I

113TH CONGRESS
2D SESSION

H. R. 5823

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

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 9, 2014

Mr. MATHESON introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Incentivizing Healthcare Quality Outcomes Act of 2014''.

(b) FINDINGS.—Congress makes the following findings:

(1) Healthcare delivery organizations are faced with an unmanageable array of quality measures and methods of risk adjustment that are overly process oriented, may not relate to health outcomes, and create a significant administrative burden.

(2) Existing quality measures and methods of risk adjustment used to adjust Medicare payments should be replaced with a comprehensive and clinically credible quality measurement system based on the rate of occurrence of potentially preventable outcomes.

(3) Payment adjustment for quality outcomes should be applied to all types of healthcare delivery organizations including hospitals, health systems, Medicare Advantage plans, health homes, and accountable care organizations as well as healthcare professionals.

SEC. 2. INCENTIVIZING HEALTHCARE QUALITY OUTCOMES.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''INCENTIVIZING HEALTHCARE QUALITY OUTCOMES

''SEC. 1899B. (a) ADJUSTMENT OF PAYMENTS TO HEALTH-CARE DELIVERY ORGANIZATION FOR POTENTIALLY PREVENTABLE OUTCOMES.—

''(1) IN GENERAL.—In order to provide an incentive for each applicable healthcare delivery organization (as defined in subsection (k)) to reduce potentially preventable outcomes, the amount of payments to the organization under this title for an applicable prospective period (as defined in such subsection) shall be the amount otherwise determined multiplied by the healthcare delivery organization-specific adjustment factor determined under paragraph (2) for such period.

''(2) HEALTHCARE DELIVERY ORGANIZATION SPECIFIC PAYMENT ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraph (B), the healthcare delivery organization-specific payment adjustment factor described in this paragraph for an applicable healthcare delivery organization for an applicable prospective period is equal to 1 minus the ratio (expressed as a percentage), as determined by the Secretary, of—

''(i) the composite aggregate payments for excess potentially preventable outcomes (described in subsection (c)(1)) for the organization and period; to

"(ii) the aggregate payments under this title to the organization for such period.

"(B) PHASE-IN OF HEALTHCARE DELIVERY ORGANIZATION-SPECIFIC ADJUSTMENT FACTOR.—In no case shall the healthcare delivery organization-specific payment adjustment factor under subparagraph (A) be—

"(i) less than 97 percent or more than 103 percent for fiscal year 2016;

"(ii) be less than 94 percent or more than 106 percent for fiscal year 2017; or

"(iii) be less than 90 percent or more than 110 percent for fiscal year 2018 and each subsequent fiscal year.

"(b) ADJUSTMENT TO THE ANNUAL UPDATE FACTOR FOR PAYMENTS TO HEALTHCARE PROFESSIONALS IN A GEOGRAPHIC REGION FOR POTENTIALLY PREVENTABLE OUTCOMES.—

"(1) IN GENERAL.—In order to provide an incentive for healthcare professionals (that are not part of an applicable healthcare delivery organization) in a geographic region to coordinate care and reduce potentially preventable outcomes, the annual update factor for traditional Medicare fee-for-service

payments to all such professionals in a geographic region established under paragraph (3) for an applicable prospective period (beginning on or after October 1, 2015) shall be equal to the annual update factor that would otherwise apply multiplied by the geographic-specific potentially preventable outcomes adjustment factor (as described in paragraph (2)) for the geographic region and period.

''(2) GEOGRAPHIC-SPECIFIC POTENTIALLY PREVENTABLE OUTCOMES ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraph (B), the geographic-specific potentially preventable outcomes adjustment factor described in this paragraph for a geographic region for an applicable prospective period is equal to 1 minus the ratio (expressed as a percentage), as determined by the Secretary, of—

''(i) the sum of the composite aggregate payments for excess potentially preventable outcomes (described in subsection (c)(1)) for Medicare beneficiaries enrolled in traditional Medicare fee-for-service across all applicable healthcare delivery organizations physically located in the geo-

graphic region for the applicable historical period; to

''(ii) the aggregate payments for Medicare beneficiaries enrolled in traditional Medicare fee-for-service across all applicable healthcare delivery organizations physically located in the geographic region for such applicable historical period.

''(B) PHASE-IN.—In no case shall the geographic-specific potentially preventable outcomes adjustment factor for a geographic region under this paragraph—

''(i) be less than 95 percent or more than 105 percent for fiscal year 2016;

''(ii) be less than 90 percent or more than 110 percent for fiscal year 2017; or

''(iii) be less than 80 percent or more than 120 percent for fiscal year 2018 and each subsequent fiscal year.

