNSET.—The Task Force shall terminate upon the submission of the report required.

(c) EXPANDING EMERGENCY MEDICAL SERVICES WORKFORCE STUDY.—

(1) GENERAL.—Not later than 90 days after the date of enactment of Expanding Emergency Medical Services (EMS) Workforce Program, the

Secretary shall establish a council to study the impacts of expanding the role of emergency medical service (EMS) providers in the triage, treatment, and transfer of patients in both emergency and non-emergency encounters and associated impacts on the EMS workforce (in this section referred to as the ''Council'').

(2) DUTIES.—Not later than 12 months after the establishment of the Council, the Council shall develop and submit a study to the Secretary of the Department of Health and Human Services that—

(A) details barriers to EMS providers to treating in-place;

(B) outlines the benefits and other considerations associated with expanding the scope of services delivered by EMS providers;

(C) examines the current EMS provider workforce's ability to expand their role in healthcare encounters;

(D) evaluates best practices for nurse navigation programs that assist in triage and dispatch of appropriate level of EMS providers;

(E) evaluates best practices for community paramedicine programs; and

(F) assesses the impacts of the Expanding Emergency Medical Services (EMS) Workforce Program on medically and socially underserved communities' access to care and emergency department utilization.

(3) CONSIDERATIONS.—In developing the study, the Council shall consider the following:

(A) Previous and existing community paramedicine programs.

(B) Previous and existing nurse navigation programs.

(C) Access to EMS services in rural communities.

(D) Current and future state of the EMS provider workforce, including projected job needs.

(E) Unique role the EMS workforce plays in engaging with the community.

(F) Training of EMS providers.

(G) Varying roles and capabilities of different levels of EMS professionals, including Emergency Medical Responder, Emergency Medical Technician, Advanced—EMT, Paramedic, Community Paramedic.

(4) PUBLIC REPORT.—Not later than 60 days after the submission of the study, the Secretary shall submit to the Congress a report containing recommendations and strategies for utilizing the EMS workforce beyond the scope of their current role in healthcare encounters.

(5) PERIOD OF APPOINTMENT.—Members shall be appointed to the Council the duration of the existence of the Council.

(6) COMPENSATION.—Council members shall serve without compensation.

(7) SUNSET.—The Council shall terminate upon the submission of the report required.

(8) FACA APPLICABILITY.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(9) COUNCIL PROCEDURES.—The Secretary, in consultation with the Comptroller General of the United States and the Director of the Office of Management and Budget, shall establish procedures for the Council to—

(A) ensure that adequate resources are available to effectively execute the responsibilities of the Council;

(B) effectively coordinate with other relevant advisory bodies and working groups to avoid unnecessary duplication;

(C) create transparency to the public and Congress with regard to Council membership, costs, and activities, including through use of modern technology and social media to disseminate information; and

(D) avoid conflicts of interest that would jeopardize the ability of the Council to make decisions and provide recommendations.

○