

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

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 “Incentivizing Healthcare Quality Outcomes Act of
6 2014”.

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

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

6 (2) Existing quality measures and methods of
7 risk adjustment used to adjust Medicare payments
8 should be replaced with a comprehensive and clini-
9 cally credible quality measurement system based on
10 the rate of occurrence of potentially preventable out-
11 comes.

12 (3) Payment adjustment for quality outcomes
13 should be applied to all types of healthcare delivery
14 organizations including hospitals, health systems,
15 Medicare Advantage plans, health homes, and ac-
16 countable care organizations as well as healthcare
17 professionals.

18 **SEC. 2. INCENTIVIZING HEALTHCARE QUALITY OUTCOMES.**

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

22 “INCENTIVIZING HEALTHCARE QUALITY OUTCOMES

23 “SEC. 1899B. (a) ADJUSTMENT OF PAYMENTS TO
24 HEALTH-CARE DELIVERY ORGANIZATION FOR POTEN-
25 Tially Preventable Outcomes.—

1 “(1) IN GENERAL.—In order to provide an in-
2 centive for each applicable healthcare delivery orga-
3 nization (as defined in subsection (k)) to reduce po-
4 tentially preventable outcomes, the amount of pay-
5 ments to the organization under this title for an ap-
6 plicable prospective period (as defined in such sub-
7 section) shall be the amount otherwise determined
8 multiplied by the healthcare delivery organization-
9 specific adjustment factor determined under para-
10 graph (2) for such period.

11 “(2) HEALTHCARE DELIVERY ORGANIZATION
12 SPECIFIC PAYMENT ADJUSTMENT FACTOR.—

13 “(A) IN GENERAL.—For purposes of para-
14 graph (1), subject to subparagraph (B), the
15 healthcare delivery organization-specific pay-
16 ment adjustment factor described in this para-
17 graph for an applicable healthcare delivery or-
18 ganization for an applicable prospective period
19 is equal to 1 minus the ratio (expressed as a
20 percentage), as determined by the Secretary,
21 of—

22 “(i) the composite aggregate pay-
23 ments for excess potentially preventable
24 outcomes (described in subsection (c)(1))
25 for the organization and period; to

1 “(ii) the aggregate payments under
 2 this title to the organization for such pe-
 3 riod.

4 “(B) PHASE-IN OF HEALTHCARE DELIV-
 5 ERY ORGANIZATION-SPECIFIC ADJUSTMENT
 6 FACTOR.—In no case shall the healthcare deliv-
 7 ery organization-specific payment adjustment
 8 factor under subparagraph (A) be—

9 “(i) less than 97 percent or more than
 10 103 percent for fiscal year 2016;

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

13 “(iii) be less than 90 percent or more
 14 than 110 percent for fiscal year 2018 and
 15 each subsequent fiscal year.

16 “(b) ADJUSTMENT TO THE ANNUAL UPDATE FAC-
 17 TOR FOR PAYMENTS TO HEALTHCARE PROFESSIONALS IN
 18 A GEOGRAPHIC REGION FOR POTENTIALLY PREVENT-
 19 ABLE OUTCOMES.—

20 “(1) IN GENERAL.—In order to provide an in-
 21 centive for healthcare professionals (that are not
 22 part of an applicable healthcare delivery organiza-
 23 tion) in a geographic region to coordinate care and
 24 reduce potentially preventable outcomes, the annual
 25 update factor for traditional Medicare fee-for-service

1 payments to all such professionals in a geographic
2 region established under paragraph (3) for an appli-
3 cable prospective period (beginning on or after Octo-
4 ber 1, 2015) shall be equal to the annual update fac-
5 tor that would otherwise apply multiplied by the geo-
6 graphic-specific potentially preventable outcomes ad-
7 justment factor (as described in paragraph (2)) for
8 the geographic region and period.

9 “(2) GEOGRAPHIC-SPECIFIC POTENTIALLY PRE-
10 VENTABLE OUTCOMES ADJUSTMENT FACTOR.—

11 “(A) IN GENERAL.—For purposes of para-
12 graph (1), subject to subparagraph (B), the ge-
13 ographic-specific potentially preventable out-
14 comes adjustment factor described in this para-
15 graph for a geographic region for an applicable
16 prospective period is equal to 1 minus the ratio
17 (expressed as a percentage), as determined by
18 the Secretary, of—

19 “(i) the sum of the composite aggre-
20 gate payments for excess potentially pre-
21 ventable outcomes (described in subsection
22 (c)(1)) for Medicare beneficiaries enrolled
23 in traditional Medicare fee-for-service
24 across all applicable healthcare delivery or-
25 ganizations physically located in the geo-

1 graphic region for the applicable historical
2 period; to

3 “(ii) the aggregate payments for
4 Medicare beneficiaries enrolled in tradi-
5 tional Medicare fee-for-service across all
6 applicable healthcare delivery organizations
7 physically located in the geographic region
8 for such applicable historical period.

9 “(B) PHASE-IN.—In no case shall the geo-
10 graphic-specific potentially preventable out-
11 comes adjustment factor for a geographic re-
12 gion under this paragraph—

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

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

17 “(iii) be less than 80 percent or more
18 than 120 percent for fiscal year 2018 and
19 each subsequent fiscal year.

