

114TH CONGRESS
1ST SESSION

H. R. 2502

To amend title XVIII of the Social Security Act to provide for bundled payments for certain episodes of care surrounding a hospitalization.

IN THE HOUSE OF REPRESENTATIVES

MAY 21, 2015

Mrs. BLACK (for herself and Mr. NEAL) 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 for bundled payments for certain episodes of care surrounding a hospitalization.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Comprehensive Care
5 Payment Innovation Act of 2015”.

1 **SEC. 2. PERMANENT, NATIONAL VOLUNTARY PAYMENT**
2 **BUNDLING.**

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

6 “NATIONAL VOLUNTARY PAYMENT BUNDLING

7 “SEC. 1866F. (a) ESTABLISHMENT AND IMPLEMEN-
8 TATION.—

9 “(1) IN GENERAL.—The Secretary shall provide
10 for bundled payments under this section for inte-
11 grated care furnished by a qualified entity during an
12 episode of care to an applicable beneficiary for appli-
13 cable conditions involving a hospitalization.

14 “(2) DEADLINE.—The Secretary shall imple-
15 ment this section not later than January 1, 2016.

16 “(3) APPLICABLE BENEFICIARY DEFINED.—In
17 this section, the term ‘applicable beneficiary’ means
18 an individual who is entitled to, or enrolled for, ben-
19 efits under part A and enrolled for benefits under
20 part B, but not enrolled under part C or in a PACE
21 program under section 1894, and who is admitted to
22 a hospital for an applicable condition.

23 “(b) QUALIFIED ENTITY AND APPLICATION PROC-
24 ESS.—

25 “(1) DEFINITIONS.—In this section:

1 “(A) IN GENERAL.—The term ‘qualified
2 entity’ means a qualified applicant that has an
3 application approved by the Secretary to receive
4 bundled payments for furnishing applicable
5 services to applicable individuals under this sec-
6 tion.

7 “(B) QUALIFIED APPLICANT.—The term
8 ‘qualified applicant’ means a corporation, part-
9 nership, or limited liability company, that is au-
10 thorized in writing by a group of providers of
11 services and suppliers, including at least a hos-
12 pital, that are otherwise participating under
13 this title to act as their agent for the purpose
14 of receiving and distributing bundled payments
15 on their behalf under this section. A qualified
16 applicant may (but is not required to) be a pro-
17 vider of services or supplier that is otherwise
18 participating under this title.

19 “(2) APPLICATION.—

20 “(A) IN GENERAL.—A qualified applicant
21 may submit to the Secretary an application to
22 become a qualified entity to receive bundled
23 payments under this section.

1 “(B) CONTENTS.—An application under
2 subparagraph (A) with respect to a group of
3 providers of services and suppliers—

4 “(i) shall contain such information
5 and assurances as the Secretary may speci-
6 fy, including with respect to the require-
7 ments under subsection (c)(1); and

8 “(ii) shall indicate the applicable con-
9 ditions with respect to which the group
10 seeks to furnish applicable services during
11 the episode of care involved and the bun-
12 dled payment methodology under sub-
13 section (g) or (h) under which the group
14 would be paid for such services.

15 “(3) CHOICE AMONG APPLICABLE CONDI-
16 TIONS.—A qualified entity may select one or more
17 applicable conditions for bundled payments under
18 this section. Nothing in this section shall be con-
19 strued as requiring, or authorizing the Secretary to
20 require, a qualified entity to select any particular ap-
21 plicable condition under this section.

22 “(4) EXPEDITED APPLICATION PROCESS FOR
23 QUALIFIED APPLICANTS SUCCESSFULLY PARTICI-
24 PATING IN THE CMI BUNDLED PAYMENT DEM-
25 ONSTRATION.—In the case of any qualified applicant

1 that the Secretary determines has successfully par-
2 ticipated in any of the payment and service delivery
3 models tested by the Center for Medicare and Med-
4 icaid Innovation under section 1115A through the
5 Bundled Payments for Care Improvement (BPCI)
6 Initiative, the Secretary shall provide for an expe-
7 dited application process under this subsection.

