

115TH CONGRESS  
1ST SESSION

# H. R. 3611

To amend title XVIII of the Social Security Act to create incentives for healthcare providers to promote quality healthcare outcomes, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 28, 2017

Mr. PAULSEN (for himself, Mr. KIND, and Mr. MARCHANT) introduced the following bill; which was referred to the Committee on Ways and Means

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## A BILL

To amend title XVIII of the Social Security Act to create incentives for healthcare providers to promote quality healthcare outcomes, and for other purposes.

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; FINDINGS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Healthcare Outcomes Act of 2017”.

6 (b) FINDINGS.—Congress makes the following find-  
7 ings:

8 (1) Payment penalties for hospital acquired  
9 conditions under section 1886(p) of the Social Secu-

1 rity Act, as added by section 3008 of the Patient  
2 Protection and Affordable Care Act, are based on a  
3 limited number of hospital acquired conditions but  
4 are applied to all Medicare inpatient prospective  
5 payments to a hospital (as defined in section  
6 1886(d) of the Social Security Act), resulting in  
7 payment penalties that are not proportional to the  
8 financial impact of the hospital acquired conditions.  
9 The method of risk adjustment used to determine  
10 the hospital acquired conditions performance of hos-  
11 pitals does not adequately account for the chronic  
12 illness burden and severity of illness of Medicare  
13 beneficiaries.

14 (2) Payment penalties for hospital readmissions  
15 under section 1886(q) of the Social Security Act, as  
16 added by section 3025 of the Patient Protection and  
17 Affordable Care Act, are based on a limited number  
18 of clinical conditions, including readmissions that  
19 are not related to the prior discharge and are not  
20 proportional to the overall financial impact of the re-  
21 admission performance of the hospital. The method  
22 of risk adjustment used to determine the readmis-  
23 sion performance of hospitals does not adequately  
24 account for the chronic illness burden and severity  
25 of illness of Medicare beneficiaries.

1           (3) Payment penalties and bonuses for hospital  
2 Value Based Purchasing under section 1886(o) of  
3 the Social Security Act, as added by section 3001 of  
4 the Patient Protection and Affordable Care Act, are  
5 overly complex and burdensome, are based on arbitrary  
6 weighting factors, and are not proportional to  
7 the overall financial impact of the value based purchasing  
8 performance of the hospital. The methods of  
9 risk adjustment used to determine the value based  
10 purchasing performance of hospitals does not adequately  
11 account for the chronic illness burden and  
12 severity of illness of Medicare beneficiaries.

13           (4) Per case payment penalties for hospital acquired  
14 conditions under section 1886(d)(4)(D), as  
15 added by section 5001(c) of the Deficit Reduction  
16 Act of 2005, are duplicative with the payment penalties  
17 for hospital acquired conditions under section  
18 1886(p) of the Social Security Act, as added by section  
19 3008 of the Patient Protection and Affordable  
20 Care Act.

21           (5) The payment penalties for hospital acquired  
22 conditions and readmissions and the payment penalties  
23 and bonuses for hospital value based purchasing  
24 should be restructured to be based on a  
25 comprehensive and clinically credible definition of

1 potentially-avoidable outcomes, including potentially-  
2 avoidable complications, potentially-avoidable re-  
3 admissions, potentially-avoidable return emergency  
4 room visits and post-acute case episode expenditures,  
5 be based on the risk adjusted comparison of the po-  
6 tentially-avoidable outcomes for a hospital to nation-  
7 wide average rates and include both payment pen-  
8 alties and bonuses that are proportional to the ac-  
9 tual financial impact of the potentially-avoidable out-  
10 comes.

11 (6) The existing methods of risk adjustment  
12 used to determine the quality of care performance of  
13 hospitals under such sections 1886(p), 1886(q),  
14 1886(o), and 1886(d)(4)(D) of the Social Security  
15 Act should be replaced by a methodology that is  
16 composed of exhaustive and mutually exclusive risk  
17 categories that are clinically credible and explicitly  
18 recognize the severity of illness and chronic illness  
19 burden of Medicare beneficiaries, thereby accounting  
20 for patient characteristics that may impact access to  
21 care.

