H.R. 4673 Bill Summary
The Bundling and Coordinating Post-Acute Care Act of 2014
(BACPAC Act of 2014)

Section I. Bill Title.

H.R. 4673 The Bundling and Coordinating Post-Acute Care Act of 2014 (known as BACPAC Act of 2014)

Section II. Purposes.

The purposes of this Act are to –

" (1) foster the delivery of high-quality post-acute care (PAC) 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."

Section III. Providing Bundled Payments for Post-Acute Care Services under Parts A and B of Medicare.

This section amends Medicare and adds a new section pertaining to "bundled payments for post-acute care services."

For "qualifying discharges" occurring on or after January 1, 2016 – instead of payments provided under parts A and B, a single payment amount will be provided to a "PAC coordinator."

PAC bundle covers services given to an individual during a PAC period (defined as beginning on the date of a qualifying discharge and ending on the date that is the earlier than 90 days after the date of the discharge or the date on which the individual is admitted to a hospital for receiving services for a condition not related to the acute care inpatient stay) in a PAC area (defined as an area where a PAC coordinator has a PAC agreement).

PAC services include:

- Post-hospital extended care services;
- Home health services;
- Inpatient services provided in a rehabilitation facility;
- Inpatient hospitals services provided by a long-term care hospital;
- Durable medical equipment (DME);
- Outpatient prescription drugs and biologicals; and
- Skilled nursing facility (SNF) services.

PAC services do NOT include:

- Physicians' services;
- Hospice care;
- Outpatient hospital services;
- Ambulance services;
- Outpatient physical therapy (PT) services;
- Outpatient occupational therapy (OT) services;
- Outpatient speech-language pathology services; and
- Items and services described in section 1861(s)(9) [Medical and Other Health Services defined]

Nonapplication of Certain Coverage Limitations

- For Skilled Nursing Facilities (SNFs): The three-day stay requirement for SNF care is waived for the provision of "post-hospital extended care services."
- For home care: The homebound requirement for home health services is waived for the provision of "home health" services.
- For Long Term Care Hospitals (LTCHs): Any requirement that a specified percentage of the discharged Medicare inpatient population of an LTCH or its

satellite facility be admitted to the hospital or its satellite facility from its co-located hospital is waived.

Definitions

- **PAC Physician** is a physician who has "primary responsibility with respect to supervising the delivery of services during the course of the PAC period."
- **PAC Provider** is a "provider of services or supplier furnishing such [PAC] services."
- **PAC Network Agreement** is, for an individual who has selected a PAC coordinator for PAC services, "an agreement of a PAC coordinator with one or more PAC providers to provide such services" to the individual.
- **PAC Readmission** with respect to an individual "receiving a PAC bundle," refers to that individual's "admission to a hospital within 90 days of the date of the qualifying discharge of the individual for the purposes of receiving services for a condition that is related to the condition for which the individual received the acute care inpatient hospital services."
- **PAC Assessment Tool** means the "Continuity Assessment Record and Evaluation (CARE) tool."
- **Qualifying Discharge** means a discharge "after receiving inpatient hospital services (as defined by the Secretary) in a subsection (d) hospital for which the discharge plan includes the furnishing of PAC services." (The underlying statutory definition of subsection (d) hospitals includes "rehabilitation hospitals (as defined by the Secretary)."
- **PAC Coordinator** refers to "an entity (such as a hospital, health insurance issuer, third-party benefit manager, or PAC provider) that has entered into an agreement with the Secretary and is certified, under a process established by the Secretary, as meeting appropriate requirements specified by the Secretary, including [financial solvency, capacity to manage care and funding, PAC network agreements to ensure availability of care, credit-worthiness, medical director employed, etc.]."
- **Agreement with Secretary** of Health and Human Services (HHS) will be determined by the Secretary, and shall include provisions regarding: care coordination; PAC area covered; payment; and distribution of savings.