8 “(c) REQUIREMENTS FOR QUALIFIED ENTITIES.—

9 “(1) REQUIREMENTS.—

10 “(A) IN GENERAL.—The Secretary shall
11 develop requirements for qualified entities to re-
12 ceive bundled payments for furnishing applica-
13 ble services for applicable conditions during an
14 episode of care under this section.

15 “(B) AGREEMENT PERIOD.—Under such
16 requirements, a qualified entity shall agree to
17 receive bundled payments for the furnishing of
18 such services for a 5-year period (each such
19 year in such period referred to in this section
20 as an ‘agreement year’).

21 “(C) BENEFICIARY TRANSPARENCY.—Such
22 requirements shall ensure transparency between
23 a qualified entity and applicable beneficiaries
24 such that notice is provided to an applicable
25 beneficiary sufficiently in advance, to the extent

practicable, of the beneficiary’s inpatient admission for the applicable condition and episode of care involved. Such a notice shall include—

“(i) appropriate notice of bundled payments for the applicable condition for the episode of care involved; and

“(ii) a statement informing the beneficiary of the beneficiary’s right to select the providers of services and suppliers furnishing items and services related to the episode of care.

“(D) METHODOLOGY AND MEASURES FOR QUALITY AND EFFICIENCY ARRANGEMENTS.—

Insofar as a qualified entity uses or seeks to implement a quality and efficiency arrangement under subsection (i), the qualified entity shall specify in the application to the Secretary in detail the methodology for allocating savings under the arrangement and the specific measures to be used to assess the quality of care under the arrangement.

“(2) PROVISION OF DATA BY SECRETARY.—

“(A) CLAIMS DATA.—

“(i) AVAILABILITY FOR APPLICATION.—The Secretary shall furnish to a

1 group of providers of services and suppliers
2 interested in submitting an application
3 under subsection (b)(2) claims data under
4 parts A and B, including complete claims
5 files, for applicable conditions relating to
6 the providers and suppliers in the group
7 that are sufficiently specific to permit such
8 group to determine whether to submit such
9 application.

10 “(ii) AVAILABILITY DURING AGREE-
11 MENT PERIOD.—Such claims data shall
12 also be furnished to a qualified entity
13 monthly during the agreement period de-
14 scribed in paragraph (1)(B) of any ap-
15 proved application with respect to an appli-
16 cable condition relating to all providers of
17 services and suppliers participating in the
18 group under this title for such applicable
19 condition.

20 “(B) QUALITY DATA.—The Secretary shall
21 furnish to a qualified entity data on quality
22 measures with respect to any applicable condi-
23 tion under an approved application during the
24 agreement period for the entity for each episode
25 of care and across the continuum of care.

1 “(d) APPLICABLE CONDITIONS.—

2 “(1) INITIAL CONDITIONS.—In this section, the
3 term ‘applicable condition’ means any of the fol-
4 lowing procedures furnished as part of inpatient hos-
5 pital services:

6 “(A) Hip/Knee joint replacement.

7 “(B) Lumbar spine fusion.

8 “(C) Coronary artery bypass graft.

9 “(D) Heart valve replacement.

10 “(E) Percutaneous coronary intervention
11 with stent.

12 “(F) Colon resection.

13 “(2) DISCRETION TO ADD CONDITIONS.—Such
14 term also includes such additional procedures or
15 conditions as the Secretary may select. In selecting
16 such procedures or conditions, the Secretary may
17 take into consideration the factors described in sec-
18 tion 1866D(a)(2)(B).

19 “(e) APPLICABLE SERVICES; EPISODE OF CARE.—In
20 this section:

21 “(1) APPLICABLE SERVICES.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), the term ‘applicable services’ means
24 the following items and services:

25 “(i) Acute care inpatient services.

1 “(ii) Physicians’ services delivered in
2 and outside of an acute care hospital set-
3 ting.

4 “(iii) Outpatient hospital services.