''(3) GEOGRAPHIC REGION.—

''(A) IN GENERAL.—For the purposes of this subsection and subject to subparagraph (B), the Secretary shall establish geographic regions to which healthcare professionals shall be assigned.

''(B) RESTRICTIONS.—

''(i) GEOGRAPHIC REGIONS.—To the extent practical, the Secretary shall define geographic regions based on core base statistical areas as defined by the Director of the Office of Management and Budget.

''(ii) ASSIGNMENT OF HEALTHCARE PROFESSIONALS TO GEOGRAPHIC REGIONS.—The geographic region to which a healthcare professional is assigned shall be the geographic region in which a plurality of Medicare beneficiaries treated by such professional for the applicable historical period reside, as determined by the Secretary.

''(4) REPORT ON USING INDIVIDUAL HEALTHCARE PROFESSIONAL PERFORMANCE.—No later than January 1, 2017, the Secretary shall submit to Congress a report proposing a method of combining the potentially preventable outcomes performance of individual healthcare professionals with the geographic-specific potentially preventable outcomes performance for a geographic region under paragraph (2) for the purpose of determining the potentially preventable outcomes adjustment factor

under paragraph (1) to the annual adjustment factor for payments to such individual healthcare professionals.

''(c) COMPOSITE AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE OUTCOMES.—

''(1) IN GENERAL.—The composite aggregate payments for excess potentially preventable outcomes for an applicable healthcare delivery organization or geographic region for an applicable historical period described in this paragraph is equal to the sum of the following for the healthcare delivery organization or geographic region and period:

''(A) PREVENTABLE COMPLICATIONS.—The aggregate payments for excess inpatient potentially preventable complications (as defined in subsection (e)(1)(B)).

''(B) PREVENTABLE READMISSIONS.—The aggregate payments for excess potentially preventable readmissions (as defined in subsection (f)(1)(B)).

''(C) PREVENTABLE ADMISSIONS.—The aggregate payments for excess potentially preventable admissions computed (as defined in subsection (g)(1)(B)).

"(D) PREVENTABLE EMERGENCY ROOM VISITS.—The aggregate payments for excess potentially preventable emergency room visits (as defined in subsection (h)(1)(B)).

"(E) PREVENTABLE OUTPATIENT ANCILLARY SERVICES.—The aggregate payments for excess potentially preventable outpatient ancillary services (as defined in subsection (i)(1)(B)).

"(2) OFFSETTING POTENTIALLY PREVENTABLE OUTCOME VALUES BEING POSITIVE OR NEGATIVE.—The aggregate payments for individual excess potentially preventable outcomes under subsections (e)(1)(B), (f)(1)(B), (g)(1)(B), (h)(1)(B), and (i)(1)(B) may have a positive value (indicating the healthcare delivery organization had more potentially preventable outcomes than expected) or a negative value (indicating the healthcare delivery organization had fewer potentially preventable outcomes than expected). The summing of the individual excess potentially preventable outcomes in paragraph (1) for potentially preventable outcomes allows negative values for individual potentially preventable outcomes to offset in part or in whole positive values of other potentially preventable outcomes.

''(3) EXCLUSIONS.—The Secretary shall determine the applicability of each type of potentially preventable outcome to different types of healthcare delivery organizations and may exclude potentially preventable outcomes from the calculation of aggregate payments referred to in paragraph (1) for types of healthcare delivery organizations if the Secretary determines that such outcomes are not applicable for such types of organizations.

''(d) SUPERSEDING EXISTING PAYMENT ADJUSTMENTS FOR QUALITY; BUDGET NEUTRAL ADJUSTMENT.—

''(1) IN GENERAL.—For applicable prospective periods beginning on or after October 1, 2015, no payment adjustment for quality performance shall be made pursuant any of the following provisions:

''(A) Payment adjustments for hospital acquired conditions under section 1886(d)(4)(D), as added by section 5001(c) of Deficit Reduction Act of 2005.

''(B) Payment adjustments for value based purchasing for inpatient hospital services under section 1886(o) and for physicians' services under section 1848(p).

"(C) Payment adjustments for hospital readmissions under section 1886(q), as added by section 3025 of the Patient Protection and Affordable Care Act.

"(D) Payment adjustments for hospital acquired conditions under section 1886(p), as added by section 3008 of the Patient Protection and Affordable Care Act.

"(E) Payment adjustments for Medicare Advantage Plans under Sections 1853(n) and 1853(o).

"(F) Other payment adjustments for quality as determined by the Secretary.

"(2) PAYMENT ADJUSTMENTS FOR REPORTING QUALITY INFORMATION UNCHANGED.—Payment adjustments for reporting quality information that are unrelated to actual quality performance under sections 1833(t)(17), 1848(a), 1848(k), 1848(m) and 1833(i)(2)(D) shall not be affected by this subsection.