20 “(3) GEOGRAPHIC REGION.—

21 “(A) IN GENERAL.—For the purposes of
22 this subsection and subject to subparagraph
23 (B), the Secretary shall establish geographic re-
24 gions to which healthcare professionals shall be
25 assigned.

1 “(B) RESTRICTIONS.—

2 “(i) GEOGRAPHIC REGIONS.—To the
3 extent practical, the Secretary shall define
4 geographic regions based on core base sta-
5 tistical areas as defined by the Director of
6 the Office of Management and Budget.

7 “(ii) ASSIGNMENT OF HEALTHCARE
8 PROFESSIONALS TO GEOGRAPHIC RE-
9 GIONS.—The geographic region to which a
10 healthcare professional is assigned shall be
11 the geographic region in which a plurality
12 of Medicare beneficiaries treated by such
13 professional for the applicable historical
14 period reside, as determined by the Sec-
15 retary.

16 “(4) REPORT ON USING INDIVIDUAL
17 HEALTHCARE PROFESSIONAL PERFORMANCE.—No
18 later than January 1, 2017, the Secretary shall sub-
19 mit to Congress a report proposing a method of
20 combining the potentially preventable outcomes per-
21 formance of individual healthcare professionals with
22 the geographic-specific potentially preventable out-
23 comes performance for a geographic region under
24 paragraph (2) for the purpose of determining the
25 potentially preventable outcomes adjustment factor

1 under paragraph (1) to the annual adjustment fac-
2 tor for payments to such individual healthcare pro-
3 fessionals.

4 “(c) COMPOSITE AGGREGATE PAYMENTS FOR EX-
5 CESS POTENTIALLY PREVENTABLE OUTCOMES.—

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

13 “(A) PREVENTABLE COMPLICATIONS.—
14 The aggregate payments for excess inpatient
15 potentially preventable complications (as de-
16 fined in subsection (e)(1)(B)).

17 “(B) PREVENTABLE READMISSIONS.—The
18 aggregate payments for excess potentially pre-
19 ventable readmissions (as defined in subsection
20 (f)(1)(B)).

21 “(C) PREVENTABLE ADMISSIONS.—The
22 aggregate payments for excess potentially pre-
23 ventable admissions computed (as defined in
24 subsection (g)(1)(B)).

1 “(D) PREVENTABLE EMERGENCY ROOM
2 VISITS.—The aggregate payments for excess po-
3 tentially preventable emergency room visits (as
4 defined in subsection (h)(1)(B)).

5 “(E) PREVENTABLE OUTPATIENT ANCIL-
6 LARY SERVICES.—The aggregate payments for
7 excess potentially preventable outpatient ancil-
8 lary services (as defined in subsection
9 (i)(1)(B)).

10 “(2) OFFSETTING POTENTIALLY PREVENTABLE
11 OUTCOME VALUES BEING POSITIVE OR NEGATIVE.—
12 The aggregate payments for individual excess poten-
13 tially preventable outcomes under subsections
14 (e)(1)(B), (f)(1)(B), (g)(1)(B), (h)(1)(B), and
15 (i)(1)(B) may have a positive value (indicating the
16 healthcare delivery organization had more potentially
17 preventable outcomes than expected) or a negative
18 value (indicating the healthcare delivery organization
19 had fewer potentially preventable outcomes than ex-
20 pected). The summing of the individual excess po-
21 tentially preventable outcomes in paragraph (1) for
22 potentially preventable outcomes allows negative val-
23 ues for individual potentially preventable outcomes
24 to offset in part or in whole positive values of other
25 potentially preventable outcomes.

1 “(3) EXCLUSIONS.—The Secretary shall deter-
2 mine the applicability of each type of potentially pre-
3 ventable outcome to different types of healthcare de-
4 livery organizations and may exclude potentially pre-
5 ventable outcomes from the calculation of aggregate
6 payments referred to in paragraph (1) for types of
7 healthcare delivery organizations if the Secretary de-
8 termines that such outcomes are not applicable for
9 such types of organizations.

10 “(d) SUPERSEDING EXISTING PAYMENT ADJUST-
11 MENTS FOR QUALITY; BUDGET NEUTRAL ADJUST-
12 MENT.—

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

17 “(A) Payment adjustments for hospital ac-
18 quired conditions under section 1886(d)(4)(D),
19 as added by section 5001(c) of Deficit Reduc-
20 tion Act of 2005.

21 “(B) Payment adjustments for value based
22 purchasing for inpatient hospital services under
23 section 1886(o) and for physicians’ services
24 under section 1848(p).

1 “(C) Payment adjustments for hospital re-
2 admissions under section 1886(q), as added by
3 section 3025 of the Patient Protection and Af-
4 fordable Care Act.

5 “(D) Payment adjustments for hospital ac-
6 quired conditions under section 1886(p), as
7 added by section 3008 of the Patient Protection
8 and Affordable Care Act.

9 “(E) Payment adjustments for Medicare
10 Advantage Plans under Sections 1853(n) and
11 1853(o).

12 “(F) Other payment adjustments for qual-
13 ity as determined by the Secretary.

14 “(2) PAYMENT ADJUSTMENTS FOR REPORTING
15 QUALITY INFORMATION UNCHANGED.—Payment ad-
16 justments for reporting quality information that are
17 unrelated to actual quality performance under sec-
18 tions 1833(t)(17), 1848(a), 1848(k), 1848(m) and
19 1833(i)(2)(D) shall not be affected by this sub-
20 section.