22 **SEC. 2. HOSPITAL OUTCOMES.**

23 (a) PAYMENT ADJUSTMENTS FOR HOSPITAL OUT-  
24 COMES.—Section 1886 of the Social Security Act (42

1 U.S.C. 1395ww) is amended by adding at the end the fol-  
2 lowing new subsection:

3 “(t) HOSPITAL OUTCOMES.—

4 “(1) IN GENERAL.—In the case of an applicable  
5 hospital for an applicable prospective period begin-  
6 ning on or after October 1, 2018—

7 “(A) for each discharge of such hospital  
8 occurring during such period, in addition to and  
9 after application of any increase under para-  
10 graph (6) of subsection (o) and any adjustment  
11 under paragraph (7) of such subsection to the  
12 base operating DRG payment amount (as de-  
13 fined in paragraph (7)(D) of such subsection)  
14 that would otherwise apply to such hospital  
15 during such period without application of this  
16 subsection, such operating DRG payment  
17 amount shall be adjusted by the value based  
18 outcome adjustment factor described in para-  
19 graph (2) for the hospital for such period; and

20 “(B) the value based outcome adjustment  
21 factor shall apply only with respect to the appli-  
22 cable prospective period, and the Secretary shall  
23 not take into account such adjustment factor in  
24 making payments to hospitals under this sec-

1           tion in a subsequent applicable prospective pe-  
2           riod.

3           “(2) VALUE BASED OUTCOME ADJUSTMENT  
4           FACTOR.—

5                   “(A) IN GENERAL.—For purposes of para-  
6           graph (1), the value based outcome adjustment  
7           factor described in this paragraph for an appli-  
8           cable hospital for an applicable prospective pe-  
9           riod, subject to subparagraph (B), is equal to  
10          1.0 minus the value based outcome performance  
11          fraction determined under paragraph (3) for  
12          the hospital and period.

13                   “(B) HOSPITAL-SPECIFIC CAP AND  
14          FLOOR.—In no circumstance may the value  
15          based outcome adjustment factor for an appli-  
16          cable hospital for an applicable prospective pe-  
17          riod under subparagraph (A) be—

18                           “(i) for applicable prospective periods  
19                           occurring in fiscal years 2019 through  
20                           2022, less than 0.97 or more than 1.03;  
21                           and

22                           “(ii) for applicable prospective periods  
23                           occurring in or after fiscal year 2023, less  
24                           than 0.95 or more than 1.05.

1           “(3) DETERMINATION OF VALUE BASED OUT-  
2           COME PERFORMANCE FRACTION.—

3           “(A) IN GENERAL.—The value based out-  
4           come performance fraction for an applicable  
5           hospital for an applicable prospective period,  
6           subject to subparagraph (C), is equal to the  
7           ratio of—

8           “(i) the total hospital-specific finan-  
9           cial impact, as defined in subparagraph  
10          (B), for the hospital and data collection  
11          period with respect to such applicable pro-  
12          spective period; to

13          “(ii) the aggregate amount of stand-  
14          ardized hospital payments (as defined in  
15          paragraph (4)(H)(ii)(I)) made to the hos-  
16          pital during the data collection period with  
17          respect to such applicable prospective pe-  
18          riod.

19          “(B) TOTAL HOSPITAL-SPECIFIC FINAN-  
20          CIAL IMPACT DESCRIBED.—

21          “(i) IN GENERAL.—For purposes of  
22          subparagraph (A), the term ‘total hospital-  
23          specific financial impact’ means, with re-  
24          spect to a hospital for an applicable pro-  
25          spective period, the sum, subject to clause

1 (ii), of the financial impacts determined in  
2 accordance with paragraph (4)(G) for such  
3 hospital and data collection period with re-  
4 spect to each performance category de-  
5 scribed in paragraph (5).

6 “(ii) PERFORMANCE CATEGORY CON-  
7 TRIBUTION UPPER LIMIT.—

8 “(I) IN GENERAL.—In the case  
9 that the financial impact for such a  
10 performance category, as determined  
11 in accordance with paragraph (4)(G)  
12 for a hospital and hospital data collec-  
13 tion period, exceeds the amount cal-  
14 culated under subclause (II) with re-  
15 spect to such hospital and period, the  
16 Secretary shall, in applying clause (i)  
17 with respect to such hospital and pe-  
18 riod, substitute the amount calculated  
19 under such subclause for the financial  
20 impact that is so determined with re-  
21 spect to such performance category.

22 “(II) CALCULATION OF  
23 AMOUNT.—The Secretary shall, with  
24 respect to a hospital for an applicable  
25 prospective period, calculate an



1 amount that is equal to the product of  
2 0.03 and the aggregate amount of  
3 standardized hospital payments (as  
4 defined in paragraph (4)(G)(ii)(I))  
5 made to the hospital during the data  
6 collection period with respect to such  
7 applicable prospective period.

