I

115TH CONGRESS
1ST SESSION

H. R. 3611

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

IN THE HOUSE OF REPRESENTATIVES

JULY 28, 2017

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

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A BILL

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

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

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Healthcare Outcomes Act of 2017''.

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

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

rity Act, as added by section 3008 of the Patient Protection and Affordable Care Act, are based on a limited number of hospital acquired conditions but are applied to all Medicare inpatient prospective payments to a hospital (as defined in section 1886(d) of the Social Security Act), resulting in payment penalties that are not proportional to the financial impact of the hospital acquired conditions. The method of risk adjustment used to determine the hospital acquired conditions performance of hospitals does not adequately account for the chronic illness burden and severity of illness of Medicare beneficiaries.

(2) Payment penalties for hospital readmissions under section 1886(q) of the Social Security Act, as added by section 3025 of the Patient Protection and Affordable Care Act, are based on a limited number of clinical conditions, including readmissions that are not related to the prior discharge and are not proportional to the overall financial impact of the readmission performance of the hospital. The method of risk adjustment used to determine the readmission performance of hospitals does not adequately account for the chronic illness burden and severity of illness of Medicare beneficiaries.

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

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

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

potentially-avoidable outcomes, including potentially-avoidable complications, potentially-avoidable readmissions, potentially-avoidable return emergency room visits and post-acute case episode expenditures, be based on the risk adjusted comparison of the potentially-avoidable outcomes for a hospital to nationwide average rates and include both payment penalties and bonuses that are proportional to the actual financial impact of the potentially-avoidable outcomes.

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

SEC. 2. HOSPITAL OUTCOMES.

(a) PAYMENT ADJUSTMENTS FOR HOSPITAL OUTCOMES.—Section 1886 of the Social Security Act (42

U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(t) HOSPITAL OUTCOMES.—

"(1) IN GENERAL.—In the case of an applicable hospital for an applicable prospective period beginning on or after October 1, 2018—

"(A) for each discharge of such hospital occurring during such period, in addition to and after application of any increase under paragraph (6) of subsection (o) and any adjustment under paragraph (7) of such subsection to the base operating DRG payment amount (as defined in paragraph (7)(D) of such subsection) that would otherwise apply to such hospital during such period without application of this subsection, such operating DRG payment amount shall be adjusted by the value based outcome adjustment factor described in paragraph (2) for the hospital for such period; and

"(B) the value based outcome adjustment factor shall apply only with respect to the applicable prospective period, and the Secretary shall not take into account such adjustment factor in making payments to hospitals under this sec-

tion in a subsequent applicable prospective period.

"(2) VALUE BASED OUTCOME ADJUSTMENT FACTOR.—

"(A) IN GENERAL.—For purposes of paragraph (1), the value based outcome adjustment factor described in this paragraph for an applicable hospital for an applicable prospective period, subject to subparagraph (B), is equal to 1.0 minus the value based outcome performance fraction determined under paragraph (3) for the hospital and period.

"(B) HOSPITAL-SPECIFIC CAP AND FLOOR.—In no circumstance may the value based outcome adjustment factor for an applicable hospital for an applicable prospective period under subparagraph (A) be—

"(i) for applicable prospective periods occurring in fiscal years 2019 through 2022, less than 0.97 or more than 1.03; and

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

''(3) DETERMINATION OF VALUE BASED OUTCOME PERFORMANCE FRACTION.—

''(A) IN GENERAL.—The value based outcome performance fraction for an applicable hospital for an applicable prospective period, subject to subparagraph (C), is equal to the ratio of—

''(i) the total hospital-specific financial impact, as defined in subparagraph (B), for the hospital and data collection period with respect to such applicable prospective period; to

''(ii) the aggregate amount of standardized hospital payments (as defined in paragraph (4)(H)(ii)(I)) made to the hospital during the data collection period with respect to such applicable prospective period.

''(B) TOTAL HOSPITAL-SPECIFIC FINANCIAL IMPACT DESCRIBED.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the term 'total hospital-specific financial impact' means, with respect to a hospital for an applicable prospective period, the sum, subject to clause

(ii), of the financial impacts determined in accordance with paragraph (4)(G) for such hospital and data collection period with respect to each performance category described in paragraph (5).

"(ii) PERFORMANCE CATEGORY CONTRIBUTION UPPER LIMIT.—

"(I) IN GENERAL.—In the case that the financial impact for such a performance category, as determined in accordance with paragraph (4)(G) for a hospital and hospital data collection period, exceeds the amount calculated under subclause (II) with respect to such hospital and period, the Secretary shall, in applying clause (i) with respect to such hospital and period, substitute the amount calculated under such subclause for the financial impact that is so determined with respect to such performance category.