21 “(3) MANDATED REDUCTIONS UNDER CURRENT
22 LAW.—The Secretary shall determine the annual re-
23 ductions in payment mandated by the provisions de-
24 scribed in paragraph (1) for fiscal year 2016 and for
25 each subsequent fiscal year.

1 “(4) PAYMENT REDUCTION FACTOR TO
 2 ACHIEVE BUDGET NEUTRALITY.—The Secretary
 3 shall determine a payment reduction factor for fiscal
 4 year 2016 and for each subsequent fiscal year, to be
 5 applied under subsections (e)(1)(A)(ii), (f)(1)(A)(ii),
 6 (g)(1)(A)(ii), (h)(1)(A)(ii), and (i)(1)(A)(ii), subject
 7 to the limitations in subsections (a)(2)(B) and
 8 (b)(2)(B), so that there is an aggregate payment re-
 9 duction under this section for such fiscal year equiv-
 10 alent to the aggregate reduction in payment deter-
 11 mined under paragraph (3) for such fiscal year.

12 “(e) AGGREGATE PAYMENTS FOR EXCESS INPA-
 13 TIENT POTENTIALLY PREVENTABLE COMPLICATIONS.—

14 “(1) EXCESS INPATIENT POTENTIALLY PRE-
 15 VENTABLE COMPLICATIONS; AGGREGATE PAYMENTS
 16 FOR EXCESS INPATIENT POTENTIALLY PREVENT-
 17 ABLE COMPLICATIONS DEFINED.—In this section:

18 “(A) EXCESS INPATIENT POTENTIALLY
 19 PREVENTABLE COMPLICATIONS.—

20 “(i) IN GENERAL.—The term ‘excess
 21 inpatient potentially preventable complica-
 22 tions’ means, for an applicable hospital
 23 and other applicable healthcare delivery or-
 24 ganizations determined appropriate by the
 25 Secretary for an applicable historical pe-

1 riod for each type of inpatient hospital po-
2 tentially preventable complication identified
3 under paragraph (2), the sum across all
4 risk classes (as defined in clause (iii)) of
5 the difference between—

6 “(I) the expected number of in-
7 patient hospital potentially prevent-
8 able complications for the type of
9 complication for the applicable hos-
10 pital based on the standard complica-
11 tion rate computed under clause (ii)
12 in each risk class; and

13 “(II) the applicable hospital’s ac-
14 tual number of inpatient hospital po-
15 tentially preventable complications for
16 the type of inpatient potentially pre-
17 ventable complication in each risk
18 class in the applicable historical pe-
19 riod.

20 Such difference may be a positive or nega-
21 tive number.

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

1 tient hospital potentially preventable com-
2 plication in each risk class in the applica-
3 ble historical period, multiplied by the pay-
4 ment reduction factor established under
5 subsection (d)(3) for the applicable pro-
6 spective period.

7 “(iii) RISK CLASSES.—In this sub-
8 paragraph, the term ‘risk classes’ means
9 such exhaustive and mutually exclusive
10 risk classes as the Secretary shall establish
11 in order to apply a risk-adjustment meth-
12 odology that meets the criteria in sub-
13 section (j)(2) and account for the age, rea-
14 son for admission, severity of illness, and
15 other risk factors identified by the Sec-
16 retary of patients at the time of hospital
17 admission.

18 “(B) AGGREGATE PAYMENTS FOR EXCESS
19 INPATIENT HOSPITAL POTENTIALLY PREVENT-
20 ABLE COMPLICATIONS.—

21 “(i) IN GENERAL.—The term ‘aggre-
22 gate payments for excess inpatient hospital
23 potentially preventable complications’
24 means, for an applicable hospital and other
25 applicable healthcare delivery organizations

1 determined appropriate by the Secretary
2 and applicable historical period, for all
3 types of inpatient hospital potentially pre-
4 ventable complications identified under
5 paragraph (2), an amount equal to the
6 sum of the amount determined under
7 clause (ii) for such hospital and other ap-
8 plicable healthcare delivery organizations
9 determined appropriate by the Secretary
10 for each type of inpatient hospital poten-
11 tially preventable complication for such pe-
12 riod.

13 “(ii) AMOUNT DETERMINED.—The
14 amount determined under this clause, with
15 respect to an applicable hospital and other
16 applicable healthcare delivery organizations
17 determined appropriate by the Secretary
18 and an applicable historical period, for a
19 type of inpatient hospital potentially pre-
20 ventable complication identified under
21 paragraph (2) is equal to the product of—

22 “(I) the excess inpatient hospital
23 potentially preventable complications
24 (as defined in subparagraph (A)) of
25 the applicable hospital and other ap-

1 applicable healthcare delivery organiza-
2 tions determined appropriate by the
3 Secretary for the type of inpatient
4 hospital potentially preventable com-
5 plication during the applicable histor-
6 ical period; and

7 “(II) the estimated national aver-
8 age standardized incremental cost of
9 that inpatient hospital potentially pre-
10 ventable complication for applicable
11 hospitals and other applicable
12 healthcare delivery organizations de-
13 termined appropriate by the Secretary
14 during the applicable historical period
15 (as determined under clause (iii)) ad-
16 justed by each hospital’s applicable
17 payment adjustment factors.