8 “(C) BUDGET NEUTRALITY OF VALUE  
9 BASED OUTCOME ADJUSTMENT FACTOR ACROSS  
10 ALL HOSPITALS.—The Secretary shall deter-  
11 mine a budget neutrality reduction fraction  
12 that, when applied in paragraph (4)(B)(ii), will  
13 result in a value based outcome adjustment fac-  
14 tor determined under subparagraph (A) for an  
15 applicable prospective period that reduces the  
16 total payments under subsection (d) across all  
17 applicable hospitals and all potentially-avoidable  
18 outcomes for such period by an amount equal  
19 to the reduction in payments under such sub-  
20 section for such period that would have resulted  
21 from the application of subsections (d)(4)(D),  
22 (o), (p), and (q) if the amendments made by  
23 the Healthcare Outcomes Act of 2017 had not  
24 applied.

1           “(4) PROCESS FOR DETERMINING FINANCIAL  
2 IMPACTS.—For purposes of paragraph (3), the Sec-  
3 retary shall, for each performance category described  
4 in paragraph (5) and each data collection period  
5 that is with respect to an applicable prospective pe-  
6 riod beginning on or after October 1, 2018, deter-  
7 mine each of the following:

8           “(A) NATIONWIDE-AVERAGE RATES.—With  
9 respect to each risk category specified under  
10 paragraph (6)(B), the ratio of—

11           “(i) the number of discharges occur-  
12 ring among (or, in the case of the perform-  
13 ance category described in paragraph  
14 (5)(D), the total amount of standardized  
15 post acute care episode expenditures made  
16 with respect to) all applicable hospitals  
17 during such applicable data collection pe-  
18 riod that are with respect to such risk cat-  
19 egory and that involve the potentially-  
20 avoidable outcomes in such performance  
21 category; to

22           “(ii) the number of applicable dis-  
23 charges among all applicable hospitals for  
24 such applicable data collection period and  
25 risk category.

1           “(B) NATIONWIDE TARGET RATES.—With  
2           respect to each risk category specified under  
3           paragraph (6)(B), the product of—

4                   “(i) subject to subparagraph (H), the  
5                   applicable ratio determined under subpara-  
6                   graph (A) for such period and risk cat-  
7                   egory; and

8                   “(ii) the budget neutrality reduction  
9                   fraction determined under paragraph  
10                  (3)(C) for such period.

11           “(C) HOSPITAL-SPECIFIC ACTUAL NUM-  
12           BER.—With respect to each applicable hospital  
13           and each such risk category, the number of dis-  
14           charges (or, in the case of the performance cat-  
15           egory described in paragraph (5)(D), the total  
16           amount of standardized post acute care episode  
17           expenditures) occurring with respect to such  
18           hospital during such applicable data collection  
19           period that involve (or, in the case of such per-  
20           formance category, that are with respect to) the  
21           potentially-avoidable outcomes in such perform-  
22           ance category.

23           “(D) HOSPITAL-SPECIFIC EXPECTED NUM-  
24           BER.—With respect to each applicable hospital,  
25           each applicable data collection period, and each

1 such risk category, the number that is the prod-  
2 uct of—

3 “(i) subject to subparagraph (H), the  
4 product determined under subparagraph  
5 (B) for such period and risk category; and

6 “(ii) the number of applicable dis-  
7 charges of the hospital for such period and  
8 risk category.

9 “(E) HOSPITAL-SPECIFIC POTENTIALLY-  
10 AVOIDABLE OUTCOME PERFORMANCE.—With  
11 respect to each applicable hospital and applica-  
12 ble data collection period, the difference be-  
13 tween—

14 “(i) the sum of the numbers deter-  
15 mined under subparagraph (C) for the hos-  
16 pital for such period for all risk categories;  
17 and

18 “(ii) the sum of the numbers deter-  
19 mined under subparagraph (D) for the  
20 hospital for such period for all risk cat-  
21 egories.

22 “(F) FINANCIAL IMPACT.—

23 “(i) With respect to each applicable  
24 hospital and applicable data collection pe-  
25 riod, the financial impact attributable to

1 potentially-avoidable outcomes performance  
2 within such performance category, deter-  
3 mined as the product of the following:

4 “(I) the difference calculated  
5 under subparagraph (E) for such hos-  
6 pital and period; and

7 “(II) the financial conversion fac-  
8 tor determined in accordance with  
9 clause (ii) for the performance cat-  
10 egory.

