

114TH CONGRESS
2D SESSION

H. R. 6274

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

SEPTEMBER 28, 2016

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

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 “Hospital Outcomes Act of 2016”.

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

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

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

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

1 (3) The payment penalties for hospital acquired
2 conditions and readmission should be restructured to
3 be based on a comprehensive and clinically credible
4 definition of potentially-avoidable complications and
5 potentially-avoidable readmissions, be based on the
6 risk adjusted rate of occurrence potentially-avoidable
7 complications and potentially-avoidable readmissions
8 and include both payment penalties and bonuses
9 that are proportional to the actual financial impact
10 of potentially-avoidable complications and poten-
11 tially-avoidable readmissions.

12 (4) The existing methods of risk adjustment
13 used to determine the quality of care performance of
14 hospitals should be restructured and replaced by a
15 methodology that is composed of exhaustive and mu-
16 tually exclusive risk categories that are clinically
17 credible and explicitly recognize the severity of ill-
18 ness and chronic illness burden of Medicare bene-
19 ficiaries, thereby accounting for patient characteris-
20 tics that may impact access to care.

21 **SEC. 2. HOSPITAL OUTCOMES.**

22 (a) PAYMENT ADJUSTMENTS FOR HOSPITAL OUT-
23 COMES.—Section 1886 of the Social Security Act (42
24 U.S.C. 1395ww) is amended by adding at the end the fol-
25 lowing new subsection:

1 “(t) HOSPITAL OUTCOMES.—

2 “(1) IN GENERAL.—In the case of an applicable
3 hospital for an applicable prospective period begin-
4 ning on or after October 1, 2017—

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

19 “(B) the potentially-avoidable outcome ad-
20 justment factor shall apply only with respect to
21 the applicable prospective period, and the Sec-
22 retary shall not take into account such adjust-
23 ment factor in making payments to hospitals
24 under this section in a subsequent applicable
25 prospective period.

1 “(2) POTENTIALLY-AVOIDABLE OUTCOME AD-
2 JUSTMENT FACTOR.—

3 “(A) IN GENERAL.—For purposes of para-
4 graph (1), the potentially-avoidable outcome ad-
5 justment factor described in this paragraph for
6 an applicable hospital for an applicable prospec-
7 tive period, subject to subparagraph (B), is
8 equal to 1.0 minus the potentially-avoidable
9 outcome performance fraction determined under
10 paragraph (3) for the hospital and period.

11 “(B) HOSPITAL-SPECIFIC CAP AND
12 FLOOR.—In no circumstance may the poten-
13 tially-avoidable outcome adjustment factor for
14 an applicable hospital for an applicable prospec-
15 tive period under subparagraph (A) be—

16 “(i) for applicable prospective periods
17 occurring in fiscal years 2018 through
18 2020, less than 0.97 or more than 1.03;
19 and

20 “(ii) for applicable prospective periods
21 occurring in or after fiscal year 2021, less
22 than 0.95 or more than 1.05.

23 “(3) DETERMINATION OF POTENTIALLY-AVOID-
24 ABLE OUTCOME PERFORMANCE FRACTION.—

“(A) IN GENERAL.—The potentially-avoid-
able outcome performance fraction for an appli-
cable hospital for an applicable prospective pe-
riod, subject to subparagraph (C), is equal to
the ratio of—

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

“(ii) the aggregate amount of stand-
ardized payments (as defined in paragraph
(4)(G)(ii)) made to the hospital during the
data collection period with respect to such
applicable prospective period.

“(B) TOTAL HOSPITAL-SPECIFIC FINAN-
CIAL IMPACT DESCRIBED.—For purposes of
subparagraph (A), the term ‘total hospital-spe-
cific financial impact’ means, with respect to a
hospital for an applicable prospective period,
the sum of the following:

“(i) The financial impact determined
in accordance with paragraph (4)(F) for
such hospital and data collection period
with respect to the performance category

1 described in paragraph (5)(A) (relating to
2 complications).

3 “(ii) The financial impact determined
4 in accordance with subsection (4)(F) for
5 such hospital and data collection period
6 with respect to the performance category
7 described in paragraph (5)(B) (relating to
8 readmissions).

9 “(C) BUDGET NEUTRALITY OF POTEN-
10 Tially-AVOIDABLE OUTCOME ADJUSTMENT
11 FACTOR ACROSS ALL HOSPITALS.—The Sec-
12 retary shall determine a budget neutrality rate
13 reduction fraction that, when applied in para-
14 graph (4)(B)(ii), will result in a potentially-
15 avoidable outcome factor determined under sub-
16 paragraph (A) for an applicable prospective pe-
17 riod that reduces the total payments under sub-
18 section (d) across all applicable hospitals and
19 all potentially-avoidable outcomes for such pe-
20 riod by an amount equal to the reduction in
21 payments under such subsection for such period
22 that would have resulted from the application of
23 subsections (p) and (q) if the amendments
24 made by the Hospital Outcomes Act of 2016
25 had not applied.

