To amend title XVIII of the Social Security Act to provide bundled payments for post-acute care services under parts A and B of Medicare, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 19, 2015

Mr. McKinley (for himself, Mr. Tom Price of Georgia, and Mr. Menerney) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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 provide bundled payments for post-acute care services under parts A and B of Medicare, 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.

This Act may be cited as the “Bundling and Coordinating Post-Acute Care Act of 2015” and as the “BACPAC Act of 2015”.
SEC. 2. PURPOSES.

The purposes of this Act are to—

(1) foster the delivery of high-quality post-acute care services in the most cost-effective manner possible;

(2) preserve the ability of patients, with the guidance of their physicians, to select their preferred providers of post-acute care services;

(3) promote competition among post-acute care providers on the basis of quality, cost, accountability, and customer service;

(4) achieve long-term sustainability by ensuring operational stability through regional breadth and the engagement of experienced care PAC coordinators;

(5) advance innovation in fields including telehealth, care coordination, medication management, and hospitalization avoidance; and

(6) provide for the financial security of the Medicare program by achieving substantial program savings through maximized efficiencies, cost avoidance, and outcomes improvement.
SEC. 3. PROVIDING BUNDLED PAYMENTS FOR POST-ACUTE CARE SERVICES UNDER PARTS A AND B OF MEDICARE.

Title XVIII of the Social Security Act is amended by inserting after section 1866E (42 U.S.C. 1395cc–5) the following new section:

"PROVIDING BUNDLED PAYMENTS FOR POST-ACUTE CARE SERVICES

"Sec. 1866F. (a) IN GENERAL.—For a PAC bundle with respect to qualifying discharges occurring on or after January 1, 2017, instead of the payment otherwise provided under parts A and B, there shall be paid a single payment amount (determined under subsection (d) and as limited under paragraph (4) of such subsection) to be paid to a PAC coordinator (as described in subsection (c)) selected by an individual under such subsection.

"(b) PAC-RELATED DEFINITIONS.—In this section:

"(1) PAC BUNDLE.—The term ‘PAC bundle’ means PAC services furnished to an individual during a PAC period in a PAC area.

"(2) PAC SERVICES.—

"(A) IN GENERAL.—The term ‘PAC services’ includes—

"(i) post-hospital extended care services, subject to subparagraph (C)(i);
“(ii) home health services, subject to clauses (ii) and (iii) of subparagraph (C);

“(iii) inpatient services provided in a rehabilitation facility, subject to subparagraph (C)(iii);

“(iv) inpatient hospital services provided by a long-term care hospital, subject to subparagraph (C)(iv);

“(v) durable medical equipment;

“(vi) outpatient physical therapy services;

“(vii) outpatient occupational therapy services;

“(viii) outpatient prescription drugs and biologicals; and

“(ix) skilled nursing facility services.

“(B) EXCEPTIONS.—Such term does not include—

“(i) physicians’ services;

“(ii) hospice care;

“(iii) outpatient hospital services;

“(iv) ambulance services;

“(v) outpatient speech-language pathology services; and
“(vi) the items and services described in section 1861(s)(9).

“(C) NONAPPLICATION OF CERTAIN COVERAGE LIMITATIONS.—

“(i) WAIVER OF SKILLED NURSING FACILITY THREE DAY STAY REQUIREMENT.—In applying subparagraph (A)(i), the 3-day stay requirement described in section 1861(i) (requiring that an individual’s inpatient stay in a discharging hospital be for a duration of not less than 3 consecutive days) shall not apply.

“(ii) WAIVER OF HOMEBOUND REQUIREMENT FOR HOME HEALTH SERVICES.—In applying subparagraph (A)(ii), the requirements cited in sections 1814(a)(2)(C) and 1835(a)(2)(A) that home health services are or were required because the individual is or was confined to the home of the individual shall not apply.

“(iii) WAIVER OF FACE-TO-FACE DOCUMENTATION REQUIREMENT.—In applying the subparagraph (A)(ii), the requirements cited in sections 1814(a)(2)(C) and 1835(a)(2)(A) that the face-to-face en-
counter described in each such section must be documented shall not apply.