18 “(iii) METHODOLOGY FOR ESTI-
19 MATING NATIONAL AVERAGE INCRE-
20 MENTAL COST OF INPATIENT HOSPITAL
21 POTENTIALLY PREVENTABLE COMPLICA-
22 TIONS.—In carrying out clause (ii)(II), the
23 Secretary shall establish and apply a meth-
24 odology to estimate the national average
25 standardized incremental cost of each inpa-

1 tient hospital potentially preventable com-
2 plication identified under paragraph (2).

3 “(2) INPATIENT HOSPITAL POTENTIALLY PRE-
4 VENTABLE COMPLICATIONS.—For purposes of this
5 subsection, the Secretary shall select a methodology
6 of identifying potentially preventable complications
7 that includes each inpatient hospital complication
8 that meets all of the following requirements:

9 “(A) The complication occurs during the
10 stay and was not present on admission as an
11 inpatient.

12 “(B) The complication is a harmful event,
13 such as a surgical complication, or an acute ill-
14 ness, such as an infection or an acute exacer-
15 bation of underlying chronic disease.

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

20 “(D) The complication may be reasonably
21 construed as related to the care rendered dur-
22 ing the stay.

23 “(E) The complication meets criteria appli-
24 cable under subsection (j)(1) to the outcome de-
25 scribed in this subsection.

1 “(f) AGGREGATE PAYMENTS FOR EXCESS POTEN-
2 TIALY PREVENTABLE READMISSIONS.—

3 “(1) EXCESS POTENTIALLY PREVENTABLE RE-
4 ADMISSIONS; AGGREGATE PAYMENTS FOR EXCESS
5 POTENTIALLY PREVENTABLE READMISSIONS DE-
6 FINED.—For purposes of this subsection:

7 “(A) EXCESS POTENTIALLY PREVENTABLE
8 READMISSIONS.—

9 “(i) IN GENERAL.—The term ‘excess
10 potentially preventable readmissions’
11 means, for an applicable hospital or other
12 applicable healthcare delivery organization
13 determined appropriate by the Secretary
14 for an applicable historical period and with
15 respect to potentially preventable readmis-
16 sions identified under paragraph (2) for
17 each risk class (as defined in clause (iii))
18 the difference between—

19 “(I) the expected number of po-
20 tentially preventable readmissions for
21 the applicable hospital based on the
22 standard readmission rate in each risk
23 class (as defined in clause (ii)); and

24 “(II) the applicable hospital’s ac-
25 tual number of potentially preventable

1 readmissions in each risk class for the
2 applicable historical period.

3 Such difference may be a positive or nega-
4 tive number.

5 “(ii) STANDARD READMISSION
6 RATE.—In carrying out clause (i)(I), the
7 standard readmission rate shall be based
8 on the average potentially preventable re-
9 admission rate in each risk class, as estab-
10 lished under clause (iii), in the applicable
11 historical period, multiplied by the pay-
12 ment reduction factor established under
13 subsection (d)(3) for the applicable pro-
14 spective period.

15 “(iii) RISK ADJUSTMENT.—In this
16 subparagraph, the term ‘risk classes’
17 means such exhaustive and mutually exclu-
18 sive risk classes as the Secretary shall es-
19 tablish in order to apply a risk-adjustment
20 methodology that meets the criteria in sub-
21 section (j)(2) and account for the age, rea-
22 son for admission, severity of illness, and
23 other risk factors identified by the Sec-
24 retary of patients that were present in pa-
25 tients at the time of hospital discharge

1 from the hospital admission that preceded
2 their readmission.

3 “(B) AGGREGATE PAYMENTS FOR EXCESS
4 POTENTIALLY PREVENTABLE READMISSIONS.—

5 “(i) IN GENERAL.—The term ‘aggre-
6 gate payments for excess potentially pre-
7 ventable readmissions’ means, for an appli-
8 cable historical period, for all potentially
9 preventable readmissions identified under
10 paragraph (2), an amount equal to the
11 amount determined under clause (ii).

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

20 “(I) the excess potentially pre-
21 ventable readmissions in the risk class
22 for the applicable hospital and other
23 applicable healthcare delivery organi-
24 zations determined appropriate by the

1 Secretary for the applicable historical
2 period; and

3 “(II) the average payment for po-
4 tentially preventable readmissions (as
5 defined in clause (iii)) in the risk class
6 for applicable hospitals and other ap-
7 plicable healthcare delivery organiza-
8 tions determined appropriate by the
9 Secretary for the applicable historical
10 period.

11 “(iii) AVERAGE PAYMENT FOR POTEN-
12 Tially PREVENTABLE READMISSIONS.—In
13 clause (ii)(II), the term ‘average payment
14 for potentially preventable readmissions for
15 a risk class’ means, for applicable hospitals
16 and other applicable healthcare delivery or-
17 ganizations determined appropriate by the
18 Secretary for an applicable historical pe-
19 riod, the average payment for all poten-
20 tially preventable readmissions that follow
21 a prior discharge in that risk class.

22 “(2) POTENTIALLY PREVENTABLE READMIS-
23 SIONS.—For purposes of this subsection, the Sec-
24 retary shall select a methodology of identifying po-
25 tentially preventable readmissions under paragraph

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

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

6 “(i) the provision of appropriate care
7 consistent with accepted standards in the
8 prior discharge;

9 “(ii) adequate discharge planning;

10 “(iii) adequate post-discharge fol-
11 lowup; or

12 “(iv) improved coordination between
13 the inpatient and outpatient healthcare
14 teams.