11 “(ii) FINANCIAL CONVERSION FAC-  
12 TORS.—For purposes of clause (i), the Sec-  
13 retary shall determine a financial conver-  
14 sion factor for the performance category  
15 that—

16 “(I) in the case of the perform-  
17 ance category described in paragraph  
18 (5)(A), is, with respect to inpatient  
19 hospital services that are furnished  
20 with respect to a discharge, equal to  
21 the average amount of increase in the  
22 standardized payments for such inpa-  
23 tient hospital services for such dis-  
24 charge that is attributable to the po-  
25 tentially-avoidable complication;

1 “(II) in the case of the perform-  
2 ance category described in paragraph  
3 (5)(B), is, with respect to an initial  
4 discharge, equal to the average stand-  
5 ardized payment for inpatient hospital  
6 services that are furnished with re-  
7 spect to a potentially-avoidable read-  
8 mission following the initial discharge;

9 “(III) in the case of the perform-  
10 ance category described in paragraph  
11 (5)(C), is, with respect to an initial  
12 discharge, equal to the average stand-  
13 ardized payment for hospital emer-  
14 gency room services that are furnished  
15 with respect to a potentially-avoidable  
16 return emergency room visit following  
17 the initial discharge; and

18 “(IV) in the case of the perform-  
19 ance category described in paragraph  
20 (5)(D), is equal to 1.0.

21 “(G) DEFINITIONS.—For purposes of this  
22 section:

23 “(i) POTENTIALLY-AVOIDABLE OUT-  
24 COMES.—The term ‘potentially-avoidable  
25 outcomes’ means, as applicable—

1           “(I) a potentially-avoidable com-  
2           plication within the category described  
3           in paragraph (5)(A);

4           “(II) a potentially-avoidable read-  
5           mission within the category described  
6           in paragraph (5)(B);

7           “(III) a potentially-avoidable  
8           emergency room visit within the cat-  
9           egory described in paragraph (5)(C);  
10          and

11          “(IV) post-acute care episode ex-  
12          penditures within the category de-  
13          scribed in paragraph (5)(D).

14          “(ii) STANDARDIZED PAYMENTS.—

15                 “(I) STANDARDIZED HOSPITAL  
16                 PAYMENT.—The term ‘standardized  
17                 hospital payment’ means payment for  
18                 inpatient hospital services under sec-  
19                 tion 1886(d) furnished by an applica-  
20                 ble hospital that is adjusted to remove  
21                 payment adjustments that are not di-  
22                 rectly related to the amount and type  
23                 of services to be utilized for patient  
24                 care (such as local or regional price  
25                 differences, graduate indirect medical

1 education payments, disproportionate  
2 share payments, and such other ad-  
3 justments as may be determined by  
4 the Secretary).

5 “(II) STANDARDIZED POST-  
6 ACUTE CARE EPISODE EXPENDI-  
7 TURES.—The term ‘standardized post-  
8 acute care episode expenditures’  
9 means post-acute care episode expend-  
10 itures, adjusted to remove any pay-  
11 ment adjustments not directly related  
12 to the amount and type of services to  
13 be utilized for patient care (such as  
14 adjustments for local or regional price  
15 differences).

16 “(iii) APPLICABLE DISCHARGES.—  
17 With respect to an applicable data collec-  
18 tion period and risk category, the term ‘ap-  
19 plicable discharges’ means, in the case of—

20 “(I) the performance category  
21 described in paragraph (5)(A), dis-  
22 charges occurring during such appli-  
23 cable data collection period that are  
24 with respect to such risk category;  
25 and



1                   “(II) the performance category  
2                   described in paragraph (5)(B), dis-  
3                   charges occurring during such appli-  
4                   cable data collection period that are  
5                   with respect to such risk category and  
6                   that are not identified as potentially-  
7                   avoidable readmissions under the  
8                   methodology selected under paragraph  
9                   (6)(A).

10                   “(iv) DOCUMENTED.—The term ‘doc-  
11                   umented’ means, with respect to a read-  
12                   mission or discharge (as applicable) of an  
13                   individual entitled to benefits under part  
14                   A, that the circumstances of such readmis-  
15                   sion or discharge are documented in the  
16                   medical record of the individual.

17                   “(H) EXCEPTION TO USE OF NATIONWIDE-  
18                   AVERAGE RATES.—In the case that the method-  
19                   ology selected under paragraph (6)(B) for such  
20                   performance category does not meet the criteria  
21                   described in clause (iii) of such paragraph, and  
22                   that there is a systematic negative bias in the  
23                   payment adjustments against hospitals treating  
24                   a disproportionate share of full-benefit dual eli-

1           gible individuals (as defined in section  
2           1935(c)(6)), the Secretary shall—

3                   “(i) develop groups of hospitals based  
4                   on the overall proportion of inpatients in  
5                   such hospitals who are full-benefit dual eli-  
6                   gible individuals (as defined in section  
7                   1935(c)(6));

8                   “(ii) determine, with respect to each  
9                   such group and each risk category speci-  
10                  fied under paragraph (6)(B), the ratio  
11                  of—

