**American Academy of Physical Medicine and Rehabilitation**

Comprehensive Care Payment Innovation Act & Post-Acute Care Bill Summaries

* Comprehensive Care Payment Innovation Act of 2015 (H.R. 2502)
* Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2015 (H.R. 1458)

On Thursday, May 21, 2015, Rep. Diane Black (R-TN) introduced the **Comprehensive Care Payment Innovation Act of 2015 (H.R. 2502)**. The bill currently has one cosponsor, Rep. Richard Neal (D-MA), and was referred to the House Committees on Ways and Means and Energy and Commerce. Rep. Black previously introduced a bill, H.R. 3796, by the same name in the 113th Congress. This bill, along with Rep. David McKinley’s bill of a similar nature (the **Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2015 (H.R. 1458)**), is generally referred to as Medicare “bundling” legislation. However, Rep. McKinley’s bill only bundles post-acute care settings, while Rep. Black’s bill bundles both acute and post-acute care settings.

**Overview**. The Comprehensive Care Payment Innovation Act of 2015 seeks to amend Title XVIII (Medicare) of the Social Security Act (SSA) by adding a new section that instructs the Secretary of the Department of Health and Human Services (HHS) to provide for bundled payments for integrated care furnished by a “qualified entity” during an “episode of care” to an “applicable beneficiary” for “applicable conditions” involving a hospitalization.

**Applicable Beneficiary**. An applicable beneficiary is an individual who is entitled to, or enrolled in, benefits under Medicare Part A and enrolled for benefits under Medicare Part B, but is not enrolled in Medicare Part C or in a Program of All-inclusive Care for the Elderly (PACE), and who is admitted to a hospital for an applicable condition.

**Qualified Entity (Bundle Holder)**. A qualified entity is a corporation, partnership, or limited liability company (LLC) that is authorized by a group of providers of services and suppliers, including at least a hospital that participates in Medicare or may be a provider of services or supplier that participates in Medicare. Entities must submit an application to be approved by the Secretary to receive bundled payments.

The bill directs the Secretary to develop requirements for qualified entities to receive bundled payments. Such requirements must ensure transparency for applicable beneficiaries, including a notice provided to applicable beneficiaries. Under such requirements, qualified entities must agree to receive bundled payments for a five-year agreement period.

**Applicable Conditions**. Applicable conditions include the following procedures furnished as part of inpatient hospital services:

* Hip/knee joint replacement;
* Lumbar spine fusion;
* Coronary artery bypass graft (CABG);
* Heart valve replacement;
* Percutaneous coronary intervention with stent; and
* Colon resection.

The Secretary may select additional procedures or conditions.

**Applicable Services**. Applicable services include:

* Acute care inpatient services;
* Physicians’ services delivered inside and outside of an acute care hospital;
* Outpatient hospital services;
* Post-acute care services, including home health services, skilled nursing facility services, inpatient rehabilitation hospital services, and inpatient hospital services furnished by a long-term care hospital (LTCH); and
* Other services the Secretary deems appropriate.

**Exception.** The sole exception to the bundle mentioned in the bill are items and services described in SSA §1861(s)(9),1 except for off-the-shelf orthotic devices that meet the following criteria:

* The Secretary has included those devices in an actively operative competitive bidding program;
* The devices require adjustment only by the patient and not by any other person, such as a caretaker or supplier; and
* The Secretary provides notification of the identity of those devices pursuant to notice and comment rulemaking.

No therapies mentioned as applicable services or as exceptions. Interestingly, occupational therapy, physical therapy, and speech-language pathology services are not mentioned in the bill as either as part of the bundle or as exceptions to the bundle.

**Episode of Care**. An episode of care is the period consisting of:

* The three days prior to admission to a hospital;
* The duration of the initial inpatient stay in such hospital; and
* The 90 days following discharge from the acute care hospital.

The Secretary may establish a period, other than the one previously described, for an episode of care based on data analyses.

**Bundled Payments.** Under the legislation, the Secretary must develop bundled payments for qualified entities which provide comprehensive payment for the costs of applicable services furnished to an applicable beneficiary for an episode of care, including readmission related to the applicable condition (but excluding unrelated readmissions). Bundled payments may be made under a fee-for-service model or a prospective payment model. Computation of bundled payments must be based on the spending targets outlined in Section 2(f)(2) of this Act.

**Fee-for-Service Bundled Payment Model**. If a qualified entity selects a fee-for-service bundled payment model, the Secretary must pay providers amounts payable under Medicare Parts A and B for such services in the same manner as such providers would otherwise be paid under such Parts. Computation of fee-for-service bundled payments, spending targets, and reconciliation is outlined in Section 2(g) of this Act.

[Note: This provision prohibits the qualified entity/bundle holder from negotiating deep discounts from downstream providers, which removes one of the principal methods of achieving savings but also lessens the fear that downstream providers will have for participation in bundled payment programs. This provision may also help preserve the quality of care provided as it is likely to prevent a “race to the bottom” in terms of lowest bid providers and suppliers.]

**Prospective Bundled Payment Model for Advanced Qualified Entities**. A qualified entity may elect to receive a prospective bundled payment for each episode of care. Such spending targets will be computed in the same manner as the fee-for-service bundled payment model.

**Quality**. Qualified entities may enter into quality and efficiency arrangements under which providers work to improve the quality and efficiency of care.

For each applicable condition, the Secretary must select quality measures for care provided by healthcare providers to which bundled payments are made. The Secretary must develop longitudinal quality and efficiency measures to assess qualified entities’ performance with respect to patient outcomes. Qualified entities must submit quality data to the Secretary each year for which they agree to receive bundled payments.

**Waivers**. The Secretary must waive such provisions of this title, as may be necessary to carry out the program, as specified in Section 2(k)(1) of this Act. The Secretary may modify or terminate waivers under certain circumstances, as specified in Section 2(k)(2) of this Act.

**Reports**. The Secretary must conduct an independent evaluation regarding the impact of bundled payments. The evaluation must address health outcomes, access to care, reduced spending, and quality measures. An interim report must be submitted no later than March 1, 2019, and a final report must be submitted no later than March 1, 2021.

**Next Steps.** It is expected that the House Ways and Means Committee will hold a hearing on this bill in the near future.