15 “(B) The readmission is for a condition or
16 procedure related to the care during the prior
17 admission or during the care immediately fol-
18 lowing the prior discharge, including—

19 “(i) a readmission for the same or
20 closely related condition or procedure as
21 the prior discharge;

22 “(ii) a readmission for an infection or
23 other complication of care;

1 “(iii) a readmission for a condition or
2 procedure indicative of a failed surgical
3 intervention; and

4 “(iv) a readmission for an acute de-
5 compensation of a coexisting chronic dis-
6 ease.

7 “(C) The readmission is back to the same
8 hospital or to any other hospital.

9 “(D) The readmission does not occur
10 under any of the following circumstances:

11 “(i) The original discharge was a pa-
12 tient-initiated discharge and was against
13 medical advice and the circumstances of
14 such discharge and readmission are docu-
15 mented in the patient’s medical record.

16 “(ii) The readmission was a planned
17 readmission.

18 “(iii) Such other exclusion as the Sec-
19 retary determines appropriate.

20 “(E) The readmission meets criteria appli-
21 cable under subsection (j)(1) to the outcome de-
22 scribed in this subsection.

23 “(g) AGGREGATE PAYMENTS FOR EXCESS POTEN-
24 Tially Preventable Admissions.—

1 “(1) EXCESS POTENTIALLY PREVENTABLE AD-
2 MISSIONS; AGGREGATE PAYMENTS FOR EXCESS PO-
3 TENTIALLY PREVENTABLE ADMISSIONS DEFINED.—

4 In this subsection:

5 “(A) EXCESS POTENTIALLY PREVENTABLE
6 ADMISSIONS.—

7 “(i) IN GENERAL.—The term ‘excess
8 potentially preventable admissions’ means,
9 for an applicable healthcare delivery orga-
10 nization for an applicable historical period
11 and with respect to potentially preventable
12 admissions identified under paragraph (2),
13 for each risk class (as defined in clause
14 (iii)) the difference between—

15 “(I) the expected number of
16 beneficiaries with one or more poten-
17 tially preventable admissions for the
18 applicable healthcare delivery organi-
19 zation based on the standard poten-
20 tially preventable admission rate for
21 beneficiaries in each risk class; and

22 “(II) the applicable healthcare
23 delivery organization’s actual number
24 of beneficiaries with one or more po-
25 tentially preventable admissions in

1 each risk class for the applicable his-
2 torical period for beneficiaries as-
3 signed to the risk class.

4 Such difference may be a positive or nega-
5 tive number.

6 “(ii) STANDARD POTENTIALLY PRE-
7 VENTABLE ADMISSION RATE.—In carrying
8 out clause (i)(I), the standard potentially
9 preventable admission rate shall be based
10 on the average number of beneficiaries
11 with one or more potentially preventable
12 admissions in each risk class, as defined in
13 clause (iii), in the applicable historical pe-
14 riod, multiplied by the payment reduction
15 factor established under subsection (d)(3)
16 for the applicable prospective period.

17 “(iii) RISK ADJUSTMENT.—In this
18 subparagraph, the term ‘risk classes’
19 means such exhaustive and mutually exclu-
20 sive risk classes as the Secretary shall es-
21 tablish in order to apply a risk-adjustment
22 methodology that meets the criteria in sub-
23 section (j)(2) and account for the age, rea-
24 son for admission, severity of illness, and
25 other risk factors identified by the Sec-

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

8 “(B) AGGREGATE PAYMENTS FOR EXCESS
9 POTENTIALLY PREVENTABLE ADMISSIONS.—

10 “(i) IN GENERAL.—The term ‘aggre-
11 gate payments for excess potentially pre-
12 ventable admissions’ means, for an applica-
13 ble historical period, for potentially pre-
14 ventable admissions identified under para-
15 graph (2), an amount equal to the amount
16 determined under clause (ii).

17 “(ii) AMOUNT DETERMINED.—The
18 amount determined under this clause, with
19 respect to an applicable healthcare delivery
20 organization and an applicable historical
21 period, for all beneficiaries with one or
22 more potentially preventable admissions
23 identified under paragraph (2) is equal to
24 the sum across all risk classes of the prod-
25 uct of—

1 “(I) the excess potentially pre-
2 ventable admissions (as defined in
3 subparagraph (A)) in the risk class
4 for the applicable healthcare delivery
5 organization during the applicable his-
6 torical period; and

7 “(II) the average payment per
8 beneficiary of all potentially prevent-
9 able admissions for beneficiaries in
10 the risk class (as determined under
11 clause (iii)) for applicable healthcare
12 delivery organizations during the ap-
13 plicable historical period.

14 “(iii) AVERAGE PAYMENT PER BENE-
15 FICIARY OF ALL POTENTIALLY PREVENT-
16 ABLE ADMISSIONS.—The term ‘average
17 payment per beneficiary of all potentially
18 preventable admissions’ for a risk class
19 means, for applicable healthcare delivery
20 organizations for an applicable historical
21 period, the average payment per bene-
22 ficiary for all potentially preventable ad-
23 missions in the risk class.