“(iv) Nonapplication of rehabilitation facility percentage requirement.—In applying subparagraph (A)(iii), any requirement that a specified percentage of the inpatient population served by the facility require intensive rehabilitation services for treatment of one or more of the conditions specified in section 412.29(b)(2) of title 42, Code of Federal Regulations, as of December 19, 2013, shall not apply.

“(v) Nonapplication of long-term care hospital percentage requirement.—In applying subparagraph (A)(iv), any requirement that a specified percentage of the discharged Medicare inpatient population of the long-term care hospital or its satellite facility be admitted to the hospital or its satellite facility from its colocated hospital shall not apply.

“(vi) Nonapplication of such other requirements as determined by the Secretary.—In applying sub-
paragraph (A), any other such requirement that the Secretary determines it is necessary not to apply in order to ensure appropriate implementation of this section shall not apply.

“(3) PAC PERIOD.—The term ‘PAC period’ means the period beginning on the date of a qualifying discharge (as defined in paragraph (10)) and ending on the date that is the earlier of the following:

“(A) The date that is 90 days after the date of such discharge.

“(B) The date on which the individual is admitted to a hospital for purposes of receiving services for a condition that is not related to the condition for which the individual received the acute care inpatient hospital services described in paragraph (10)(A).

“(4) PAC AREA.—The term ‘PAC area’ means an area with respect to which a PAC coordinator has a PAC agreement in effect under subsection (c)(1)(B).

“(5) PAC PHYSICIAN.—The term ‘PAC physician’ means, with respect to an individual receiving a PAC bundle, the physician who has primary re-
sponsibility with respect to supervising the delivery of services during the course of a PAC period.

“(6) PAC PROVIDER.—The term ‘PAC provider’ means, with respect to PAC services, the provider of services or supplier furnishing such services.

“(7) PAC NETWORK AGREEMENT.—The term ‘PAC network agreement’ means, in the case that an individual has selected a PAC coordinator under subsection (c)(4)(A) for the furnishing of PAC services, an agreement of a PAC coordinator with one or more PAC providers to provide such services to such individual.

“(8) PAC READMISSION.—The term ‘PAC readmission’ means, with respect to an individual receiving a PAC bundle, the individual’s admission to a hospital within 90 days of the date of the qualifying discharge of the individual, for purposes of receiving services for a condition that is related to the condition for which the individual received the acute care inpatient hospital services described in paragraph (10)(A).

“(9) PAC ASSESSMENT TOOL.—The term ‘PAC assessment tool’ means the Continuity Assessment Record and Evaluation (CARE) tool (or such equivalent assessment tool as the Secretary may specify).
“(10) QUALIFYING DISCHARGE.—Subject to subsection (e), the term ‘qualifying discharge’ means a discharge after receiving acute care inpatient hospital services (as defined by the Secretary) in a subsection (d) hospital (as defined in section 1886(d)(1)(B)) for which the discharge plan includes the furnishing of PAC services.

“(11) CRG.—The term ‘CRG’ means a condition-related group established under subsection (d)(1).

“(c) PAC COORDINATORS.—

“(1) IN GENERAL.—In this section, the term ‘PAC coordinator’ means a hospital, PAC provider, insurer, third-party administrator, or combination of hospital and PAC provider that—

“(A) is certified, under a process established by the Secretary, as meeting appropriate requirements specified by the Secretary, including the requirements specified in paragraph (2); and

“(B) has entered into and has in effect a PAC agreement with the Secretary described in paragraph (3).

For purposes of subparagraph (A), an entity that meets the requirements specified in paragraph (2)
directly or indirectly (including through an arrange-
ment with one or more insurance providers or bene-
fits administrators) shall be considered as meeting
the requirements specified in such paragraph.

“(2) REQUIREMENTS.—The requirements speci-
cified in this paragraph, with respect to an entity
serving a PAC area, are the following:

“(A) FINANCIAL SOLVENCY.—The entity
has the capacity, and provides sufficient assur-
ances of solvency, to bear financial risk as a
PAC coordinator under this section.

