

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> 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.

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## 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.

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          TIALY 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 aggreg-  
20 ate 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 geographic 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          TIALY 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-

1           tion of a State Medicaid program or a major  
2           payer or be certified by an entity with a con-  
3           tract under section 1890(a).

4           “(E) Be open, transparent, and available  
5           for review and comment.

6           “(F) To the extent possible, be in the pub-  
7           lic domain.

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

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

20                 “(A) The methodology is comprehensive  
21                 with a uniform structure.

22                 “(B) The methodology is clinically mean-  
23                 ingful and explicitly recognize severity of illness,  
24                 chronic illness burden, and patients with exten-  
25                 sive 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-

1 comes' means inpatient potentially preventable com-  
2 plications under subsection (e)(2), potentially pre-  
3 ventable readmissions under subsection (f)(2), poten-  
4 tially preventable admissions under subsection  
5 (g)(2), potentially preventable emergency room visits  
6 under subsection (h)(2), and potentially preventable  
7 outpatient procedures and tests under subsection  
8 (i)(2).”.

9 (b) REPORTING OF POTENTIALLY PREVENTABLE  
10 OUTCOMES.—

11 (1) REPORTING TO HEALTHCARE DELIVERY OR-  
12 GANIZATIONS.—For each applicable historical pe-  
13 riod, the Secretary of Health and Human Services  
14 (in this section referred to as the “Secretary”) shall  
15 provide confidential reports to applicable healthcare  
16 delivery organizations with respect to potentially pre-  
17 ventable outcomes. The confidential reports shall be  
18 provided to a healthcare delivery organization at  
19 least 90 days before the date of their release to the  
20 public regarding potentially preventable outcomes of  
21 the healthcare delivery organization.

22 (2) REPORTING HEALTH DELIVERY ORGANIZA-  
23 TION SPECIFIC INFORMATION.—

24 (A) IN GENERAL.—The Secretary shall  
25 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-

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

3 (2) ELIGIBLE HEALTHCARE DELIVERY ORGANI-  
4 ZATION.—For purposes of this subsection for a fis-  
5 cal year, an eligible healthcare delivery organization  
6 is an applicable healthcare delivery organization that  
7 has a healthcare delivery organization-specific ad-  
8 justment factor for the fiscal year (as determined  
9 under section 1899B(a)(2) of the Social Security  
10 Act, as added by subsection (a)), that is lower than  
11 the healthcare delivery organization-specific adjust-  
12 ment factor (under such section) for 75 percent of  
13 all other healthcare delivery organizations in such  
14 fiscal year.

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

17 (4) LIMITATIONS.—

18 (A) USE OF GRANT FUNDS.—A healthcare  
19 delivery organization that applies for and re-  
20 ceives a grant under this subsection shall use  
21 such grant to implement processes that lower  
22 the rate of potentially preventable outcomes.

23 (B) TERM OF GRANT.—Grants under this  
24 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).

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