"(3) MANDATED REDUCTIONS UNDER CURRENT LAW.—The Secretary shall determine the annual reductions in payment mandated by the provisions described in paragraph (1) for fiscal year 2016 and for each subsequent fiscal year.

"(4) PAYMENT REDUCTION FACTOR TO ACHIEVE BUDGET NEUTRALITY.—The Secretary shall determine a payment reduction factor for fiscal year 2016 and for each subsequent fiscal year, to be applied under subsections (e)(1)(A)(ii), (f)(1)(A)(ii), (g)(1)(A)(ii), (h)(1)(A)(ii), and (i)(1)(A)(ii), subject to the limitations in subsections (a)(2)(B) and (b)(2)(B), so that there is an aggregate payment reduction under this section for such fiscal year equivalent to the aggregate reduction in payment determined under paragraph (3) for such fiscal year.

"(e) AGGREGATE PAYMENTS FOR EXCESS INPATIENT POTENTIALLY PREVENTABLE COMPLICATIONS.—

"(1) EXCESS INPATIENT POTENTIALLY PREVENTABLE COMPLICATIONS; AGGREGATE PAYMENTS FOR EXCESS INPATIENT POTENTIALLY PREVENTABLE COMPLICATIONS DEFINED.—In this section:

"(A) EXCESS INPATIENT POTENTIALLY PREVENTABLE COMPLICATIONS.—

"(i) IN GENERAL.—The term 'excess inpatient potentially preventable complications' means, for an applicable hospital and other applicable healthcare delivery organizations determined appropriate by the Secretary for an applicable historical pe-

riod for each type of inpatient hospital potentially preventable complication identified under paragraph (2), the sum across all risk classes (as defined in clause (iii)) of the difference between—

"(I) the expected number of inpatient hospital potentially preventable complications for the type of complication for the applicable hospital based on the standard complication rate computed under clause (ii) in each risk class; and

"(II) the applicable hospital's actual number of inpatient hospital potentially preventable complications for the type of inpatient potentially preventable complication in each risk class in the applicable historical period.

Such difference may be a positive or negative number.

"(ii) STANDARD COMPLICATION RATE.—In carrying out clause (i)(I), the standard complication rate shall be based on the average rate of each type of inpa-

tient hospital potentially preventable complication in each risk class in the applicable historical period, multiplied by the payment reduction factor established under subsection (d)(3) for the applicable prospective period.

''(iii) RISK CLASSES.—In this subparagraph, the term 'risk classes' means such exhaustive and mutually exclusive risk classes as the Secretary shall establish in order to apply a risk-adjustment methodology that meets the criteria in subsection (j)(2) and account for the age, reason for admission, severity of illness, and other risk factors identified by the Secretary of patients at the time of hospital admission.

''(B) AGGREGATE PAYMENTS FOR EXCESS INPATIENT HOSPITAL POTENTIALLY PREVENTABLE COMPLICATIONS.—

''(i) IN GENERAL.—The term 'aggregate payments for excess inpatient hospital potentially preventable complications' means, for an applicable hospital and other applicable healthcare delivery organizations

determined appropriate by the Secretary and applicable historical period, for all types of inpatient hospital potentially preventable complications identified under paragraph (2), an amount equal to the sum of the amount determined under clause (ii) for such hospital and other applicable healthcare delivery organizations determined appropriate by the Secretary for each type of inpatient hospital potentially preventable complication for such period.

''(ii) AMOUNT DETERMINED.—The amount determined under this clause, with respect to an applicable hospital and other applicable healthcare delivery organizations determined appropriate by the Secretary and an applicable historical period, for a type of inpatient hospital potentially preventable complication identified under paragraph (2) is equal to the product of—

''(I) the excess inpatient hospital potentially preventable complications (as defined in subparagraph (A)) of the applicable hospital and other ap-

plicable healthcare delivery organizations determined appropriate by the Secretary for the type of inpatient hospital potentially preventable complication during the applicable historical period; and

''(II) the estimated national average standardized incremental cost of that inpatient hospital potentially preventable complication for applicable hospitals and other applicable healthcare delivery organizations determined appropriate by the Secretary during the applicable historical period (as determined under clause (iii)) adjusted by each hospital's applicable payment adjustment factors.

''(iii) METHODOLOGY FOR ESTIMATING NATIONAL AVERAGE INCREMENTAL COST OF INPATIENT HOSPITAL POTENTIALLY PREVENTABLE COMPLICATIONS.—In carrying out clause (ii)(II), the Secretary shall establish and apply a methodology to estimate the national average standardized incremental cost of each inpa-

tient hospital potentially preventable complication identified under paragraph (2).