5 “(iv) Post-acute care services, includ-
6 ing home health services, skilled nursing
7 services, inpatient rehabilitation services,
8 and inpatient hospital services furnished by
9 a long-term care hospital.

10 “(v) Subject to subparagraph (B),
11 other services the Secretary determines ap-
12 propriate.

13 “(B) EXCEPTION.—Such term does not in-
14 clude items and services described in section
15 1861(s)(9), except for those off-the-shelf
16 orthotic devices described in section
17 1847(a)(2)(C) that meet the following condi-
18 tions:

19 “(i) The Secretary has included those
20 devices in an actively operating competitive
21 bidding program under section 1847.

22 “(ii) The devices require adjustment
23 only by the patient and not by any other
24 person, such as a caretaker or supplier.

1 “(iii) The Secretary has provided noti-
2 fication of the identity of those devices
3 pursuant to notice and comment rule-
4 making.

5 “(2) EPISODE OF CARE.—

6 “(A) IN GENERAL.—Subject to subpara-
7 graph (B), the term ‘episode of care’ means,
8 with respect to an applicable condition and an
9 applicable beneficiary, the period consisting
10 of—

11 “(i) the 3 days prior to the admission
12 of the applicable beneficiary to a hospital
13 with respect to the applicable condition;

14 “(ii) the duration of the applicable
15 beneficiary’s initial inpatient stay in such
16 hospital for the applicable condition; and

17 “(iii) the 90 days following the dis-
18 charge of the applicable beneficiary from
19 such hospital.

20 “(B) ESTABLISHMENT OF PERIOD BY THE
21 SECRETARY.—The Secretary, as appropriate,
22 may establish a period (other than the period
23 described in subparagraph (A)) for an episode
24 of care under this section based on data anal-
25 yses.

1 “(3) DISCHARGING HOSPITAL.—The term ‘dis-
2 charging hospital’ means, with respect to applicable
3 services in an episode of care, the hospital referred
4 to in paragraph (2)(A).

5 “(f) BUNDLED PAYMENT DEVELOPMENT.—

6 “(1) IN GENERAL.—Subject to the succeeding
7 provisions of this subsection, the Secretary shall de-
8 velop bundled payments for qualified entities. A bun-
9 dled payment shall provide for comprehensive pay-
10 ment for the costs of applicable services furnished to
11 an applicable beneficiary during an episode of care
12 for an applicable condition, including readmissions
13 related to the applicable condition but excluding un-
14 related readmissions, under either a fee-for-service
15 model with shared savings and losses (under sub-
16 section (g)) or under a prospective payment model
17 for advanced qualified entities (under subsection
18 (h)). Bundled payments shall be based on the spend-
19 ing targets computed under paragraph (2).

20 “(2) COMPUTATION OF SPENDING TARGETS.—

21 “(A) IN GENERAL.—The Secretary shall
22 compute under this paragraph, for each quali-
23 fied entity for each applicable condition for an
24 episode of care beginning in an agreement year
25 (beginning with 2016) that is attributable to a

1 discharging hospital, a spending target equal to
2 the updated amount computed under subpara-
3 graph (C) for that entity, episode, and year.

4 “(B) INITIAL WEIGHTED AVERAGE CAL-
5 CULATION FOR DISCHARGING HOSPITALS.—

6 “(i) IN GENERAL.—Using fee-for-serv-
7 ice claims data from the base period (as
8 defined in subparagraph (D)), subject to
9 clause (ii), the Secretary shall first cal-
10 culate a base average spending target for
11 each applicable condition for each dis-
12 charging hospital equal to a weighted aver-
13 age of spending under parts A and B for
14 all applicable services for such applicable
15 condition associated with initial admissions
16 to such hospital computed as the sum of
17 the following (with respect to such hos-
18 pital):

19 “(I) 60 percent of the standard-
20 ized spending per episode in the most
21 recent year in the base period.

22 “(II) 30 percent of the standard-
23 ized spending per episode in the pre-
24 vious year.

1 “(III) 10 percent of the stand-
2 ardized spending per episode in the
3 second previous year.