12                           “(I) the number of discharges oc-  
13                           curring among (or, in the case of the  
14                           performance category described in  
15                           paragraph (5)(D), the total amount of  
16                           standardized post acute care episode  
17                           expenditures made with respect to) all  
18                           applicable hospitals in such group  
19                           during such applicable data collection  
20                           period that are with respect to such  
21                           risk category and that involve the po-  
22                           tentially-avoidable outcomes in such  
23                           performance category; to

24                           “(II) the number of applicable  
25                           discharges occurring among (or, in

1 the case of the performance category  
2 described in paragraph (5)(D), the  
3 total amount of standardized post  
4 acute care episode expenditures made  
5 with respect to) all applicable hos-  
6 pitals in such group for such applica-  
7 ble data collection period and risk cat-  
8 egory;

9 “(iii) treat each reference in this  
10 paragraph to the ratio determined under  
11 subparagraph (A) for a period and risk  
12 category as a reference to the ratio deter-  
13 mined under clause (ii) for a group, period,  
14 and risk category; and

15 “(iv) treat each reference in this para-  
16 graph to the product determined under  
17 subparagraph (B) for a period and risk  
18 category as a reference to the ratio deter-  
19 mined under such subparagraph for a  
20 group, period, and risk category.

21 “(5) PERFORMANCE CATEGORIES DE-  
22 SCRIBED.—The performance categories described in  
23 this paragraph are the following:

24 “(A) POTENTIALLY-AVOIDABLE COMPLICA-  
25 TIONS.—The performance category of complica-

1           tions (referred to in this section as ‘potentially-  
2           avoidable complications’) that, with respect to  
3           items and services furnished to an individual  
4           entitled to benefits under part A in an applica-  
5           ble hospital, meet all of the following require-  
6           ments:

7                   “(i) The complication occurs during  
8                   the stay of the individual and was not  
9                   present at the time of the admission of  
10                  such individual to such hospital as an inpa-  
11                  tient.

12                  “(ii) The complication is a harmful  
13                  event (such as a surgical complication) or  
14                  an acute illness (such as an infection or an  
15                  acute exacerbation of underlying chronic  
16                  disease).

17                  “(iii) The complication is potentially  
18                  avoidable with adequate care and treat-  
19                  ment.

20                  “(iv) The complication is not a nat-  
21                  ural progression of the underlying illnesses  
22                  of the individual that are present on ad-  
23                  mission of such individual to such hospital.

24                  “(v) The complication may be reason-  
25                  ably construed as related to the care ren-

1           dered during the stay of the individual at  
2           the hospital.

3           “(B) POTENTIALLY-AVOIDABLE READMIS-  
4           SIONS.—

5                   “(i) IN GENERAL.—The performance  
6           category of readmissions (referred to in  
7           this section as ‘potentially-avoidable re-  
8           admissions’) of individuals entitled to bene-  
9           fits under part A to any hospitals following  
10          a discharge (referred to in this section as  
11          an ‘initial discharge’) of such individuals to  
12          an applicable hospital if the initial dis-  
13          charge and readmission involved satisfy all  
14          of the following requirements:

15                           “(I) The readmission of the indi-  
16                           vidual could reasonably have been pre-  
17                           vented by—

18                                   “(aa) the provision of appro-  
19                                   priate care during the episode of  
20                                   care ending in such initial dis-  
21                                   charge that was consistent with  
22                                   accepted standards;

23                                   “(bb) adequate discharge  
24                                   planning with respect to such ini-  
25                                   tial discharge;

1           “(cc) adequate post-dis-  
2 charge follow-up with respect to  
3 such initial discharge; or

4           “(dd) improved coordination  
5 between the providers furnishing  
6 the inpatient or outpatient hos-  
7 pital services during the episode  
8 of care ending in such initial dis-  
9 charge and the providers fur-  
10 nishing care during the post-dis-  
11 charge period with respect to  
12 such initial discharge.

13           “(II) The readmission is for a  
14 condition or procedure related to the  
15 episode of care ending in such initial  
16 discharge, including a readmission for  
17 a condition or procedure that is any of  
18 the following:

19           “(aa) The same (or a closely  
20 related) condition or procedure as  
21 the condition addressed in, or the  
22 procedure provided during the  
23 episode of care ending in such  
24 initial discharge.

1                   “(bb) An infection or other  
2 complication of care provided  
3 during the episode of care ending  
4 in such initial discharge.

5                   “(cc) A condition or proce-  
6 dure indicative of a failed proce-  
7 dure provided during the episode  
8 of care ending in such initial dis-  
9 charge.

10                   “(dd) An acute decompensa-  
11 tion of a coexisting chronic dis-  
12 ease that was precipitated by the  
13 care furnished during the episode  
14 of care ending in such initial dis-  
15 charge.