''(2) INPATIENT HOSPITAL POTENTIALLY PREVENTABLE COMPLICATIONS.—For purposes of this subsection, the Secretary shall select a methodology of identifying potentially preventable complications that includes each inpatient hospital complication that meets all of the following requirements:

''(A) The complication occurs during the stay and was not present on admission as an inpatient.

''(B) The complication is a harmful event, such as a surgical complication, or an acute illness, such as an infection or an acute exacerbation of underlying chronic disease.

''(C) The complication could reasonably be prevented with adequate care and treatment and is not a natural progression of a patient's underlying illnesses present on admission.

''(D) The complication may be reasonably construed as related to the care rendered during the stay.

''(E) The complication meets criteria applicable under subsection (j)(1) to the outcome described in this subsection.

''(f) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE READMISSIONS.—

''(1) EXCESS POTENTIALLY PREVENTABLE READMISSIONS; AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE READMISSIONS DEFINED.—For purposes of this subsection:

''(A) EXCESS POTENTIALLY PREVENTABLE READMISSIONS.—

''(i) IN GENERAL.—The term 'excess potentially preventable readmissions' means, for an applicable hospital or other applicable healthcare delivery organization determined appropriate by the Secretary for an applicable historical period and with respect to potentially preventable readmissions identified under paragraph (2) for each risk class (as defined in clause (iii)) the difference between—

''(I) the expected number of potentially preventable readmissions for the applicable hospital based on the standard readmission rate in each risk class (as defined in clause (ii)); and

''(II) the applicable hospital's actual number of potentially preventable

readmissions in each risk class for the applicable historical period.

Such difference may be a positive or negative number.

"(ii) STANDARD READMISSION RATE.—In carrying out clause (i)(I), the standard readmission rate shall be based on the average potentially preventable readmission rate in each risk class, as established under clause (iii), in the applicable historical period, multiplied by the payment reduction factor established under subsection (d)(3) for the applicable prospective period.

"(iii) RISK ADJUSTMENT.—In this subparagraph, the term 'risk classes' means such exhaustive and mutually exclusive risk classes as the Secretary shall establish in order to apply a risk-adjustment methodology that meets the criteria in subsection (j)(2) and account for the age, reason for admission, severity of illness, and other risk factors identified by the Secretary of patients that were present in patients at the time of hospital discharge

from the hospital admission that preceded their readmission.

"(B) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE READMISSIONS.—

"(i) IN GENERAL.—The term 'aggregate payments for excess potentially preventable readmissions' means, for an applicable historical period, for all potentially preventable readmissions identified under paragraph (2), an amount equal to the amount determined under clause (ii).

"(ii) AMOUNT DETERMINED.—The amount determined under this clause, with respect to an applicable hospital and other applicable healthcare delivery organizations determined appropriate by the Secretary and an applicable historical period, is equal to the sum across all risk classes of the product of—

"(I) the excess potentially preventable readmissions in the risk class for the applicable hospital and other applicable healthcare delivery organizations determined appropriate by the

Secretary for the applicable historical period; and

''(II) the average payment for potentially preventable readmissions (as defined in clause (iii)) in the risk class for applicable hospitals and other applicable healthcare delivery organizations determined appropriate by the Secretary for the applicable historical period.

''(iii) AVERAGE PAYMENT FOR POTENTIALLY PREVENTABLE READMISSIONS.—In clause (ii)(II), the term 'average payment for potentially preventable readmissions for a risk class' means, for applicable hospitals and other applicable healthcare delivery organizations determined appropriate by the Secretary for an applicable historical period, the average payment for all potentially preventable readmissions that follow a prior discharge in that risk class.

''(2) POTENTIALLY PREVENTABLE READMISSIONS.—For purposes of this subsection, the Secretary shall select a methodology of identifying potentially preventable readmissions under paragraph

(1) that includes each readmission that meets all of the following requirements:

''(A) The readmission is within 30 days from the date of the initial discharge and could reasonably have been prevented by—

''(i) the provision of appropriate care consistent with accepted standards in the prior discharge;

''(ii) adequate discharge planning;

''(iii) adequate post-discharge followup; or

''(iv) improved coordination between the inpatient and outpatient healthcare teams.

''(B) The readmission is for a condition or procedure related to the care during the prior admission or during the care immediately following the prior discharge, including—

''(i) a readmission for the same or closely related condition or procedure as the prior discharge;

''(ii) a readmission for an infection or other complication of care;

"(iii) a readmission for a condition or procedure indicative of a failed surgical intervention; and

"(iv) a readmission for an acute decompensation of a coexisting chronic disease.

"(C) The readmission is back to the same hospital or to any other hospital.

"(D) The readmission does not occur under any of the following circumstances:

"(i) The original discharge was a patient-initiated discharge and was against medical advice and the circumstances of such discharge and readmission are documented in the patient's medical record.