4 “(ii) EXCLUSION OF OUTLIERS AND
5 STANDARDIZATION.—In calculating the
6 amount of the base average spending tar-
7 get for an applicable condition under
8 clause (i) for a discharging hospital, the
9 Secretary shall—

10 “(I) exclude from the calculation
11 payments for episodes of care for the
12 applicable condition that exceed the
13 95th percentile of all such spending
14 for such episodes of care and applica-
15 ble condition, as estimated by the Sec-
16 retary, based on the most recent data
17 available; and

18 “(II) standardize the spending
19 made in each year in the base period
20 to each provider of service or supplier
21 to remove the spending adjustments
22 in effect in such year relating to pro-
23 vider or supplier location (such as
24 area wage indices) and provider type
25 (such as indirect medical education

1 adjustments and disproportionate
2 share hospital adjustments).

3 “(C) TRENDING THE SPENDING TARGETS
4 BASED ON NATIONAL GROWTH RATES TO
5 AGREEMENT YEAR; PERIODIC REBASING FOR
6 NEW AGREEMENT PERIODS.—

7 “(i) IN GENERAL.—The Secretary
8 shall update the base average spending tar-
9 gets for all discharging hospitals under
10 subparagraph (B) for each applicable con-
11 dition and agreement year based on trends
12 in the national fee-for-service claims data
13 for applicable services furnished during an
14 episode of care for an applicable condition
15 from the base period to the agreement year
16 involved. Such update shall not vary by
17 discharging hospital.

18 “(ii) PERIODIC REBASING FOR NEW
19 AGREEMENT PERIODS.—At the start of
20 each new agreement period, the Secretary
21 shall update the base period and calculate
22 new spending targets under the previous
23 provisions of this paragraph for a dis-
24 charging hospital and applicable condi-
25 tions, including providing for adjustments

1 by provider location and provider type of
2 the type described in subparagraph
3 (B)(ii)(II).

4 “(D) BASE PERIOD DEFINED.—In this
5 paragraph, except as provided in subparagraph
6 (C)(ii), the term ‘base period’ means the most
7 recent 3-year period for which complete data
8 are available to carry out this subsection.

9 “(g) FEE-FOR-SERVICE BUNDLED PAYMENT MODEL
10 WITH SHARED SAVINGS AND SHARED LOSSES.—

11 “(1) FEE-FOR-SERVICE-BASED PAYMENT.—If
12 the payment model under this subsection is selected
13 by a qualified entity, the Secretary shall pay pro-
14 viders of services and suppliers of the entity for ap-
15 plicable services for an applicable condition during
16 an episode of care amounts payable under parts A
17 and B for such services in the same manner as such
18 providers and suppliers would otherwise be paid
19 under such parts (referred to in this subsection as
20 ‘fee-for-service payments’).

21 “(2) SHARED SAVINGS AND LOSSES.—

22 “(A) COMPUTATION OF EACH QUALIFIED
23 ENTITY’S ACTUAL STANDARDIZED AVERAGE
24 SPENDING PER EPISODE OF CARE.—In applying
25 this subsection, in calculating the actual stand-

ardized average fee-for-service spending per episode of care for a discharging hospital for each applicable condition in each agreement year, the Secretary shall exclude outlier episodes of care described in subsection (f)(2)(B)(ii)(I), as estimated by the Secretary, based on data applicable to payments in the agreement year and shall standardize such spending per episode of care in the manner provided in subsection (f)(2)(B)(ii)(II). For the purpose of identifying outlier episodes of care for each applicable condition, the percentile ranking of each episode of care and applicable condition and the 95th percentile shall be based on payments standardized by adjustments for provider location and provider type of the type described in subsection (f)(2)(B)(ii)(II).