24 “(2) POTENTIALLY PREVENTABLE ADMIS-
25 SIONS.—For purposes of this subsection, the Sec-

1 retary shall select a methodology of identifying po-
 2 tentially preventable admissions under paragraph (1)
 3 that includes each admission that meets all of the
 4 following requirements:

5 “(A) The admission could reasonably have
 6 been prevented with adequate access to ambula-
 7 tory care or coordinated healthcare services.

8 “(B) The services provided as part of the
 9 admission could be safely performed in an out-
 10 patient facility.

11 “(C) The admission is not of a beneficiary
 12 with extensive comorbid disease or high severity
 13 of illness that may necessitate that care be de-
 14 livered in a hospital setting.

15 “(D) The admission meets criteria applica-
 16 ble under subsection (j)(1) to the outcome de-
 17 scribed in this subsection.

18 “(h) AGGREGATE PAYMENTS FOR EXCESS POTEN-
 19 Tially Preventable Emergency Room Visits.—

20 “(1) EXCESS POTENTIALLY PREVENTABLE
 21 EMERGENCY ROOM VISITS; AGGREGATE PAYMENTS
 22 FOR EXCESS POTENTIALLY PREVENTABLE EMER-
 23 GENCY ROOM VISITS DEFINED.—In this subsection:

24 “(A) EXCESS POTENTIALLY PREVENTABLE
 25 EMERGENCY ROOM VISITS.—

1 “(i) IN GENERAL.—The term ‘excess
2 potentially preventable emergency room
3 visits’ means, for an applicable healthcare
4 delivery organization for an applicable his-
5 torical period and with respect to poten-
6 tially preventable emergency room visits
7 identified under paragraph (2), for each
8 risk class (as defined in clause (iii)) the
9 difference between—

10 “(I) the expected number of
11 beneficiaries with one or more poten-
12 tially preventable emergency room vis-
13 its for the applicable healthcare deliv-
14 ery organization based on the stand-
15 ard potentially preventable emergency
16 room visit rate for beneficiaries in
17 each risk class (as defined in clause
18 (ii)); and

19 “(II) the applicable healthcare
20 delivery organization’s actual number
21 of beneficiaries with one or more po-
22 tentially preventable emergency room
23 visits for the applicable historical pe-
24 riod for beneficiaries assigned to the
25 risk class.

1 Such difference may be a positive or nega-
2 tive number.

3 “(ii) STANDARD POTENTIALLY PRE-
4 VENTABLE EMERGENCY ROOM VISIT
5 RATE.—In carrying out clause (i)(I), the
6 standard potentially preventable emergency
7 room visit rate shall be based on the aver-
8 age number of beneficiaries with one or
9 more potentially preventable emergency
10 room visits in each risk class, as defined in
11 clause (iii) in the applicable historical pe-
12 riod, multiplied by the payment reduction
13 factor established under subsection (d)(3)
14 for the applicable prospective period.

15 “(iii) RISK ADJUSTMENT.—In this
16 subparagraph, the term ‘risk classes’
17 means such exhaustive and mutually exclu-
18 sive risk classes as the Secretary shall es-
19 tablish in order to apply a risk-adjustment
20 methodology that meets the criteria in sub-
21 section (j)(2) and account for the age, rea-
22 son for admission, severity of illness, and
23 other risk factors identified by the Sec-
24 retary. The risk class for a beneficiary
25 shall be assigned based on the beneficiary’s

1 chronic illness burden and history of
2 healthcare services for a time period of not
3 less than 6 months preceding the begin-
4 ning of the applicable historical period.

5 “(B) AGGREGATE PAYMENTS FOR EXCESS
6 POTENTIALLY PREVENTABLE EMERGENCY
7 ROOM VISITS.—

8 “(i) IN GENERAL.—The term ‘aggre-
9 gate payments for excess potentially pre-
10 ventable emergency room visits’ means, for
11 an applicable historical period, for poten-
12 tially preventable emergency room visits
13 identified under paragraph (2), an amount
14 equal to the amount determined under
15 clause (ii).

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

1 “(I) the excess potentially pre-
2 ventable emergency room visits (as de-
3 fined in subparagraph (A)) in the risk
4 class for the applicable healthcare de-
5 livery organization during the applica-
6 ble historical period; and

7 “(II) the average payment per
8 beneficiary of all potentially prevent-
9 able emergency room visits for bene-
10 ficiaries in the risk class (as deter-
11 mined under clause (iii)) for applica-
12 ble healthcare delivery organizations
13 during the applicable historical period.

14 “(iii) AVERAGE PAYMENT PER BENE-
15 FICIARY OF ALL POTENTIALLY PREVENT-
16 ABLE EMERGENCY ROOM VISITS.—The
17 term ‘average payment per beneficiary of
18 all potentially preventable emergency room
19 visits’ means, for applicable healthcare de-
20 livery organizations for an applicable his-
21 torical period for a risk class, the average
22 payment per beneficiary for all potentially
23 preventable emergency room visits in the
24 risk class.

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

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

11 “(B) The beneficiary involved does not
 12 have an extensive comorbid disease or high se-
 13 verity of illness that may necessitate that care
 14 be delivered in an emergency room setting.

15 “(C) The visit meets criteria applicable
 16 under subsection (j)(1) to the outcome de-
 17 scribed in this subsection.