“(B) CAPACITY TO MANAGE CARE AND
FUNDING.—The entity has the capability to
manage the care and funding for PAC services
in such area.

“(C) PAC NETWORK AGREEMENTS.—

“(i) NETWORK CAPACITY TO SERVE
PAC AREA.—

“(I) IN GENERAL.—The entity
has entered into PAC network agree-
ments with a sufficient number of
PAC providers in a PAC area to meet,
with respect to such area, such net-
work adequacy requirements as are
established by the Secretary.
“(II) Preservation of Patient Choice.—The network adequacy requirements described in subclause (I) shall include a requirement that the entity has, with respect to any group of PAC providers described in subclause (III), a governance or financial relationship (outside of the PAC network agreement) with less than 50 percent of the PAC providers in such group.

“(III) Groups Described.—The groups of PAC providers described in this subclause are the following:

“(aa) The group of all the PAC providers with which the entity has entered into PAC network agreements.

“(bb) Any group of PAC providers with which the entity has entered into PAC network agreements that consists solely of a single type of provider and that includes all of the PAC providers with which the entity has entered
into such agreements that are
such type of provider.

“(ii) LIMITATION ON BALANCE BILL-
ing.—Such a PAC network agreement
shall provide that the PAC provider shall
accept as payment in full for PAC services
furnished by such PAC provider the appli-
cable amount described in paragraph
(3)(C).

“(iii) QUALITY ASSURANCE.—Such a
PAC network agreement shall provide that
the PAC provider shall have in effect a
written plan of quality assurance and im-
provement, and procedures implementing
such plan, that meet such quality stand-
ards as the Secretary specifies.

“(D) CREDIT-WORTHINESS.—The entity
has demonstrated credit-worthiness.

“(E) MEDICAL DIRECTOR.—The entity em-
loys or contracts with a medical director who
has an appropriate medical background.

“(F) PAC COORDINATOR PERFORM-
ANCE.—The entity has in effect a written plan
of quality assurance and improvement, and pro-
cedures implementing such plan, that meet such
quality standards as the Secretary may specify. For purposes of implementing the preceding sentence, the standards specified by the Secretary shall address access to care, beneficiary choice, clinical quality of network providers, patient experience of care, care coordination, efficiency, and such other domains as are identified by the Secretary.

“(3) TERMS OF PAC AGREEMENT.—The PAC agreement described in this paragraph between an entity and the Secretary shall, with respect to the PAC area specified under subparagraph (B), have such terms and conditions as are specified by the Secretary consistent with this section and shall include the following:

“(A) CARE COORDINATION.—With respect to an individual who selects the entity under paragraph (4)(A)—

“(i) the individual shall select one or more PAC providers in such area to furnish, directly or indirectly, clinically appropriate PAC services (as determined through the use of the PAC assessment tool) to the individual; and
“(ii) the entity shall coordinate the furnishing of all such services for the individual.

“(B) PAC AREA COVERED.—The PAC agreement shall specify the PAC area under the PAC agreement.

“(C) PAYMENT AMOUNT FOR PAC SERVICES.—For PAC services furnished by a PAC provider and furnished with respect to a qualifying discharge, the entity shall pay the PAC provider under the PAC network agreement between the entity and the PAC provider—

“(i) with respect to such PAC services that are services for which the PAC provider would receive payment under this title without regard to this section, an amount that is not less than the amount that would otherwise be paid to such PAC provider under this title for such services; and

“(ii) with respect to such PAC services that are services for which the PAC provider would not receive payment under this title without regard to this section, an
amount specified under such PAC network agreement; and

“(D) DISTRIBUTION OF SAVINGS.—Insofar as the payment amount to a PAC coordinator under subsection (d)(3) for a PAC bundle furnished to an individual is greater than the aggregate amounts paid to PAC providers under subparagraph (C) for such bundle for such individual, the entity shall not retain an amount greater than 55 percent of such savings and shall pay an amount equivalent to—

“(i) not less than 15 percent of such savings to such PAC providers;

“(ii) not less than 15 percent of such savings to the PAC physician of the individual; and

“(iii) in the case that there is no PAC readmission of the individual, not less than 15 percent of such savings to the hospital discharging the individual immediately prior to the furnishing of such services.