"(ii) The readmission was a planned readmission.

"(iii) Such other exclusion as the Secretary determines appropriate.

"(E) The readmission meets criteria applicable under subsection (j)(1) to the outcome described in this subsection.

"(g) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE ADMISSIONS.—

''(1) EXCESS POTENTIALLY PREVENTABLE ADMISSIONS; AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE ADMISSIONS DEFINED.—In this subsection:

''(A) EXCESS POTENTIALLY PREVENTABLE ADMISSIONS.—

''(i) IN GENERAL.—The term 'excess potentially preventable admissions' means, for an applicable healthcare delivery organization for an applicable historical period and with respect to potentially preventable admissions identified under paragraph (2), for each risk class (as defined in clause (iii)) the difference between—

''(I) the expected number of beneficiaries with one or more potentially preventable admissions for the applicable healthcare delivery organization based on the standard potentially preventable admission rate for beneficiaries in each risk class; and

''(II) the applicable healthcare delivery organization's actual number of beneficiaries with one or more potentially preventable admissions in

each risk class for the applicable historical period for beneficiaries assigned to the risk class.

Such difference may be a positive or negative number.

''(ii) STANDARD POTENTIALLY PREVENTABLE ADMISSION RATE.—In carrying out clause (i)(I), the standard potentially preventable admission rate shall be based on the average number of beneficiaries with one or more potentially preventable admissions in each risk class, as defined in clause (iii), in the applicable historical period, multiplied by the payment reduction factor established under subsection (d)(3) for the applicable prospective period.

''(iii) RISK ADJUSTMENT.—In this subparagraph, the term 'risk classes' means such exhaustive and mutually exclusive risk classes as the Secretary shall establish in order to apply a risk-adjustment methodology that meets the criteria in subsection (j)(2) and account for the age, reason for admission, severity of illness, and other risk factors identified by the Sec-

retary. The risk class for a beneficiary shall be assigned under this subparagraph based on the beneficiary's chronic illness burden and history of healthcare services for a time period of not less than 6 months preceding the beginning of the applicable historical period.

''(B) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE ADMISSIONS.—

''(i) IN GENERAL.—The term 'aggregate payments for excess potentially preventable admissions' means, for an applicable historical period, for potentially preventable admissions identified under paragraph (2), an amount equal to the amount determined under clause (ii).

''(ii) AMOUNT DETERMINED.—The amount determined under this clause, with respect to an applicable healthcare delivery organization and an applicable historical period, for all beneficiaries with one or more potentially preventable admissions identified under paragraph (2) is equal to the sum across all risk classes of the product of—

"(I) the excess potentially preventable admissions (as defined in subparagraph (A)) in the risk class for the applicable healthcare delivery organization during the applicable historical period; and

"(II) the average payment per beneficiary of all potentially preventable admissions for beneficiaries in the risk class (as determined under clause (iii)) for applicable healthcare delivery organizations during the applicable historical period.

"(iii) AVERAGE PAYMENT PER BENEFICIARY OF ALL POTENTIALLY PREVENTABLE ADMISSIONS.—The term 'average payment per beneficiary of all potentially preventable admissions' for a risk class means, for applicable healthcare delivery organizations for an applicable historical period, the average payment per beneficiary for all potentially preventable admissions in the risk class.

"(2) POTENTIALLY PREVENTABLE ADMISSIONS.—For purposes of this subsection, the Sec-

retary shall select a methodology of identifying potentially preventable admissions under paragraph (1) that includes each admission that meets all of the following requirements:

"(A) The admission could reasonably have been prevented with adequate access to ambulatory care or coordinated healthcare services.

"(B) The services provided as part of the admission could be safely performed in an outpatient facility.

"(C) The admission is not of a beneficiary with extensive comorbid disease or high severity of illness that may necessitate that care be delivered in a hospital setting.

"(D) The admission meets criteria applicable under subsection (j)(1) to the outcome described in this subsection.

"(h) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS.—

"(1) EXCESS POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS; AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS DEFINED.—In this subsection:

"(A) EXCESS POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS.—

"(i) IN GENERAL.—The term 'excess potentially preventable emergency room visits' means, for an applicable healthcare delivery organization for an applicable historical period and with respect to potentially preventable emergency room visits identified under paragraph (2), for each risk class (as defined in clause (iii)) the difference between—

"(I) the expected number of beneficiaries with one or more potentially preventable emergency room visits for the applicable healthcare delivery organization based on the standard potentially preventable emergency room visit rate for beneficiaries in each risk class (as defined in clause (ii)); and

"(II) the applicable healthcare delivery organization's actual number of beneficiaries with one or more potentially preventable emergency room visits for the applicable historical period for beneficiaries assigned to the risk class.

Such difference may be a positive or negative number.