18 “(i) AGGREGATE PAYMENTS FOR EXCESS POTEN-
 19 Tially Preventable Outpatient Procedures and
 20 Tests.—

21 “(1) EXCESS POTENTIALLY PREVENTABLE
 22 OUTPATIENT PROCEDURES AND TESTS; AGGREGATE
 23 PAYMENTS FOR EXCESS POTENTIALLY PREVENT-
 24 ABLE OUTPATIENT PROCEDURES AND TESTS DE-
 25 FINED.—In this subsection:

1 “(A) EXCESS POTENTIALLY PREVENTABLE
2 OUTPATIENT PROCEDURES AND TESTS.—

3 “(i) IN GENERAL.—The term ‘excess
4 potentially preventable outpatient proce-
5 dures and tests’ means, for an applicable
6 healthcare delivery organization for an ap-
7 plicable historical period and with respect
8 to potentially preventable outpatient proce-
9 dures and tests identified under paragraph
10 (2), for each risk class (as defined in
11 clause (iii)) the difference between—

12 “(I) the expected number of
13 beneficiaries with one or more poten-
14 tially preventable outpatient proce-
15 dures and tests for the applicable
16 healthcare delivery organization based
17 on the standard potentially prevent-
18 able rate of potentially preventable
19 outpatient procedures and tests for
20 beneficiaries in each risk class (as de-
21 fined in clause (ii)); and

22 “(II) the applicable healthcare
23 delivery organization’s actual number
24 of beneficiaries with one or more po-
25 tentially preventable outpatient proce-

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

5 Such difference may be a positive or nega-
6 tive number.

7 “(ii) STANDARD POTENTIALLY PRE-
8 VENTABLE RATE OF OUTPATIENT PROCE-
9 DURES AND TESTS.—In carrying out
10 clause (i)(I), the standard potentially pre-
11 ventable rate of outpatient procedures and
12 tests shall be based on the average number
13 of beneficiaries with one or more poten-
14 tially preventable outpatient procedures
15 and tests in each risk class, as defined in
16 clause (iii) in the applicable historical pe-
17 riod, multiplied by the payment reduction
18 factor established under subsection (d)(3)
19 for the applicable prospective period.

20 “(iii) RISK ADJUSTMENT.—In this
21 subparagraph, the term ‘risk classes’
22 means such exhaustive and mutually exclu-
23 sive risk classes as the Secretary shall es-
24 tablish in order to apply a risk-adjustment
25 methodology that meets the criteria in sub-

1 section (j)(2) and account for the age, rea-
 2 son for admission, severity of illness, and
 3 other risk factors identified by the Sec-
 4 retary. The risk class for a beneficiary
 5 shall be assigned based on the beneficiary's
 6 chronic illness burden and history of
 7 healthcare services for a time period of not
 8 less than 6 months preceding the begin-
 9 ning of the applicable historical period.

10 “(B) AGGREGATE PAYMENTS FOR EXCESS
 11 POTENTIALLY PREVENTABLE OUTPATIENT PRO-
 12 CEDURES AND TESTS.—

13 “(i) IN GENERAL.—The term ‘aggre-
 14 gate payments for excess potentially pre-
 15 ventable outpatient procedures and tests’
 16 means, for an applicable historical period,
 17 for all beneficiaries with one or more po-
 18 tentially preventable outpatient procedures
 19 and tests identified under paragraph (2),
 20 an amount equal to the amount determined
 21 under clause (ii).

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

1 period, for potentially preventable out-
2 patient procedures and tests identified
3 under paragraph (2) is equal to the sum
4 across all risk classes of the product of—

5 “(I) the excess potentially pre-
6 ventable outpatient procedures and
7 tests (as defined in subparagraph (A))
8 for the risk class for the applicable
9 healthcare delivery organization dur-
10 ing the applicable historical period;
11 and

12 “(II) the average payment per
13 beneficiary of all potentially prevent-
14 able outpatient procedures and tests
15 for beneficiaries in the risk class (as
16 determined under clause (iii)) for ap-
17 plicable healthcare delivery organiza-
18 tions during the applicable historical
19 period.

20 “(iii) AVERAGE PAYMENT PER BENE-
21 FICIARY OF ALL POTENTIALLY PREVENT-
22 ABLE OUTPATIENT PROCEDURES AND
23 TESTS.—The term ‘average payment per
24 beneficiary of all potentially preventable
25 outpatient procedures and tests’ for a risk

1 class means, for applicable healthcare de-
2 livery organizations for an applicable his-
3 torical period, the average payment per
4 beneficiary of all potentially preventable
5 outpatient procedures and tests in the risk
6 class.

7 “(2) POTENTIALLY PREVENTABLE OUTPATIENT
8 PROCEDURES AND TESTS.—For purposes of this
9 subsection, the Secretary shall select a methodology
10 of identifying potentially preventable outpatient pro-
11 cedures and tests that includes each procedure or
12 test that meets all of the following requirements:

13 “(A) The procedure or test is provided or
14 ordered by a physician or other healthcare pro-
15 vider to supplement or support the evaluation
16 or treatment of a beneficiary including a proce-
17 dure, diagnostic test, laboratory test, therapy
18 service, or radiology service.

19 “(B) The procedure or test may be over-
20 used in the provision healthcare or treatment.

21 “(C) The procedure or test is not for a
22 beneficiary with extensive comorbid disease or
23 high severity of illness that may necessitate fre-
24 quent monitoring with outpatient procedures
25 and tests.