1 “(4) PROCESS OF DETERMINATION OF POTEN-
2 TIALY-AVOIDABLE OUTCOMES PERFORMANCE; FI-
3 NANCIAL IMPACT.—For purposes of paragraph (3),
4 the Secretary shall, for each performance category
5 described in paragraph (5) and each data collection
6 period that is with respect to an applicable prospec-
7 tive period beginning on or after October 1, 2017,
8 determine each of the following:

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

12 “(i) the number of discharges occur-
13 ring among all applicable hospitals during
14 such applicable data collection period that
15 are with respect to such risk category and
16 that involve the potentially-avoidable out-
17 comes in such performance category; to

18 “(ii) the number of applicable dis-
19 charges among all applicable hospitals for
20 such applicable data collection period and
21 risk category.

22 “(B) NATIONWIDE TARGET RATES.—With
23 respect to each risk category specified under
24 paragraph (6)(B), the product of—

1 “(i) subject to subparagraph (H), the
2 ratio determined under subparagraph (A)
3 for such period and risk category; and

4 “(ii) the budget neutrality rate reduc-
5 tion fraction determined under paragraph
6 (3)(C) for such period.

7 “(C) HOSPITAL-SPECIFIC ACTUAL NUM-
8 BER.—With respect to each applicable hospital
9 and each such risk category, the number of dis-
10 charges occurring with respect to such hospital
11 during such applicable data collection period
12 that involve the potentially-avoidable outcomes
13 in such performance category.

14 “(D) HOSPITAL-SPECIFIC EXPECTED NUM-
15 BER.—With respect to each applicable hospital,
16 each applicable data collection period, and each
17 such risk category, the number that is the prod-
18 uct of—

19 “(i) subject to subparagraph (H), the
20 ratio determined under subparagraph (B)
21 for such period and risk category; and

22 “(ii) the number of applicable dis-
23 charges of the hospital for such period and
24 risk category.

1 “(E) HOSPITAL-SPECIFIC POTENTIALLY-
2 AVOIDABLE OUTCOME PERFORMANCE.—With
3 respect to each applicable hospital and applica-
4 ble data collection period, the difference be-
5 tween—

6 “(i) the sum of the numbers deter-
7 mined under subparagraph (C) for the hos-
8 pital for such period for all risk categories;
9 and

10 “(ii) the sum of the numbers deter-
11 mined under subparagraph (D) for the
12 hospital for such period for all risk cat-
13 egories.

14 “(F) FINANCIAL IMPACT.—

15 “(i) With respect to each applicable
16 hospital and applicable data collection pe-
17 riod, the financial impact attributable to
18 potentially-avoidable outcomes performance
19 within such performance category, deter-
20 mined as the product of the following:

21 “(I) the difference calculated
22 under subparagraph (E) for such hos-
23 pital and period; and

24 “(II) the financial conversion fac-
25 tor determined in accordance with

1 clause (ii) for the performance cat-
2 egory.

3 “(ii) FINANCIAL CONVERSION FAC-
4 TORS.—For purposes of clause (i), the Sec-
5 retary shall determine a financial conver-
6 sion factor for the performance category
7 that—

8 “(I) in the case of the perform-
9 ance category described in paragraph
10 (5)(A), is, with respect to inpatient
11 hospital services that are furnished
12 with respect to a discharge, equal to
13 the average amount of increase in the
14 standardized payments for such inpa-
15 tient hospital services for such dis-
16 charge that is attributable to the po-
17 tentially-avoidable complication; and

18 “(II) in the case of the perform-
19 ance category described in paragraph
20 (5)(B), is, with respect to an initial
21 discharge, equal to the average stand-
22 ardized payment for inpatient hospital
23 services that are furnished with re-
24 spect to a potentially-avoidable read-
25 mission following the initial discharge.

1 “(G) DEFINITIONS.—For purposes of this
2 section:

3 “(i) POTENTIALLY-AVOIDABLE OUT-
4 COMES.—The term ‘potentially-avoidable
5 outcomes’ means, as applicable—

6 “(I) a potentially-avoidable com-
7 plication within the category described
8 in paragraph (5)(A); and

9 “(II) a potentially-avoidable read-
10 mission within the category described
11 in paragraph (5)(B).