''(ii) STANDARD POTENTIALLY PREVENTABLE EMERGENCY ROOM VISIT RATE.—In carrying out clause (i)(I), the standard potentially preventable emergency room visit rate shall be based on the average number of beneficiaries with one or more potentially preventable emergency room visits in each risk class, as defined in clause (iii) in the applicable historical period, multiplied by the payment reduction factor established under subsection (d)(3) for the applicable prospective period.

''(iii) RISK ADJUSTMENT.—In this subparagraph, the term 'risk classes' means such exhaustive and mutually exclusive risk classes as the Secretary shall establish in order to apply a risk-adjustment methodology that meets the criteria in subsection (j)(2) and account for the age, reason for admission, severity of illness, and other risk factors identified by the Secretary. The risk class for a beneficiary shall be assigned based on the beneficiary's

chronic illness burden and history of healthcare services for a time period of not less than 6 months preceding the beginning of the applicable historical period.

''(B) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS.—

''(i) IN GENERAL.—The term 'aggregate payments for excess potentially preventable emergency room visits' means, for an applicable historical period, for potentially preventable emergency room visits identified under paragraph (2), an amount equal to the amount determined under clause (ii).

''(ii) AMOUNT DETERMINED.—The amount determined under this clause, with respect to an applicable healthcare delivery organization and an applicable historical period, for all beneficiaries with one or more potentially preventable emergency room visits identified under paragraph (2) is equal to the sum across all risk classes of the product of—

"(I) the excess potentially preventable emergency room visits (as defined in subparagraph (A)) in the risk class for the applicable healthcare delivery organization during the applicable historical period; and

"(II) the average payment per beneficiary of all potentially preventable emergency room visits for beneficiaries in the risk class (as determined under clause (iii)) for applicable healthcare delivery organizations during the applicable historical period.

"(iii) AVERAGE PAYMENT PER BENEFICIARY OF ALL POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS.—The term 'average payment per beneficiary of all potentially preventable emergency room visits' means, for applicable healthcare delivery organizations for an applicable historical period for a risk class, the average payment per beneficiary for all potentially preventable emergency room visits in the risk class.

''(2) POTENTIALLY PREVENTABLE EMERGENCY ROOM VISITS.—For purposes of this subsection, the Secretary shall select a methodology of identifying potentially preventable emergency room visits under paragraph (1) that includes each such visit that meets all of the following requirements:

''(A) The visit did not require emergency medical attention because the condition could be treated or prevented by a physician or other healthcare provider in a nonemergency setting.

''(B) The beneficiary involved does not have an extensive comorbid disease or high severity of illness that may necessitate that care be delivered in an emergency room setting.

''(C) The visit meets criteria applicable under subsection (j)(1) to the outcome described in this subsection.

''(i) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS.—

''(1) EXCESS POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS; AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS DEFINED.—In this subsection:

"(A) EXCESS POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS.—

"(i) IN GENERAL.—The term 'excess potentially preventable outpatient procedures and tests' means, for an applicable healthcare delivery organization for an applicable historical period and with respect to potentially preventable outpatient procedures and tests identified under paragraph (2), for each risk class (as defined in clause (iii)) the difference between—

"(I) the expected number of beneficiaries with one or more potentially preventable outpatient procedures and tests for the applicable healthcare delivery organization based on the standard potentially preventable rate of potentially preventable outpatient procedures and tests for beneficiaries in each risk class (as defined in clause (ii)); and

"(II) the applicable healthcare delivery organization's actual number of beneficiaries with one or more potentially preventable outpatient proce-

dures and tests in each risk class for the applicable historical period for beneficiaries assigned to the risk class.

Such difference may be a positive or negative number.

"(ii) STANDARD POTENTIALLY PREVENTABLE RATE OF OUTPATIENT PROCEDURES AND TESTS.—In carrying out clause (i)(I), the standard potentially preventable rate of outpatient procedures and tests shall be based on the average number of beneficiaries with one or more potentially preventable outpatient procedures and tests in each risk class, as defined in clause (iii) in the applicable historical period, multiplied by the payment reduction factor established under subsection (d)(3) for the applicable prospective period.

"(iii) RISK ADJUSTMENT.—In this subparagraph, the term 'risk classes' means such exhaustive and mutually exclusive risk classes as the Secretary shall establish in order to apply a risk-adjustment methodology that meets the criteria in sub-

section (j)(2) and account for the age, reason for admission, severity of illness, and other risk factors identified by the Secretary. The risk class for a beneficiary shall be assigned based on the beneficiary's chronic illness burden and history of healthcare services for a time period of not less than 6 months preceding the beginning of the applicable historical period.