“(B) COMPUTATION OF GROSS SHARED SAVINGS AND SHARED LOSSES FOR EACH APPLICABLE CONDITION FOR EACH DISCHARGING HOSPITAL.—For purposes of applying subparagraph (C), if actual standardized average fee-for-service payments to a qualified entity for all episodes of care for an applicable condition in

1 an agreement year for a discharging hospital,
2 as calculated under subparagraph (A), are—

3 “(i) less than the applicable spending
4 target under subsection (f)(2)(C) for such
5 condition, year, and hospital, there shall be
6 a gross shared savings for such applicable
7 condition, year, and hospital equal to 60
8 percent of the difference between such ac-
9 tual average payments and the spending
10 target for such condition, year, and hos-
11 pital; or

12 “(ii) greater than such applicable
13 spending target, there shall be a gross
14 shared loss for such applicable condition,
15 year, and hospital equal to 60 percent of
16 such difference.

17 “(C) RETROSPECTIVE RECONCILIATION.—

18 “(i) TOTALING GROSS SHARED SAV-
19 INGS AND LOSSES FOR ALL CONDITIONS
20 AND ALL DISCHARGING HOSPITALS FOR A
21 QUALIFIED ENTITY.—At the end of each
22 agreement year for each qualified entity,
23 for purposes of applying clauses (ii) and
24 (iii), the Secretary shall aggregate the
25 gross shared savings and the gross shared

1 losses under subparagraph (B) of such en-
2 tity for the year for all applicable condi-
3 tions and for all discharging hospitals.

4 “(ii) PAYMENT TO ENTITY OF NET
5 SAVINGS.—Subject to clause (iv) and sub-
6 section (j)(3) (relating to quality perform-
7 ance thresholds), if such aggregate gross
8 shared savings exceeds such aggregate
9 gross shared losses for a qualified entity
10 for an agreement year, the Secretary shall
11 pay to the qualified entity a lump sum
12 amount equal to such excess for such year.

13 “(iii) COLLECTION FROM ENTITY OF
14 NET LOSSES.—Subject to clause (iv), if
15 such aggregate gross shared losses exceeds
16 such aggregate gross shared savings for a
17 qualified entity for an agreement year, the
18 qualified entity shall pay to the Secretary
19 (and the Secretary shall collect from the
20 entity) a lump sum amount equal to such
21 excess for such year.

22 “(iv) CAP ON PAYMENTS.—In no case
23 shall the payment under clause (ii) or (iii)
24 with respect to a qualified entity for an
25 agreement year exceed 10 percent of the

1 aggregate spending target for that quali-
2 fied entity for all applicable conditions and
3 all discharging hospitals for that year.

4 “(h) PROSPECTIVE BUNDLED PAYMENT MODEL FOR
5 ADVANCED QUALIFIED ENTITIES.—

6 “(1) IN GENERAL.—Subject to approval by the
7 Secretary, if the payment model under this sub-
8 section is selected, a qualified entity may elect to re-
9 ceive a prospective bundled payment for each episode
10 of care for each applicable condition and discharging
11 hospital in the agreement year equal to the spending
12 target for such episode, year, and hospital under
13 subsection (f)(2) and the provisions of subsection (g)
14 do not apply. Such spending target shall be ad-
15 justed, in the same manner described in subsection
16 (g)(2)(B), in order to take into account outlier epi-
17 sodes of care and standardized adjustments for pro-
18 vider location and provider type of the type de-
19 scribed in subsection (f)(2)(B)(ii)(II).

20 “(2) RULE OF CONSTRUCTION.—Nothing in
21 this section shall be construed as prohibiting a quali-
22 fied entity that receives bundled payments under
23 this subsection from participating in an accountable
24 care organization under section 1899.

1 “(3) RELATIONSHIP TO BPCI.—The Secretary
2 may not terminate the Bundled Payments for Care
3 Improvement initiative conducted pursuant to sec-
4 tion 1115A until the prospective bundled payment
5 model is implemented under this subsection.

6 “(i) QUALITY AND EFFICIENCY ARRANGEMENTS.—

7 “(1) IN GENERAL.—Subject to subsection
8 (c)(1)(D) (relating to application requirements for
9 notice of quality and efficiency arrangements and
10 their structure) and subsection (j)(3) (relating to
11 minimum quality performance thresholds), qualified
12 entities participating in either the fee-for-service
13 bundled payment model under subsection (g) or the
14 prospective bundled payment model under subsection
15 (h) may enter into quality and efficiency arrange-
16 ments under which physicians and other health care
17 practitioners work to improve the quality and effi-
18 ciency of care under this title.