16                   “(III) The readmission is not a  
17 documented readmission with respect  
18 to a documented discharge that was  
19 initiated by the individual contrary to  
20 medical advice provided to such indi-  
21 vidual during the episode of care with  
22 respect to such initial discharge.

23                   “(IV) The readmission could not  
24 reasonably be considered a planned  
25 readmission.

1                   “(V) The readmission occurs dur-  
2                   ing the 30-day period following an in-  
3                   patient discharge of such an indi-  
4                   vidual from the applicable hospital  
5                   with respect to such initial discharge.

6                   “(VI) The readmission was not  
7                   due to a traumatic injury that oc-  
8                   curred after the episode of care end-  
9                   ing in such initial discharge.

10                  “(VII) The readmission does not  
11                  fall under such other exclusions as the  
12                  Secretary determines appropriate.

13                  “(ii) READMISSION CHAINS.—For  
14                  purposes of this subsection, in the case  
15                  that an individual has multiple readmis-  
16                  sions with respect to an initial discharge  
17                  that, but for the application of this clause,  
18                  would be considered potentially-avoidable  
19                  readmissions with respect to such initial  
20                  discharge, the following shall apply:

21                         “(I) Only one of such readmis-  
22                         sion may be considered a potentially-  
23                         avoidable readmission with respect to  
24                         such initial discharge.



1                   “(II) None of such readmissions  
2                   may be considered a new initial dis-  
3                   charge for purposes of this subsection.

4                   “(C) POTENTIALLY-AVOIDABLE RETURN  
5                   EMERGENCY ROOM VISITS.—The performance  
6                   category of return emergency room visits (re-  
7                   ferred to in this section as ‘potentially-avoidable  
8                   return emergency room visits’) of individuals  
9                   entitled to benefits under part A to any hos-  
10                  pitals following a discharge (referred to in this  
11                  section as an ‘initial discharge’) of such individ-  
12                  uals to an applicable hospital if the initial dis-  
13                  charge and return emergency room visit in-  
14                  volved would satisfy the requirements described  
15                  in subclauses (I), (II), (III), (V), (VI), and  
16                  (VII) if—

17                   “(i) the references in such subclauses  
18                   to readmissions instead were references to  
19                   return emergency room visits; and

20                   “(ii) the reference in such subclause  
21                   (V) to a 30-day period instead were a ref-  
22                   erence to a 15-day period.

23                   “(D) POST-ACUTE CARE EPISODE EXPEND-  
24                   ITURES.—

1           “(i) IN GENERAL.—The performance  
2           category, in the case of individuals entitled  
3           to benefits under part A and enrolled in  
4           part B who are discharged from an appli-  
5           cable hospital (referred to in this section as  
6           an ‘initial discharge’), of expenditures (re-  
7           ferred to in this section as ‘post-acute care  
8           episode expenditures’) that are made (in-  
9           cluding any cost-sharing amounts expended  
10          by the individual) with respect to items  
11          and services furnished to such individuals  
12          for which payment is made under this title  
13          and that are so furnished during the re-  
14          spective post-acute care episode periods ap-  
15          plicable to such individuals, subject to  
16          clause (ii), if the initial discharge and indi-  
17          vidual (as applicable) satisfy all of the fol-  
18          lowing requirements:

19                   “(I) The initial discharge is as-  
20                   signed to an applicable DRG (as de-  
21                   fined in clause (iii)).

22                   “(II) The individual was entitled  
23                   to benefits under part A and enrolled  
24                   in part B for the entirety of the post-

1 acute care episode period that is with  
2 respect to the initial discharge.

3 “(III) The individual did not  
4 have a readmission that is not a po-  
5 tentially-avoidable readmission during  
6 the post-acute care episode period  
7 that is with respect to the initial dis-  
8 charge.

9 “(IV) The initial discharge was  
10 not a documented discharge that was  
11 initiated by the individual contrary to  
12 medical advice provided to such indi-  
13 vidual during the episode of care with  
14 respect to such initial discharge.

15 “(V) Such other requirements as  
16 the Secretary may specify.

17 “(ii) EXCEPTIONS.—Such category  
18 shall not include expenditures with respect  
19 to any of the following:

20 “(I) Expenditures that are with  
21 respect to readmissions of an indi-  
22 vidual that occur during the 30-day  
23 period following an inpatient dis-  
24 charge of such an individual.

1           “(II) Expenditures that are with  
2           respect to return emergency room vis-  
3           its of an individual that occur during  
4           the 15-day period following an inpa-  
5           tient discharge of such an individual.

6           “(III) Such other expenditures as  
7           may be specified by the Secretary.