Payments shall be made under each of clauses (i), (ii), and (iii) to individuals and entities independent of whether payment may be made
to such an individual or entity under another such clause.

“(E) MAINTENANCE OF ADVISORY COMMITTEE.—The entity shall maintain an advisory committee of PAC providers and of patient stakeholders to advise the entity regarding its activities under this section.

“(F) USE OF TECHNOLOGY.—

“(i) IN GENERAL.—The entity shall utilize information technology to receive and maintain documentation regarding interactions between PAC providers that have entered into PAC network agreements with the entity and individuals who have selected the entity under paragraph (4)(A).

“(ii) FORMAT.—The entity shall receive and maintain the documentation described in clause (i) in data fields that are in a format that allows and for such data fields to integrate with electronic medical records in a standardized manner (as determined by the Secretary).

“(G) EVIDENCE-BASED GUIDELINES.—The entity shall encourage PAC providers that have entered into PAC network agreements with the
entity to use evidence-based guidelines to in-
form clinical care decisions made with respect
to individuals who have selected the entity
under paragraph (4)(A).

“(4) Selection and change of selection
of PAC coordinators by individual.—

“(A) In general.—The Secretary shall
establish a process for the selection and change
of selection of a PAC coordinator by an indi-
vidual who is receiving inpatient hospital serv-
ices and whose discharge has been or is likely
to be classified as a qualifying discharge.

“(B) Limitation on selection due to
network adequacy.—The process established
under subparagraph (A) may not allow an indi-
vidual to select (or to change a selection to) a
PAC coordinator in a PAC area unless the PAC
coordinator has entered into PAC network
agreements with such PAC providers in such
PAC area such that the PAC coordinator has a
sufficient number and range of health care pro-
fessionals and providers willing to provide serv-
ices under the terms of the PAC agreement.

“(C) Limitation on selection imposed
by discharging hospital.—
“(i) IN GENERAL.—Subject to clause (ii), the process established under subpara-
graph (A) shall allow the hospital in which the individual receives the acute care inpa-
tient hospital services described in sub-
section (b)(10) to limit the selection of a PAC coordinator by the individual to such PAC coordinators as the hospital identifies (such as through the adoption, by the hos-
pital, of additional standards that a PAC coordinator must meet in order for such an individual to select the PAC coordinator).

“(ii) MINIMUM SELECTION STAND-
ARDS.—With respect to an individual de-
scribed in clause (i), a hospital described in such clause may not, in identifying PAC coordinators under such clause from which the individual may make a selection de-
scribed in subparagraph (A), do either of the following:

“(I) Identify less than two PAC coordinators.

“(II) Identify only PAC coordinators that have a governance or finan-
cial relationship with the hospital.
“(D) ASSIGNMENT IN CASE OF NO SELECTION BY INDIVIDUAL.—In the case that an individual described in subparagraph (A) does not select a PAC coordinator through the process established under such subparagraph, the Secretary shall assign a PAC coordinator to the individual. For purposes of this section, an assignment described in the preceding sentence shall be considered to be a selection by the individual under subparagraph (A).

“(5) CONSTRUCTION RELATING TO PAC COORDINATORS OFFERING NON-PAC SERVICES.—Nothing in this section shall be construed as prohibiting PAC providers from offering, either directly or indirectly, services that contribute to patient care, safety, and readmission avoidance (such as medication management, telehealth technologies, home environment services, and transportation services) that are not PAC services.

“(6) CONSTRUCTION REGARDING FLEXIBILITY IN THE DELIVERY OF PAC SERVICES.—Nothing in this section shall be construed to prevent a PAC network agreement from permitting a PAC provider to subcontract for the furnishing of PAC services that the PAC provider is otherwise obligated to provide
under the agreement so long as the subcontractor meets the same terms and conditions in furnishing such services as would apply if the PAC provider were to provide such services.