19 “(2) TYPES OF ARRANGEMENTS.—The arrange-
20 ments under paragraph (1) shall take into account
21 the utilization of the resources of providers of serv-
22 ices and suppliers and may provide for a distribution
23 of a portion of any shared savings (or internal sav-
24 ing, as the case may be) realized under this section
25 to qualifying providers and suppliers.

1 “(j) QUALITY MEASURES.—

2 “(1) SELECTION; DEVELOPMENT.—

3 “(A) SELECTION.—For each applicable
4 condition, the Secretary shall select quality
5 measures related to care provided by providers
6 of services and suppliers through qualified enti-
7 ties to which bundled payments are made under
8 this section. In selecting quality measures, to
9 the extent appropriate and practicable, the Sec-
10 retary shall choose measures that—

11 “(i) are endorsed and validated by the
12 entity with a contract under section 1890;

13 “(ii) pertain to the National Quality
14 Strategy’s six priorities;

15 “(iii) are used by the Secretary under
16 other provisions of this title; and

17 “(iv) minimize the incremental data
18 extraction and reporting burden on pro-
19 viders and suppliers.

20 “(B) DEVELOPMENT OF ELECTRONICALLY
21 SPECIFIED EPISODIC MEASURES.—The Sec-
22 retary shall develop longitudinal quality and ef-
23 ficiency measures to assess performance of
24 qualified entities with respect to patient out-
25 comes and the care provided for each applicable

1 condition across the associated episodes of care.
2 Such measures shall be electronically specified
3 for submittal through the use of qualified elec-
4 tronic health records (as defined in section
5 3000(13) of the Public Health Service Act (42
6 U.S.C. 300jj(13))).

7 “(2) REPORTING ON QUALITY MEASURES.—

8 “(A) IN GENERAL.—A qualified entity
9 shall submit data to the Secretary on quality
10 measures selected under paragraph (1) for each
11 agreement year in a form and manner specified
12 by the Secretary consistent with the succeeding
13 provisions of this paragraph.

14 “(B) SUBMISSION OF DATA THROUGH
15 ELECTRONIC HEALTH RECORD.—To the extent
16 practicable, such data shall be submitted
17 through the use of a qualified electronic health
18 record (as defined in section 3000(13) of the
19 Public Health Service Act (42 U.S.C.
20 300jj(13))).

21 “(C) SUBMISSION OF DATA USED IN
22 OTHER PROGRAMS.—Insofar as quality meas-
23 ures established under paragraph (1) are the
24 same as those measures used by the Secretary
25 under other provisions of this title, such as

those selected under section 1886(b)(3)(B)(viii), the Secretary shall use existing processes for the submission of data for such measures under this paragraph.

“(3) QUALITY PERFORMANCE THRESHOLDS.—

“(A) ESTABLISHMENT.—For each applicable condition, the Secretary shall establish minimum quality performance thresholds for the measures established under paragraph (1). In the case of a quality and efficiency arrangement, such performance thresholds shall be developed using the quality measures identified by the qualified entity in its application under subsection (c)(1)(D) if approved by the Secretary.

“(B) LOSS OF SHARED SAVINGS PAYMENT AND QUALITY AND EFFICIENCY ARRANGEMENTS FOR FAILURE TO MEET MINIMUM QUALITY PERFORMANCE THRESHOLDS.—If a qualified entity fails to meet the minimum quality performance thresholds established under subparagraph (A) for an agreement year—

“(i) no payment may be made to the entity under subsection (g)(2)(C)(ii) with respect to that year; and

1 “(ii) the entity may not implement
2 any quality and efficiency arrangement
3 under subsection (i) for that year.