"(B) AGGREGATE PAYMENTS FOR EXCESS POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS.—

"(i) IN GENERAL.—The term 'aggregate payments for excess potentially preventable outpatient procedures and tests' means, for an applicable historical period, for all beneficiaries with one or more potentially preventable outpatient procedures and tests identified under paragraph (2), an amount equal to the amount determined under clause (ii).

"(ii) AMOUNT DETERMINED.—The amount determined under this clause, with respect to an applicable healthcare delivery organization and an applicable historical

period, for potentially preventable outpatient procedures and tests identified under paragraph (2) is equal to the sum across all risk classes of the product of—

"(I) the excess potentially preventable outpatient procedures and tests (as defined in subparagraph (A)) for the risk class for the applicable healthcare delivery organization during the applicable historical period; and

"(II) the average payment per beneficiary of all potentially preventable outpatient procedures and tests for beneficiaries in the risk class (as determined under clause (iii)) for applicable healthcare delivery organizations during the applicable historical period.

"(iii) AVERAGE PAYMENT PER BENEFICIARY OF ALL POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS.—The term 'average payment per beneficiary of all potentially preventable outpatient procedures and tests' for a risk

class means, for applicable healthcare delivery organizations for an applicable historical period, the average payment per beneficiary of all potentially preventable outpatient procedures and tests in the risk class.

''(2) POTENTIALLY PREVENTABLE OUTPATIENT PROCEDURES AND TESTS.—For purposes of this subsection, the Secretary shall select a methodology of identifying potentially preventable outpatient procedures and tests that includes each procedure or test that meets all of the following requirements:

''(A) The procedure or test is provided or ordered by a physician or other healthcare provider to supplement or support the evaluation or treatment of a beneficiary including a procedure, diagnostic test, laboratory test, therapy service, or radiology service.

''(B) The procedure or test may be overused in the provision healthcare or treatment.

''(C) The procedure or test is not for a beneficiary with extensive comorbid disease or high severity of illness that may necessitate frequent monitoring with outpatient procedures and tests.

''(D) The procedure or test meets criteria applicable under subsection (j)(1) to the outcome described in this subsection.

''(j) SELECTION OF METHODS FOR IDENTIFYING POTENTIALLY PREVENTABLE OUTCOMES AND METHOD OF RISK ADJUSTMENT.—

''(1) SELECTION CRITERIA FOR METHOD FOR IDENTIFYING POTENTIALLY PREVENTABLE OUTCOMES.—The Secretary shall select a methodology of identifying each of the potentially preventable outcomes. For each type of potentially preventable outcome the methodology selected shall meet the following criteria:

''(A) Be comprehensive with a uniform structure.

''(B) Have available a method of risk adjustment that meets the criteria in paragraph (2).

''(C) Be clinically meaningful having exclusions for beneficiaries for whom the outcome is not potentially preventable including those beneficiaries with extensive comorbid disease or high severity of illness.

''(D) To the extent possible have been successfully implemented in the payment organiza-

tion of a State Medicaid program or a major payer or be certified by an entity with a contract under section 1890(a).

"(E) Be open, transparent, and available for review and comment.

"(F) To the extent possible, be in the public domain.

"(G) If commercially available methods are the only viable methods that meet the criteria in subparagraphs (A), (B), (C), and (D), the Secretary may select such commercial methods as long as such methods meet the criteria in subparagraph (E).

"(2) SELECTION CRITERIA FOR METHOD OF RISK ADJUSTMENT.—The Secretary shall select a methodology for risk adjusting the rate of each of the potentially preventable outcomes. For each type of potentially preventable outcome, the methodology for risk adjustment shall meet the following criteria:

"(A) The methodology is comprehensive with a uniform structure.

"(B) The methodology is clinically meaningful and explicitly recognize severity of illness, chronic illness burden, and patients with extensive comorbid disease or high severity of illness.

"(C) To the extent possible, the methodology has been successfully implemented in payment under a State Medicaid program or by a major payer or is certified by an entity with a contract under section 1890(a).

"(D) The methodology is open and transparent and available for review and comment.

"(E) To the extent possible, the methodology is in the public domain.

"(F) If commercially available methods are the only viable methods that meet the criteria in subparagraphs (A), (B), and (C), the Secretary may select such commercial methods as long as such methods meet the criteria in subparagraph (D).

"(k) DEFINITIONS.—In this section:

"(1) APPLICABLE HEALTHCARE DELIVERY ORGANIZATION.—The term 'applicable healthcare delivery organization' means a Medicare Advantage Plan receiving payments under part C, health home, accountable care organization, applicable hospital (as defined in subparagraph (C)), ambulatory surgery center, federally qualified health center, or other healthcare delivery organization identified by the Secretary.