“(d) PAYMENT AMOUNTS.—

“(1) CLASSIFICATION OF CONDITIONS BY CRGS; METHODOLOGY FOR CLASSIFICATION.—The Secretary shall use standardized post-acute care assessment data reported pursuant to section 1899B to establish a classification of the conditions of individuals receiving a PAC bundle by CRG and a methodology for classifying specific PAC bundles within these groups. The methodology shall, to the extent feasible, classify such bundles through the use of the PAC assessment tool.

“(2) COMPUTATION OF BASE RATE.—

“(A) IN GENERAL.—The Secretary shall compute an average payment rate for PAC bundles classified in each CRG and furnished during a PAC period ending in the base year selected under subparagraph (B).

“(B) BASE YEAR SELECTION.—The Secretary shall select as a base year the most recent year ending before the date of the enact-
ment of this section for which data are available to carry out this section.

“(C) BUDGET-NEUTRAL COMPUTATION.—
The average payment rate for a PAC bundle classified in a CRG shall be computed in a manner so that, if it had been applied in the base year, the aggregate payments for PAC bundles classified in such CRG and furnished during a PAC period ending in such year would be equivalent to the aggregate payments under this title for such bundles.

“(3) CALCULATION OF PAYMENT AMOUNT BASED ON BASE RATE.—Subject to the succeeding provisions of this subsection, the amount of the single payment described in this paragraph, with respect to a PAC bundle classified within a CRG and furnished to an individual during a PAC period ending—

“(A) in 2020, is the base average payment rate for such bundle computed under paragraph (2), increased by such percentage as the Secretary estimates is the average rate of increase in payments under this title for such bundle between the base year and 2020; and
“(B) in a subsequent year, is the amount of the single payment for such bundle computed under this paragraph for the previous year, increased, subject to paragraph (4), by such percentage as the Secretary estimates is the average rate of increase in payments under this title for such bundle between such previous year and such subsequent year.

“(4) Calculation of annual percentage increase.—In calculating the percentage increases applied under paragraph (3)(B), the Secretary shall ensure that total expenditures for all PAC bundles provided in accordance with this section over the 8-fiscal year period beginning with fiscal year 2020 do not exceed 96 percent of the expenditures that would have been made over such period but for the application of this section.

“(5) Adjustment for readmissions during PAC period.—The amount paid to a PAC coordinator under this subsection for a PAC bundle in a PAC period that includes a PAC readmission shall be reduced by an amount equal to the aggregate amount of payments made for such PAC readmission of such individual.
“(6) Adjustment for geographic, risk, and socio-economic and demographic factors.—The Secretary shall adjust the amount of payment described in paragraph (3) with respect to services furnished to an individual in a PAC area in a budget-neutral manner for a year—

“(A) by an appropriate factor that reflects variations in costs for the furnishing of PAC bundles among different geographic areas;

“(B) by an appropriate factor that accounts for variations in costs for the furnishing of such PAC services to the individual based upon the health status of the individual; and

“(C) by an appropriate factor that accounts for variations in socioeconomic and demographic characteristics of the individual, such as whether the individual is both eligible for benefits under title XVIII and eligible under a State plan for medical assistance under title XIX, and whether the individual has a willing and able caregiver.

“(7) Adjustment in case of change of selection by individual.—In the case of a change of selection of PAC coordinator by the individual under subsection (c)(4) during a PAC period, the
Secretary shall adjust the amount of payment described in paragraph (3) in order to provide appropriate partial payments to be paid to the PAC coordinator selected initially by the individual and to the PAC coordinator selected under the change of selection by the individual. The method of calculating the respective amounts of such appropriate partial payments shall be based on the method used for the Home Health Partial Episode Payment adjustment.

“(8) ADJUSTMENT IN CASE OF DEATH OF INDIVIDUAL.—In the case of the death of an individual during a PAC period who has selected a PAC coordinator under subsection (c)(4), the Secretary shall adjust the amount of payment described in paragraph (3) to the PAC coordinator in a manner that reduces such payment by a proportion equal to the proportion by which the 90-day PAC period of the individual was reduced by the death of the individual.