"(II) CALCULATION OF AMOUNT.—The Secretary shall, with respect to a hospital for an applicable prospective period, calculate an

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

''(C) BUDGET NEUTRALITY OF VALUE BASED OUTCOME ADJUSTMENT FACTOR ACROSS ALL HOSPITALS.—The Secretary shall determine a budget neutrality reduction fraction that, when applied in paragraph (4)(B)(ii), will result in a value based outcome adjustment factor determined under subparagraph (A) for an applicable prospective period that reduces the total payments under subsection (d) across all applicable hospitals and all potentially-avoidable outcomes for such period by an amount equal to the reduction in payments under such subsection for such period that would have resulted from the application of subsections (d)(4)(D), (o), (p), and (q) if the amendments made by the Healthcare Outcomes Act of 2017 had not applied.

''(4) PROCESS FOR DETERMINING FINANCIAL IMPACTS.—For purposes of paragraph (3), the Secretary shall, for each performance category described in paragraph (5) and each data collection period that is with respect to an applicable prospective period beginning on or after October 1, 2018, determine each of the following:

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

''(i) the number of discharges occurring among (or, in the case of the performance category described in paragraph (5)(D), the total amount of standardized post acute care episode expenditures made with respect to) all applicable hospitals during such applicable data collection period that are with respect to such risk category and that involve the potentially-avoidable outcomes in such performance category; to

''(ii) the number of applicable discharges among all applicable hospitals for such applicable data collection period and risk category.

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

"(i) subject to subparagraph (H), the applicable ratio determined under subparagraph (A) for such period and risk category; and

"(ii) the budget neutrality reduction fraction determined under paragraph (3)(C) for such period.

"(C) HOSPITAL-SPECIFIC ACTUAL NUMBER.—With respect to each applicable hospital and each such risk category, the number of discharges (or, in the case of the performance category described in paragraph (5)(D), the total amount of standardized post acute care episode expenditures) occurring with respect to such hospital during such applicable data collection period that involve (or, in the case of such performance category, that are with respect to) the potentially-avoidable outcomes in such performance category.

"(D) HOSPITAL-SPECIFIC EXPECTED NUMBER.—With respect to each applicable hospital, each applicable data collection period, and each

such risk category, the number that is the product of—

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

"(ii) the number of applicable discharges of the hospital for such period and risk category.

"(E) HOSPITAL-SPECIFIC POTENTIALLY-AVOIDABLE OUTCOME PERFORMANCE.—With respect to each applicable hospital and applicable data collection period, the difference between—

"(i) the sum of the numbers determined under subparagraph (C) for the hospital for such period for all risk categories; and

"(ii) the sum of the numbers determined under subparagraph (D) for the hospital for such period for all risk categories.

"(F) FINANCIAL IMPACT.—

"(i) With respect to each applicable hospital and applicable data collection period, the financial impact attributable to

potentially-avoidable outcomes performance within such performance category, determined as the product of the following:

''(I) the difference calculated under subparagraph (E) for such hospital and period; and

''(II) the financial conversion factor determined in accordance with clause (ii) for the performance category.

''(ii) FINANCIAL CONVERSION FACTORS.—For purposes of clause (i), the Secretary shall determine a financial conversion factor for the performance category that—

''(I) in the case of the performance category described in paragraph (5)(A), is, with respect to inpatient hospital services that are furnished with respect to a discharge, equal to the average amount of increase in the standardized payments for such inpatient hospital services for such discharge that is attributable to the potentially-avoidable complication;

"(II) in the case of the performance category described in paragraph (5)(B), is, with respect to an initial discharge, equal to the average standardized payment for inpatient hospital services that are furnished with respect to a potentially-avoidable readmission following the initial discharge;

"(III) in the case of the performance category described in paragraph (5)(C), is, with respect to an initial discharge, equal to the average standardized payment for hospital emergency room services that are furnished with respect to a potentially-avoidable return emergency room visit following the initial discharge; and

"(IV) in the case of the performance category described in paragraph (5)(D), is equal to 1.0.