8           “(iii) ADDITIONAL DEFINITIONS.—

9           “(I) APPLICABLE DRG.—For  
10           purposes of clause (i)(I), the term ‘ap-  
11           plicable DRG’ means a diagnosis-re-  
12           lated group (including, as applicable,  
13           a sub-categorization of a diagnosis-re-  
14           lated group) for which there is a rea-  
15           sonable expectation that the pattern  
16           of post-acute care expenditures is sta-  
17           ble and predictable based on the rea-  
18           son for the initial discharge.

19           “(II) POST-ACUTE CARE EPISODE  
20           PERIOD.—

21           “(aa) IN GENERAL.—For  
22           purposes of clause (i), the term  
23           ‘post-acute care episode period’  
24           means, with respect to an initial  
25           discharge of an individual and

1 subject to item (bb), the period  
2 consisting of the 30-day period  
3 that begins with the date of such  
4 initial discharge.

5 “(bb) NO OVERLAP OF PERI-  
6 ODS.—For purposes of this sub-  
7 section, an individual may not be  
8 considered, at any one time, to be  
9 within more than one post-acute  
10 care episode.

11 “(6) SELECTION OF METHODS FOR IDENTI-  
12 FYING POTENTIALLY-AVOIDABLE OUTCOMES AND  
13 METHOD OF RISK ADJUSTMENT.—

14 “(A) METHODS FOR IDENTIFYING POTEN-  
15 Tially-AVOIDABLE OUTCOMES.—The Secretary  
16 shall select a methodology for identifying poten-  
17 tially-avoidable complications and a method-  
18 ology for identifying potentially-avoidable re-  
19 admissions, and shall specify the circumstances  
20 under which such complications and such re-  
21 admissions would be considered potentially  
22 avoidable. Each such methodology shall meet  
23 the following criteria:

24 “(i) The methodology shall provide—

1           “(I) in the case of potentially-  
2           avoidable complications, a comprehen-  
3           sive identification of all conditions  
4           that could reasonably be considered a  
5           complication of care that meets the  
6           requirements under paragraph (5)(A)  
7           to be included as a potentially-avoid-  
8           able complication; and

9           “(II) in the case of potentially-  
10          avoidable readmissions, a comprehen-  
11          sive identification of all initial dis-  
12          charges described in paragraph (5)(B)  
13          and corresponding readmissions de-  
14          scribed in such paragraph that each  
15          meet the requirements for such read-  
16          mission to be included as a poten-  
17          tially-avoidable readmission.

18          “(ii) To the extent possible, the meth-  
19          odology shall be a methodology that has  
20          been successfully implemented for the pur-  
21          pose of adjusting payments to hospitals by  
22          a State plan under title XIX or by a major  
23          commercial payer or be a methodology that  
24          has been certified by an entity with a con-  
25          tract under section 1890(a).

1           “(iii) The methodology shall be open,  
2           transparent, and available for review and  
3           comment by the public.

4           “(iv) The Secretary may select propri-  
5           etary methodologies that meet the criteria  
6           in clauses (i) through (iii).

7           “(B) SELECTION CRITERIA FOR METHOD  
8           OF RISK ADJUSTMENT.—For purposes of para-  
9           graph (4), the Secretary shall, with respect to  
10          each category described in a subparagraph of  
11          paragraph (5), select a methodology for speci-  
12          fying risk categories and for assigning individ-  
13          uals entitled to benefits under part A to such  
14          categories, and shall so specify such risk cat-  
15          egories and so assign such individuals to such  
16          categories. Each such methodology shall meet  
17          the following criteria:

18               “(i) The methodology shall result in  
19               an exhaustive and mutually exclusive list of  
20               risk categories.

21               “(ii) The methodology shall be clini-  
22               cally credible and explicitly account for the  
23               severity of illness, chronic illness burden,  
24               and extensive comorbid diseases and high  
25               severity of illness of patients.

1           “(iii) The methodology shall account  
2 for patient characteristics that may impact  
3 access to care.

4           “(iv) The methodology shall assign a  
5 risk category to an individual based on the  
6 condition of the individual at the time of—

7                   “(I) in the case of potentially-  
8 avoidable complications, hospital ad-  
9 mission; and

10                   “(II) in the case of potentially-  
11 avoidable readmissions, hospital dis-  
12 charge with respect to the initial dis-  
13 charge.

14           “(v) To the extent possible, the meth-  
15 odology shall be a methodology that has  
16 been successfully implemented for the pur-  
17 pose of adjusting payments to hospitals by  
18 a State plan under title XIX or by a major  
19 commercial payer or be a methodology that  
20 has been certified by an entity with a con-  
21 tract under section 1890(a).