12 “(ii) STANDARDIZED PAYMENTS.—
13 The term ‘standardized payment’ means
14 payment for inpatient hospital services
15 under section 1886(d) furnished by an ap-
16 plicable hospital that is adjusted to remove
17 payment adjustments that are not directly
18 related to the amount and type of services
19 to be utilized for patient care (such as
20 local or regional price differences, graduate
21 indirect medical education payments, dis-
22 proportionate share payments, and such
23 other adjustments as may be determined
24 by the Secretary).

1 “(iii) APPLICABLE DISCHARGES.—

2 With respect to an applicable data collec-
3 tion period and risk category, the term ‘ap-
4 plicable discharges’ means, in the case of—

5 “(I) the performance category
6 described in paragraph (5)(A), dis-
7 charges occurring during such appli-
8 cable data collection period that are
9 with respect to such risk category;
10 and

11 “(II) the performance category
12 described in paragraph (5)(B), dis-
13 charges occurring during such appli-
14 cable data collection period that are
15 with respect to such risk category and
16 that are not identified as potentially-
17 avoidable readmissions under the
18 methodology selected under paragraph
19 (6)(A).

20 “(H) EXCEPTION TO USE OF NATIONWIDE-
21 AVERAGE RATES.—In the case that the method-
22 ology selected under paragraph (6)(B) for such
23 performance category does not meet the criteria
24 described in clause (iii) of such paragraph, the
25 Secretary shall—

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

6 “(ii) compute, with respect to each
7 such group and each risk category speci-
8 fied under paragraph (6)(B)—

9 “(I) the number of discharges oc-
10 ccurring among all applicable hospitals
11 in such group during such applicable
12 data collection period that are with re-
13 spect to such risk category and that
14 involve the potentially-avoidable out-
15 comes in such performance category;
16 to

17 “(II) the number of applicable
18 discharges occurring among all appli-
19 cable hospitals in such group for such
20 applicable data collection period and
21 risk category; and

22 “(iii) treat each reference in this
23 paragraph to the ratio determined under
24 subparagraph (A) or (B), as applicable, for
25 a period and risk category as a reference

1 to the ratio determined under subpara-
2 graph (A) or (B), as applicable, for a
3 group, period, and risk category.

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

7 “(A) POTENTIALLY-AVOIDABLE COMPLICA-
8 TIONS.—The category of complications (re-
9 ferred to in this section as ‘potentially-avoidable
10 complications’) that, with respect to items and
11 services furnished to an individual entitled to
12 benefits under part A in an applicable hospital,
13 meet all of the following requirements:

14 “(i) The complication occurs during
15 the stay of the individual and was not
16 present at the time of the admission of
17 such individual to such hospital as an inpa-
18 tient.

19 “(ii) The complication is a harmful
20 event (such as a surgical complication) or
21 an acute illness (such as an infection or an
22 acute exacerbation of underlying chronic
23 disease).

1 “(iii) The complication is potentially
2 avoidable with adequate care and treat-
3 ment.

4 “(iv) The complication is not a nat-
5 ural progression of the underlying illnesses
6 of the individual that are present on ad-
7 mission of such individual to such hospital.

8 “(v) The complication may be reason-
9 ably construed as related to the care ren-
10 dered during the stay of the individual at
11 the hospital.

12 “(B) POTENTIALLY-AVOIDABLE READMIS-
13 SIONS.—

14 “(i) IN GENERAL.—The category of
15 readmissions (referred to in this section as
16 ‘potentially-avoidable readmissions’) of in-
17 dividuals entitled to benefits under part A
18 to any hospitals following a discharge (re-
19 ferred to in this section as an ‘initial dis-
20 charge’) of such individuals to an applica-
21 ble hospital if the initial discharge and re-
22 admission involved satisfy all of the fol-
23 lowing requirements:

1 “(I) The readmission of the indi-
2 vidual could reasonably have been pre-
3 vented by—

4 “(aa) the provision of appro-
5 priate care during the episode of
6 care ending in such initial dis-
7 charge that was consistent with
8 accepted standards;

9 “(bb) adequate discharge
10 planning with respect to such ini-
11 tial discharge;

12 “(cc) adequate post-dis-
13 charge follow-up with respect to
14 such initial discharge; or

15 “(dd) improved coordination
16 between the providers furnishing
17 the inpatient or outpatient hos-
18 pital services during the episode
19 of care ending in such initial dis-
20 charge and the providers fur-
21 nishing care during the post-dis-
22 charge period with respect to
23 such initial discharge.

24 “(II) The readmission is for a
25 condition or procedure related to the

1 episode of care ending in such initial
2 discharge, including a readmission for
3 a condition or procedure that is any of
4 the following:

5 “(aa) The same (or a closely
6 related) condition or procedure as
7 the condition addressed in, or the
8 procedure provided during the
9 episode of care ending in such
10 initial discharge.

11 “(bb) An infection or other
12 complication of care provided
13 during the episode of care ending
14 in such initial discharge.