"(G) DEFINITIONS.—For purposes of this section:

"(i) POTENTIALLY-AVOIDABLE OUTCOMES.—The term 'potentially-avoidable outcomes' means, as applicable—

''(I) a potentially-avoidable complication within the category described in paragraph (5)(A);

''(II) a potentially-avoidable readmission within the category described in paragraph (5)(B);

''(III) a potentially-avoidable emergency room visit within the category described in paragraph (5)(C); and

''(IV) post-acute care episode expenditures within the category described in paragraph (5)(D).

''(ii) STANDARDIZED PAYMENTS.—

''(I) STANDARDIZED HOSPITAL PAYMENT.—The term 'standardized hospital payment' means payment for inpatient hospital services under section 1886(d) furnished by an applicable hospital that is adjusted to remove payment adjustments that are not directly related to the amount and type of services to be utilized for patient care (such as local or regional price differences, graduate indirect medical

education payments, disproportionate share payments, and such other adjustments as may be determined by the Secretary).

''(II) STANDARDIZED POST-ACUTE CARE EPISODE EXPENDITURES.—The term 'standardized post-acute care episode expenditures' means post-acute care episode expenditures, adjusted to remove any payment adjustments not directly related to the amount and type of services to be utilized for patient care (such as adjustments for local or regional price differences).

''(iii) APPLICABLE DISCHARGES.—With respect to an applicable data collection period and risk category, the term 'applicable discharges' means, in the case of—

''(I) the performance category described in paragraph (5)(A), discharges occurring during such applicable data collection period that are with respect to such risk category; and

''(II) the performance category described in paragraph (5)(B), discharges occurring during such applicable data collection period that are with respect to such risk category and that are not identified as potentially-avoidable readmissions under the methodology selected under paragraph (6)(A).

''(iv) DOCUMENTED.—The term 'documented' means, with respect to a readmission or discharge (as applicable) of an individual entitled to benefits under part A, that the circumstances of such readmission or discharge are documented in the medical record of the individual.

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

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

"(i) develop groups of hospitals based on the overall proportion of inpatients in such hospitals who are full-benefit dual eligible individuals (as defined in section 1935(c)(6));

"(ii) determine, with respect to each such group and each risk category specified under paragraph (6)(B), the ratio of—

"(I) the number of discharges occurring among (or, in the case of the performance category described in paragraph (5)(D), the total amount of standardized post acute care episode expenditures made with respect to) all applicable hospitals in such group during such applicable data collection period that are with respect to such risk category and that involve the potentially-avoidable outcomes in such performance category; to

"(II) the number of applicable discharges occurring among (or, in

the case of the performance category described in paragraph (5)(D), the total amount of standardized post acute care episode expenditures made with respect to) all applicable hospitals in such group for such applicable data collection period and risk category;

''(iii) treat each reference in this paragraph to the ratio determined under subparagraph (A) for a period and risk category as a reference to the ratio determined under clause (ii) for a group, period, and risk category; and

''(iv) treat each reference in this paragraph to the product determined under subparagraph (B) for a period and risk category as a reference to the ratio determined under such subparagraph for a group, period, and risk category.

''(5) PERFORMANCE CATEGORIES DESCRIBED.—The performance categories described in this paragraph are the following:

''(A) POTENTIALLY-AVOIDABLE COMPLICATIONS.—The performance category of complica-

tions (referred to in this section as 'potentially-avoidable complications') that, with respect to items and services furnished to an individual entitled to benefits under part A in an applicable hospital, meet all of the following requirements:

"(i) The complication occurs during the stay of the individual and was not present at the time of the admission of such individual to such hospital as an inpatient.

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

"(iii) The complication is potentially avoidable with adequate care and treatment.

"(iv) The complication is not a natural progression of the underlying illnesses of the individual that are present on admission of such individual to such hospital.

"(v) The complication may be reasonably construed as related to the care ren-

dered during the stay of the individual at the hospital.

''(B) POTENTIALLY-AVOIDABLE READMISSIONS.—

''(i) IN GENERAL.—The performance category of readmissions (referred to in this section as 'potentially-avoidable readmissions') of individuals entitled to benefits under part A to any hospitals following a discharge (referred to in this section as an 'initial discharge') of such individuals to an applicable hospital if the initial discharge and readmission involved satisfy all of the following requirements:

''(I) The readmission of the individual could reasonably have been prevented by—

''(aa) the provision of appropriate care during the episode of care ending in such initial discharge that was consistent with accepted standards;

''(bb) adequate discharge planning with respect to such initial discharge;

"(cc) adequate post-discharge follow-up with respect to such initial discharge; or

"(dd) improved coordination between the providers furnishing the inpatient or outpatient hospital services during the episode of care ending in such initial discharge and the providers furnishing care during the post-discharge period with respect to such initial discharge.