“(9) USE OF PAC ASSESSMENT TOOL FOR PURPOSES OF ADJUSTMENT FOR RISK FACTORS.—In determining an appropriate factor under paragraph (6)(B) with respect to an individual, the Secretary shall take into account an assessment of the individual conducted using the PAC assessment tool.
“(e) PHASE-IN.—

“(1) Determination of PAC expenditures by CRG.—Based on the most recent data available, the Secretary shall determine the aggregate amount of expenditures under this title for PAC services furnished during the PAC period for each CRG (as defined in paragraph (b)(11)).

“(2) Ranking of CRGs by volume of expenditure.—The Secretary shall rank the CRGs in order based on the aggregate amount of expenditures for PAC services described in clause (i) for each CRG.

“(3) Grouping of CRGs.—The Secretary shall group CRGs into four groups as follows:

“(A) First group.—The first group consists of the CRGs that have the highest rank under clause (ii) and that collectively account for 25 percent of the aggregate amount of expenditures for PAC services described in clause (i).

“(B) Second group.—The second group consists of the CRGs that have the next highest rank under clause (ii) after the first group in subclause (I) and that collectively account for
25 percent of the aggregate amount of expenditures for PAC services described in clause (i).

“(C) Third Group.—The third group consists of the CRGs that have the next highest rank under clause (ii) after the second group in subclause (II) and that collectively account for 25 percent of the aggregate amount of expenditures for PAC services described in clause (i).

“(D) Fourth Group.—The fourth group consists of the CRGs that are not included in the first, second, or third group under this clause.

“(4) Phase-in by CRG Grouping.—In applying this section for discharges in—

“(A) 2020, only discharges that are classified within the first group under subclause (I) of clause (iii) shall be included;

“(B) 2021, only discharges that are classified within the first or second group under subclause (I) or (II) of clause (iii) shall be included;

“(C) 2022, only discharges that are classified within the first, second, or third group under subclause (I), (II), or (III) of clause (iii) shall be included; and
“(D) 2023 and subsequent years, dis-
charges that are classified within any group of
CRGs shall be included.”.

SEC. 4. STUDY AND REPORT ON INTEGRATION OF POST-
ACUTE CARE PAYMENTS WITH ACUTE CARE
PAYMENTS.

(a) STUDY.—The Secretary of Health and Human
Services shall conduct a study to examine the feasibility
of integrating (or “bundling”) all payments under the
Medicare program for post acute care services under sec-
tion 1866F of the Social Security Act, as added by section
3, with payments for acute care inpatient hospital services
(as defined by the Secretary pursuant to subsection
(b)(10) of such section 1866F) in a subsection (d) hospital
(as defined in section 1886(d)(1)(B) of such Act (42
U.S.C. 1395ww(d)(1)(B))), including an examination of
the anticipated timing and impact of such integration.

(b) REPORT.—Not later than January 1, 2020, the
Secretary shall submit a report to the Committees on
Ways and Means and on Energy and Commerce in the
House of Representatives, and to the Committee on Fi-
nance in the Senate, on the results of the study conducted
under subsection (a).
SEC. 5. MORATORIUM ON IPPS PAYMENT RATE IN CERTAIN CASES.

Section 1886(m)(6) of the Social Security Act (42 U.S.C. 1395ww(m)(6)) is amended in—

(1) subparagraph (A)(i), by striking “2015” and inserting “2021”;

(2) subparagraph (B)(i)(I), by striking “2016” and “2017” and inserting “2022” and “2023”, respectively;

(3) subparagraph (B)(i)(II), by striking “2018” and inserting “2024”;

(4) subparagraph (C)(i), by striking “2016” and inserting “2022”;

(5) subparagraph (C)(ii), by striking “2020” and inserting “2026”; and

(6) subparagraph (C)(iv), by striking “2020” and inserting “2026”.

SEC. 6. TRANSITIONAL CARE MANAGEMENT PAYMENTS FOR PHYSICIANS.

For purposes of encouraging transitional care management by PAC physicians (as defined in section 1866F(b)(5) of the Social Security Act), in carrying out section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)), the Secretary of Health and Human Services shall establish a new Transitional Care Management (TCM) code to pay for care management by such a PAC.
1 physician or revise and expand the use of existing TCM
2 codes 99495 and 99494.