22           “(vi) The methodology shall be open,  
23 transparent, and available for review and  
24 comment by the public.



1                   “(vii) The Secretary may select pro-  
2                   prietary methodologies that meet the cri-  
3                   teria in clauses (i) through (vi).

4                   “(C) PUBLICATION OF SPECIFICATIONS.—  
5                   Not later than 15 days prior to each applicable  
6                   prospective year, the Secretary shall make  
7                   available, such as by publicly posting on the  
8                   Internet Web site of the Centers for Medicare  
9                   & Medicaid Services the annual updates to each  
10                  methodology selected under a subparagraph of  
11                  this paragraph.

12                  “(7) REPORTING BY SECRETARY.—

13                  “(A) REPORTS TO HOSPITALS.—For each  
14                  data collection period that is with respect to an  
15                  applicable prospective period beginning on or  
16                  after October 1, 2018, the Secretary shall pro-  
17                  vide to each applicable hospital, not later than  
18                  the first day of such applicable prospective pe-  
19                  riod, a confidential report with respect to the  
20                  potentially-avoidable outcomes of such hospital  
21                  during such data collection period.

22                  “(B) REPORTS TO PUBLIC.—For each data  
23                  collection period that is with respect to an ap-  
24                  plicable prospective period described in para-  
25                  graph (1), the Secretary shall, not later than 90

1 days after the first day of such applicable pro-  
2 spective period, make available to the public  
3 (including by posting on the Hospital Compare  
4 Web site) in an easily understandable format  
5 information regarding the performance of each  
6 applicable hospital during such data collection  
7 period with respect to potentially-avoidable out-  
8 comes.

9 “(8) DEFINITIONS.—In this subsection:

10 “(A) APPLICABLE HOSPITAL.—The term  
11 ‘applicable hospital’ means a subsection (d) hos-  
12 pital.

13 “(B) DATA COLLECTION PERIOD.—The  
14 term ‘data collection period’ means, with re-  
15 spect to an applicable prospective period, a pe-  
16 riod specified by the Secretary that is the most  
17 recent period for which data are available for  
18 purposes of determining the potentially-avoid-  
19 able outcome adjustment factor described in  
20 paragraph (2) to be applied for such applicable  
21 prospective period.

22 “(C) APPLICABLE PROSPECTIVE PERIOD.—  
23 The term ‘applicable prospective period’ means  
24 a fiscal year.

1           “(9) LIMITATION ON JUDICIAL REVIEW.—There  
2 shall be no administrative or judicial review under  
3 section 1869, section 1878, or otherwise of a poten-  
4 tially-avoidable outcome adjustment factor applied  
5 under this section.”.

6           (b) CONFORMING AMENDMENTS.—

7           (1) SUNSETTING EXISTING HOSPITAL VALUE-  
8 BASED PURCHASING PROGRAM.—Section 1886(o)(2)  
9 of the Social Security Act (42 U.S.C. 1395ww(o)(2))  
10 is amended—

11                   (A) in the heading, by inserting “AND END  
12 WITH FISCAL YEAR 2018” after “2013”; and

13                   (B) by adding “, and before October 1,  
14 2018” before the period at the end.

15           (2) SUNSETTING EXISTING ADJUSTMENT FOR  
16 COMPLICATIONS.—Section 1886(p) of the Social Se-  
17 curity Act (42 U.S.C. 1395ww(p)) is amended—

18                   (A) in paragraph (1), by inserting “(before  
19 fiscal year 2019)” after “a subsequent fiscal  
20 year”; and

21                   (B) in paragraph (5), by inserting “(before  
22 fiscal year 2019)” after “each subsequent fiscal  
23 year”.

1           (3) SUNSETTING EXISTING ADJUSTMENT FOR  
2 READMISSIONS.—Section 1886(q) of the Social Se-  
3 curity Act (42 U.S.C. 1395ww(q)) is amended—

4           (A) in paragraph (1), by inserting “and  
5 ending before October 1, 2018” after “October  
6 1, 2012,”;

7           (B) in paragraph (3)(C)(iii), by inserting  
8 “before fiscal year 2019” after “and subsequent  
9 fiscal years”; and

10          (C) in paragraph (5)(B), by inserting “and  
11 ending with fiscal year 2018” after “fiscal year  
12 2015”.

13          (4) SUNSETTING EXISTING ADJUSTMENT FOR  
14 CERTAIN HOSPITAL ACQUIRED INFECTIONS.—Sec-  
15 tion 1886(d)(4)(D) of the Social Security Act (42  
16 U.S.C. 1395ww(d)(4)(D)) is amended by inserting  
17 “and before October 1, 2018” after “2008,”.

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