15 “(cc) A condition or proce-
16 dure indicative of a failed proce-
17 dure provided during the episode
18 of care ending in such initial dis-
19 charge.

20 “(dd) An acute decompensa-
21 tion of a coexisting chronic dis-
22 ease that was precipitated by the
23 care furnished during the episode
24 of care ending in such initial dis-
25 charge.

1 “(III) The readmission is not a
2 documented readmission with respect
3 to a documented discharge that was
4 initiated by the individual contrary to
5 medical advice provided to such indi-
6 vidual during the episode of care with
7 respect to such initial discharge.

8 “(IV) The readmission could not
9 reasonably be considered a planned
10 readmission.

11 “(V) The readmission occurs dur-
12 ing the 30-day period following an in-
13 patient discharge of such an indi-
14 vidual from the applicable hospital
15 with respect to such initial discharge.

16 “(VI) The readmission was not
17 due to a traumatic injury that oc-
18 curred after the episode of care end-
19 ing in such initial discharge.

20 “(VII) The readmission does not
21 fall under such other exclusions as the
22 Secretary determines appropriate.

23 “(ii) DEFINITIONS.—For purposes of
24 this subsection:

1 “(I) READMISSION.—The term
2 ‘readmission’ means a readmission
3 that satisfies the criteria described in
4 clause (i)(V).

5 “(II) DOCUMENTED.—The term
6 ‘documented’ means, with respect to a
7 readmission or discharge (as applica-
8 ble) of an individual entitled to bene-
9 fits under part A, that the cir-
10 cumstances of such readmission or
11 discharge are documented in the med-
12 ical record of the individual.

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

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

1 “(i) The methodology shall provide—

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

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

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

1 has been certified by an entity with a con-
2 tract under section 1890(a).

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

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

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

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

23 “(ii) The methodology shall be clini-
24 cally credible and explicitly account for the
25 severity of illness, chronic illness burden,

1 and extensive comorbid diseases and high
2 severity of illness of patients.

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

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

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

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

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

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

4 “(vii) The Secretary may select pro-
5 prietary methodologies that meet the cri-
6 teria in clauses (i) through (vi).

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

15 “(7) REPORTING BY SECRETARY.—

16 “(A) REPORTS TO HOSPITALS.—For each
17 data collection period that is with respect to an
18 applicable prospective period beginning on or
19 after October 1, 2017, the Secretary shall pro-
20 vide to each applicable hospital, not later than
21 the first day of such applicable prospective pe-
22 riod, a confidential report with respect to the
23 potentially-avoidable outcomes of such hospital
24 during such data collection period.

“(B) REPORTS TO PUBLIC.—For each data collection period that is with respect to an applicable prospective period described in paragraph (1), the Secretary shall, not later than 90 days after the first day of such applicable prospective period, make available to the public (including by posting on the Hospital Compare Web site) in an easily understandable format information regarding the performance of each applicable hospital during such data collection period with respect to potentially-avoidable outcomes.

“(8) DEFINITIONS.—In this subsection:

“(A) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means a subsection (d) hospital.

“(B) DATA COLLECTION PERIOD.—The term ‘data collection period’ means, with respect to an applicable prospective period, a period specified by the Secretary that is the most recent period for which data are available for purposes of determining the potentially-avoidable outcome adjustment factor described in paragraph (2) to be applied for such applicable prospective period.

1 “(C) APPLICABLE PROSPECTIVE PERIOD.—

2 The term ‘applicable prospective period’ means
3 a fiscal year.

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

9 (b) CONFORMING AMENDMENTS.—

10 (1) RELATIONSHIP TO EXISTING PAYMENTS.—

11 Section 1886(o) of the Social Security Act (42
12 U.S.C. 1395ww(o)) is amended—

13 (A) in paragraph (6)(A), by inserting “and
14 before application of subsection (t)” after
15 “(7)(B)(i)”; and

16 (B) in paragraph (7)(B)(i), by inserting “,
17 before application of subsection (t),” after “The
18 Secretary shall”.

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

22 (A) in paragraph (1), by inserting “(before
23 fiscal year 2018)” after “a subsequent fiscal
24 year”; and

1 (B) in paragraph (5), by inserting “(before
2 fiscal year 2018)” after “each subsequent fiscal
3 year”.

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

7 (A) in paragraph (1), by inserting “and
8 ending before October 1, 2017” after “October
9 1, 2012,”;

10 (B) in paragraph (3)(C)(iii), by inserting
11 “before fiscal year 2018” after “and subsequent
12 fiscal years”; and

13 (C) in paragraph (5)(B), by inserting “and
14 ending with fiscal year 2017” after “fiscal year
15 2015”.

○