

**SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.**

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

“(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

“(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of—**[As revised by section 10309]**

“(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

“(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

“(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

“(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

“(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

“(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

“(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

“(3) ADJUSTMENT FACTOR.—

“(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

“(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

“(ii) the floor adjustment factor specified in subparagraph (C).

“(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

“(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

“(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

“(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

“(i) fiscal year 2013 is 0.99;

“(ii) fiscal year 2014 is 0.98; or

“(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

“(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

“(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term ‘aggregate payments for excess readmissions’ means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

“(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

“(ii) the number of admissions for such condition for such hospital for such applicable period; and

“(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

“(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term ‘aggregate payments for all discharges’ means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

“(C) EXCESS READMISSION RATIO.—

“(i) IN GENERAL.—Subject to clause (ii), the term ‘excess readmissions ratio’ means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

“(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

“(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

“(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

“(5) DEFINITIONS.—For purposes of this subsection:

“(A) APPLICABLE CONDITION.—The term ‘applicable condition’ means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

“(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

“(ii) measures of such readmissions—

“(I) have been endorsed by the entity with a contract under section 1890(a); and

“(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior

discharge (such as a planned readmission or transfer to another applicable hospital).

“(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(C) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

“(D) APPLICABLE PERIOD.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify.

“(E) READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

“(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

“(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

“(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

“(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The determination of base operating DRG payment amounts.

“(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

“(C) The measures of readmissions as described in paragraph (5)(A)(ii).

“(8) READMISSION RATES FOR ALL PATIENTS.—

“(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

“(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

“(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—

“(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

“(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

“(D) DEFINITIONS.—For purposes of this paragraph:

“(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

“(ii) The term ‘specified hospital’ means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.”.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