"(II) The readmission is for a condition or procedure related to the episode of care ending in such initial discharge, including a readmission for a condition or procedure that is any of the following:

"(aa) The same (or a closely related) condition or procedure as the condition addressed in, or the procedure provided during the episode of care ending in such initial discharge.

"(bb) An infection or other complication of care provided during the episode of care ending in such initial discharge.

"(cc) A condition or procedure indicative of a failed procedure provided during the episode of care ending in such initial discharge.

"(dd) An acute decompensation of a coexisting chronic disease that was precipitated by the care furnished during the episode of care ending in such initial discharge.

"(III) The readmission is not a documented readmission with respect to a documented discharge that was initiated by the individual contrary to medical advice provided to such individual during the episode of care with respect to such initial discharge.

"(IV) The readmission could not reasonably be considered a planned readmission.

"(V) The readmission occurs during the 30-day period following an inpatient discharge of such an individual from the applicable hospital with respect to such initial discharge.

"(VI) The readmission was not due to a traumatic injury that occurred after the episode of care ending in such initial discharge.

"(VII) The readmission does not fall under such other exclusions as the Secretary determines appropriate.

"(ii) READMISSION CHAINS.—For purposes of this subsection, in the case that an individual has multiple readmissions with respect to an initial discharge that, but for the application of this clause, would be considered potentially-avoidable readmissions with respect to such initial discharge, the following shall apply:

"(I) Only one of such readmission may be considered a potentially-avoidable readmission with respect to such initial discharge.

"(II) None of such readmissions may be considered a new initial discharge for purposes of this subsection.

"(C) POTENTIALLY-AVOIDABLE RETURN EMERGENCY ROOM VISITS.—The performance category of return emergency room visits (referred to in this section as 'potentially-avoidable return emergency room visits') of individuals entitled to benefits under part A to any hospitals following a discharge (referred to in this section as an 'initial discharge') of such individuals to an applicable hospital if the initial discharge and return emergency room visit involved would satisfy the requirements described in subclauses (I), (II), (III), (V), (VI), and (VII) if—

"(i) the references in such subclauses to readmissions instead were references to return emergency room visits; and

"(ii) the reference in such subclause (V) to a 30-day period instead were a reference to a 15-day period.

"(D) POST-ACUTE CARE EPISODE EXPENDITURES.—

"(i) IN GENERAL.—The performance category, in the case of individuals entitled to benefits under part A and enrolled in part B who are discharged from an applicable hospital (referred to in this section as an 'initial discharge'), of expenditures (referred to in this section as 'post-acute care episode expenditures') that are made (including any cost-sharing amounts expended by the individual) with respect to items and services furnished to such individuals for which payment is made under this title and that are so furnished during the respective post-acute care episode periods applicable to such individuals, subject to clause (ii), if the initial discharge and individual (as applicable) satisfy all of the following requirements:

"(I) The initial discharge is assigned to an applicable DRG (as defined in clause (iii)).

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

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

''(III) The individual did not have a readmission that is not a potentially-avoidable readmission during the post-acute care episode period that is with respect to the initial discharge.

''(IV) The initial discharge was not a documented discharge that was initiated by the individual contrary to medical advice provided to such individual during the episode of care with respect to such initial discharge.

''(V) Such other requirements as the Secretary may specify.

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

''(I) Expenditures that are with respect to readmissions of an individual that occur during the 30-day period following an inpatient discharge of such an individual.

"(II) Expenditures that are with respect to return emergency room visits of an individual that occur during the 15-day period following an inpatient discharge of such an individual.

"(III) Such other expenditures as may be specified by the Secretary.

"(iii) ADDITIONAL DEFINITIONS.—

"(I) APPLICABLE DRG.—For purposes of clause (i)(I), the term 'applicable DRG' means a diagnosis-related group (including, as applicable, a sub-categorization of a diagnosis-related group) for which there is a reasonable expectation that the pattern of post-acute care expenditures is stable and predictable based on the reason for the initial discharge.

"(II) POST-ACUTE CARE EPISODE PERIOD.—

"(aa) IN GENERAL.—For purposes of clause (i), the term 'post-acute care episode period' means, with respect to an initial discharge of an individual and

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

''(bb) NO OVERLAP OF PERIODS.—For purposes of this subsection, an individual may not be considered, at any one time, to be within more than one post-acute care episode.