Payment

For a qualifying discharge PAC services before January 1, 2019, entity "shall pay the PAC provider … an amount not less than the amount that would otherwise be paid to such PAC provider under this title for such services, and, 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."

Payment "on or after January 1, 2019, the entity shall pay the PAC provider under such PAC network agreement an amount specified under such agreement."

Distribution of Savings

If the payment to a PAC coordinator for a PAC coordinator 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 70 percent of such savings and shall pay an amount equivalent to

(i) Not less than 10 percent of such savings to such PAC providers;

(ii) Not less than 10 percent of such savings to the PAC physician of the individual;

(iii) In the case that there is no PAC readmission of the individual, not less than 10 percent of such savings to the hospital discharging the individual immediately prior to the furnishing of such services."

The PAC [bundle coordinating] entity shall maintain an advisory committee of PAC providers and of patient stakeholders to advise the entity regarding its activities.

Selection and Change of Selection of PAC Coordinators

Secretary "shall establish a process for the selection and change of selection of a PAC coordinator by an individual receiving inpatient hospital services and whose discharge has been or is likely to be classified as a qualifying discharge."

Individuals are not able to select or change a selection "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 professionals and providers willing to provide services under the terms of the PAC agreement."

Other Provisions

PAC providers can offer – and are not prohibited by anything in the legislation – 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."

Subcontracting is permitted 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."

Secretary "shall 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."

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 [as selected by the Secretary]."

Budget Neutral Computation – the average payment rate for a PAC bundle classified in a CRG shall be computed in a manner so that the aggregate payments for PAC bundles would be the same as the aggregate payments otherwise.

Secretary shall "ensure that total expenditures for all PAC bundles provided in accordance with this section do not exceed 96 percent of the applicable baseline over the 8-fiscal-year period beginning with fiscal year 2016."

Secretary shall "determine the aggregate amount of expenditures under this title for PAC services furnished during the PAC period for each CRG [condition related group]."

Secretary "shall rank the CRGs in order based on the aggregate amount of expenditures for PAC services for each CRG."

Secretary shall create for groups of CRGs:

(1) Highest rank and 25% of aggregate amount of expenditures for PAC services;

(2) Next highest rank and 25% of aggregate amount of expenditures for PAC services;

(3) Next highest rank and 25% of aggregate amount of expenditures for PAC services; and

(4) CRGs not included in the first, second, and third group.

Adjustment for Readmissions During PAC Period

In the event of a PAC readmission, the payment for a PAC bundle in a PAC period "shall be reduced by an amount equal to the aggregate amount of payments made for such PAC readmission of such equivalent."

Geographic and Risk Adjustments

Secretary "shall adjust the amount of payment" with respect to "services furnished to an individual in a PAC area in a budget-neutral manner for a year" and (A) reflects variations in costs among geographic areas, (B) accounts for variations in costs for the furnishing of such PAC services based upon the health status of the individual [Secretary shall take into account an assessment using the PAC assessment tool]; and (C) accounts for historical local (hospital referral cluster) pricing.

In the case of a change of selection of PAC coordinator by the individual during a PAC period, the Secretary "shall adjust the amount of payment … in order to provide appropriate partial payments to be paid to the PAC coordinator selected initially … and to the PAC coordinator selected under the change of selection by the individual." The partial payment shall be based on the method used for the Home Health Partial Episode Payment adjustment.

Phase-In by CRG Grouping

- In 2016, only discharges classified in the CRG first grouping shall be included.
- In 2017, only discharges classified within first or second CRG groupings shall be included.
- In 2018, only discharges classified within the first, second, or third CRG groupings shall be included.
- In 2019 and subsequent years, discharges that are classified within any group of CRGs shall be included.

Section IV. Transitional Care Management Payments for Physicians.

To encourage transitional care management by PAC physicians, Secretary shall "establish a new Transitional Care Management (TCM) code to pay for care management by such a PAC physician or revise and expand the use of existing TCM codes 99495 and 99494."