1 “(D) The procedure or test meets criteria
2 applicable under subsection (j)(1) to the out-
3 come described in this subsection.

4 “(j) SELECTION OF METHODS FOR IDENTIFYING PO-
5 TENTIALLY PREVENTABLE OUTCOMES AND METHOD OF
6 RISK ADJUSTMENT.—

7 “(1) SELECTION CRITERIA FOR METHOD FOR
8 IDENTIFYING POTENTIALLY PREVENTABLE OUT-
9 COMES.—The Secretary shall select a methodology
10 of identifying each of the potentially preventable out-
11 comes. For each type of potentially preventable out-
12 come the methodology selected shall meet the fol-
13 lowing criteria:

14 “(A) Be comprehensive with a uniform
15 structure.

16 “(B) Have available a method of risk ad-
17 justment that meets the criteria in paragraph
18 (2).

19 “(C) Be clinically meaningful having exclu-
20 sions for beneficiaries for whom the outcome is
21 not potentially preventable including those
22 beneficiaries with extensive comorbid disease or
23 high severity of illness.

24 “(D) To the extent possible have been suc-
25 cessfully 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.

1 “(C) To the extent possible, the method-
2 ology has been successfully implemented in pay-
3 ment under a State Medicaid program or by a
4 major payer or is certified by an entity with a
5 contract under section 1890(a).

6 “(D) The methodology is open and trans-
7 parent and available for review and comment.

8 “(E) To the extent possible, the method-
9 ology is in the public domain.

10 “(F) If commercially available methods are
11 the only viable methods that meet the criteria
12 in subparagraphs (A), (B), and (C), the Sec-
13 retary may select such commercial methods as
14 long as such methods meet the criteria in sub-
15 paragraph (D).

16 “(k) DEFINITIONS.—In this section:

17 “(1) APPLICABLE HEALTHCARE DELIVERY OR-
18 GANIZATION.—The term ‘applicable healthcare deliv-
19 ery organization’ means a Medicare Advantage Plan
20 receiving payments under part C, health home, ac-
21 countable care organization, applicable hospital (as
22 defined in subparagraph (C)), ambulatory surgery
23 center, federally qualified health center, or other
24 healthcare delivery organization identified by the
25 Secretary.

1 “(2) APPLICABLE HISTORICAL PERIOD.—The
2 term ‘applicable historical period’ means, with re-
3 spect to an applicable healthcare delivery organiza-
4 tion for a fiscal year, the most recent 2-year period
5 for which data from the organization are available
6 for purposes of this section.

7 “(3) APPLICABLE HOSPITAL.—The term ‘appli-
8 cable hospitals’ means a subsection (d) hospital (as
9 defined in section 1886(d)(1)(B).

10 “(4) APPLICABLE PROSPECTIVE PERIOD.—The
11 term ‘applicable prospective period’ means—

12 “(A) with respect to an organization, the
13 fiscal year in which the healthcare delivery or-
14 ganization specific adjustment factor under sub-
15 section (a)(2) for an applicable historical period
16 applies to the payments to the healthcare deliv-
17 ery organization; and

18 “(B) with respect to healthcare profes-
19 sionals, the year in which the geographic-spe-
20 cific potentially preventable outcomes adjust-
21 ment factor under subsection (b)(2) for an ap-
22 plicable historical period applies to payments to
23 the professionals.

24 “(5) POTENTIALLY PREVENTABLE OUT-
25 COMES.—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-

1 garding potentially preventable outcomes of
2 each applicable healthcare delivery organization.

3 (B) OPPORTUNITY TO REVIEW AND SUB-
4 MIT CORRECTIONS.—The Secretary shall ensure
5 that an applicable healthcare delivery organiza-
6 tion has the opportunity to review, and submit
7 corrections for, the information to be made pub-
8 lic prior to such information being made public.

9 (C) WEB SITE POSTING.—Such informa-
10 tion shall be posted on the Hospital Compare
11 Internet Web Site in an easily understandable
12 format.

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

20 (d) QUALITY IMPROVEMENT GRANTS.—

21 (1) IN GENERAL.—Subject to paragraph
22 (4)(D), beginning in fiscal year 2017 the Secretary
23 shall award quality improvement grants to eligible
24 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.

1 (C) REPORTS.—A healthcare delivery orga-
2 nization that applies for and receives a grant
3 under this subsection shall, not later than 30
4 months after the date of receiving such grant,
5 submit a report to the Secretary on the proc-
6 esses funded by such grant and the resulting
7 impact on rates of potentially preventable out-
8 comes.

9 (D) AMOUNT OF GRANTS.—The aggregate
10 amount of funds awarded as grants under this
11 subsection for a fiscal year shall not exceed 5
12 percent of the sum of the composite aggregate
13 payments for excess potentially preventable out-
14 comes for all healthcare delivery organizations
15 in the applicable historical period (as deter-
16 mined under section 1899B(c)(1) of the Social
17 Security Act).

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

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

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

4 (f) APPLICATION OF DEFINITIONS.—In this section,
5 the terms “applicable healthcare delivery organization”,
6 “applicable historical period”, “potentially preventable
7 outcomes” have the meanings given such terms in section
8 1899B(j) of the Social Security Act, as added by sub-
9 section (a).

○