''(6) SELECTION OF METHODS FOR IDENTIFYING POTENTIALLY-AVOIDABLE OUTCOMES AND METHOD OF RISK ADJUSTMENT.—

''(A) METHODS FOR IDENTIFYING POTENTIALLY-AVOIDABLE OUTCOMES.—The Secretary shall select a methodology for identifying potentially-avoidable complications and a methodology for identifying potentially-avoidable readmissions, and shall specify the circumstances under which such complications and such readmissions would be considered potentially avoidable. Each such methodology shall meet the following criteria:

''(i) The methodology shall provide—

"(I) in the case of potentially-avoidable complications, a comprehensive identification of all conditions that could reasonably be considered a complication of care that meets the requirements under paragraph (5)(A) to be included as a potentially-avoidable complication; and

"(II) in the case of potentially-avoidable readmissions, a comprehensive identification of all initial discharges described in paragraph (5)(B) and corresponding readmissions described in such paragraph that each meet the requirements for such readmission to be included as a potentially-avoidable readmission.

"(ii) To the extent possible, the methodology shall be a methodology that has been successfully implemented for the purpose of adjusting payments to hospitals by a State plan under title XIX or by a major commercial payer or be a methodology that has been certified by an entity with a contract under section 1890(a).

''(iii) The methodology shall be open, transparent, and available for review and comment by the public.

''(iv) The Secretary may select proprietary methodologies that meet the criteria in clauses (i) through (iii).

''(B) SELECTION CRITERIA FOR METHOD OF RISK ADJUSTMENT.—For purposes of paragraph (4), the Secretary shall, with respect to each category described in a subparagraph of paragraph (5), select a methodology for specifying risk categories and for assigning individuals entitled to benefits under part A to such categories, and shall so specify such risk categories and so assign such individuals to such categories. Each such methodology shall meet the following criteria:

''(i) The methodology shall result in an exhaustive and mutually exclusive list of risk categories.

''(ii) The methodology shall be clinically credible and explicitly account for the severity of illness, chronic illness burden, and extensive comorbid diseases and high severity of illness of patients.

''(iii) The methodology shall account for patient characteristics that may impact access to care.

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

''(I) in the case of potentially-avoidable complications, hospital admission; and

''(II) in the case of potentially-avoidable readmissions, hospital discharge with respect to the initial discharge.

''(v) To the extent possible, the methodology shall be a methodology that has been successfully implemented for the purpose of adjusting payments to hospitals by a State plan under title XIX or by a major commercial payer or be a methodology that has been certified by an entity with a contract under section 1890(a).

''(vi) The methodology shall be open, transparent, and available for review and comment by the public.

''(vii) The Secretary may select proprietary methodologies that meet the criteria in clauses (i) through (vi).

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

''(7) REPORTING BY SECRETARY.—

''(A) REPORTS TO HOSPITALS.—For each data collection period that is with respect to an applicable prospective period beginning on or after October 1, 2018, the Secretary shall provide to each applicable hospital, not later than the first day of such applicable prospective period, a confidential report with respect to the potentially-avoidable outcomes of such hospital 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.

''(C) APPLICABLE PROSPECTIVE PERIOD.—The term 'applicable prospective period' means a fiscal year.

''(9) LIMITATION ON JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of a potentially-avoidable outcome adjustment factor applied under this section.''.

(b) CONFORMING AMENDMENTS.—

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

(A) in the heading, by inserting ''AND END WITH FISCAL YEAR 2018'' after ''2013''; and

(B) by adding '', and before October 1, 2018'' before the period at the end.

(2) SUNSETTING EXISTING ADJUSTMENT FOR COMPLICATIONS.—Section 1886(p) of the Social Security Act (42 U.S.C. 1395ww(p)) is amended—

(A) in paragraph (1), by inserting ''(before fiscal year 2019)'' after ''a subsequent fiscal year''; and

(B) in paragraph (5), by inserting ''(before fiscal year 2019)'' after ''each subsequent fiscal year''.

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

(A) in paragraph (1), by inserting ''and ending before October 1, 2018'' after ''October 1, 2012,'';

(B) in paragraph (3)(C)(iii), by inserting ''before fiscal year 2019'' after ''and subsequent fiscal years''; and

(C) in paragraph (5)(B), by inserting ''and ending with fiscal year 2018'' after ''fiscal year 2015''.

(4) SUNSETTING EXISTING ADJUSTMENT FOR CERTAIN HOSPITAL ACQUIRED INFECTIONS.—Section 1886(d)(4)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)) is amended by inserting ''and before October 1, 2018'' after ''2008,''.

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