''(2) APPLICABLE HISTORICAL PERIOD.—The term 'applicable historical period' means, with respect to an applicable healthcare delivery organization for a fiscal year, the most recent 2-year period for which data from the organization are available for purposes of this section.

''(3) APPLICABLE HOSPITAL.—The term 'applicable hospitals' means a subsection (d) hospital (as defined in section 1886(d)(1)(B).

''(4) APPLICABLE PROSPECTIVE PERIOD.—The term 'applicable prospective period' means—

''(A) with respect to an organization, the fiscal year in which the healthcare delivery organization specific adjustment factor under subsection (a)(2) for an applicable historical period applies to the payments to the healthcare delivery organization; and

''(B) with respect to healthcare professionals, the year in which the geographic-specific potentially preventable outcomes adjustment factor under subsection (b)(2) for an applicable historical period applies to payments to the professionals.

''(5) POTENTIALLY PREVENTABLE OUTCOMES.—The term 'potentially preventable out-

comes' means inpatient potentially preventable complications under subsection (e)(2), potentially preventable readmissions under subsection (f)(2), potentially preventable admissions under subsection (g)(2), potentially preventable emergency room visits under subsection (h)(2), and potentially preventable outpatient procedures and tests under subsection (i)(2).''.

(b) REPORTING OF POTENTIALLY PREVENTABLE OUTCOMES.—

(1) REPORTING TO HEALTHCARE DELIVERY ORGANIZATIONS.—For each applicable historical period, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide confidential reports to applicable healthcare delivery organizations with respect to potentially preventable outcomes. The confidential reports shall be provided to a healthcare delivery organization at least 90 days before the date of their release to the public regarding potentially preventable outcomes of the healthcare delivery organization.

(2) REPORTING HEALTH DELIVERY ORGANIZATION SPECIFIC INFORMATION.—

(A) IN GENERAL.—The Secretary shall make information available to the public re-

garding potentially preventable outcomes of each applicable healthcare delivery organization.

(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable healthcare delivery organization has the opportunity to review, and submit corrections for, the information to be made public prior to such information being made public.

(C) WEB SITE POSTING.—Such information shall be posted on the Hospital Compare Internet Web Site in an easily understandable format.

(c) APPLICABILITY TO MEDICAID.—The Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act regulations relating to payment adjustments for potentially preventable outcomes (as defined in section 1899B(k) of such Act) as appropriate for the Medicaid program. Such regulations shall be in effect no later than October 1, 2017.

(d) QUALITY IMPROVEMENT GRANTS.—

(1) IN GENERAL.—Subject to paragraph (4)(D), beginning in fiscal year 2017 the Secretary shall award quality improvement grants to eligible healthcare delivery organizations described in para-

graph (2) that meet the criteria established under paragraph (3).

(2) ELIGIBLE HEALTHCARE DELIVERY ORGANIZATION.—For purposes of this subsection for a fiscal year, an eligible healthcare delivery organization is an applicable healthcare delivery organization that has a healthcare delivery organization-specific adjustment factor for the fiscal year (as determined under section 1899B(a)(2) of the Social Security Act, as added by subsection (a)), that is lower than the healthcare delivery organization-specific adjustment factor (under such section) for 75 percent of all other healthcare delivery organizations in such fiscal year.

(3) CRITERIA.—The Secretary shall establish criteria for awarding grants under this subsection.

(4) LIMITATIONS.—

(A) USE OF GRANT FUNDS.—A healthcare delivery organization that applies for and receives a grant under this subsection shall use such grant to implement processes that lower the rate of potentially preventable outcomes.

(B) TERM OF GRANT.—Grants under this subsection shall be for 2 years.

(C) REPORTS.—A healthcare delivery organization that applies for and receives a grant under this subsection shall, not later than 30 months after the date of receiving such grant, submit a report to the Secretary on the processes funded by such grant and the resulting impact on rates of potentially preventable outcomes.

(D) AMOUNT OF GRANTS.—The aggregate amount of funds awarded as grants under this subsection for a fiscal year shall not exceed 5 percent of the sum of the composite aggregate payments for excess potentially preventable outcomes for all healthcare delivery organizations in the applicable historical period (as determined under section 1899B(c)(1) of the Social Security Act).

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2017 through 2021.

(e) GAO REPORT.—Not later than January 1, 2018, the Comptroller General of the United States shall submit to Congress a report on the impact of section 1899B of the Social Security Act, as added by subsection (a), on

Medicare beneficiaries care, Medicare expenditures, and Medicare providers, including the quality of care furnished under the Medicare program.

(f) APPLICATION OF DEFINITIONS.—In this section, the terms ''applicable healthcare delivery organization'', ''applicable historical period'', ''potentially preventable outcomes'' have the meanings given such terms in section 1899B(j) of the Social Security Act, as added by subsection (a).

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