4 “(k) WAIVERS.—

5 “(1) IN GENERAL.—The Secretary shall waive
6 such provisions of this title and title XI as may be
7 necessary to carry out the program, including the
8 following:

9 “(A) With respect to authorizing quality
10 and efficiency arrangements between qualified
11 entities and providers of services and suppliers,
12 section 1877(a) (relating to physician self-refer-
13 ral), paragraphs (1) and (2) of sections
14 1128A(b) (relating to the gainsharing civil
15 money penalties), and paragraphs (1) and (2)
16 of section 1128B(b) (relating to the anti-kick-
17 back statute).

18 “(B) Section 1128A(a)(5) of the Act (re-
19 lating to the inducement civil money penalties).

20 “(C) Section 1861(i) (relating to the 3-day
21 acute hospitalization prerequisite before eligi-
22 bility for post-hospital extended care services).

23 “(D) With respect to home health serv-
24 ices—

1 “(i) sections 1814(a)(2)(C) and
2 1835(a)(2)(A) (relating to the requirement
3 that an individual be confined to home in
4 order to be eligible for benefits for home
5 health services);

6 “(ii) limitations on the amount, fre-
7 quency, and duration on home health serv-
8 ices; and

9 “(iii) prohibitions of free preoperative
10 home safety assessments by home health
11 agencies for patients scheduled to undergo
12 surgery (such as under Advisory Opinion
13 No. 06–01 of the Inspector General of the
14 Department of Health and Human Serv-
15 ices).

16 “(2) AUTHORITY TO MODIFY WAIVERS UNDER
17 CERTAIN CIRCUMSTANCES.—

18 “(A) IN GENERAL.—In the case of a quali-
19 fied entity with respect to which one or more
20 waivers under paragraph (1) is in effect, if
21 upon a review of the performance or an audit
22 of the entity the Secretary finds a pattern of
23 deficiencies or harm to applicable beneficiaries,
24 the Secretary may modify or revoke any such

1 waiver at any time as applied to that qualified
2 entity.

3 “(B) TERMINATION OF CERTAIN WAIVERS
4 IN THE CASE OF EXCESS SHARED LOSSES.—

5 “(i) IN GENERAL.—Subject to the
6 process described in clause (ii), in the case
7 of a qualified entity that has selected the
8 payment model under subsection (g) and
9 has gross shared losses exceeding the cap
10 under subsection (g)(2)(C)(iv) with respect
11 to an applicable condition, the Secretary
12 shall terminate waivers described in para-
13 graphs (1)(C) and (1)(D) with respect to
14 such qualified entity and applicable condi-
15 tion.

16 “(ii) PRE-TERMINATION NOTICE.—
17 The Secretary shall establish a process
18 whereby a qualified entity is furnished no-
19 tice of any deficiency that may give rise to
20 a termination of waivers under clause (i)
21 not later than 6 months before the pro-
22 posed effective date of the termination.

23 “(l) INDEPENDENT EVALUATION AND REPORTS ON
24 PROGRAM.—

1 “(1) INDEPENDENT EVALUATION.—The Sec-
2 retary shall conduct an independent evaluation of
3 the impact of providing bundled payments to quali-
4 fied entities under this section. Such evaluation shall
5 include an examination of the extent to which the
6 bundling of payments this section have resulted in—

7 “(A) improved health outcomes;

8 “(B) improved access to care for applicable
9 beneficiaries;

10 “(C) reduced spending under this title; and

11 “(D) improvement in performance on qual-
12 ity measures selected under subsection
13 (j)(1)(A).

14 “(2) REPORTS.—

15 “(A) INTERIM REPORT.—Not later than
16 March 1, 2019, the Secretary shall submit to
17 Congress a report on the initial results of the
18 independent evaluation conducted under para-
19 graph (1).

20 “(B) FINAL REPORT.—Not later than
21 March 1, 2021, the Secretary shall submit to
22 Congress a report on the final results of the
23 independent evaluation conducted under para-
24 graph (1) and may include recommendations
25 for the expansion of bundled payment meth-

1 odologies and applicable conditions under this
2 section as the Secretary determines to be appro-
3 priate.”.

○